STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155703	A. BUILDING **01** B. WING _____	R **05/14/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE VILLAGE INC	**1111 CHURCH AVE** **JASPER, IN 47546**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 000}	Initial Comments A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 03/27/2024 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.473. Survey Date: 05/14/2024 Facility Number: 003240 Provider Number: 155703 AIM Number: 201274720 At this Post Survey Revisit, Brookside Village Inc. was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has a capacity of 27 certified beds and had a census of 27 at the time of this visit. Quality Review completed on 05/15/24	{E 000}		
{K 000}	INITIAL COMMENTS A Post Survey Revisit (PSR) to the survey which exited on 03/27/2024 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 05/14/2024 Facility Number: 003240 Provider Number: 155703 AIM Number: 201274720 At this Life Safety Code survey, Brookside Village Inc was found in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart	{K 000}		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155703	A. BUILDING **01** B. WING _____	R **05/14/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE VILLAGE INC	**1111 CHURCH AVE** **JASPER, IN 47546**

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{K 000}	Continued From page 1 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), and 410 IAC 16.2. This building was surveyed with Chapter 19 Existing Health Care Occupancies. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors connected to the fire alarm control panel in the corridors, spaces open to the corridors, and all eight resident sleeping rooms on the 200 hall, plus hard wired single station smoke detectors with battery back up in all ten resident rooms in the 300 hall. The facility has a capacity of 27 and had a census of 27 at the time of this survey. All areas where residents have customary access were sprinklered, and all areas providing facility services were sprinklered, except one detached shed used for facility storage. Quality Review completed on 05/15/24	{K 000}		