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	03/11/2025

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: 03/11/25 Facility Number: 000152 Provider Number: 155248 AIM Number: 100267510 At this Emergency Preparedness survey, Brickyard Healthcare-Brentwood 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 114 certified beds, with a current census of 92. Quality Review completed on 03/18/25	E 0000		
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: 03/11/25 Facility Number: 000152 Provider Number: 155248 AIM Number: 100267510 At this Life Safety Code survey, Brickyard	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shelley Brown	Executive Director	03/31/2025

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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	Healthcare-Brentwood 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 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 92 at the time of this survey. Quality Review completed on 03/18/25			
K 0200 SS=E Bldg. 01	NFPA 101 Means of Egress Requirements - Other Based on observation and interview, the facility failed to ensure 3 of 4 egress doors from the public rest rooms, were not equipped with a locking device that would require the use of a key to unlock from the inside in the case of fire or other emergencies in accordance with LSC 7.1.10.1. This deficient practice could affect three residents, staff or visitors. Findings include: Based on observations on 03/11/25 during a tour of the facility with the Maintenance Director, the following was noted: a. At 1:30 p.m. the Men's and Women's public restrooms in the front hall were both equipped with a slide latch on the inside of the door that could not be opened from the corridor side.	K 0200	**K200 Egress Requirement Date 5/7/2025** **K200---What corrective action was accomplished for the resident found to have been affected by the deficient practice.** ·By 5/7/2025 The Maintenance Director will have removed the locking device from the public restroom and replaced it with one that requires a key. **·---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**	05/07/2025

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	b. At 1:44 p.m. the public restroom in the 200 hall was equipped with a slide latch on the inside of the door that could not be opened from the corridor side. Based on interview at the time of each observation, the Maintenance Director agreed these restroom doors could not be unlocked from the corridor side and should be removed. This finding was reviewed with the Area Vice President and Maintenance Director during the exit conference. 3.1-19(b)		**into place or what systematic changes will be made to ensure that the deficient practice does not reoccur.** ·Executive Director educated Maintenance Director on ensuring public restroom doors have a locking device that utilizes a key. **---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?** Maintenance Director/ Designee will audit public door to ensure it is equipped with a locking device that requires a key. Maintenance Director/ Designee will audit 3X's a week X4 weeks, 1x week X 4 weeks, and 1X per month X4 months. Director of Maintenance/ Designee will report findings to QAPI X 6 months. **---Systematic changes will be completed by 5/7/2025** **Brentwood is requesting paper compliance for K200**	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Based on observation and interview, the facility failed to ensure the means of egress through 1 of 10 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	K 0222	**K222 Egress Doors** **Date 5/7/2025** **K222---What corrective action was accomplished for the resident found to have been affected by the deficient practice.** By 5/7/2025 Maintenance Director will have posted the code	05/07/2025

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	permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect up to 10 residents, staff, and visitors. Findings include: Based on observation on 03/11/25 at 2:28 p.m. during a tour of the facility with the Maintenance Director, the service hall exit door was equipped with a magnetic lock that required a code on the adjacent keypad to release and open. The code to open this exit door was not posted in a conspicuous place and the door was not provided with delayed egress. Based on interview at the time of observation, the Maintenance Director said, and pointed to, the code posted on the top of the keypad box adjacent to the door. Furthermore, based on interview at the time of observation, the Maintenance Director acknowledged not everyone that could use this exit door would see or know where to look for the code to open the exit door. This finding was reviewed with the Area Vice President and Maintenance Director during the exit conference. 3.1-19(b)		to ensure the service hall exit code is posted in a conspicuous place. **---How will other residents who may have the potential to be affected be identified?** All residents, visitors, and staff 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.** ·Executive Director educated Maintenance Director on ensuring service hall exit door code is posted in a conspicuous place. **---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?** ·Maintenance Director will audit service hall exit door to ensure door code is posted in a conspicuous place. Maintenance Director/ Designee will audit 3X's a week X4 weeks, 1x week X 4 weeks, and 1X per month X4 months. Director of Maintenance/ Designee will report findings to QAPI X 6 months. **---Systematic changes will be completed by 5/7/2025** **Brentwood is requesting paper compliance for K222**	
K 0293 SS=E	NFPA 101 Exit Signage			

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Bldg. 01	Based on observation and interview, the facility failed to ensure 2 of over 20 EXIT signs were continuously illuminated. This deficient practice could affect at least 20 residents, as well as staff and visitors. Findings include: Based on observations on 03/11/25 during a tour of the facility with the Maintenance Director, the following was noted: a. At 1:42 p.m. the EXIT sign above the 200 hall west exit door was not fully illuminated. b. At 2:29 p.m. the EXIT sign above the service hall exit door (near the kitchen and activity room) was not fully illuminated. Based on interview at the time of observation, the Maintenance Director agreed the two EXIT signs were not fully illuminated and said he was in the process of replacing several EXIT signs in the facility. This finding was reviewed with the Area Vice President and Maintenance Director during the exit conference. 3.1.19(b)	K 0293	**K293 Exit Signage** **Date 5/7/2025** **K293---What corrective action was accomplished for the resident found to have been affected by the deficient practice.** ·By 5/7/2025 Maintenance Director will have replaced both exit signs to ensure continuous illumination. **---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.** ·Executive Director educated Maintenance Director on ensuring exit signs fully illuminate and replace any exit sign that doesn't fully illuminate. **---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?** Maintenance Director/ Designee will audit exit signs to ensure they fully illuminate. Maintenance Director/ Designee will audit 3X's a week X4 weeks, 1x week X 4 weeks, and 1X per month X4 months. Director of Maintenance/ Designee will report	05/07/2025

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			findings to QAPI X 6 months. **---Systematic changes will be completed by 5/7/2025** **Brentwood is requesting paper compliance for K293**	
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Based on record review and interview, the facility failed to ensure the preventative maintenance for all battery operated smoke alarms in resident rooms was conducted according to manufacturer's published instructions. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents. Findings include: Based on record review on 03/11/25 at 10:46 a.m. with the Maintenance Director present, the "Battery Operated Smoke Detectors" showed monthly testing of the battery operated smoke alarms. The manufacturer's published instructions on the back side of each smoke alarm stated the alarms require weekly testing. Based on interview at the time of record review, the Maintenance Director stated the smoke alarms are tested monthly, and agreed the alarms should be tested weekly according to manufacturer's published	K 0300	**K300 Protection** **Date 5/7/2025** **K300---What corrective action was accomplished for the resident found to have been affected by the deficient practice.** ·By 5/7/2025 Maintenance Director will have incorporated weekly preventative maintenance checks into TELS, ensuring the weekly testing of all battery-operated smoke alarms in resident rooms. **---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.** ·Executive Director educated Maintenance Director on completing weekly testing of all battery-operated smoke alarms in resident rooms. **---How will the corrective action(s) be monitored to**	05/07/2025

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	instructions. This finding was reviewed with the Area Vice President and Maintenance Director during the exit conference. 3.1-19(b)		**ensure the deficient practice will not reoccur and what QA program will be put into place?** Maintenance Director/ Designee will audit weekly testing of all battery-operated smoke alarms in resident rooms. Maintenance Director/ Designee will audit 3X's a week X4 weeks, 1x week X 4 weeks, and 1X per month X4 months. Director of Maintenance/ Designee will report findings to QAPI X 6 months. **---Systematic changes will be completed by 5/7/2025** **Brentwood is requesting paper compliance for K300**	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Based on observation and interview, the facility failed to ensure 1 of over 10 hazardous area doors, such as a storage room door, was provided with a door that would resist the passage of smoke. This deficient practice could at least 10 residents and staff. Findings include: Based on observation on 03/11/25 at 2:10 p.m. during a tour of the facility with the Maintenance Director, Room 521 was being used as a storage room with at least 10 extra large cardboard boxes and other combustible items. The room was over 50 square feet in size. There were two half inch holes around the door knob, one on top and one on bottom, which would not resistant the passage of smoke to the corridor in the event of a fire. Based on interview at the time of observation, the	K 0321	**K321 Hazardous Areas-Enclosure** **Date 5/7/2025** **K321---What corrective action was accomplished for the resident found to have been affected by the deficient practice.** ·By 5/7/2025 The Maintenance Director will have repaired the two half inch door holes around the doorknob in room 521. **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**	05/07/2025

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	Maintenance Director acknowledged the holes around the door knob to room 521 and said he would put the original door handle back on the door and eliminate the holes. This finding was reviewed with the Area Vice President and Maintenance Director during the exit conference. 3.1-19(b)		**ensure that the deficient practice does not reoccur.** Executive Director educated Maintenance Director to ensure resident doors don't have door holes. **---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?** ·Maintenance Director/ Designee will audit resident rooms to ensure no door holes are present. 3X's a week X4 weeks, 1x week X 4 weeks, and 1X per month X4 months. Director of Maintenance/ Designee will report findings to QAPI X 6 months. **---Systematic changes will be completed by 5/7/2025** **Brentwood is requesting paper compliance for K321**	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Based on record review, observation, and interview, the facility failed to ensure the pull station for 1 of 1 kitchen range hood suppression was placed on the wall in the path of egress from the kitchen. This deficient practice could affect mostly kitchen staff, plus over 30 residents while in the main dining room which was adjacent to the kitchen. Findings include: Based on record review on 03/11/25 at 11:29 a.m.	K 0324	**K324 Cooking Facilities** **Date 5/7/2025** **K324---What corrective action was accomplished for the resident found to have been affected by the deficient practice.** ·By 5/7/2025 the electrician will have completed the required electrical work, and Tristate Fire will have installed the new fire suppression system.	05/07/2025

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	with the Maintenance Director present, the kitchen range hood suppression inspection report dated 10/22/24 from the facility's range hood inspection vendor stated "Pull station is not in path of egress. It is located around the backside of the hood with a dividing wall next to it. In order to use pull station, you would need to go behind the hood." Based on interview at the time of record review, the Maintenance Director said he has signed a quote from the vendor for the replacement of the entire range hood system and relocating the range hood pull station to the path of egress from the kitchen. He further said there is no date set for replacement as of yet. Based on observation at 2:40 p.m., it was confirmed the range hood pull station was located on the wall on the back side of the hood system and not in the path of egress. This finding was reviewed with the Area Vice President and Maintenance Director during the exit conference. 3.1-19(b)		**---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.** ·Executive Director educated Maintenance Director on ensuring kitchen range hood suppression is placed on the wall in the path of egress from the kitchen. **---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?** Maintenance Director/ Designee will audit the kitchen range hood suppression to ensure it is placed in the path of egress. Maintenance Director/ Designee will audit 3X's a week X4 weeks, 1x week X 4 weeks, and 1X per month X4 months. Director of Maintenance/ Designee will report findings to QAPI X 6 months. **---Systematic changes will be completed by 5/7/2025** **Brentwood is requesting paper compliance for K324**	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing 1. Based on observation and interview, the facility failed to ensure sprinkler heads in 2 of 8	K 0353	**K353 Sprinkler System-Maintenance and Testing**	05/07/2025

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	smoke compartments, and 2 of 2 outside overhangs/carport covered with corrosion or 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 at least 20 resident, as well as staff and visitors. Findings include: Based on observations on 03/11/25 between 1:00 p.m. and 4:00 p.m. during a tour of the facility with the Maintenance Director, the following was noted: a. At 1:40 p.m. there was a sprinkler head under the 200 hall west entrance/exit overhang covered with corrosion. b. At 1:51 p.m. there was a sprinkler head in the Medical Records room partially covered with paint. c. At 2:51 p.m. there was a sprinkler head in the front Janitor's Closet covered with corrosion. d. At 3:10 p.m. there were nine concealed sprinkler heads with metal covers under the front entrance/exit carport/overhang covered with corrosion. Based on interview at the time of each observation, the Maintenance Director acknowledged the previously mentioned sprinkler heads were covered with corrosion and paint.		**Date 5/7/2025** **K353---What corrective action was accomplished for the resident found to have been affected by the deficient practice.** ·By 5/7/2025 Tristate Fire will have replaced 200 hall west entrance, Medical Records, Janitor's closet and front entrance/ exit carport/ overhang area with new sprinkler heads. By 5/7/2025 Tristate Fire will have provided facility with spare pendent type concealed sprinkler heads. **---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.** ·Executive Director educated Maintenance Director on ensuring sprinkler heads are free from corrosion and paint and having spare pendent type concealed sprinkler heads. **---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?** Maintenance Director/ Designee will audit sprinkler heads to ensure they are free from corrosion and paint and will audit	

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	This finding was reviewed with the Area Vice President and Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler system was provided with the minimum number of spare sprinklers in a spare sprinkler cabinet on the premises for the types and temperature ratings of the sprinklers on the property. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations on 03/11/25 at 3:10 p.m. during a tour of the facility with the Maintenance Director, pendent type concealed sprinkler heads were installed under the front entrance/exit overhang/carport. Based on observation of the spare sprinkler head cabinet in the Mechanical Room/Sprinkler Riser Room at 3:18 p.m., there were no pendent type concealed sprinkler heads within the spare sprinkler cabinet or on the		to ensure facility has spare pendent type concealed sprinkle heads. Maintenance Director/ Designee will audit 3X's a week X4 weeks, 1x week X 4 weeks, and 1X per month X4 months. Director of Maintenance/ Designee will report findings to QAPI X 6 months. **---Systematic changes will be completed by 5/7/2025** **Brentwood is requesting paper compliance for K353**	

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(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
	premises. Based on interview at the time of the observations, the Maintenance Director agreed the spare sprinkler cabinet did not contain any pendent type concealed spare sprinkler heads. This finding was reviewed with the Area Vice President and Maintenance Director during the exit conference. 3.1-19(b)			
K 0355 SS=F Bldg. 01	NFPA 101 Portable Fire Extinguishers 1. Based on observation and interview, the facility failed to ensure at least 4 of 28 portable fire extinguishers observed were installed in accordance with NFPA 10. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, Section 6.1.3.8.1 states fire extinguishers having a gross weight not exceeding 40 lb. shall be installed so that the top of the fire extinguisher is not more than five feet above the floor. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on observations on 03/11/25 during a tour of the facility with the Maintenance Director, the following was noted: a. At 2:17 p.m. the portable fire extinguisher in the Maintenance Office was mounted on the wall and measured at 5 feet 8 inches at the top of the extinguisher. b. At 2:38 p.m. the portable fire extinguisher in the main dining room was in a wall mounted box and measured at 5 feet 8 inches at the top of the extinguisher. c. At 2:43 p.m. the portable fire extinguisher in the	K 0355	**K355 Portable Fire Extinguishers** **Date 5/7/2025** **K355---What corrective action was accomplished for the resident found to have been affected by the deficient practice.** ·By 5/7/2025 Maintenance Director will have completed installing the 4 noted portable fire extinguishers to ensure the top of the fire extinguisher is not more than five feet above the floor. By 5/7/2025 Maintenance Director will have a conspicuously placed placard near the portable K class fire extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. **---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.	05/07/2025

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	Laundry Room was mounted on the wall and measured at 5 feet 8 inches at the top of the extinguisher. d. At 2:59 p.m. the portable fire extinguisher in the ACU Activities/Dining Room was in a wall mounted box and measured at 5 feet 8 inches at the top of the extinguisher. Based on interview, this was acknowledged by the Maintenance Director at the time of each observation. This finding was reviewed with the Area Vice President and Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to maintain 1 of 1 portable fire extinguisher in the kitchen cooking area in accordance with the requirements of NFPA 10. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, Section 5.5.5 states fire extinguishers provided for the protection of cooking appliances using combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. NFPA 10, 5.5.5.3 states a placard shall be placed near the extinguisher that states that the protection system shall be actuated prior to using the fire extinguisher. Since the fixed fire extinguishing system will automatically shut off the fuel source to the cooking appliance, the fixed system should be activated before using the portable fire extinguisher. In this instance, the portable fire extinguisher is supplemental protection. This deficient practice could affect staff in the kitchen, plus residents while in the main dining room which was adjacent to the kitchen.		**---What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not reoccur.** ·Executive Director educated Maintenance Director on ensuring the top of the fire extinguisher is not more than five feet above the floor and to ensure a conspicuously placed placard is near the portable K class fire extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. **---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?** Maintenance Director/ Designee will audit portable fire extinguishers to ensure the top of the fire extinguisher is not more than five feet above the floor and will audit to ensure a conspicuously placed placard is near the portable K class fire extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Maintenance Director/ Designee will audit 3X's a week X4 weeks, 1x week X 4 weeks, and 1X per month X4 months. Director of Maintenance/ Designee will report findings to QAPI X 6 months. **---Systematic changes will be**	

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	Findings include: Based on observation on 03/11/25 at 2:35 p.m. during a tour of the facility with the Maintenance Director, the portable K Class fire extinguisher located in the kitchen did not contain a conspicuously placed placard near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Based on interview at the time of observation, the Maintenance Director said he was not aware of the placard but would order one as soon as possible. This finding was reviewed with the Area Vice President and Maintenance Director during the exit conference. 3.1-19(b)		**completed by 5/7/2025** **Brentwood is requesting paper compliance for K355**	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 1 of over 100 corridor doors would close complete and latch into its door frame. This deficient practice could affect at least 20 residents, staff and visitors. Findings include: Based on observations on 03/11/25 at 2:18 p.m. during a tour of the facility with the Maintenance Director, the door to the small closet next to the North Unit exit door did not close completely and latch into the door frame. There was a cloth stuffed into the latching plate preventing the door from close completely and latching into the door frame. Based on interview at the time of observation, the Maintenance Director said he	K 0363	**K363 Corridor- Doors** **Date 5/7/2025** **K363---What corrective action was accomplished for the resident found to have been affected by the deficient practice.** ·By 5/7/2025 Maintenance Director will have removed the cloth that was preventing the latch plate from closing completely and latching into the door frame. **---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.	05/07/2025

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	didn't know why someone would put the cloth in the latching plate, but removed it at the time of observation. This finding was reviewed with the Area Vice President and Maintenance Director during the exit conference. 3.1-19(b)		**---What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not reoccur.** Executive Director educated Maintenance Director/ Staff on not utilizing cloths in latch plates as this prevents the door from closing completely and latching into the door frame. **---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?** Maintenance Director/ Designee will audit latch plates to ensure they are free from cloths that prevent the door from closing completely and latching into the door frame. Maintenance Director/ Designee will audit 3X's a week X4 weeks, 1x week X 4 weeks, and 1X per month X4 months. Director of Maintenance/ Designee will report findings to QAPI X 6 months. **---Systematic changes will be completed by 5/7/2025** **Brentwood is requesting paper compliance for K363**	
K 0711 SS=F Bldg. 01	NFPA 101 Evacuation and Relocation Plan Based on record review and interview, the facility failed to provide a complete facility specific written fire safety plan for the protection of all residents to accurately address all life safety	K 0711	**K711 Evacuation and Relocation Plan** **Date 5/7/2025** **K711---What corrective**	05/07/2025

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	systems, plus a system addressing all items required by NFPA 101, 2012 edition, Section 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire Section 19.2.3.4(4) states any required aisle or corridor shall not be less than 48 inches in clear width where serving as means of egress from patient sleeping rooms. Projections into the required width shall be permitted for wheeled equipment provided the relocation of wheeled equipment during a fire or similar emergency is addressed in the written fire safety plan and training program for the facility. The wheeled equipment is limited to: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect all occupants in the event of an emergency. Findings include: Based on a review of the facility's Fire Plan on 03/11/25 at 12:42 p.m. Maintenance Director present, the plan did address evacuation of the smoke compartment, however, the plan did not identify where the smoke barriers were located in the facility and evacuation in detail. Based on interview at the time of record review, the		**action was accomplished for the resident found to have been affected by the deficient practice.** ·By 5/7/2025 The Maintenance Director will have added color-coded identifiers to the floor plan to indicate the location of smoke barriers in the EPP Fire Plan and Evacuation. **---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.** ·Executive Director educated Maintenance Director on adding color-coded identifiers to the floor plan to indicate the location of smoke barriers in the EPP Fire Plan and Evacuation. **---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?** ·Maintenance Director/ Designee will audit the floor plan to ensure the accuracy of smoke barrier color-coded identifiers in the EPP Fire Plan and Evacuation. 3X's a week X4 weeks, 1x week X 4 weeks, and 1X per month X4 months. Director	

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	Maintenance Director acknowledged the Fire Plan did not identify where the smoke barriers were located in the facility and evacuation in detail. This finding was reviewed with the Area Vice President and Maintenance Director during the exit conference. 3.1-19(b)		of Maintenance/ Designee will report findings to QAPI X 6 months. **---Systematic changes will be completed by 5/7/2025** **Brentwood is requesting paper compliance for K711**	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills 1. Based on record review and interview, the facility failed to provide quarterly fire drill documentation for 1 of 3 shifts during 1 of 4 quarters. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on review of the facility's fire drill reports on 03/11/25 at 10:23 a.m. with the Maintenance Director present, there was no fire drill documentation available for the third shift (night) of the third quarter (July, August, and September) of 2024. Based on interview at the time of record review, the Maintenance Director acknowledged there was no fire drill report available to review for the third shift of the third quarter of 2024. This finding was reviewed with the Area Vice President and Maintenance Director during the exit conference. 3.1-19(b) 3.1-51(c) 2. Based on record review and interview, the	K 0712	**K712 Fire Drills** **Date 5/7/2025** **K712---What corrective action was accomplished for the resident found to have been affected by the deficient practice.** ·By 5/7/2025 The Maintenance Director will have conducted a monthly fire drill at a varied time and date. **---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.** ·Executive Director educated Maintenance Director on varying time and dates of monthly fire drills. **---How will the corrective action(s) be monitored to**	05/07/2025

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	facility failed to ensure fire drills were held at varied times for 1 of 3 employee shifts during 3 of 4 quarters, and varied dates of each month for 9 of 13 fire drills performed during the past 12 month period. This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's fire drill reports on 03/11/25 10:23 a.m. with the Maintenance Director present, the following was noted: a. 3 of 4 first shift (day) fire drills were performed at 1:10 p.m., 1:18 p.m., and 2:09 p.m. b. 9 of 13 fire drills were performed during the last three days of each month. Based on interview at the time of record review, the Maintenance Director acknowledged the times of the first shift fire drills were performed, and the dates of fire drills during the last three days of each month and agreed the times and dates were not varied enough. This finding was reviewed with the Area Vice President and Maintenance Director during the exit conference. 3.1-19(b) 3.1-51(c)		**ensure the deficient practice will not reoccur and what QA program will be put into place?** ·Maintenance Director/ Designee will audit monthly fire drills to ensure they vary in time and date. 3X's a week X4 weeks, 1x week X 4 weeks, and 1X per month X4 months. Director of Maintenance/ Designee will report findings to QAPI X 6 months. **---Systematic changes will be completed by 5/7/2025** **Brentwood is requesting paper compliance for K712**	
K 0761 SS=E Bldg. 01	NFPA 101 Maintenance, Inspection & Testing - Doors Based on observation, record review, and interview; the facility failed to ensure an annual inspection and testing of 1 of 1 oxygen room fire door assembly was completed in accordance with 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	K 0761	**K761 Maintenance, Inspection and Testing- Doors** **Date 5/7/2025** **K761---What corrective action was accomplished for the resident found to have been affected by the deficient**	05/07/2025

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	by approved self-closing fire door assemblies. (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.		**practice.** ·By 5/7/2025 The Maintenance Director will have completed 02 transfilling room annual fire door assembly inspection. **---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.** Executive Director educated Maintenance Director on completing and adding checks for the oxygen transfilling room fire door assembly in TELS. **---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?** ·Maintenance Director/ Designee will audit to ensure annual fire door assembly inspection in 02 transfilling room is completed and documented in TELS 3X's a week X4 weeks, 1x week X 4 weeks, and 1X per month X4 months. Director of Maintenance/ Designee will report findings to QAPI X 6 months. **---Systematic changes will be completed by 5/7/2025** **Brentwood is requesting paper**	

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	(9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (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 at least 20 residents, as well as staff, and visitors. Findings include: Based on record review on 03/11/25 at 11:32 a.m. with the Maintenance Director present, the facility was unable to provide documentation for an annual inspection of the oxygen transfilling room fire door assembly for the past 12 month period or prior. Based on interview at the time of record review, the Maintenance Director said there was no documentation of an annual inspection of the oxygen transfilling room fire door assembly available to review for the past 12 month period. Based on observations during a tour of the facility between 1:00 p.m. and 4:00 p.m., there was one oxygen transfilling room fire door assembly noted in the facility. This finding was reviewed with the Area Vice President and Maintenance Director during the exit conference. 3.1-19(b)		**compliance for K761**	
K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Based on observation, record review, and interview; the facility failed to ensure complete documentation was available for nonhospital-grade electrical receptacles in all	K 0914	**K914 Electrical Systems-Maintenance and Testing Date 5/7/2025** **K914---What corrective**	05/07/2025

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	resident room locations tested at least annually. NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review on 03/11/25 at 11:56 a.m. with the Maintenance Director present, there was documentation available of an annual resident room receptacle test dated 01/2025 for all non hospital-grade receptacles, however, the documentation was not complete. It only included a measured retention force. The report did not include: Physical Integrity, Grounding, and Polarity. Based on interview at the time of record review, the Maintenance Director confirmed the 01/2025 report only included a measured retention force for each resident room receptacle tested. Based on observations between 1:00 p.m. and 4:00 p.m. during a tour of the facility with the Maintenance Director, there were at least four electrical receptacles in each resident room.		**action was accomplished for the resident found to have been affected by the deficient practice.** ·By 5/7/2025 The Maintenance Director will have completed and added checks for physical integrity, grounding, and polarity to the TELS preventative maintenance program for annual resident room receptacle inspections. **---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.** Executive Director educated Maintenance Director on adding checks for physical integrity, grounding, and polarity to the TELS preventative maintenance program for annual resident room receptacle inspections. **---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?** ·Maintenance Director/ Designee will audit to ensure room receptacles have been tested for physical integrity, grounding, and polarity and are documented in	

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	This finding was reviewed with the Area Vice President and Maintenance Director during the exit conference. 3.1-19(b)		TELS 3X's a week X4 weeks, 1x week X 4 weeks, and 1X per month X4 months. Director of Maintenance/ Designee will report findings to QAPI X 6 months. **---Systematic changes will be completed by 5/7/2025** **Brentwood is requesting paper compliance for K914**	
K 0921 SS=F Bldg. 01	NFPA 101 Electrical Equipment - Testing and Maintenanc Based on record review, observation, and interview; the facility failed to conduct the required maintenance and maintain complete documentation of inspections for Patient Care Related Electrical Equipment (PCREE). NFPA 99 2012 edition, sections 10.3 and 10.5 states the physical integrity, resistance, leakage current, and touch current tests for fixed and portable PCREE is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate	K 0921	**K921 Electrical Equipment-Testing and Maintenance** **Date 5/7/2025** **K921---What corrective action was accomplished for the resident found to have been affected by the deficient practice.** ·By 5/7/2025 The Maintenance Director will have completed and added TELS preventive maintenance checks for testing of PCREE i.e.-electric beds, nebulizers, oxygen, concentrators, air pumps for air mattresses and other electrical medical equipment **---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.**	05/07/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155248	A. BUILDING 01 B. WING	03/11/2025

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
	compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. This deficient practice could affect all residents. Findings include: Based on record review on 03/11/25 at 11:44 a.m. with the Maintenance Director present, there was no documentation for the testing of PCREE, such as electric beds, nebulizers, oxygen concentrators, air pumps for air mattresses, and other electrical medical equipment. Based on interview at the time of record review, the Maintenance Director said the facility has purchased the equipment to test PCREE, but has not yet tested and documented the PCREE items. Based on observation between 1:00 p.m. and 4:00 p.m. during a tour of the facility with the Maintenance Director, it was revealed the facility provided PCREE such as electric beds, oxygen concentrators, air pumps for air mattresses, and other electrical medical equipment was present in the facility. This finding was reviewed with the Area Vice President and Maintenance Director during the exit conference. 3.1-19(b)		Executive Director educated Maintenance Director on adding PCREE checks to TELS preventive maintenance and complete annual PCREE checks. **---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?** ·Maintenance Director/ Designee will audit to ensure annual PCREE checks are completed and documented in TELS 3X's a week X4 weeks, 1x week X 4 weeks, and 1X per month X4 months. Director of Maintenance/ Designee will report findings to QAPI X 6 months. **---Systematic changes will be completed by 5/7/2025** **Brentwood is requesting paper compliance for K921**	
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage room where oxygen transfilling takes place, was provided with properly working mechanical ventilation. This deficient practice could affect at least 20 residents, as well as staff and visitors.	K 0927	**K927 Gas Equipment-Transfilling Cylinders** **Date 5/7/2025** **K927---What corrective action was accomplished for the resident found to have**	05/07/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155248	A. BUILDING 01 B. WING	03/11/2025

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

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	Findings include: Based on observation on 03/11/25 at 2:01 p.m. during a tour of the facility with the Maintenance Director, the oxygen storage/transfilling room was equipped with a mechanically vented exhaust fan, however, it was not working at the time of observation. Based on interview at the time of observation, the Maintenance Director agreed the mechanically vented exhaust fan was not working. This finding was reviewed with the Area Vice President and Maintenance Director during the exit conference. 3.1-19(b)		**been affected by the deficient practice.** ·By 5/7/2025 The Maintenance Director will have replaced the exhaust fan motor in the transfilling oxygen room. **---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.** Executive Director educated Maintenance Director on ensuring the transfilling oxygen room exhaust fan is properly operating. **---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?** ·Maintenance Director/ Designee will audit to ensure the exhaust fan is properly working in the 02 transfilling room 3X's a week X4 weeks, 1x week X 4 weeks, and 1X per month X4 months. Director of Maintenance/ Designee will report findings to QAPI X 6 months. **---Systematic changes will be completed by 5/7/2025** **Brentwood is requesting paper compliance for K927**	