STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING -- B. WING	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(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: 07/11/24 Facility Number: 000165 Provider Number: 155264 AIM Number: 100288220 At this Emergency Preparedness survey, Golden Living Center-Golden Rule was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 170 certified beds. At the time of the survey, the census was 77. Quality Review completed on 07/18/24	E 0000	Preparation, submission and implementation of this Plan of Correction does not constitute an admission or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction was prepared and executed as a means to continuously improve the quality of care and comply with all applicable state and federal requirements. The facility respectfully requests a desk review of our responses to 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). Survey Date: 07/11/24 Facility Number: 000165 Provider Number: 155264 AIM Number: 100288220 At this Life Safety Code survey, Golden Living	K 0000	Preparation, submission and implementation of this Plan of Correction does not constitute an admission or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction was prepared and executed as a means to continuously improve the quality of care and comply with all applicable state and federal requirements.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lynn Adams	Executive Director	08/02/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Center-Golden Rule 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 V (000) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery-operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 170 and had a census of 77 at the time of this survey. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility had one large detached storage garage which was not sprinkled. Quality Review completed on 07/18/24		The facility respectfully requests a desk review of our responses to this survey.	
K 0226 SS=E Bldg. 01	NFPA 101 Horizontal Exits Horizontal Exits Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5 Based on observation and interview, the facility failed to ensure 1 of over 6 sets of horizontal exit fire door sets were arranged to automatically close and latch. LSC section 7.2.4.3.10 requires all fire door assemblies in horizontal exits shall be self-closing or automatic-closing. In addition NFPA 80, the Standard for Fire Doors and Other Opening Protectives, section 6.1.4.2.1 states	K 0226	What corrective action will be accomplished for those residents found to be affected by the deficient practice: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	08/02/2024

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	self-closing doors shall swing easily and freely and shall be equipped with a closing device to cause the door to close and latch each time it is opened. This deficiency could affect 26 residents in 2 smoke compartments. Findings include: Based on observations and interviews during a tour of the facility with the Maintenance Director and the Executive Director on 07/11/24 between 12:10 p.m. and 1:45 p.m., the double set of rated fire doors near memory care unit did not close and latch. The aforementioned doors are in a fire wall assembly and a parapet was evident on the roof above the double doors. The MD stated that the doors were in fact part of the firewall and that it was a block firewall from end to end and from floor through the roof. The MD stated that they would need to add latching hardware to the door set similar to the other fire doors throughout the facility. This finding was acknowledged by the ED and MD at the time of discovery and again at the exit conference with both the ED and MD present. 3.1-19(b)		actions will be taken What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur How the corrective actions will be monitors to ensure the deficient practice will not recur, what quality assurance program will be put in place Date of compliance: 8/2/2024	
K 0761 SS=E Bldg. 01	Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of at least 1 fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies.	K 0761	What corrective action will be accomplished for those residents found to be affected by the deficient practice: No residents were affected by this alleged deficient practice. The identified fire door has been inspected and no issues were	08/02/2024

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	(See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame.		identified. The identified door has now been added to the annual inspection list. (Attachment 3) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken All other fire doors throughout the facility have been reviewed to ensure they are included on the annual inspection list. (Attachment 3) 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 Director or his will conduct routine observations of all fire doors to ensure that all fire doors are on the inspection list. The Maintenace Director or his designee will make changes to the inspection list should any additional fire doors be added to the facility. (Attachment 3) How the corrective actions will be monitors to ensure the deficient practice will not recur, what quality assurance program will be put into place The Maintenace Director will present his inspection report of the fire doors monthly during the QAPI meeting and adjustments will be made to the plan based upon the committee recommendations. Date of compliance: 8/2/2024	

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	(10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect 20 residents. Findings include: Based on records review, observation and interview with the Executive Director (ED) and the Maintenance Director (MD) on 07/11/24 between 10:10 a.m. and 1:45: p.m., no documentation of an annual inspection for the fire door assembly at the Oxygen Transfilling room was available for review. Based on observation during the tour the Oxygen Transfilling room has one 90-minute fire door assembly. Based on interview at the time of records review and observation, the MD stated the annual fire door inspection was not completed within the last year and he was not aware it was a fire door. This finding was acknowledged by the ED and MD at the time of discovery and again at the exit conference with both the ED and MD present. 3.1-19(b)			
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens 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			

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	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 Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords power strips powering medical equipment met the required UL rating of 1363A or 60601-1. This deficient practice affects 2 residents. Findings include: Based on observations and interviews during a tour of the facility with the Maintenance Director and the Executive Director on 07/11/24 between 12:10 p.m. and 1:45 p.m., an oxygen concentrator was plugged in to a power strip along with other non-medical electrical components such as a phone charger. Based on interview at the time of observation, the MD agreed an oxygen concentrator was plugged in to a power strip with other non-medical devices. This finding was acknowledged by the ED and MD at the time of discovery and again at the exit conference with both the ED and MD present. 3.1-19(b)	K 0920	What corrective action will be accomplished for those residents found to be affected by the deficient practice: The resident that was identified to be affected by this by this alleged deficient practice has been identified. The identified medical grade surge protector has been observed. The items that are medical are plugged into that surge protector and those that are not medical grade are plugged into another surge protector. (Attachment 4) The resident has been re-educated on the importance of utilizing surge protectors identified for medical use only for medical devices only. How other residents having the potential to be affected by the same deficient practice will be	08/02/2024

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			identified and what corrective actions will be taken All residents currently residing in the facility that utilizes surge protectors have the potential to be affected by this alleged deficient practice. Observational rounds were completed by the Maintenance Director and any issues related to surge protectors identified were corrected. (Attachment 5) What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur The Maintenace Director or his designee will conduct routine observations in resident rooms to ensure if surge protectors are in use that medical devices are not plugged into a surge protector with items that are non-medical. (Attachment 6A and 6B) How the corrective actions will be monitors to ensure the deficient practice will not recur, what quality assurance program will be put in place The Maintenace Director will present said audits during the monthly QAPI meeting and adjustments will be made to the plan based upon the committee recommendations.	

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			Date of compliance: 8/2/2024	