STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155248	A. BUILDING -- B. WING	02/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - BRENTWOOD CARE CENTER	30 E CHANDLER AVE EVANSVILLE, IN 47713

(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: 02/14/24 Facility Number: 000152 Provider Number: 155248 AIM Number: 100267510 At this Emergency Preparedness survey, Brickyard Healthcare-Brentwood Care Center was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 114 certified beds, with a current census of 86. Quality Review completed on 02/20/24 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000		
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e)			

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

Shelley Brown | Executive Director | 03/06/2024

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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	(e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by			

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	reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October			

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	22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 1 of 1 generator during 11 of the past 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. Chapter 6-4.4.1.3 of 2012 NFPA 99 requires batteries for on-site generators shall be maintained in accordance with NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems. 8.3.7 requires storage batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications. 8.3.7.2 states defective batteries shall be repaired or replaced immediately upon discovery of defects. Chapter 6.5.4.2 of NFPA 99 requires a written record of inspection, performance,	E 0041	**E041 Hospital CAH and LTC Emergency Power** **Date 2/15/2024** **E041---What corrective action was accomplished for the resident found to have been affected by the deficient practice.** Maintenance Director added monthly generator load testing to his monthly tasks. **---How will other residents who may have the potential to be affected be identified?** All residents, staff and visitors have the potential to be affected. **---What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not reoccur.** ·Evapar educated Maintenance Director on how to preform monthly generator load tests. **---How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur and what QA program will be put into place?** Results of life safety issues will be reported by Maintenance/	02/15/2024

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	exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the generator inspection and testing reports on 02/14/24 between 9:45 a.m. and 2:30 p.m. with the Director of Maintenance present, there was no monthly generator load test documentation available for February through December of 2023 for the emergency generator. Based on interview at the time of record review, the Director of Maintenance said he only became aware that a monthly load test was required and added it to the January 2024 schedule. This finding was reviewed with the Executive Director and Director of Maintenance during the exit conference.		designee to QAPI no less than quarterly in perpetuity. **---Systematic changes will be completed by 2/15/2024** **Brentwood is requesting paper compliance for E041**	
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: 02/14/24 Facility Number: 000152 Provider Number: 155248 AIM Number: 100267510 At this Life Safety Code survey, Brickyard Healthcare-Brentwood Care Center was found not in compliance with Requirements for Participation	K 0000		

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	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 was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, plus battery operated smoke alarms in all resident sleeping rooms. The facility has a capacity of 114 and had a census of 86 at the time of this survey. Quality Review completed on 02/20/24			
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors 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			

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	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 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			

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	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 1 of 9 exit doors were 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 at least 10 residents, staff, and visitors. Findings include: Based on observations on 02/14/24 between 2:30 p.m. and 5:00 p.m. during a tour of the facility with the Director of Maintenance, the exit door in the Service Hall was equipped with a magnetic lock that required a code on the adjacent keypad to release and open. The code to open this door was not posted. This was acknowledged by the Director of Maintenance at the time of observation. This finding was reviewed with the Executive Director and Director of Maintenance during the exit conference. 3.1-19(b)	K 0222	**K222 Egress Doors** **Date 2/15/2024** **K222---What corrective action was accomplished for the resident found to have been affected by the deficient practice.** On 2/15/2024 Maintenance Director assessed door and corrected door to egress. **---How will other residents who may have the potential to be affected be identified?** All residents have the potential to be affected. **---What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not reoccur.** ·Maintenance Director educated on ensuring service hall door egresses. **---How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur and what QA program will be put into place?** Results of life safety issues will be reported by Maintenance/ designee to QAPI no less than quarterly in perpetuity. **---Systematic changes will be completed by 2/15/2024** **Brentwood is requesting paper compliance for K222**	02/15/2024

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K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on observation and interview, the facility failed to ensure 1 of 5 battery powered emergency light sets was maintained in accordance with LSC 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. LSC 7.9.2.7 states the emergency lighting system shall be either continuously in operation or shall be capable of repeated automatic operation without manual intervention. This deficient practice could affect all residents, as well as staff and visitors. Findings include: Based on observations on 02/14/24 between 2:30 p.m. and 5:00 p.m. during a tour of the facility with the Director of Maintenance, the battery backup light set at the generator did not illuminate when tested several times. Based on interview at the time of observation, the Director of Maintenance acknowledged the battery backup light set at the generator did not illuminate when tested several times. This finding was reviewed with the Executive Director and Director of Maintenance during the exit conference. 3.1-19(b)	K 0291	**K291 Emergency Lighting Date 2/15/2024** **K291---What corrective action was accomplished for the resident found to have been affected by the deficient practice.** On 2/15/2024 Maintenance Director replaced the battery backup light for the generator. **---How will other residents who may have the potential to be affected be identified?** All residents have the potential to be affected. **---What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not reoccur.** ·Administrator educated Maintenance Director on the importance of ensuring the emergency lights luminate when tested. **---How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur and what QA program will be put into place?** Results of life safety issues will be reported by Maintenance/	02/15/2024

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			designee to QAPI no less than quarterly in perpetuity. **---Systematic changes will be completed by 2/15/2024** **Brentwood is requesting paper compliance for K291**	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 1. Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm system in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all occupants in the facility.	K 0345	**K345 Fire Alarm System-Testing and Maintenance Date 2/28/2024** **K345---What corrective action was accomplished for the resident found to have been affected by the deficient practice.** On 2/19/2024 Tristate Fire replaced missing smoke detector cover cap in the FACP/ sprinkler riser room. On 2/28/2024 Tristate Fire completed a visual and functioning fire alarm system inspection and testing. All devices passed inspection. **---How will other residents who may have the potential to be affected be identified?**	02/28/2024

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	Findings include: Based on record review on 02/14/24 between 9:45 a.m. and 2:30 p.m. with the Director of Maintenance present, there was documentation provided regarding an annual fire alarm system inspection dated 01/25/24 by the facility's fire alarm inspection vendor, however, this report indicated only 39 of the 44 hard wired smoke detectors, 5 of 5 heat detectors, and 1 of 11 pull stations were visually and functionally tested/inspected. The facility did have additional documentation of quarterly fire alarm inspections were the following was noted: a. Report dated 10/19/23 had 9 of 44 hard wired smoke detectors, 5 of 5 heat detectors, and 1 of 11 pull stations were visually and functionally tested/inspected. b. Report dated 07/11/23 had 0 of 44 hard wired smoke detectors, 5 of 5 heat detectors, and 0 of 11 pull stations were visually and functionally tested/inspected. c. Report dated 04/11/23 had 0 of 44 hard wired smoke detectors, 0 of 5 heat detectors, and 11 of 11 pull stations were visually and functionally tested/inspected. The culmination of of all four quarterly reports indicates that all 44 hard wired smoke detectors and all 11 pull stations were only visually and functionally tested once each during the past 12 month period. Based on interview at the time of record review, this was confirmed by the Director of Maintenance who said he would speak with the fire alarm inspection vendor to make sure all devices were visually inspected at least twice per every 12 month period. This finding was reviewed with the Executive		All residents have the potential to be affected. **---What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not reoccur.** ·Administrator educated Maintenance Director on the importance of ensuring Tristate Fire/ designee inspects all devices visually at least twice per every 12 month period and doesn't remove the smoke detector cover cap. **---How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur and what QA program will be put into place?** Results of life safety issues will be reported by Maintenance/ designee to QAPI no less than quarterly in perpetuity. **---Systematic changes will be completed by 2/28/2024** **Brentwood is requesting paper compliance for K345**	

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	Director and Director of Maintenance during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure complete documentation was available to show what testing instrument was used to test all smoke detectors for sensitivity. NFPA 72, National Fire Alarm Code, 2010 Edition, Section 14.4.5.3.1 states detector sensitivity shall be checked within 1 year of installation, and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range, the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or areas where nuisance alarms show an increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the methods: (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/fire alarm control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range. (5) Other calibrated sensitivity method acceptable to the authority having jurisdiction. Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated, or replaced.			

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BRICKYARD HEALTHCARE - BRENTWOOD CARE CENTER	30 E CHANDLER AVE EVANSVILLE, IN 47713

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	The detector sensitivity cannot be tested or measured using any spray device that administers an unmeasured concentration of aerosol into the detector. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on record review on 02/14/24 between 9:45 a.m. and 2:30 p.m. with the Director of Maintenance present, there was documentation available to show a smoke detector sensitivity test of all smoke detectors was performed on 01/19/23 by the facility's fire alarm system inspection vendor, however, the report did not include the name of the manufacturer's calibrated sensitivity test instrument. This was confirmed by the Director of Maintenance at the time of record review. This finding was reviewed with the Executive Director and Director of Maintenance during the exit conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors,			

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	etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect at least 10 residents, as well as staff, and visitors. Findings include: Based on observations on 02/14/24 between 2:30 p.m. and 5:00 p.m. during a tour of the facility with the Director of Maintenance, the ceiling mounted smoke detector in the fire alarm control panel (FACP)/sprinkler riser room was missing the cover cap and exposing the sensing chamber. Based on interview at the time of observation, the Director of Maintenance agreed the smoke detector in the FACP/sprinkler riser room was missing the cover cap. This finding was reviewed with the Executive Director and Director of Maintenance during the exit conference. 3.1-19(b)			
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____			

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	c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on observation and interview, the facility failed to ensure sprinkler heads in 1 of 9 smoke compartments covered with paint were replaced. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect up to 25 residents, staff, and visitors in the 500 Unit. Findings include: Based on observations on 02/14/24 between 2:30 p.m. and 5:00 p.m. during a tour of the facility with the Director of Maintenance, there were two sprinkler heads in the 500 Unit shower room covered with paint. Based on interview at the time of observation, the Director of Maintenance agreed the two sprinkler heads in the 500 Unit shower room were covered with paint and should be replaced. This finding was reviewed with the Executive Director and Director of Maintenance during the exit conference. 3.1-19(b)	K 0353	**K353 Sprinkler System-Maintenance and Testing** **Date 3/5/2024** **K353---What corrective action was accomplished for the resident found to have been affected by the deficient practice.** On 3/5/2024 Tristate Fire Protection replaced both shower heads in the 500-hall shower room. On 2/15/2024 TELS added wet sprinkler gauge checks to preventive maintenances weekly tasks. **---How will other residents who may have the potential to be affected be identified?** All residents have the potential to be affected. **---What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not reoccur.** ·Administrator educated Maintenance Director on the importance of ensuring sprinkler heads are free from paint. Wet sprinkler gauge check is completed weekly. **---How will the corrective action(s) be monitored to ensure the deficient practice**	03/05/2024

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	2. Based on record review, observation, and interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25 for 1 of 1 wet sprinkler system. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and the normal water pressure is being maintained. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on record review on 02/14/24 between 9:45 a.m. and 2:30 p.m. with the Director of Maintenance present, there was weekly sprinkler gauge inspection documentation during the past 12 month period for the dry pipe sprinkler system, however, there was no monthly sprinkler gauge inspection documentation available during the past 12 month period for the wet pipe sprinkler system. Based on observations between 2:30 p.m. and 5:00 p.m. there were two sprinkler gauges on the dry pipe system and two sprinkler gauges on the wet pipe system. Based on interview at the time of observation, the Director of Maintenance said he was instructed to only document to two sprinkler gauges on the dry pipe system on a weekly basis. This finding was reviewed with the Executive Director and Director of Maintenance during the exit conference.		**will not reoccur and what QA program will be put into place?** Results of life safety issues will be reported by Maintenance/ designee to QAPI no less than quarterly in perpetuity. **---Systematic changes will be completed by 3/5/2024** **Brentwood is requesting paper compliance for K353**	

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K 0355 SS=E Bldg. 01	3.1-19(b) NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 2 of 28 portable fire extinguishers were provided with monthly inspection tags. NFPA 10, Standard for Portable Fire Extinguishers, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic device/system at a minimum of 30-day intervals. Section 7.2.2 states periodic inspection or electronic monitoring of fire extinguishers shall include a check of at least the following items: (1) Location in designated place (2) No obstruction to access or visibility (3) Pressure gauge reading or indicator in the operable range or position (4) Fullness determined by weighing or hefting for self expelling-type extinguishers, cartridge-operated extinguishers, and pump tanks (5) Condition of tires, wheels, carriage, hose, and nozzle for wheeled extinguishers (6) Indicator for nonrechargeable extinguishers using push to-test pressure indicators. Section 7.2.4.1 states personnel making manual inspections shall keep records of all fire extinguishers inspected, including those found to require corrective action. Section 7.2.4.3 requires where at least monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded.	K 0355	**K355- Portable Fire Extinguishers** **Date 2/28/2024** **K355---What corrective action was accomplished for the resident found to have been affected by the deficient practice.** On 2/28/2024 Tristate Fire placed monthly inspection tags on the therapy closet and 100 hall corridor fire extinguishers. **---How will other residents who may have the potential to be affected be identified?** All residents have the potential to be affected. **---What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not reoccur.** ·Administrator educated Maintenance Director on the importance of ensuring Tristate provides all inspection tags for fire extinguishers. **---How will the corrective**	02/15/2024

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	Section 7.2.4.4 requires where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Section 7.2.4.5 requires records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect at least 20 residents, as well as staff and visitors. Findings include: Based on observations on 02/14/24 between 2:30 p.m. and 5:00 p.m. during a tour of the facility with the Director of Maintenance, the fire extinguisher in the Therapy closet and the fire extinguisher in the 100 hall corridor near room 109 did not have monthly inspection tags provided. The annual inspection of all fire extinguishers by the facility's vendor was performed in January of 2024. Based on interview at the time of each observation, the Director of Maintenance acknowledged the missing fire extinguisher tags and said he would contact the fire extinguisher vendor as soon as possible. This finding was reviewed with the Executive Director and Director of Maintenance during the exit conference. 3.1-19(b)		**action(s) be monitored to ensure the deficient practice will not reoccur and what QA program will be put into place?** Results of life safety issues will be reported by Maintenance/ designee to QAPI no less than quarterly in perpetuity. **---Systematic changes will be completed by 2/28/2024** **Brentwood is requesting paper compliance for K355**	
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			

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	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 1 of over 20 wet locations, was provided with ground fault circuit interrupter (GFCI) protection against electric shock. 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 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. Informational Note: See 215.9 for ground-fault circuit interrupter protection for personnel on feeders. (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	K 0511	**K511- Utilities- Gas and Electric** **Date 2/15/2024** **K511---What corrective action was accomplished for the resident found to have been affected by the deficient practice.** On 2/15/2024 Maintenance Director corrected therapy gym's ground fault circuit interrupter by rewiring. **---How will other residents who may have the potential to be affected be identified?** All residents have the potential to be affected. **---What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not reoccur.** ·Administrator educated Maintenance Director on the importance of ensuring ground fault circuit interrupter are wired correctly. **---How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur and what QA program will be put into place?** Results of life safety issues will be reported by Maintenance/ designee to QAPI no less than quarterly in perpetuity. **---Systematic changes will be**	02/15/2024

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	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. (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 mostly staff in the Physical Therapy gym. Findings include: Based on observations on 01/14/24 between 2:30 p.m. and 5:00 p.m. during a tour of the facility with the Director of Maintenance, the electric receptacle within two feet of the sink in the Physical Therapy gym was provided with a GFCI receptacle. When tested with a GFCI testing device the receptacle did not break the electrical circuit. The GFCI tester indicated the receptacle was wired Hot/Neutral Reverse. Based on		**completed by 2/15/2024** **Brentwood is requesting paper compliance for K511**	

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	interview at the time of observation, the Director of Maintenance agreed the receptacle in the Physical Therapy gym was not properly GFCI protected. This finding was reviewed with the Executive Director and Director of Maintenance during the exit conference. 3.1-19(b)			
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to ensure fire drills were held at varied times and varied dates for all shifts and quarters. This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's fire drill reports on 02/14/24 between 9:45 a.m. and 2:30 p.m. with the Director of Maintenance present, the following was noted: a. 11 of 12 fire drills conducted during the past 12 month period were held during the last days of	K 0712	**Date 3/2/2024** **K-712---What corrective action was accomplished for the resident found to have been affected by the deficient practice.** Maintenance Director educated that fire drills need to be held at various times and varied dates for all shifts and quarters. February's fire drill time and date varied from March's. **---How will other residents who may have the potential to be**	03/02/2024

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	each month. b. All three second quarter fire drills of 2023 were held on 05/30/23 and 05/31/23, and all three third quarter fire drills of 2023 were held on 08/30/23 and 08/31/23. c. All four third shift fire drills during the past 12 month period were held between 11:40 p.m. and 12:10 p.m. Based on interview at the time of record review, the Director of Maintenance acknowledged the times dates of all fire drills conducted during the past 12 month period and agreed they were not varied by time or date. This finding was reviewed with the Executive Director and Director of Maintenance during the exit conference. 3.1-19(b) 3.1-51(c)		**affected be identified?** All residents have the potential to be affected. **---What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not reoccur.** ·Administrator educated Maintenance Director on the importance of ensuring quarterly fire drills are held on various shifts. **·---How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur and what QA program will be put into place?** Results of life safety issues will be reported by Maintenance/ designee to QAPI no less than quarterly in perpetuity. **---Systematic changes will be completed by 3/2/2024** **Brentwood is requesting paper compliance for K-712**	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.			

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	Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 1 of 1 generator during 11 of the past 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. Chapter 6-4.4.1.3 of 2012 NFPA 99 requires batteries for on-site generators shall be maintained in accordance with NFPA 110, 2010	K 0918	**K-918 Electrical Systems-Essential Electric System Date 2/15/2024** **K-918---What corrective action was accomplished for the resident found to have been affected by the deficient practice.** Maintenance Director added monthly generator load testing to his monthly tasks. **---How will other residents who may have the potential to be affected be identified?** All residents, staff and	02/15/2024

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - BRENTWOOD CARE CENTER	30 E CHANDLER AVE EVANSVILLE, IN 47713

(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
	Edition, Standard for Emergency and Standby Power Systems. 8.3.7 requires storage batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications. 8.3.7.2 states defective batteries shall be repaired or replaced immediately upon discovery of defects. Chapter 6.5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the generator inspection and testing reports on 02/14/24 between 9:45 a.m. and 2:30 p.m. with the Director of Maintenance present, there was no monthly generator load test documentation available for February through December of 2023 for the emergency generator. Based on interview at the time of record review, the Director of Maintenance said he only became aware that a monthly load test was required and added it to the January 2024 schedule. This finding was reviewed with the Executive Director and Director of Maintenance during the exit conference. 3.1-19(b)		visitors have the potential to be affected. **---What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not reoccur.** ·Evapar educated Maintenance Director on how to preform monthly generator load tests. **---How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur and what QA program will be put into place?** Results of life safety issues will be reported by Maintenance/ designee to QAPI no less than quarterly in perpetuity. **---Systematic changes will be completed by 2/15/2024** **Brentwood is requesting paper compliance for K-918**	