STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155120	A. BUILDING -- B. WING	04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - BRANDYWINE CARE CENTER	745 N SWOPE ST GREENFIELD, IN 46140

(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: 04/15/25 Facility Number: 000050 Provider Number: 155120 AIM Number: 100266170 At this Emergency Preparedness survey, BRICKYARD HEALTHCARE - BRANDYWINE 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 128 certified beds. At the time of the survey, the census was 86. Quality Review completed on 04/23/25	E 0000	K000 Preparation, Submission, and Implementation of this plan of correction does not constitute an admission or agreement with the facts and conclusions set forth by the survey report. Our plan of correction was prepared and executed to continuously improve the quality of care and comply with all applicable federal and state requirements.	
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: 04/15/25 Facility Number: 000050 Provider Number: 155120 AIM Number: 100266170 At this Life Safety Code survey, BRICKYARD	K 0000	K000 Preparation, Submission, and Implementation of this plan of correction does not constitute an admission or agreement with the facts and conclusions set forth by the survey report. Our plan of correction was prepared and executed to continuously improve the quality of care and comply with all applicable federal and state requirements.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Colleen McCreary-Warnick	Executive Director	05/06/2025

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 - BRANDYWINE 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 (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and areas not separated from the corridor. The facility has battery operated smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 128 and had a census of 86 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 04/23/25			
K 0226 SS=E Bldg. 01	NFPA 101 Horizontal Exits Based on observation and interview, the facility failed to ensure 1 of over 3 horizontal exit fire door sets were arranged to automatically close and latch. LSC section 7.2.4.3.10 requires all fire door assemblies in horizontal exits shall be self-closing or automatic-closing. In addition NFPA 80, the Standard for Fire Doors and Other Opening Protectives, section 6.1.4.2.1 states self-closing doors shall swing easily and freely and shall be equipped with a closing device to cause the door to close and latch each time it is opened. This deficient could affect 21 residents in 2 smoke	K 0226	K226 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Near resident room number 52, the door was repaired to latch properly into the frame. How be identified and what	05/07/2025

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	compartments when occupied. Findings include: Based on observation and interviews with the Maintenance Director (MD) and Executive Director (ED) on 04/15/25, at 12:32 p.m., the 1 ½ hour rated fire door set near Resident Room # 52 was used as a horizontal exit and as a smoke barrier. When tested the doors failed to latch into the frame. Based on interview at the time of observation, the MD stated the fire door set was not latching into the frame and would need adjustment This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the MD and ED present. 3.1-19(b)		corrective action(s be taken? The deficit could affect 21 residents in 2 smoke compartments when occupied. Door to ensure they latched monitoring form will be created to ensure doors are latching properly in the door frames on a monthly basis. What corrective actions will be taken? A monitoring form will be created to ensure doors are latching properly in the door frames on a monthly basis. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur? A monitoring form will be created to ensure doors are latching properly in the door frames . The monthly audits will be completed by the Maintenace department, maintenance will report to QAPI monthly in perpetuity regarding life safety tags. By what date be completed?	

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			Systemic changes will be completed on 5/7/25.	
K 0325 SS=E Bldg. 01	NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) Based on observation and interview, the facility failed to ensure 1 of over 20 alcohol-based hand sanitizer dispensers were not installed over an ignition source. NFPA 101, Section 19.3.2.6(8) states dispensers shall not be installed in the following locations: (a) Above an ignition source within a 1-inch horizontal distance from each side of the ignition source (b) To the side of an ignition source within a 1-inch horizontal distance from the ignition source (c) Beneath an ignition source within a 1-inch vertical distance from the ignition source This deficient practice could affect 8 residents in one smoke compartment. Findings include: Based on observation and interviews with the Maintenance Director (MD) and Executive Director (ED) on 04/15/25, at 12:15 p.m., an alcohol-based hand sanitizer dispenser was installed on the wall directly above an electrical switch in the "ACU KITCHEN BREAK ROOM." Based on interview at the time of observation, the MD confirmed the alcohol-based hand sanitizer dispenser was installed on the wall directly above an electrical switch. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the MD and ED	K 0325	K325 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The alcohol-based hand sanitizer dispenser was removed from the break room. How be identified and what corrective action(s be taken? This deficient practice could affect 8 residents within 1 smoke audit was completed of all hand sanitizer dispensers to ensure they were properly located away from electrical switches. A monitoring form will be created to ensure alcohol-based sanitizers will not be located above an electrical switch and will be monitored on a monthly basis. What corrective actions will be taken?	05/07/2025

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	present. 3.1-19(b)		A monitoring form will be created to ensure alcohol-based sanitizers will not be located above an electrical switch and will be monitored on a monthly basis. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur? A monitoring form will be created to ensure alcohol-based sanitizers will not be located above an electrical switch and will be monitored on a monthly basis. The monthly audits will be completed by the Maintenace department, maintenance will report to QAPI monthly in perpetuity regarding life safety tags. By what date be completed? Systemic changes will be completed on 5/7/25.	
K 0341 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Installation Based on observation and interview, the facility	K 0341	K341	05/07/2025

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	failed to maintain the fire alarm system to assure that it had accurate time and date information in accordance with the requirements of NFPA 101-2012 edition, Sections 19.3.4 and 9.6 and NFPA 72 - 2010 edition, Sections 14.1, 14.1.1. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observation and interviews with the Maintenance Director (MD) and Executive Director (ED) on 04/15/25, at 12:04 p.m., the date on the fire alarm control panel was incorrect. The display on the main fire alarm control panel indicated the date to be one day earlier than the actual date. Based on interview at the time of observation, the MD indicated he was unaware of the discrepancy and would contact the alarm company to have the displayed date and time updated on the fire alarm control panel. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the MD and ED present. 3.1-19(b)		What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The date on the fire alarm control panel has been corrected. How be identified and what corrective action(s be taken? This deficient practice could affect all residents. The date on the fire alarm control panel has been corrected. A monitoring form will be created to ensure the fire alarm control panel is dated/current and will be monitored on a monthly basis. What corrective actions will be taken? A monitoring form will be created to ensure the fire alarm control panel is dated/current and will be monitored on a monthly basis. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur?	

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			A monitoring form will be created to ensure the fire alarm control panel is dated/current and will be monitored on a monthly basis. The monthly audits will be completed by the Maintenace department, maintenance will report to QAPI monthly in perpetuity regarding life safety tags. By what date be completed? Systemic changes will be completed on 5/7/25.	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Based on observation and interview, the facility failed to ensure the spray pattern for sprinkler heads was not obstructed in the Medical Supply Closest in accordance with 19.3.5.1. NFPA 13, 2010 edition, Section 8.5.5.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in 8.5.5.2 and 8.5.5.3 or additional sprinklers shall be provided to ensure adequate coverage of the hazard. Sections 8.5.5.2 and 8.5.5.3 do not permit continuous or noncontinuous obstructions less than or equal to 18 inches below the sprinkler deflector or in a horizontal plane more than 18 inches below the sprinkler deflector that prevent the spray pattern from fully developing. This deficient practice could affect up to 4 staff.	K 0351	K351 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The medical supply closet storage items were lowered below 18 inches from the ceiling. How be identified and what corrective action(s be taken?	05/07/2025

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	Findings include: Based on observation and interviews with the Maintenance Director (MD) and Executive Director (ED) on 04/15/25, at 11:45 a.m., in the Medical Supply Close storage was stacked within 18 inches of the ceiling. Based on interview at the time of observation, the MD acknowledged storage in the shelves was near the ceiling. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the MD and ED present. 3.1-19(b)		This deficient practice could affect up to 4 staff members. A monitoring form will be created to ensure the medical supplies in the closet storage are lowered below 18 inches from the ceiling and will be monitored on a monthly basis. What corrective actions will be taken? A monitoring form will be created to ensure the medical supplies in the closet storage are lowered below 18 inches from the ceiling and will be monitored on a monthly basis. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur? A monitoring form will be created to ensure the medical supplies in the closet storage are lowered below 18 inches from the ceiling and will be monitored on a monthly basis. The monthly audits will be completed by the Maintenace department, maintenance will report to QAPI monthly in perpetuity regarding life safety tags.	

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			By what date be completed? Systemic changes will be completed on 5/7/25.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on record review and interview, the facility failed to maintain 1 of 1 accelerator devices and switches on the automatic sprinkler system in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on observation and interviews with the Maintenance Director (MD) and Executive Director (ED) on 04/15/25, at 12:35 p.m., the	K 0353	K353 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The sprinkler riser gauge accelerator was returned to service and is working properly. How be identified and what corrective action(s be taken? This deficient practice could affect all residents, staff, and visitors in the facility. A monitoring form will be created to ensure the sprinkler riser gauge accelerator is working properly and will be monitored on a monthly basis.	05/07/2025

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	sprinkler riser had a gauge which was reflecting no pressure. The MD stated that the sprinkler servicing company had indicated that the DRY Sprinkler System's accelerator had an issue and had been bypassed. The MD stated that the situation with the accelerator had started around the time of the fire back in January. No documentation was presented to indicate the issue had been fixed. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the MD and ED present. 3.1-19(b)		What corrective actions will be taken? A monitoring form will be created to ensure the sprinkler riser gauge accelerator is working properly and will be monitored on a monthly basis. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur? A monitoring form will be created to ensure the sprinkler riser gauge accelerator is working properly and will be monitored on a monthly basis. The monthly audits will be completed by the Maintenace department, maintenance will report to QAPI monthly in perpetuity regarding life safety tags. By what date be completed? Systemic changes will be completed on 5/7/25.	

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K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Based on observation and interview, the facility failed to ensure 1 of 1 portable fire extinguishers in the maintenance shop was installed in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Section 6.1.3.4 states portable fire extinguishers other than wheeled extinguishers shall be installed using any of the following means. (1) Securely on a hanger intended for the extinguishers. (2) In the bracket supplied by the extinguisher manufacture. (3) In a listed bracket approved for such purpose. (3) In a cabinet or wall recess. This deficient practice was not in a resident care area but could affect staff in the maintenance shop. Findings include: Based on observation and interviews with the Maintenance Director (MD) and Executive Director (ED) on 04/15/25, at 12:42 p.m., an ABC portable fire extinguisher in the maintenance shop was sitting on the floor unsecured. Based on interview at the time of observation, the Maintenance Director agreed the extinguisher was sitting on the floor and stated it was intended to go into a smoking shed but there was uncertainty about the shed's future. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the MD and ED present. 3.1-19(b)	K 0355	K355 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The fire extinguisher has been removed from the floor in the maintenance room and has been mounted to the wall properly. How be identified and what corrective action(s be taken? This deficient practice was not in care area but could affect staff in the maintenance shop. An audit was completed to ensure extinguishers were properly mounted. A monitoring form will be created to ensure the fire extinguishers are mounted properly to the wall and will be monitored on a monthly basis. What corrective actions will be taken? A monitoring form will be created to ensure the fire extinguishers are mounted properly to the wall and	05/07/2025

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			will be monitored on a monthly basis. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur? A monitoring form will be created to ensure the fire extinguishers are mounted properly to the wall and will be monitored on a monthly basis. The monthly audits will be completed by the Maintenace department, maintenance will report to QAPI monthly in perpetuity regarding life safety tags. By what date be completed? Systemic changes will be completed on 5/7/25.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors 1. Based on observation and interview, the facility failed to ensure all corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke.	K 0363	K363 What corrective action will be	05/07/2025

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	This deficient practice could affect staff and 15 plus residents. Findings include: Based on observation and interviews with the Maintenance Director (MD) and Executive Director (ED) on 04/15/25, the following doors failed to latch positively into their respective door frames: a) At 11:45 a.m. the Double door set between the kitchen and the dining area. b) At 11:50 a.m. the Medical Supply Closet stored briefs. c) At 12:45 p.m. the Linen Closet near Resident Room #5. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the MD and ED present. 2. Based on observation and interview, the facility failed to ensure 1 of over 50 corridor doors would resist the passage of smoke. This deficient practice could affect 4 staff. Findings include: Based on observation and interviews with the Maintenance Director (MD) and Executive Director (ED) on 04/15/25, at 12:17 p.m., the door to the Soiled side of the laundry area was missing latching hardware on the door frame side. When completely shut the door did not latch positively into the door frame, creating a gap through with smoke could pass. The MD stated that the door latching hardware had arrived and would be		accomplished for those residents found to have been affected by the deficient practice? The double door set between the kitchen and the dining room, the medical supply closet stored briefs and the linen closet near resident room #5 was repaired to latch properly. The door to the soiled side of the laundry room was repaired and the latching hardware was replaced. The materials were on backorder prior to the the material arrived on the morning of the survey. How be identified and what corrective action(s be taken? This deficient practice could affect 15 residents and staff members. An audit was completed to ensure doors latched monitoring form will be created to ensure doors are latching properly and will be monitored on a monthly basis. What corrective actions will be taken? A monitoring form will be created to ensure doors are latching properly and will be monitored on a monthly basis.	

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	installed soon. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the MD and ED present. 3.1-19(b)		What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur? A monitoring form will be created to ensure doors are latching properly and will be monitored on a monthly basis. The monthly audits will be completed by the Maintenace department, maintenance will report to QAPI monthly in perpetuity regarding life safety tags. By what date be completed? Systemic changes will be completed on 5/7/25.	
K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills Based on record review and interview, the facility failed to conduct quarterly fire drills on unexpected days and at unexpected times under varying conditions. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on records review and interview with the Maintenance Director (MD) and Executive	K 0712	712 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Fire drills will be varied to include different times and dates each	05/07/2025

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	155120	A. BUILDING 01 B. WING	04/15/2025

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	Director (ED) on 04/15/25 at 11:35 a.m., 6 of 12 quarterly fire drills were conducted near the end of the month, around the 30th day of the month. These conditions do not allow fire drills to be conducted on unexpected and unpredictable days. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the MD and ED present. 3.1-19(b) 3.1-51(c)		month. How be identified and what corrective action(s be taken? This deficient practice could affect all residents, staff, and visitors in the facility. A schedule of the dates and times will be created to ensure fire drills are varied and include different times and dates each month. What corrective actions will be taken? A schedule of the dates and times will be created to ensure fire drills are varied and include different times and dates. The fire drills will remain unpredictable for staffing to ensure fire drills are at least 2 hours apart during different times throughout the month. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur? A schedule of the dates and times will be created to ensure fire drills are varied and include different	

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			times and dates. The fire drills will remain unpredictable for staffing to ensure fire drills are at least 2 hours apart during different times throughout the month. The monthly audits will be completed by the Maintenace department, maintenance will report to QAPI monthly in perpetuity regarding life safety tags. By what date be completed? Systemic changes will be completed on 5/7/25.	
K 0781 SS=E Bldg. 01	NFPA 101 Portable Space Heaters Based on observation and interview, the facility failed to ensure 1 of 1 Portable Space Heating devices in use in the facility in nonsleeping staff and employee areas contained a heating element which did not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This deficient practice could affect up to 3 staff in the DON office. Findings include: Based on observation and interviews with the Maintenance Director (MD) and Executive Director (ED) on 04/15/25, at 12:02 p.m., a portable space heater was in use in the DON office. Based on interview at the time of the observations, the	K 0781	K781 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The space heater in the DON office has been removed from the facility. How be identified and what corrective action(s be taken? This deficient practice could affect up to 3 staff members in the DON Office. An audit was completed to ensure there were no other space monitoring form will be created to ensure maintenance and documentation on space heaters including the maximum	05/07/2025

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	Maintenance Director agreed a space heater was being used. The provided policy addressed the use of "heat producing devices" in living and sleeping environments but did not address the maintenance and documentation of regular maintenance on such appliances, including the maximum temperature of the heating element (to not exceed 212 degrees). No documentation was presented to verify the maximum temperature of the heating element in the aforementioned portable space heater. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the MD and ED present. 3.1-19(b)		temperature of the heating element on a portable heater does not exceed 212 degrees Fahrenheit. What corrective actions will be taken? A monthly monitoring form will be created to ensure maintenance and documentation on space heaters including the maximum temperature of the heating element on a portable heater does not exceed 212 degrees Fahrenheit. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur? A monthly monitoring form will be created to ensure maintenance and documentation on space heaters including the maximum temperature of the heating element on a portable heater does not exceed 212 degrees Fahrenheit. The monthly audits will be completed by the Maintenace department, maintenance will report to QAPI monthly in perpetuity regarding life safety tags. By what date be completed? Systemic changes will be completed on 5/7/25.	
K 0920 SS=D Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords power strips powering medical equipment met the required UL rating of 1363A or 60601-1. This deficient practice	K 0920	K920 What corrective action will be accomplished for those residents found to have been affected by the	05/07/2025

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	affects one resident in room 57. Findings include: Based on observation and interviews with the Maintenance Director (MD) and Executive Director (ED) on 04/15/25, at 12:35 p.m., an oxygen concentrator was plugged into a power strip that did not meet 1363A or 60601-1. Based on interview at the time of observation, the Maintenance Director agreed an oxygen concentrator was plugged into a power strip that did not meet 1363A or 60601-1 and that the aforementioned power strip was also powering non-medical appliances and electronics. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the MD and ED present. 3.1-19(b)		deficient practice? The oxygen concentrator plug was originally plugged into the power strip and has since been removed from the power strip. The oxygen concentrator plug is now directly plugged into the wall outlet. How be identified and what corrective action(s be taken? This deficient practice could affect 1 resident in room #57. An audit was completed to ensure there were no oxygen concentrators plugged into strip. A monitoring form will be created to ensure all oxygen concentrators are plugged into an appropriate wall outlet. What corrective actions will be taken? A monthly monitoring form will be created all oxygen concentrators are plugged into an appropriate wall outlet. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur? A monthly monitoring form will be created all oxygen concentrators are plugged into an appropriate wall outlet. The monthly audits will be completed by the Maintenace department, maintenance will report to QAPI monthly in perpetuity regarding life safety tags. By what date be completed? Systemic changes will be completed on 5/7/25.	
K 0921 SS=F Bldg. 01	NFPA 101 Electrical Equipment - Testing and Maintenanc			

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	Based on records 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 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 affects all residents. Findings include: Based on records review, interview and facility tour with the Maintenance Director (MD) and Executive Director (ED) on 04/15/25, at 9:55 a.m. and throughout the afternoons tour, no documentation was available for review for the testing of the PCREE in use throughout the	K 0921	K921 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? PCREE Testing has been completed on all electrical beds, nebulizers, oxygen concentrators, vital sign monitors, and all other electrical medical equipment. How be identified and what corrective action(s be taken? This deficient practice could affect all residents. A monitoring form will be created to ensure required maintenance and maintain complete documentation of inspections for PCREE. What corrective actions will be taken? Audits will be conducted annually and as needed for new equipment and repairs on existing equipment. What measures will be put into place and what systemic changes	05/07/2025

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	facility, as required by section 10.5.6.2 of NFPA 99, Health Care Facilities Code. Observation during the building tour revealed that the facility provided electric beds for all residents. The ED stated that PCREE such as nebulizers, oxygen concentrators, vital signs monitors, and other electrical medical equipment was present and in use at the facility. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the MD and ED present. 3.1-19(b)		will be made to ensure that the deficient practice does not reoccur? Audits will be conducted annually and as needed for new equipment and repairs on existing equipment. Annual audits and as needed audits on new & existing equipment will be completed by the Maintenace department, maintenance will report to QAPI monthly in perpetuity regarding life safety tags. By what date be completed? Systemic changes will be completed on 5/7/25.	