STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155278	A. BUILDING -- B. WING	07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - BLOOMINGTON CARE CENTER	155 E BURKS DR BLOOMINGTON, IN 47401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 07/07/22 Facility Number: 000177 Provider Number: 155278 AIM Number: 100289860 At this Emergency Preparedness survey, Brickyard HealthCare - Bloomington Care Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 153 certified beds. At the time of the survey, the census was 124. Quality Review completed on 07/13/22	E 0000	The submission of this Plan of Correction, for survey event ID NPFE21, does not indicate an admission by Bloomington Care Center that the findings and allegations contained herein are an accurate and true depiction of the quality of care and services provided to the residents of Bloomington Care Center. The Facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The Facility hereby maintains it is in substantial compliance with the requirements of participation for Comprehensive Health Care Facilities. To this end, this Plan of Correction shall serve as a credible allegation of compliance with all state and federal requirements governing the management of this Facility. It is thus submitted as a matter of statute only. We are requesting paper compliance for this survey.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).	K 0000	The submission of this Plan of Correction, for survey event ID NPFE21, does not indicate an admission by Bloomington Care Center that the findings and	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Survey Date: 07/07/22 Facility Number: 000177 Provider Number: 155278 AIM Number: 100289860 At this Life Safety Code survey, Brickyard HealthCare -Bloomington Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility with a partial basement was determined to be of Type II (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor and in all areas open to the corridor. The facility has battery operated smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 153 and had a census of 124 at the time of this survey. The Horizon Corridor containing resident rooms 17-38 was not surveyed because of a COVID 19 outbreak and isolation within the quarantined Horizon Wing. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 07/13/22		allegations contained herein are an accurate and true depiction of the quality of care and services provided to the residents of Bloomington Care Center. The Facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The Facility hereby maintains it is in substantial compliance with the requirements of participation for Comprehensive Health Care Facilities. To this end, this Plan of Correction shall serve as a credible allegation of compliance with all state and federal requirements governing the management of this Facility. It is thus submitted as a matter of statute only. We are requesting paper compliance for this survey.	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors			

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	Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door			

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	assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	Based on observation and interview, the facility failed to ensure the means of egress through the 100 Hall exit was readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 25 staff and visitors if needing to exit the facility. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director on 07/07/22 between 11:30 a.m. and 2:00 p.m., the	K 0222	**K 222 = E** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents or visitors were affected by the alleged deficient practice. The exit code was place at the cited corridor exit door. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;**	07/25/2022

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	facility corridor exit door near resident room 143, marked as a facility exit, was magnetically locked and could be opened by entering a four digit code but the code was not posted at the exit. The Maintenance Director commented that the code was likely painted over. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Administrator present. 3.1-19(b)		All residents and visitors have the potential to be affected by the alleged deficient practice. No other resident or visitors were noted to be affected by the alleged deficient practice. All corridor exit doors were reviewed and had exit codes posted. The policy title “Means of Egress—Corridors and Exits” (Exhibit A) was reviewed and no changes were made. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Maintenance Staff were educated on the on the policy titled “Means of Egress—Corridors and Exits” (Exhibit A). **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance will be put into place; and** An audit tool titled “2022 Life Safety Audits” (Exhibit F) will be utilized to monitor compliance. The Maintenance Director or designee will complete the audit weekly for two months, bimonthly for two months, and monthly for two months. This audit will be reviewed in QAPI for 6 months and at the end of 6 months of 90%	

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			compliance is achieved the audits will be complete. If compliance is not achieved in 6 months, then the QAPI Committee will continue to monitor monthly until 90% compliance is achieved. **By what date the systemic changes for each deficiency will be completed. After submitting an acceptable plan of correction, it is determined that the correction will not be completed by the date previously submitted, The Division need to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date;** **7/25/2022**	
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility failed to ensure 1 of 3 courtyard doors to the outside of the facility were not mistaken as a facility exit. LSC 7.10.8.3.1 states any door,	K 0293	**K 293 = E** **What corrective action(s) will be accomplished for those residents found to have been**	07/25/2022

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	passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT. The NO EXIT sign shall have the word NO in letters 2 inches high, with a stroke width of 3/8ths inch, and the word EXIT below the word NO, unless such sign is an approved existing sign. This deficient practice could affect 25 residents. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director on 07/07/22 between 11:30 a.m. and 2:00 p.m., (1) in the Reminiscent dining area the door to the outside courtyard and (2) the Therapy Exit sliding door were not exit doors and the doors were not posted with a "NO EXIT" sign. Based on interview at the time of the observations, the Director of Maintenance stated the courtyard and the therapy sliding doors are not exits to the public way and acknowledged the aforementioned doors did not have a "NO EXIT" sign posted. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Administrator present. 3.1-19(b)		**affected by the deficient practice;** No Residents were affected by the alleged deficient practice. A new "NO EXIT" sign was placed upon the courtyard door cited. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents have the potential to be affected by the alleged deficient practice. No other residents were affected by the alleged deficient practice. No other doors were found to be out of compliance. The policy titled "Means of Egress—Corridors and Exits" (Exhibit A) was reviewed with no changes. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Maintenance Staff were educated on the policy title "Mean of Egress—Corridors and Exits" (Exhibit A). **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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			assurance will be put into place; and An audit tool titled “2022 Life Safety Audits” (Exhibit F) will be utilized to determine compliance. The Maintenance Director or designee will complete the audit weekly for two months, bimonthly for two months, and monthly for two months. This audit will be reviewed in QAPI for 6 months and at the end of 6 months of 90% compliance is achieved the audits will be complete. If compliance is not achieved in 6 months, then the QAPI Committee will continue to monitor monthly until 90% compliance is achieved. **By what date the systemic changes for each deficiency will be completed. After submitting an acceptable plan of correction, it is determined that the correction will not be completed by the date previously submitted, The Division need to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date;** **7/25/2022**	
K 0311 SS=E Bldg. 01	NFPA 101 Vertical Openings - Enclosure Vertical Openings - Enclosure			

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	2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. Based on observation and interview, the facility failed to maintain protection of 1 of 2 stairways in accordance of 19.3.1. LSC 19.3.1 requires protection of vertical opening 39.3.1. LSC 19.3.1 requires vertical opening shall be enclosed or protected in accordance with Section 8.6. LSC 8.6.1 requires every floor that separates stories in a building shall be constructed as a smoke barrier. LSC 19.3.1.1 requires where an enclosure is provided, the construction shall have not less than a 1-hour fire resistance rating. This deficient practice could affect 28 residents. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director on 07/07/22 between 11:30 a.m. and 2:00 p.m., the exit stairwell near room 143 had a 10" by 10" hole in the ceiling. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Administrator present. 3.1-19(b)	K 0311	**K 311 = E** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were affected by the alleged deficient practice. The area noted was repaired. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents have the potential to be affected by the deficient practice. No other residents were affected by the alleged deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:**	07/25/2022

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			Maintenance staff were educated on vertical openings (Exhibit B) and the need to repair them once noted. No other areas were noted upon audit. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance will be put into place; and** An audit tool titled “2022 Life Safety Audits” (Exhibit F) will be utilized to determine compliance. The Maintenance Director or his designee will complete the audit weekly for two months, Bimonthly for two months, and monthly for two months. This audit will be reviewed in QAPI for 6 months and at the end of 6 months of 90% compliance is achieved the audits will be complete. If compliance is not achieved in 6 months, then the QAPI Committee will continue to monitor monthly until 90% compliance is achieved. **By what date the systemic changes for each deficiency will be completed. After submitting an acceptable plan of correction, it is determined that the correction will not be completed by the date previously submitted, The Division need to be contacted**	

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			as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date; **7/25/2022**	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is			

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	sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 2 of over 50 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 6 staff and 15 residents. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director on 07/07/22 between 11:30 a.m. and 2:00 p.m., the following corridor doors failed to latch positively into their respective door frames: a) The Basement Laundry Fire Door b) The Basement Central Supply Room This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Administrator present. 3.1-19(b)	K 0363	**K 363 = E** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were affected by the alleged deficient practice. Both door latches were immediately replaced. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents have the potential to be affected by the alleged deficient practice. No residents were affected by the alleged deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:**	07/25/2022

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			Maintenance staff were educated on door latching properly (Exhibit B). **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance will be put into place; and** An audit tool titled “2022 Life Safety Audits” (Exhibit F) will be utilized to determine compliance. The Maintenance Director or designee will complete the audit weekly for two months, bimonthly for two months, and monthly for two months. This audit will be reviewed in QAPI for 6 months and at the end of 6 months of 90% compliance is achieved the audits will be complete. If compliance is not achieved in 6 months, then the QAPI Committee will continue to monitor monthly until 90% compliance is achieved. **By what date the systemic changes for each deficiency will be completed. After submitting an acceptable plan of correction, it is determined that the correction will not be completed by the date previously submitted, The Division need to be contacted as soon as possible. The facility will need to submit an**	

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			amended plan of correction with the updated plan of correction date; **7/25/2022**	
K 0372 SS=D Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 of 2 smoke barriers walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. LSC Section 8.5.2.1 requires smoke barriers to be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof. 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall,	K 0372	**K 372 = E** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were affected by the alleged deficient practice. The ceiling tile was replaced. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;**	07/25/2022

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BRICKYARD HEALTHCARE - BLOOMINGTON CARE CENTER	155 E BURKS DR BLOOMINGTON, IN 47401

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	floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the movement of smoke. This deficient practice could affect 2 staff in the Chart Room. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director on 07/07/22 between 11:30 a.m. and 2:00 p.m., an unsealed penetration was discovered in the smoke barrier drop ceiling in the Chart Room where approximately a 18'X24' of ceiling tile had been removed. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Administrator present. 3.1-19(b)		All residents have the potential to be affected by the alleged deficient practice. No residents were affected by the alleged deficient practice. No other removed ceiling tiles were noted. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Maintenance staff were educated on smoke barriers (Exhibit B) and ensuring ceiling tiles are in place. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance will be put into place; and** An audit tool titled “2022 Life Safety Audits” (Exhibit F) will be utilized to determine compliance. The Maintenance Director or designee will completed the audit weekly for two months, bimonthly for two months, and monthly for two months. This audit will be reviewed in QAPI for 6 months and at the end of 6 months of 90% compliance is achieved the audits will be complete. If compliance is not achieved in 6 months, then the QAPI Committee will continue to monitor monthly until 90% compliance is achieved.	

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			By what date the systemic changes for each deficiency will be completed. After submitting an acceptable plan of correction, it is determined that the correction will not be completed by the date previously submitted, The Division need to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date; **7/25/2022**	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 3 of over 10 wet locations were provided with ground fault circuit interrupter (GFCI) protection against electric shock. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in	K 0511	**K 511 = E** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No Residents or staff were affected by the alleged deficient practice. All 3 cited receptacles were replaced with the GFCI	07/25/2022

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	210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required.		receptacles. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents and staff have the potential to be affected by the alleged deficient practice. No residents or staff were affected by the alleged deficient practice. The policy titled “Electrical Safety” (Exhibit C) was reviewed with no changes made. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance Staff were educated on the policy titled “Electrical Safety” (Exhibit C). **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance will be put into place; and** An audit tool titled “2022 Life Safety Audits” (Exhibit F) will be utilized to determine compliance. The Maintenance Director of designee will utilize the tool weekly for two months, bimonthly	

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	(6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect staff and up to 18 residents in the vicinity of the water machines Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director on 07/07/22 between 11:30 a.m. and 2:00 p.m., the water machines near (1) Station 1 and (2) Station 2 Nurses Stations were connected to an electric receptacle which was being used to power the freestanding water machines, with their own water supply. The water machines were located within 3 feet of the electric receptacle, and not provided with ground fault circuit interruption (GFCI). The Maintenance Director at the time of observation stated he did not believe the receptacles were on a GFCI circuit. Furthermore, (3) the basement sump pumps were submerged in water and connected to a receptacle which was not GFCI protected. The Maintenance Director at the time of observation stated he did not believe the receptacle was on a GFCI circuit. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Administrator present.		for two months, and monthly for two months. This audit will be reviewed in QAPI for 6 months and at the end of 6 months of 90% compliance is achieved the audits will be complete. If compliance is not achieved in 6 months, then the QAPI Committee will continue to monitor monthly until 90% compliance is achieved. **By what date the systemic changes for each deficiency will be completed. After submitting an acceptable plan of correction, it is determined that the correction will not be completed by the date previously submitted, The Division need to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date;** **7/25/2022**	

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	3.1-19(b)			
K 0741 SS=F Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 Based on observation and interview; the facility failed to ensure 2 of 2 smoking areas were maintained by disposing cigarette butts in a metal or noncombustible container with self-closing	K 0741	**K 741 = E** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	07/25/2022

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	cover devices. This deficient practice could affect all staff and residents. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director on 07/07/22 between 11:30 a.m. and 2:00 p.m., the Administrator stated that the facility had two designated smoking areas, one supervised for residents and one separate for staff. During a tour of the facility cigarette butts were observed in multiple locations around the building including immediately outside exit doors, in the mulch, and along the driveway. Next to the Station 2 Exit door, up against the building and the immediate area was populated with 300 plus cigarette butts. The Kitchen back exit door had over 100 cigarette butts on the ground immediately outside the exit door and a metal coffee can was full of cigarette butts near the building. The Maintenance Director agreed there were cigarette butts on the ground in the aforementioned locations around the facility and that smoking was a problem at the facility. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Administrator present. 3.1-19(b)		**practice;** No Residents were affected by the alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All Residents have the potential to be affected by the alleged deficient practice. No residents were affected by the alleged deficient practice. The policy titled "Employee Smoking" (Exhibit D) was reviewed and no changes were made **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** All Employees were educated on the policy titled "Employee Smoking" (Exhibit D), and, educated on the designated areas for smoking. Staff were educated on placing cigarette butts in the proper receptacles located in each designated smoking area. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance will be put into**	

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			place; and The Maintenance Director or designee will utilize the audit tool titled “2022 Life Safety Audits” (Exhibit F) to determine compliance. The audit will be completed weekly for two months, Bimonthly for two months, and monthly for two months. This audit will be reviewed in QAPI for 6 months and at the end of 6 months of 90% compliance is achieved the audits will be complete. If compliance is not achieved in 6 months, then the QAPI Committee will continue to monitor monthly until 90% compliance is achieved. **By what date the systemic changes for each deficiency will be completed. After submitting an acceptable plan of correction, it is determined that the correction will not be completed by the date previously submitted, The Division need to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date;** **7/25/2022**	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens			

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	Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 1. Based on observation and interview, the facility failed to ensure power strips in 5 locations met UL rating of 1363A or 60601-1. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 feet beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 feet 6 inches above the floor. This deficient practice affects 12 resident who reside in resident rooms. Findings include:	K 0920	**K 920 = E** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were affected by the alleged deficient practice. All power strips identified during the survey were immediately removed. **How other residents having the potential to be affected by the same deficient practice will be**	07/25/2022

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	Based on observations and interview during a tour of the facility with the Maintenance Director on 07/07/22 between 11:30 a.m. and 2:00 p.m., the following locations were using power strips outside the patient care vicinity for resident's personal electrical equipment that lacked a UL rating of 1363A or 60601-1 label on each power strip. A) Resident Room # 3 B) Resident Room # 4 C) Resident Room # 2 D) Resident Room # 101 E) Resident Room # 111 This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Administrator present. 2. Based on observation and interview, the facility failed to ensure 1 of 1 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 8 staff in the breakroom. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director on 07/07/22 between 11:30 a.m. and 2:00 p.m., in the basement breakroom a power strip was being used to power a coffee machine (high power draw equipment). The Maintenance Director removed the condition during the survey.		**identified and what corrective action(s) will be taken;** All residents have the potential to be affected by the alleged deficient practice. No residents were affected by the alleged deficient practice. A building sweep was conducted and all power strips in patient care areas and for power strips being used for high draw equipment. No other power strips were noted. The policy titled "Electrical Safety" (Exhibit C) was reviewed with no changes made. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Maintenance staff will be educated on the policy titled "Electrical Safety" (Exhibit C). **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance will be put into place; and** The audit titled "2022 Life Safety Audits" (Exhibit F) will be utilized to determine compliance. The Maintenance Director of his designee will complete the audit weekly for two weeks, bimonthly for two months, and monthly for	

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	This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Administrator present. 3.1-19(b)		two months. This audit will be reviewed in QAPI for 6 months and at the end of 6 months of 90% compliance is achieved the audits will be complete. If compliance is not achieved in 6 months, then the QAPI Committee will continue to monitor monthly until 90% compliance is achieved. **By what date the systemic changes for each deficiency will be completed. After submitting an acceptable plan of correction, it is determined that the correction will not be completed by the date previously submitted, The Division need to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date;** **7/25/2022**	
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable			

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	containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 2 oxygen storage room where oxygen transferring takes place, was provided with properly working mechanical ventilation. NFPA 99 2012 edition, 11.5.2.3.1 (2) requires oxygen transfilling rooms to be mechanically ventilated. Section 9.3.7.5.3.1 requires mechanical exhaust to maintain a negative pressure in the space continuously. This deficient practice could affect up to 21 residents in one smoke compartment. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director on 07/07/22 between 11:30 a.m. and 2:00 p.m., the oxygen storage/transfer room near Station 1 contained large liquid oxygen tanks. There were two vents in the room, but the vents did not contain a mechanically ventilated exhaust fan and it was unclear if either vent terminated to the outside air. Based on interview at the time of observation, the Maintenance Director acknowledged the vents in the oxygen room were not power ventilated stated that he was sure neither vent went to the outside. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Administrator present. 3.1-19(b)	K 0927	**K 927 = E** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No Residents were affected by the alleged deficient practice. The inoperable fan was replaced with an operable fan. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents have the potential to be affected by the deficient practice. No residents were affected by the alleged deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Maintenance staff were educated on Oxygen Storage with an inservice titled “Oxygen Safety—Storage, Handling, and Use” (Exhibit E). **How the corrective action(s)**	07/25/2022

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - BLOOMINGTON CARE CENTER	155 E BURKS DR BLOOMINGTON, IN 47401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance will be put into place; and An audit tool titled “2022 Life Safety Audits” (Exhibit F) will be utilized to determine compliance. The Maintenance Director or designee will complete the audit weekly for two weeks, bimonthly for two months, and monthly for two months. This audit will be reviewed in QAPI for 6 months and at the end of 6 months of 90% compliance is achieved the audits will be complete. If compliance is not achieved in 6 months, then the QAPI Committee will continue to monitor monthly until 90% compliance is achieved. **By what date the systemic changes for each deficiency will be completed. After submitting an acceptable plan of correction, it is determined that the correction will not be completed by the date previously submitted, The Division need to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date;** **7/25/2022**	