03/31/2025

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155240		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV  A. BUILDING COMPLETED  B. WING 03/11/2025			ETED		
		155248	B. WI	NG		03/11/	2025
	ROVIDER OR SUPPLIER			30 E CH	ADDRESS, CITY, STATE, ZIP COD HANDLER AVE		
BRICKYA	ARD HEALTHCARE	E - BRENTWOOD CARE CENTER		EVANS	VILLE, IN 47713		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
E 0000							
Bldg							,
	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.		E 00	000			
	Survey Date: 03/11	/25					
	Facility Number: 00	00152					
	Provider Number: 1						
	AIM Number: 1002	267510					
	At this Emergency I	Preparedness survey,					
	Brickyard Healthcar	re-Brentwood Care Center was					
	found in compliance	- ·					
		rements for Medicare and					
	Medicaid Participati CFR 483.73.	ing Providers and Suppliers, 42					
	The facility has 114 census of 92.	certified beds, with a current					
	Quality Review com	npleted on 03/18/25					
K 0000							l
Bldg. 01							
g	Licensure Survey w	Recertification and State ras conducted by the Indiana th in accordance with 42 CFR	K 00	000			
	Survey Date: 03/11	/25					
	Facility Number: 00 Provider Number: 1 AIM Number: 1002	155248					
	At this Life Safety (	Code survey, Brickyard					
LABORATOR	Y DIRECTOR'S OR PROV	VIDER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	<b>.</b>	TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Shelley Brown

Executive Director

Any defiency statement 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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155248		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 03/11/2025		
	ROVIDER OR SUPPLIER	- BRENTWOOD CARE CENTER		30 E C⊦	DDRESS, CITY, STATE, ZIP COD HANDLER AVE VILLE, IN 47713		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K 0200 SS=E Bldg. 01	in compliance with in Medicare/Medica Life Safety from Fir National Fire Protect Life Safety Code (L Health Care Occupation of the facility and spaces open to the operated smoke alar rooms. The facility and census of 92 at the Quality Review complete Comp	Requirements - Other on and interview, the facility of 4 egress doors from the vere not equipped with a would require the use of a key inside in the case of fire or in accordance with LSC cient practice could affect three sitors. ons on 03/11/25 during a tour the Maintenance Director, the	K 02	200	K200 Egress Requirement Date 5/7/2025  K200What corrective action was accomplished for the resident found to have been affected by the deficient practice.  By 5/7/2025 The Maintenar Director will have removed the locking device from the public restroom and replaced it with of that requires a key. How will other residents who may have the potential to be affected be identified?  All residents, staff and visite have the potential to be affected.	nce e one to ors ed.	05/07/2025

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155248	B. WI	NG		03/11/	/2025
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	t.			HANDLER AVE		
BRICKYA	ARD HEALTHCARE	- BRENTWOOD CARE CENTER		EVANS	VILLE, IN 47713		<u> </u>
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	•	public restroom in the 200 hall			into place or what systematic	С	
		a slide latch on the inside of			changes will be made to		
		not be opened from the			ensure that the deficient		
	corridor side.				practice does not reoccur.		
	Based on interview				·Executive Director educated		
		nintenance Director agreed			Maintenance Director on ensu	ring	
		rs could not be unlocked from d should be removed.			public restroom doors have a	0.7	
	the corridor side and	d should be removed.			locking device that utilizes a k	ey.	
	This finding was re	viewed with the Area Vice			How will the corrective		
		tenance Director during the			action(s) be monitored to ensure the deficient practice		
	exit conference.	tenance Director during the			will not reoccur and what QA		
	can conference.				program will be put into place		
	3.1-19(b)				Maintenance Director/		
	2.1 17(0)				Designee will audit public doo	r to	
					ensure it is equipped with a		
					locking device that requires a	kev.	
					Maintenance Director/ Design	-	
					will audit 3X's a week X4 weel		
					1x week X 4 weeks, and 1X po		
					month X4 months. Director of		
					Maintenance/ Designee will re	port	
					findings to QAPI X 6 months.		
					Systematic changes will be	е	
					completed by 5/7/2025		
					Brentwood is requesting		
					paper compliance for K200		
K 0222	NFPA 101						
SS=E	Egress Doors						
Bldg. 01	Lgiess Doors						
Diag. 01	Based on observation	on and interview, the facility	K 0	222	K222 Egress Doors		05/07/2025
		means of egress through 1 of	K U	<i>LLL</i>	Date 5/7/2025		03/07/2023
		readily accessible for residents			K222What corrective		
		iagnosis requiring specialized			action was accomplished for	•	
		Doors within a required means			the resident found to have		
		be equipped with a latch or			been affected by the deficien	ıt	
	lock that requires the use of a tool or key from the			practice.			
	_	therwise permitted by LSC			By 5/7/2025 Maintenance		
	-	cking arrangements shall be			Director will have posted the o		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155248	B. WI	NG		03/11/	2025
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	L			HANDLER AVE		
BRICKYA	ARD HEALTHCARE	- BRENTWOOD CARE CENTER	_		VILLE, IN 47713		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	*	ance with 19.2.2.2.5.2. This			to ensure the service hall exit		
	-	ould affect up to 10 residents,			code is posted in a conspicuo	us	
	staff, and visitors.				place.		
					How will other residen		
	Findings include:				who may have the potential t	io	
					be affected be identified?		
		on on 03/11/25 at 2:28 p.m.			All residents, visitors, and		
	_	facility with the Maintenance			staff have the potential to be		
		e hall exit door was equipped			affected.		
	-	k that required a code on the			What measures will be put		
		release and open. The code to			into place or what systematic	C	
	open this exit door	-			changes will be made to		
		and the door was not provided			ensure that the deficient		
		. Based on interview at the			practice does not reoccur.		
		, the Maintenance Director			·Executive Director educated		
	-	, the code posted on the top			Maintenance Director on ensu	ring	
	of the keypad box a	-			service hall exit door code is		
		on interview at the time of			posted in a conspicuous place	<del>)</del> .	
	observation, the Ma				How will the corrective		
	-	everyone that could use this			action(s) be monitored to		
		or know where to look for the			ensure the deficient practice		
	code to open the ex	it door.			will not reoccur and what QA		
	TELL: (* 1:				program will be put into plac		
	_	viewed with the Area Vice	1		·Maintenance Director will a		
		tenance Director during the			service hall exit door to ensure	9	
	exit conference.				door code is posted in a		
	2.1.10(1)				conspicuous place. Maintenar		
	3.1-19(b)				Director/ Designee will audit 3	x's a	
					week X4 weeks, 1x week X 4		
					weeks, and 1X per month X4		
					months. Director of Maintenan		
					Designee will report findings to QAPI X 6 months.	,	
						_	
					Systematic changes will b	ie	
			1		completed by 5/7/2025		
					Brentwood is requesting		
					paper compliance for K222		
K 0293	NFPA 101						
SS=E	Exit Signage						

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039					
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155248	(X2) MULTIF A. BUILDII B. WING	PLE CONSTRUCTION NG <u>01</u>	(X3) DATE SURVEY COMPLETED 03/11/2025					
	PROVIDER OR SUPPLIEI	RE-BRENTWOOD CARE CENTE	30	STREET ADDRESS, CITY, STATE, ZIP COD  30 E CHANDLER AVE  EVANSVILLE, IN 47713						
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREF TA	FIX (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	CCTION (X5) ULD BE PROPRIATE COMPLETION DATE					
Bldg. 01	failed to ensure 2 of continuously illumicould affect at least and visitors.  Findings include:  Based on observation of the facility with following was note a. At 1:42 p.m. the west exit door was b. At 2:29 p.m. the hall exit door (near was not fully illum Based on interview Maintenance Direct were not fully illum process of replacing facility.  This finding was reconstitutions.	EXIT sign above the 200 hall not fully illuminated. EXIT sign above the service the kitchen and activity room)	K 0293	K293 Exit Signage Date 5/7/2025  K293What correct action was accomplish the resident found to he been affected by the depractice.  By 5/7/2025 Maintena Director will have replace exit signs to ensure contillumination. How will other reside may have the potential affected be identified?  All residents, staff and have the potential to beWhat measures will be into place or what syste changes will be made to ensure that the deficient practice does not reocon Executive Director or exit signs fully illuminate replace any exit sign that fully illuminate. How will the corrective action(s) be monitored ensure the deficient prawill not reoccur and who program will be put into Maintenance Director Designee will audit exit sensure they fully illuminate maintenance Director Dwill audit 3X's a week X4 x week X 4 weeks, and month X4 months. Director	ed for ave efficient  ance ed both tinuous ents who to be divisitors affected. De put ematic on the cur. ucated in ensuring e and ant doesn't existence to actice that QA to place? or/ signs to ate. designee 4 weeks, I 1X per					

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Maintenance/ Designee will report

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155248	B. WI	ING	_	03/11/	2025
	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD HANDLER AVE		
BRICKYA	ARD HEALTHCARE	- BRENTWOOD CARE CENTER		EVANS	VILLE, IN 47713		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					findings to QAPI X 6 monthsSystematic changes will be completed by 5/7/2025  Brentwood is requesting paper compliance for K293	е	
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other						
Blug. U I	failed to ensure the all battery operated rooms was conducted published instruction states existing life supublic, if not require maintained. NFPA Tests. Fire-warning maintained and tests manufacturer's public requirements of Challed Inspection, testing, a shall satisfy the requirements of the equipublished instruction could affect all residual feet al	riew and interview, the facility preventative maintenance for smoke alarms in resident ed according to manufacturer's ns. NFPA 101 in 4.6.12.3 afety features obvious to the ed by the Code, shall be 72, 29.10 Maintenance and gequipment shall be ed in accordance with the ished instructions and per the apter 14. NFPA 72, 14.2.1.1.1 and maintenance programs direments of this Code and pment manufacturer's ns. This deficient practice dents.  Tiew on 03/11/25 at 10:46 a.m. the bis code in the code in	K 0.	300	K300 Protection Date 5/7/2025  K300What 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 maintenatheaches into TELS, ensuring the weekly testing of all battery-operated smoke alarm resident rooms. How will other residents we may have the potential to be affected be identified?  All residents, staff and visite 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 a battery-operated smoke alarm.	nt de noce e e e e e e e e e e e e e e e e e e	05/07/2025
	monthly, and agreed	smoke alarms are tested  If the alarms should be tested  A manufacturer's published			resident roomsHow will the corrective		
	weekiy according to	manufacturer's published	l		action(s) be monitored to		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155248		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 03/11/2025		
		100270	D. WI		ADDRESS, CITY, STATE, ZIP COD	03/11/	2020
	PROVIDER OR SUPPLIER ARD HEALTHCARE	: - BRENTWOOD CARE CENTER	30 E CHANDLER AVE				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K 0321 SS=E Bldg. 01	instructions.  This finding was re-	viewed with the Area Vice tenance Director during the			ensure the deficient practice will not reoccur and what QA program will be put into place Maintenance Director/ Designee will audit weekly tes of all battery-operated smoke alarms in resident rooms. Maintenance Director/ Designe will audit 3X's a week X4 weel 1x week X 4 weeks, and 1X per month X4 months. Director of Maintenance/ Designee will refindings to QAPI X 6 monthsSystematic changes will be completed by 5/7/2025 Brentwood is requesting paper compliance for K300	eeeks, er	
g. <b>-</b>	failed to ensure 1 of such as a storage rodoor that would resideficient practice costaff.  Findings include:  Based on observation during a tour of the Director, Room 521 room with at least 1 and other combustit 50 square feet in size holes around the doon bottom, which wo fismoke to the correspondence of the such as	on and interview, the facility Fover 10 hazardous area doors, om door, was provided with a list the passage of smoke. This ould at least 10 residents and on on 03/11/25 at 2:10 p.m. facility with the Maintenance was being used as a storage 0 extra large cardboard boxes ble items. The room was over lie. There were two half inch or knob, one on top and one rould not resistant the passage ridor in the event of a fire. at the time of observation, the	K 03	321	K321 Hazardous Areas- Enclosure Date 5/7/2025  K321What corrective action was accomplished for the resident found to have been affected by the deficient practice.  By 5/7/2025 The Maintenant Director will have repaired the half inch door holes around the doorknob in room 521.  may have the potential to be affected be identified?  All residents, staff and visite have the potential to be affected.  What measures will be put into place or what systematic changes will be made to	nce two e	05/07/2025

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155248		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION  01	(x3) date survey completed 03/11/2025			
	PROVIDER OR SUPPLIER	- E - BRENTWOOD CARE CENTE	30 E	STREET ADDRESS, CITY, STATE, ZIP COD  30 E CHANDLER AVE EVANSVILLE, IN 47713			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	around the door knowould put the origin door and eliminate the things of	or acknowledged the holes ob to room 521 and said he hal door handle back on the the holes.  viewed with the Area Vice tenance Director during the		ensure that the deficient practice does not reoccur.  Executive Director educated Maintenance Director to ensure resident doors don't have does holes. How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur and what Querogram will be put into plate of the ensure no door holes are present. 3X's a week X4 week 1x week X4 weeks, and 1X4 month X4 months. Director of Maintenance/ Designee will refindings to QAPI X 6 months. Systematic changes will be completed by 5/7/2025  Brentwood is requesting parcompliance for K321	e A ce?  ooms ks, per f eport		
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities						
	interview, the facilistation for 1 of 1 kit was placed on the with the kitchen. This domostly kitchen staff in the main dining richten.  Findings include:	riew, observation, and ty failed to ensure the pull schen range hood suppression vall in the path of egress from efficient practice could affect c, plus over 30 residents while oom which was adjacent to the riew on 03/11/25 at 11:29 a.m.	K 0324	K324 Cooking Facilities Date 5/7/2025  K324What corrective action was accomplished for the resident found to have been affected by the deficie practice.  By 5/7/2025 the electrician have completed the required electrical work, and Tristate F will have installed the new first suppression system.	nt ı will Fire		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	01	COMPL	LETED
		155248	B. W	ING		03/11/	/2025
				_			
NAME OF F	PROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP COD		
					HANDLER AVE		
BRICKY	ARD HEALTHCARE	E - BRENTWOOD CARE CENTER		EVANS	VILLE, IN 47713		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	with the Maintenan	ice Director present, the			How will other residents w	ho	
	kitchen range hood	suppression inspection report			may have the potential to be		
	dated 10/22/24 from	n the facility's range hood			affected be identified?		
	inspection vendor s	stated "Pull station is not in			·All residents, staff and visite	ors	
	path of egress. It is located around the backside				have the potential to be affect	ed.	
	of the hood with a dividing wall next to it. In order				What measures will be put	ŧ	
	to use pull station,	you would need to go behind			into place or what systemati	С	
	the hood." Based o	on interview at the time of			changes will be made to		
	record review, the l	Maintenance Director said he			ensure that the deficient		
	has signed a quote	from the vendor for the			practice does not reoccur.		
	replacement of the	entire range hood system and			·Executive Director educate	d	
	relocating the range	e hood pull station to the path			Maintenance Director on ensu	ıring	
	of egress from the l	citchen. He further said there is			kitchen range hood suppressi	on is	
	no date set for repla	acement as of yet. Based on			placed on the wall in the path	of	
	observation at 2:40	p.m., it was confirmed the			egress from the kitchen.		
	range hood pull sta	tion was located on the wall on			How will the corrective		
	the back side of the	hood system and not in the		action(s) be monitored to			
	path of egress.				ensure the deficient practice	)	
					will not reoccur and what QA	4	
	This finding was re	viewed with the Area Vice			program will be put into place	:e?	
	President and Main	tenance Director during the			Maintenance Director/		
	exit conference.				Designee will audit the kitcher	ı	
					range hood suppression to en		
	3.1-19(b)				it is placed in the path of egre		
					Maintenance Director/ Design	ee	
					will audit 3X's a week X4 wee	ks,	
					1x week X 4 weeks, and 1X p	er	
					month X4 months. Director of		
					Maintenance/ Designee will re	port	
					findings to QAPI X 6 months.		
					Systematic changes will be	е	
					completed by 5/7/2025		
					Brentwood is requesting par	er	
					compliance for K324		
V 0252	NEDA 404						
K 0353 SS=F	NFPA 101	Maintanana and Tastina					
	Sprinkier System	- Maintenance and Testing					
Bldg. 01	1 Dogod on about	vation and interview, the	17.0	252	K252 Continues Contains		05/07/2025
		sure sprinkler heads in 2 of 8	K 0	333	K353 Sprinkler System- Maintenance and Testing		05/07/2025
	I racinity ranica to this	sere sprinkler neads in 2 01 0	1		manitenance and 165tilly		1

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155248		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY  COMPLETED  03/11/2025		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD	-	
BRICKYA	ARD HEALTHCARE	- BRENTWOOD CARE CENTER	30 E CHANDLER AVE R EVANSVILLE, IN 47713				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
IAG		ts, and 2 of 2 outside		IAG	Date 5/7/2025		DATE
		overed with corrosion or			K353What corrective		
	paint were replaced	. NFPA 25, 2011 edition, at			action was accomplished fo	r	
	5.2.1.1.1 sprinklers	shall not show signs of			the resident found to have		
	-	ee of corrosion, foreign			been affected by the deficie	nt	
	-	l physical damage; and shall			practice.		
		orrect orientation (e.g.,			∙By 5/7/2025 Tristate Fire w	ill	
		r sidewall). Furthermore, at			have replaced 200 hall west		
		ler that shows signs of any of			entrance, Medical Records,	,	
	_	be replaced: (1) Leakage (2) cal Damage (4) Loss of fluid in			Janitor's closet and front entra		
		responsive element (5)			exit carport/ overhang area w		
	-	g unless painted by the			new sprinkler heads. By 5/7/2 Tristate Fire will have provide		
		rer. This deficient practice			facility with spare pendent typ		
	-	20 resident, as well as staff			concealed sprinkler heads.	C	
	and visitors.	20 resident, as wen as starr			How will other residents w	ho	
	una visitors.				may have the potential to be		
	Findings include:				affected be identified?		
	8				·All residents, staff and visit	ors	
	Based on observation	ons on 03/11/25 between 1:00			have the potential to be affect		
	p.m. and 4:00 p.m.	during a tour of the facility with			What measures will be pu		
	the Maintenance Di	rector, the following was			into place or what systemati	С	
	noted:				changes will be made to		
		re was a sprinkler head under			ensure that the deficient		
		trance/exit overhang covered			practice does not reoccur.		
	with corrosion.				Executive Director educate		
	•	re was a sprinkler head in the			Maintenance Director on ensu	ıring	
		om partially covered with			sprinkler heads are free from		
	paint.	o vrog o oministanto 1 in 41 -			corrosion and paint and havin	•	
	•	re was a sprinkler head in the et covered with corrosion.			spare pendent type concealed	ג	
		re were nine concealed			sprinkler headsHow will the corrective		
	-	n metal covers under the front			action(s) be monitored to		
	-	t/overhang covered with			ensure the deficient practice	<u>.</u>	
	corrosion.	a a . criming co , cred with			will not reoccur and what Q		
	Based on interview	at the time of each			program will be put into place		
	observation, the Ma				Maintenance Director/		
		reviously mentioned sprinkler			Designee will audit sprinkler h	eads	
		with corrosion and paint.			to ensure they are free from		
		•			corrosion and paint and will a	udit	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155248	B. WI		<u>-                                      </u>	03/11/	
		1002.10			_	00/11/	2020
NAME OF F	PROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP COD		
TWIND OF I	NO VIDER OR SETTEME			30 E CH	HANDLER AVE		
BRICKY	ARD HEALTHCARE	E - BRENTWOOD CARE CENTER		EVANS	VILLE, IN 47713		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	BROWDENG BY AN ASSAURA		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	``	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
		viewed with the Area Vice			to ensure facility has spare		
		tenance Director during the			pendent type concealed sprink	ماء	
	exit conference.	tendine Director during the			heads. Maintenance Director/	dic.	
	exit conference.				Designee will audit 3X's a wee	k V1	
	3.1-19(b)				weeks, 1x week X 4 weeks, ar		
	3.1-17(0)						
	2 Raced on observe	ration and interview, the			1X per month X4 months. Dire		
		sure 1 of 1 sprinkler system was			of Maintenance/ Designee will		
		ninimum number of spare			report findings to QAPI X 6 months.		
	*	e sprinkler cabinet on the					
		bes and temperature ratings of			Systematic changes will be completed by 5/7/2025	;	
		e property. NFPA 25,			_		
	_	spection, Testing, and			Brentwood is requesting pap	er	
		spection, Testing, and ater-Based Fire Protection			compliance for K353		
	l -	ion, Section 5.4.1.4 states a					
		inklers (never fewer than six)					
		on the premises so that any					
	_	been operated or damaged in					
		mptly replaced. The sprinklers					
	_	the types and temperature					
		clers on the property. The					
	_	kept in a cabinet located where					
		which they are subjected will at					
		degrees Fahrenheit. A special					
	_	all be provided and kept in the					
		n the removal and installation					
		deficient practice could affect					
	all residents, staff a	nd visitors.					
	E. 1 1 1						
	Findings include:						
	Based on observation	ons on 03/11/25 at 3:10 p.m.					
		facility with the Maintenance					
		ppe concealed sprinkler heads					
		r the front entrance/exit					
		Based on observation of the					
		d cabinet in the Mechanical					
	_	ser Room at 3:18 p.m., there					
		pe concealed sprinkler heads					
	within the spare spi	rinkler cabinet or on the	1				

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i '		î í				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155248	A. BU B. W		01	COMPL 03/11/	
		133246	D. W.			03/11/	2025
NAME OF P	ROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
BRICKYA	ARD HEALTHCARE	- BRENTWOOD CARE CENTER			HANDLER AVE SVILLE, IN 47713		
			1		T		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		interview at the time of the		IAG			DATE
	1	aintenance Director agreed					
		cabinet did not contain any					
		aled spare sprinkler heads.					
		viewed with the Area Vice					
		tenance Director during the					
	exit conference.						
	3.1-19(b)						
	3.1 17(0)						
K 0355	NFPA 101						
SS=F	Portable Fire Extir	nguishers					
Bldg. 01							
		ation and interview, the	K 0	355	K355 Portable Fire		05/07/2025
	-	sure at least 4 of 28 portable fire			Extinguishers		
	_	ved were installed in			Date 5/7/2025		
		FPA 10. NFPA 10, Standard for			K355What corrective		
	_	guishers, 2010 Edition, Section			action was accomplished for	'	
		extinguishers having a gross ag 40 lb. shall be installed so			the resident found to have		
	_	re extinguisher is not more			been affected by the deficien	π	
	_	the floor. This deficient			practice.  ·By 5/7/2025 Maintenance		
		t all residents, staff, and			Director will have completed		
	visitors.	t dii Tesidents, suiri, diid			installing the 4 noted portable	fire	
					extinguishers to ensure the to		
	Findings include:				the fire extinguisher is not mor		
					than five feet above the floor.		
	Based on observation	ons on 03/11/25 during a tour			5/7/2025 Maintenance Directo	-	
	of the facility with t	the Maintenance Director, the			have a conspicuously placed		
	following was noted				placard near the portable K cla	ass	
	_	portable fire extinguisher in the			fire extinguisher which states		
		was mounted on the wall and			fire protection system shall be		
		3 inches at the top of the			activated prior to using the fire	,	
	extinguisher.				extinguisher.	_	
	_	portable fire extinguisher in the			How will other residents w		
	_	vas in a wall mounted box and			may have the potential to be		
	measured at 5 feet 8 inches at the top of the				affected be identified?		
	extinguisher.	n antable fine artin artists in the			·All residents, staff and visite		
	c. At 2:43 p.m. the p	portable fire extinguisher in the	1		have the potential to be affect	ea.	

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPLETED	
		155248	B. WI	NG		03/11/2025	
				CTD FFT A	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
DDIOIO					HANDLER AVE		
BRICKYARD HEALTHCARE - BRENTWOOD CARE CENTER			EVANS	VILLE, IN 47713			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	rc	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	I C	DATE
	Laundry Room was	mounted on the wall and			What measures will be put		
		3 inches at the top of the			into place or what systemation		
	extinguisher.	•			changes will be made to		
	_	portable fire extinguisher in the			ensure that the deficient		
	_	ning Room was in a wall			practice does not reoccur.		
		neasured at 5 feet 8 inches at			·Executive Director educated	4	
	the top of the exting				Maintenance Director on ensu		
	-	, this was acknowledged by			the top of the fire extinguisher	•	
		rector at the time of each			not more than five feet above		
	observation.				floor and to ensure a		
	00001 ( 441011)				conspicuously placed placard	ie	
	This finding was re	viewed with the Area Vice			near the portable K class fire		
	_	tenance Director during the			extinguisher which states the f	ire	
	exit conference.				protection system shall be		
	exit conference.				activated prior to using the fire		
	3.1-19(b)				extinguisher.		
	3.1-17(0)				How will the corrective		
	2 Based on observ	ration and interview, the			action(s) be monitored to		
		intain 1 of 1 portable fire			ensure the deficient practice		
	-	kitchen cooking area in			will not reoccur and what QA		
	-	e requirements of NFPA 10.			program will be put into place		
		for Portable Fire Extinguishers,			Maintenance Director/	<b>G</b> :	
		on 5.5.5 states fire extinguishers			Designee will audit portable fir	Δ	
		otection of cooking appliances			extinguishers to ensure the top		
	_	cooking media (vegetable or			the fire extinguisher is not mor		
	_	) shall be listed and labeled for			than five feet above the floor a		
		A 10, 5.5.5.3 states a placard			will audit to ensure a	III	
		the extinguisher that states			conspicuously placed placard	ie	
	-	system shall be actuated prior			near the portable K class fire	13	
	_	inguisher. Since the fixed fire			extinguisher which states the f	iro	
		m will automatically shut off			protection system shall be	116	
		ne cooking appliance, the fixed			activated prior to using the fire		
		ctivated before using the			extinguisher. Maintenance		
		uisher. In this instance, the			Director/ Designee will audit 33	Y's a	
		uisher is supplemental			week X4 weeks, 1x week X 4	n s a	
		ficient practice could affect			′		
	_	plus residents while in the			weeks, and 1X per month X4 months. Director of Maintenan	col	
		which was adjacent to the					
	kitchen.	vinon was aujacent to the			Designee will report findings to	,	
	KILCHEH.				QAPI X 6 months.		
			1		Systematic changes will be	<del>)</del>	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155248		A. BUILDING <u>01</u> COMP			(X3) DATE COMPL <b>03/11</b> /	ETED	
	PROVIDER OR SUPPLIER	- BRENTWOOD CARE CENTER		30 E CF	NDDRESS, CITY, STATE, ZIP COD HANDLER AVE VILLE, IN 47713		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	IID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)		ιΤΕ	(X5) COMPLETION DATE	
K 0363	during a tour of the Director, the portab located in the kitche conspicuously place extinguisher which system shall be activextinguisher. Based observation, the Mawas not aware of the as soon as possible.  This finding was reversident and Maintexit conference.  3.1-19(b)  NFPA 101				completed by 5/7/2025 Brentwood is requesting pay compliance for K355	per	
SS=E Bldg. 01	failed to ensure 1 of close complete and deficient practice costaff and visitors.  Findings include:  Based on observation during a tour of the Director, the door to North Unit exit door latch into the door f stuffed into the latch from close complete frame. Based on into	on and interview, the facility Fover 100 corridor doors would latch into its door frame. This build affect at least 20 residents,  ons on 03/11/25 at 2:18 p.m. facility with the Maintenance of the small closet next to the or did not close completely and frame. There was a cloth thing plate preventing the door fely and latching into the door terview at the time of intenance Director said he	K 03	363	K363 Corridor- Doors Date 5/7/2025  K363What 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 laplate from closing completely latching into the door frame. How will other residents with may have the potential to be affected be identified?  All residents, staff and visit have the potential to be affect.	e latch and rho	05/07/2025

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONST		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	a. building <u>01</u>		COMPI	COMPLETED	
		155248	B. W	ING		03/11/2025		
				CTREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	PROVIDER OR SUPPLIEF	L			HANDLER AVE			
BRICK∨/	ARD HEALTHOADE	- BRENTWOOD CARE CENTER	,		SVILLE, IN 47713			
DINONIA	" TILAL I I IOANE	- BILLINI WOOD OAKE CENTER		LVANO	· · · · · · · · · · · · · · · · · · ·			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		.ΤΕ	COMPLETION		
TAG		LSC IDENTIFYING INFORMATION	-	TAG DEFICIENCY)			DATE	
		meone would put the cloth in			What measures will be put			
		ut removed it at the time of			into place or what systemati	С		
	observation.				changes will be made to			
					ensure that the deficient			
	_	viewed with the Area Vice			practice does not reoccur.			
		tenance Director during the			Executive Director education			
	exit conference.				Maintenance Director/ Staff or			
	2.1.10/1->				utilizing cloths in latch plates a			
	3.1-19(b)				this prevents the door from clo	-		
					completely and latching into the	1e		
					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/	ær		
					Designee will audit latch plate	e to		
					ensure they are free from clot			
					that prevent the door from clos			
					completely and latching into the	-		
					door frame. Maintenance Dire			
					Designee will audit 3X's a wee			
					weeks, 1x week X 4 weeks, a			
					1X per month X4 months. Dire			
					of Maintenance/ Designee will			
					report findings to QAPI X 6			
					months.			
					Systematic changes will be	е		
					completed by 5/7/2025			
					Brentwood is requesting par	er		
					compliance for K363			
K 0711	NFPA 101							
SS=F Bldg. 01	Evacuation and R	elocation Plan						
=	Based on record rev	view and interview, the facility	K 0	711	K711 Evacuation and		05/07/2025	
	failed to provide a	complete facility specific			Relocation Plan			
	written fire safety p	lan for the protection of all			Date 5/7/2025			
	residents to accurate	ely address all life safety			K711What corrective			

PRINTED: 04/03/2025 FORM APPROVED

CENTERS FOR	MEDICARE & MEDIC					OM	IB NO. 0938-039	
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) N	MULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	A. BUILDING <u>01</u>			COMPLETED	
		155248	B. W	VING		03/11/	/2025	
		E - BRENTWOOD CARE CENTE	₹	30 E CI	ADDRESS, CITY, STATE, ZIP COD HANDLER AVE SVILLE, IN 47713 PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE	
	systems, plus a syst required by NFPA 119.7.2.2. LSC 19.7 occupancy fire safet the following: (1) Use of alarms (2) Transmission of (3) Emergency phot (4) Response to alart (5) Isolation of fire (6) Evacuation of sit (7) Evacuation of sit (8) Preparation of sit (8) Preparation of sit (9) Extinguishment Section 19.2.3.4(4) corridor shall not be width where serving patient sleeping roor required width shall equipment provided equipment during a addressed in the writaining program for equipment is limited it. Equipment in use ii. Medical emergen iii. Patient lift and to This deficient praction the event of an error Findings include:  Based on a review of 03/11/25 at 12:42 p.	em addressing all items 101, 2012 edition, Section 2.2.2 requires a written health care ty plan that shall provide for  alarm to fire department the call to fire department me call to fire department oors and building for  of fire states any required aisle or eless than 48 inches in clear g as means of egress from ms. Projections into the be permitted for wheeled the relocation of wheeled fire or similar emergency is itten fire safety plan and or the facility. The wheeled d to: and carts in use every equipment not in use ransport equipment ice could affect all occupants		TAG TAG	action was accomplished for the resident found to have been affected by the deficier practice.  By 5/7/2025 The Maintenar Director will have added color-coded identifiers to the fiplan to indicate the location of smoke barriers in the EPP Fire Plan and Evacuation. How will other residents with may have the potential to be affected be identified?  All residents, staff and visite have the potential to be affected be identified? 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 additionate 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 plate on the sure the accuracy of smooth partier color-coded identifiers.	ht nce door e ho ors ed.		
	identify where the s the facility and evac	t, however, the plan did not moke barriers were located in cuation in detail. Based on e of record review, the			the EPP Fire Plan and Evacuation. 3X's a week X4 weeks, 1x week X 4 weeks, at 1X per month X4 months. Dire			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155248		A. Bl	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 03/11/2025		
	PROVIDER OR SUPPLIER	- BRENTWOOD CARE CENTER	1	30 E CI	ADDRESS, CITY, STATE, ZIP COD HANDLER AVE SVILLE, IN 47713		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	did not identify who located in the facilit	or acknowledged the Fire Plan ere the smoke barriers were y and evacuation in detail. viewed with the Area Vice tenance Director during the			of Maintenance/ Designee wi report findings to QAPI X 6 months. Systematic changes will be completed by 5/7/2025 Brentwood is requesting pa compliance for K711	)e	
K 0712 SS=F Bldg. 01	facility failed to prodocumentation for laquarters. This defice residents, as well as facility.  Findings include:  Based on review of on 03/11/25 at 10:2.  Director present, the documentation avait of the third quarter of 2024. Based on review, the Maintent there was no fire drift the third shift of the This finding was review.	review and interview, the vide quarterly fire drill of 3 shifts during 1 of 4 cient practice could affect all staff and visitors in the the facility's fire drill reports 3 a.m. with the Maintenance ere was no fire drill lable for the third shift (night) (July, August, and September) interview at the time of record nance Director acknowledged ill report available to review for third quarter of 2024.	K 0	712	K712 Fire Drills Date 5/7/2025 K712What corrective action was accomplished for the resident found to have been affected by the deficie practice.  By 5/7/2025 The Maintena Director will have conducted monthly fire drill at a varied to and date. How will other residents with may have the potential to be affected be identified?  All residents, staff and visith have the potential to be affected. What measures will be pure into place or what systematic changes will be made to ensure that the deficient practice does not reoccur.  Executive Director educate Maintenance Director on vary time and dates of monthly firedrills. How will the corrective	nt nce a me who e tors ted. it ic	05/07/2025
	2. Based on record	review and interview, the			action(s) he monitored to		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155248		A. BUI	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 03/11/2025	
	PROVIDER OR SUPPLIER	- BRENTWOOD CARE CENTER	R	30 E CH	NDDRESS, CITY, STATE, ZIP COD HANDLER AVE VILLE, IN 47713		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	F	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION
K 0761 SS=E	facility failed to ensity varied times for 1 or 4 quarters, and varied 13 fire drills perform period. This deficie residents in the facility residents in the facility residents in the facility failed by the facility failed by the failed by	the facility's fire drill reports a.m. with the Maintenance the following was noted: (day) fire drills were performed a.m., and 2:09 p.m. to were performed during the last		TAG	ensure the deficient practice will not reoccur and what Querogram will be put into place.  'Maintenance Director/ Designee will audit monthly find tills to ensure they vary in tire and date. 3X's a week X4 weet 1x week X4 weeks, and 1X period month X4 months. Director of Maintenance/ Designee will refindings to QAPI X 6 months. Systematic changes will be completed by 5/7/2025  Brentwood is requesting parcompliance for K712	A ce? re ne eks, er eport	DATE
Bldg. 01	interview; the facili inspection and testin door assembly was LSC 19.1.1.4.1.1. C dividing fire barrier	on, record review, and ty failed to ensure an annual ng of 1 of 1 oxygen room fire completed in accordance with Communicating openings in as required by 19.1.1.4.1 shall be prefiders and shall be protected	K 07	61	K761 Maintenance, Inspection and Testing- Doors Date 5/7/2025 K761What corrective action was accomplished for the resident found to have been affected by the deficient	r	05/07/2025

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CON			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ЛLDING	01	COMPLETED	
		155248	B. W	ING		03/11/2025	
NAME OF P	DOMDED OF CURRY TO		-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	C		30 E CH	HANDLER AVE		
BRICKYA	ARD HEALTHCARE	- BRENTWOOD CARE CENTER		EVANS	VILLE, IN 47713		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
		osing fire door assemblies.			practice.		
	,	3.) LSC 8.3.3.1 Openings			·By 5/7/2025 The Maintenar		
	-	ire protection rating by Table			Director will have completed 0	<b> </b>	
	_	tected by approved, listed,			transfilling room annual fire do	oor	
		semblies and fire window			assembly inspection.	1	
		r accompanying hardware,			How will other residents w		
	-	s, closing devices, anchorage,			may have the potential to be		
		nce with the requirements of			affected be identified?	200	
		for Fire Doors and Other			·All residents, staff and visite		
	Opening Protectives, except as otherwise				have the potential to be affect		
	specified in this Code. NFPA 80 5.2.1 states fire				What measures will be put		
	door assemblies shall be inspected and tested not less than annually, and a written record of the				into place or what systematic changes will be made to		
	inspection shall be signed and kept for inspection				ensure that the deficient		
	-	. 80, 5.2.4.1 states fire door					
	-	visually inspected from both			practice does not reoccur.  Executive Director educate	tod	
		overall condition of door			Maintenance Director on	ieu	
	assembly.	verall collation of door			completing and adding checks	for	
	assemory.				the oxygen transfilling room fir		
	NFPA 80 5242 et	tates as a minimum, the			door assembly in TELS.	E	
	following items sha				How will the corrective		
	-	or breaks exist in surfaces of			action(s) be monitored to		
	either the door or fr				ensure the deficient practice		
		light frames, and glazing beads			will not reoccur and what QA		
		ely fastened in place, if so			program will be put into place		
	equipped.	, <u>F</u> <del>2</del> , 50			F 9. a v vo pat into piac		
	(3) The door, frame	e, hinges, hardware, and			·Maintenance Director/		
	noncombustible thre	eshold are secured, aligned,			Designee will audit to ensure		
	and in working orde	er with no visible signs of			annual fire door assembly		
	damage.				inspection in 02 transfilling roo		
	(4) No parts are mis	_			completed and documented ir	n	
		do not exceed clearances			TELS		
	listed in 4.8.4 and 6				3X's a week X4 weeks, 1x we		
		device is operational; that is,			4 weeks, and 1X per month X	4	
		pletely closes when operated			months. Director of Maintenar		
	from the full open p				Designee will report findings to	0	
		is installed, the inactive leaf			QAPI X 6 months.		
	closes before the ac				Systematic changes will be	e	
		are operates and secures the			completed by 5/7/2025		
	door when it is in th	ne closed position.	1		Brentwood is requesting par	ner	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	01	COMPL	LETED
		155248	B. W	ING		03/11/2025	
				T			
NAME OF P	ROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP COD		
BB10107					HANDLER AVE		
BRICKY	ARD HEALTHCARE	E - BRENTWOOD CARE CENTER		EVANS	VILLE, IN 47713		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	(9) Auxiliary hardw	vare items that interfere or			compliance for K761		
	prohibit operation a	are not installed on the door or					
	frame.						
		fications to the door assembly					
	-	ed that void the label.					
		edge seals, where required, are					
		their presence and integrity.					
	_	ice could affect at least 20					
	residents, as well as	s staff, and visitors.					
	Findings include:						
	D 1 1						
		view on 03/11/25 at 11:32 a.m.					
		ce Director present, the facility					
	-	ide documentation for an					
	-	f the oxygen transfilling room for the past 12 month period or					
	-	terview at the time of record					
	-	nance Director said there was					
		of an annual inspection of the					
		room fire door assembly					
		for the past 12 month period.					
		ons during a tour of the facility					
		and 4:00 p.m., there was one					
		room fire door assembly noted					
	in the facility.	,					
	This finding was re	viewed with the Area Vice					
	_	tenance Director during the					
	exit conference.	-					
	3.1-19(b)						
K 0914	NFPA 101						
SS=F	_	s - Maintenance and					
Bldg. 01	Testing						
		on, record review, and	K 0	914	K914 Electrical Systems-		05/07/2025
		ty failed to ensure complete			Maintenance and Testing		
	documentation was				Date 5/7/2025		
	nonhospital-grade e	electrical receptacles in all	1		K914What corrective		I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPLETED	
		155248	B. W	ING		03/11/202	25
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	t .			HANDLER AVE		
BRICKYA	ARD HEALTHCARE	- BRENTWOOD CARE CENTER			VILLE, IN 47713		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE CO	OMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	resident room locati	ions tested at least annually.			action was accomplished for	•	
	NFPA 99, Health C	Care Facilities Code 2012 Edition,			the resident found to have		
	Section 6.3.4.1.3 sta	ates receptacles not listed as			been affected by the deficier	nt	
	hospital-grade, at pa	atient bed locations and in			practice.		
	locations where dee	ep sedation or general			·By 5/7/2025 The Maintenar	nce	
	anesthesia is admin	istered, shall be tested at			Director will have completed a	nd	
	intervals not exceed	ling 12 months. Additionally,			added checks for physical		
	Section 6.3.3.2, Red	ceptacle Testing in Patient Care			integrity, grounding, and polar	ity to	
	Rooms requires the	physical integrity of each			the TELS preventative	1	
	receptacle shall be	confirmed by visual inspection.			maintenance program for ann	ual	
	The continuity of th	ne grounding circuit in each			resident room receptacle		
	electrical receptacle	e shall be verified. Correct			inspections.		
	polarity of the hot and neutral connections in				How will other residents w	ho	
	each electrical recep	ptacle shall be confirmed; and			may have the potential to be		
	retention force of th	ne grounding blade of each			affected be identified?		
	electrical receptacle	e (except locking-type			·All residents, staff and visito	ors	
	receptacles) shall be	e not less than 115 grams (4			have the potential to be affect	ed.	
	ounces). This defici	ient practice could affect all			What measures will be put	:	
	residents, staff, and	visitors.			into place or what systematic	c	
					changes will be made to		
	Findings include:				ensure that the deficient		
					practice does not reoccur.		
	Based on record rev	view on 03/11/25 at 11:56 a.m.			Executive Director educat	ed	
		ce Director present, there was			Maintenance Director on addi	ng	
		lable of an annual resident			checks for physical integrity,		
	-	t dated 01/2025 for all non			grounding, and polarity to the		
		ptacles, however, the			TELS preventative maintenan		
		not complete. It only			program for annual resident ro	oom	
		d retention force. The report			receptacle inspections.		
		ysical Integrity, Grounding,			How will the corrective		
		d on interview at the time of			action(s) be monitored to		
		Maintenance Director			ensure the deficient practice		
		025 report only included a			will not reoccur and what QA	- I	
		force for each resident room			program will be put into place	e?	
	-	Based on observations					
		and 4:00 p.m. during a tour of			·Maintenance Director/		
	•	Maintenance Director, there			Designee will audit to ensure i		
		lectrical receptacles in each			receptacles have been tested		
	resident room.				physical integrity, grounding, a	and	
					polarity and are documented i	n	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u> COMPLETE			ETED
		155248	B. WING 03/11/202			2025	
				STREET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	L		1	HANDLER AVE		
BRICKYA	ARD HEALTHCARE	- BRENTWOOD CARE CENTER	)		VILLE, IN 47713		
DICIONIA	IND HEALTHOAKE	- BRENTWOOD CARE CENTER	`	LVANO	, , , , , , , , , , , , , , , , , , ,		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	TAG DEFICIENCY)			DATE	
	_	viewed with the Area Vice			TELS		
		tenance Director during the		3X's a week X4 weeks, 1x we			
	exit conference.				4 weeks, and 1X per month X4		
					months. Director of Maintenan		
	3.1-19(b)				Designee will report findings to	)	
					QAPI X 6 months.		
					Systematic changes will be	<del>)</del>	
					completed by 5/7/2025		
					Brentwood is requesting pap	er	
					compliance for K914		
K 0921	NFPA 101						
SS=F	Electrical Equipme	ont Tosting and					
Bldg. 01	Maintenanc	ent - resting and					
Diag. 01		view, observation, and	K 0	021	K921 Electrical Equipment-		05/07/2025
		ty failed to conduct the	I K U	921	Testing and Maintenance		03/07/2023
		ce and maintain complete			Date 5/7/2025		
	_	aspections for Patient Care			K921What corrective		
		Equipment (PCREE). NFPA 99			action was accomplished for		
		ns 10.3 and 10.5 states the			the resident found to have		
		esistance, leakage current, and			been affected by the deficien	ıt	
		for fixed and portable PCREE			practice.	•	
		uired in 10.3. Testing intervals			·By 5/7/2025 The Maintenan	ice	
	-	policies and protocols. All	1 ,		Director will have completed a		
		ient care rooms is tested in			added TELS preventive		
	_	.3.5.4 or 10.3.6 before being put			maintenance checks for testing	a of	
		er any repair or modification.			PCREE i.eelectric beds,	9	
		ing of several electrical			nebulizers, oxygen, concentra	tors.	
		rates compliance with NFPA			air pumps for air mattresses a		
	* *	stem. Service manuals,			other electrical medical equipn		
		ocedures provided by the			How will other residents w		
	manufacturer includ	le information as required by			may have the potential to be		
	10.5.3.1.1 and are c	onsidered in the development			affected be identified?	ļ	
	of a program for ele	ectrical equipment maintenance.			·All residents, staff and visito	ors	
		nt instructions and maintenance			have the potential to be affected		
	manuals are readily	available, and safety labels			What measures will be put		
	and condensed operating instructions on the				into place or what systematic		
		e. A record of electrical			changes will be made to	ļ	
		pairs, and modifications is			ensure that the deficient	ļ	
		riod of time to demonstrate			practice does not reoccur.	ļ	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155248		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 03/11/2025	
	PROVIDER OR SUPPLIEI	RE- BRENTWOOD CARE CENTE	30 E C	ADDRESS, CITY, STATE, ZIP COD HANDLER AVE SVILLE, IN 47713	
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  Executive Director educat	DATE ed
	maintenance and us receive continuous practice could affect Findings include:	se of electrical appliances training. This deficient		Maintenance Director on addit 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 reaccur and what OA	cks.
	with the Maintenan no documentation for as electric beds, nell air pumps for air moderate equipment of record review, the facility has pure PCREE, but has not the PCREE items. 1:00 p.m. and 4:00 with the Maintenant facility provided PC oxygen concentrate mattresses, and oth was present in the formatter of the provided provide	ce Director present, there was for the testing of PCREE, such pulizers, oxygen concentrators, attresses, and other electrical. Based on interview at the time he Maintenance Director said chased the equipment to test tryet tested and documented Based on observation between p.m. during a tour of the facility ce Director, it was revealed the CREE such as electric beds, ors, air pumps for air er electrical medical equipment		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, week X 4 weeks, and 1X per month X4 months. Director of Maintenance/ Designee will refindings to QAPI X 6 months. Systematic changes will be completed by 5/7/2025 Brentwood is requesting page compliance for K921	e? 1x port
K 0927 SS=E Bldg. 01	Based on observation failed to ensure 1 of oxygen transfilling properly working n	Transfilling Cylinders on and interview, the facility f 1 oxygen storage room where takes place, was provided with nechanical ventilation. This ould affect at least 20 residents, visitors.	K 0927	K927 Gas Equipment- Transfilling Cylinders Date 5/7/2025 K927What corrective action was accomplished for the resident found to have	05/07/2025

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 03/11/2025 155248 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 30 E CHANDLER AVE BRICKYARD HEALTHCARE - BRENTWOOD CARE CENTER **EVANSVILLE, IN 47713** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE been affected by the deficient Findings include: practice. By 5/7/2025 The Maintenance Based on observation on 03/11/25 at 2:01 p.m. Director will have replaced the during a tour of the facility with the Maintenance exhaust fan motor in the Director, the oxygen storage/transfilling room was transfilling oxygen room. equipped with a mechanically vented exhaust fan, ---How will other residents who however, it was not working at the time of may have the potential to be observation. Based on interview at the time of affected be identified? observation, the Maintenance Director agreed the ·All residents, staff and visitors mechanically vented exhaust fan was not working. have the potential to be affected. ---What measures will be put This finding was reviewed with the Area Vice into place or what systematic President and Maintenance Director during the changes will be made to exit conference. ensure that the deficient practice does not reoccur. 3.1-19(b) 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.

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---Systematic changes will be completed by 5/7/2025

Brentwood is requesting paper

compliance for K927