PRINTED: 12/06/2024
FORM APPROVED

T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		JLTIPLE CO	ONSTRUCTION	(X3) DATE	CLIDATEM
OF CORRECTION	IDENTIFICATION NUMBER				(A3) DATE	SURVEY
155138		A. BU	ILDING		COMPLETED	
	155138	B. WI	NG		11/14/2024	
		R	2860 CI	HURCHMAN AVE	•	
SUMMARYS	STATEMENT OF DEFICIENCIE	1	ID			(X5)
			PROVIDER'S PLAN OF CORE PREFIX (EACH CORRECTIVE ACTION SH			COMPLETION
			TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE
conducted by the In-	diana Department of Health in	E 00	000			
Facility Number: 00 Provider Number: 1002 At this Emergency I Brickyard Healthcan was found in compl Preparedness Requi Medicaid Participate CFR 483.73. The facility has 115 the survey, the cens	200063 155138 266210 Preparedness survey, re - Churchman Care Center iance with Emergency rements for Medicare and ing Providers and Suppliers, 42 certified beds. At the time of us was 67.					
Licensure Survey w Department of Heal 483.90(a). Survey Date: 11/14 Facility Number: 00 Provider Number: 11	as conducted by the Indiana th in accordance with 42 CFR //24 00063 155138	K 00	000			
	An Emergency Preproducted by the Inaccordance with 42 Survey Date: 11/14 Facility Number: 00 Provider Number: 1002 At this Emergency I Brickyard Healthcan was found in compl Preparedness Requi Medicaid Participatis CFR 483.73. The facility has 115 the survey, the censure Survey was populated by the Complete Survey of the S	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 11/14/24 Facility Number: 000063 Provider Number: 155138 AIM Number: 100266210 At this Emergency Preparedness survey, Brickyard Healthcare - Churchman 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 115 certified beds. At the time of the survey, the census was 67. Quality Review completed on 11/20/24 A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR	RD HEALTHCARE - CHURCHMAN CARE CENTER SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 11/14/24 Facility Number: 000063 Provider Number: 155138 AIM Number: 100266210 At this Emergency Preparedness survey, Brickyard Healthcare - Churchman 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 115 certified beds. At the time of the survey, the census was 67. Quality Review completed on 11/20/24 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: 11/14/24 Facility Number: 000063 Provider Number: 155138	ROVIDER OR SUPPLIER RD HEALTHCARE - CHURCHMAN CARE CENTER SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 11/14/24 Facility Number: 000063 Provider Number: 155138 AIM Number: 100266210 At this Emergency Preparedness survey, Brickyard Healthcare - Churchman 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 115 certified beds. At the time of the survey, the census was 67. Quality Review completed on 11/20/24 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: 11/14/24 Facility Number: 000063 Provider Number: 155138	RD HEALTHCARE - CHURCHMAN CARE CENTER SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 11/14/24 Facility Number: 000063 Provider Number: 155138 AlM Number: 100266210 At this Emergency Preparedness survey, Brickyard Healthcare - Churchman 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 115 certified beds. At the time of the survey, the census was 67. Quality Review completed on 11/20/24 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: 11/14/24 Facility Number: 000063 Provider Number: 155138	ROYDER OR SUPPLIER RD HEALTHCARE - CHURCHMAN CARE CENTER SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL. REGULATORY OR LSC IDENTIFYING INFORMATION An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 11/14/24 Facility Number: 000063 Provider Number: 155138 AIM Number: 100266210 At this Emergency Preparedness survey, Brickyard Healthcare - Churchman 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 115 certified beds. At the time of the survey, the census was 67. Quality Review completed on 11/20/24 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: 11/14/24 Facility Number: 000063 Provider Number: 155138

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

At this Life Safety Code survey, Brickyard

TITLE (X6) DATE

Thomas Johnson Executive Director 12/02/2024

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 disclodays 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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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	LDING	01	COMPLETED	
		155138	B. WIN	IG		11/14/2024	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
BRICKYA	ARD HEALTHCARE	- CHURCHMAN CARE CENTER		INDIAN	APOLIS, IN 46203		
(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 APPROPRIATE		ΓE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		nman Care Center was found with Requirements for					
	-	dicare/Medicaid, 42 CFR					
	Subpart 483.90(a), Life Safety from Fire and the						
		National Fire Protection					
) 101, Life Safety Code (LSC),					
	410 IAC 16.2.	g Health Care Occupancies and					
	410 I/IC 10.2.						
	This one-story facil	ity with a basement was					
	determined to be of Type III (200) construction						
	• •	d except for the bathroom in					
	resident sleeping Room 43. The facility has a fire alarm system with smoke detection on all levels in						
	-	all areas open to the corridor.					
		ery operated smoke detectors					
	-	ent sleeping rooms. The					
		ty of 115 and had a census of					
	67 at the time of this	s visit.					
	All areas where resi	dents have customary access					
	-	cept for the bathroom in					
		oom 43. All areas providing					
	facility services wer	re sprinklered.					
	Quality Review con	npleted on 11/20/24					
K 0161	NFPA 101						
SS=F	Building Construct	tion Type and Height					
Bldg. 01	Based on observation	on and interview, the facility	K 01	61	K 161 Continued From page 3	K	12/02/2024
		building construction type			161 Based on observations wi	th	
		e as listed in Table 19.1.6.1.			the Executive Director and the		
	-	ires a Type III(200) one story			Maintenance Director during a		
		be fully sprinklered. This buld affect all residents, staff			of the facility from 12:00 p.m. t 1:50 p.m. on 11/14/24, this one		
	and visitors.	one arrest air residents, starr			story sprinklered building was		
					constructed of concrete block	and	
	Findings include:				the interior load bearing walls		
					wood frame. This results in a		

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Event ID:

T24C21

Facility ID: 000063

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155138	(X2) MULTIPLE C A. BUILDING B. WING	O1	(X3) DATE SURVEY COMPLETED 11/14/2024
	PROVIDER OR SUPPLIER	E - CHURCHMAN CARE CENTER	2860 (CADDRESS, CITY, STATE, ZIP COD CHURCHMAN AVE NAPOLIS, IN 46203	
BRICKY/ (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF Based on observation Director and the Matour of the facility for 11/14/24, this one so constructed of concluded bearing walls within a construction type (200). Based on obte Director and the Matour of the facility for 11/14/24, the bathred 43 was not sprinkle time of the observation Director agreed the Room 43 was not proposed to the sprinkler. These findings were	E - CHURCHMAN CARE CENTER STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LESC IDENTIFYING INFORMATION Ons with the Executive aintenance Director during a from 12:00 p.m. to 1:50 p.m. on tory sprinklered building was rete block and the interior were wood frame. This results oe classification of Type III servations with the Executive aintenance Director during a from 12:00 p.m. to 1:50 p.m. on boom for resident sleeping Room d. Based on interview at the tions, the Maintenance bathroom for resident sleeping rovided with an automatic e reviewed with the Executive aintenance Director during the		PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S CONSTRUCTION THE APPROVIDER'S CONSTRUCTION THE APPROVIDER'S CONSTRUCTION TO THE APPROVIDER'S CONSTRUCTION THE APPROVIDER'S CONSTRUCTION TO THE APPROVIDER'S CONSTRUCTION THE APPROVIDER CONSTRUCTION THE APPROVIDER CONSTRUCTION THE APPROVIDER'S CONSTRUCTION THE APPROVIDER CONSTRUCTION THE APPROVIDER CONSTRUCTION TO THE APPROVIDER CONSTRUCTION THE APPROVIDER CONSTRUCTION TO THE APPROVIDER CONSTRUCTION THE APPROVIDER CONSTRUCTION TO THE APPROVIDER CONTRIBUTION THE APPROVIDER CONSTRUCTION TO THE APPROVIDER CONTRIBUTION THE APPROVIDER CONSTRUCTION TO THE APPROVIDER CONTRIBUTION THE APPROVIDENCE OF	DATE COMPLETION DATE tion of utive ace a facility n. on was erview ons, the ed the oing with an I an dded audited nkler I an dded. smoke al to be cient s facility y 6 will arding
K 0324 SS=D	NFPA 101 Cooking Facilities			DOCUMENTATION INCLURESULTS OF FULL FACIL SPRINKLER COVERAGE AND COMPLETED TELS	LITY AUDIT

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Event ID:

T24C21

Facility ID: 000063

If continuation sheet

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-039
	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155138		JILDING	ONSTRUCTION 01	(X3) DATE COMPL 11/14/	ETED
NAME OF P	ROVIDER OR SUPPLIER	1		l	ADDRESS, CITY, STATE, ZIP COD HURCHMAN AVE		
BRICKY	ARD HEALTHCARE	- CHURCHMAN CARE CENTER		INDIAN	IAPOLIS, IN 46203		
(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 0351 SS=E Bldg. 01	failed to ensure 1 of system was maintain NFPA 96, Standard Fire Protection of C Operations, 2011 Enguires rooftop term or provided with a lawith flexible weather service hold-open round cleaning that is equipment. This detover two kitchen states are supported by the service hold-open round cleaning that is equipment. This detover two kitchen states are supported by the service hold-open round cleaning that is equipment. This detover two kitchen states are supported by the service hold-open round cleaning include: Based on review of inspection contracted dated 02/13/24 and Director during reconstructed dated 02/13/24 and Director during reconstruction and the service on interview at the support of the service holds and need on interview at the support of the service of the s	the kitchen range hood or's "Job Service Report" 08/21/24 with the Maintenance ord review from 9:05 a.m. to 14/24, fans for the kitchen range is. The "Notes" section of orts stated, "Both fans are d hinge kits installed". Based time of record review, the for stated hinge kits have not after 02/13/24. The reviewed with the Executive aintenance Director during the statement of the control of th	K 0.	324	K 324 Continued From page 5 324 fans are down blast and r hinge kits installed". Based on interview at the time of record review, the Maintenance Direct stated hinge kits have not beed installed on or after 02/13/24 1 Hinge kits were installed the kitchen hood exhaust fans 2 Hinge kits were installed the kitchen hood exhaust fans all residents have potential to affected by the alleged deficite practice 3 Upon installation Maintenance inspected the hin kits. 4 No further audits are requas this is a permanent fix. Maintenance will report to QA no less than quarterly in perper regarding life safety.	need ctor on and be nt uired	12/02/2024
		on and interview, the facility a complete automatic	K 0.	351	K 351 Continued From page 6 351 facility. This deficient practical from the continued of th		12/02/2024

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155138		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01 ADDRESS, CITY, STATE, ZIP COD	(X3) DATE SURVEY COMPLETED 11/14/2024	
	PROVIDER OR SUPPLIE	R E - CHURCHMAN CARE CENTER	2860 C	HURCHMAN AVE IAPOLIS, IN 46203	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	facility. This defice 10 residents, staff a resident sleeping R Findings include: Based on observation Director and the M tour of the facility 11/14/24, the bathred 43 was not sprinkle time of the observation of the obser	as installed throughout the ient practice could affect over and visitors in the vicinity of oom 43. ons with the Executive faintenance Director during a from 12:00 p.m. to 1:50 p.m. on oom for resident sleeping Room ed. Based on interview at the ations, the Maintenance bathroom for resident sleeping provided with an automatic re reviewed with the Executive faintenance Director during the		could affect over 10 residents, and visitors in the vicinity of resident sleeping Room 43. Findings include: Based on observations with the Executiv Director and the Maintenance Director during a tour of the fa from 12:00 p.m. to 1:50 p.m. of 11/14/24, the bathroom for resident sleeping Room 43 was not sprinkled. Based on intervat the time of the observations Maintenance Director agreed bathroom for resident sleeping Room 43 was not provided with automatic sprinkler. 1 1 Resident room 43 had a automatic sprinkler head added and the entire facility was aud to verify all areas have sprinkle heads. 2 Resident room 43 had are automatic sprinkler head added and the entire facility was aud to verify all areas have sprinkle heads. 2 Resident room 43 had are automatic sprinkler head added. The residents in the same smc compartment have potential to affected by the alleged deficite practice 3 An inspection task was added to tels to check the facility for sprinkler coverage every 6 months. 4 Maintenance director will report to QAPI no less than quarterly in perpetuity regardir life safety issues.	cility on as iew s, the the g th an ed ited er n ed. oke o be nt lity
K 0353 SS=E Bldg. 01		- Maintenance and Testing on and interview, the facility	K 0353	K 353	12/02/2024

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED	
		155138	B. WING		11/14/2024	
			STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	R		CHURCHMAN AVE		
BRICKY	ARD HEALTHCARE	- CHURCHMAN CARE CENTER		NAPOLIS, IN 46203		
Braidian		- OTIGITORINI, II V OTITLE VERY ET		VII 0210, IIV 10200		
(X4) ID	SUMMARY	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	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
		f over 100 sprinkler heads in		Continued From page 8 K 353		
		vere painted were replaced in		Director and the Maintenance		
		FPA 25. NFPA 25, Standard for		Director during a tour of the fa	-	
	the Inspection, Testing, and Maintenance of			from 12:00 p.m. to 1:50 p.m. o		
	Water-Based Fire Protection Systems, 2011			11/14/24, the deflector for the		
		2.1.1.1 states sprinklers shall not		ceiling mounted sprinkler insta		
	_	ge; shall be free of corrosion,		in the closet for resident sleep	-	
	-	aint, and physical damage; and		Room 2 was painted. Based of	n	
		the correct orientation (e.g.,		interview at the time of the		
		or sidewall). Furthermore, at		observations, the Maintenanc		
		tler that shows signs of any of		Director agreed the deflector t	or	
	the following shall be replaced:			the aforementioned sprinkler		
	(1) Leakage			location was painted.		
	(2) Corrosion (3) Physical Damag	70		1 The sprinkler head in resident room 2 closet was		
	1 ' ' ' '	the glass bulb heat responsive				
	element	the glass build heat responsive		changed. 2 The sprinkler head in		
	(5) Loading			resident room 2 closet was		
	` '	painted by the sprinkler		changed. Residents in the sar	mo	
	manufacturer.	painted by the sprinkler		smoke compartment have	ile	
		sprinklers that are loaded with		potential to be affected by the		
		to clean sprinklers with		alleged deficient practice.		
	_	y a vacuum provided that the		3 A monthly Fire Sprinkler		
	_	touch the sprinkler.		system in-house inspection w	as	
		ice could affect over 10		added to make sure sprinkler		
		visitors in the vicinity of		heads are clean and functional	al.	
	resident sleeping R	-		4 Maintenance director will		
]			report to QAPI no less than		
	Findings include:			quarterly in perpetuity regarding	na	
				life safety issues.	<u> </u>	
	Based on observation	ons with the Executive				
	Director and the Ma	aintenance Director during a				
		From 12:00 p.m. to 1:50 p.m. on				
	· ·	etor for the ceiling mounted				
		n the closet for resident				
	_	as painted. Based on interview				
		oservations, the Maintenance				
	Director agreed the	deflector for the				
	aforementioned spr	inkler location was painted.				
		_				

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155138	B. WI	NG		11/14/	2024
	ROVIDER OR SUPPLIER	E - CHURCHMAN CARE CENTER		2860 CI	ADDRESS, CITY, STATE, ZIP COD HURCHMAN AVE APOLIS, IN 46203		
(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	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	e reviewed with the Executive aintenance Director during the					
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extir	nguishers					
Blag. 01	failed to ensure 1 of were inspected at le inspections were do and initials of the poinspection in accord 9.7.4.1 states portable selected, installed, i accordance with NF Standard for Portable Edition, Section 7.2 shall be inspected ei an electronic monitor minimum of 30-day manual inspections manual inspections of the person perfor recorded. Where m conducted, records is be kept on a tag or lextinguisher, on an maintained on file, or Records shall be kept the last 12 monthly performed. This de over 10 residents, stof the A Wing nurse Findings include:	ation and interview, the facility of 20 portable fire extinguishers east monthly and the ecumented including the date erson performing the dance with NFPA 10. LSC ble fire extinguishers shall be inspected and maintained in FPA 10. NFPA 10, the le Fire Extinguishers, 2010 2.1.2 states fire extinguishers either manually or by means of coring device/system at a r intervals. Where monthly are conducted, the date the ewas performed and the initials eming the inspection shall be enanual inspections are for manual inspections shall label attached to the fire inspection checklist or by an electronic method. pt to demonstrate that at least inspections have been efficient practice could affect taff and visitors in the vicinity e's station.	K 03	355	the wall mounted ABC type portable fire extinguisher local in the Pantry at the A Wing nurse's station had missing monthly inspection documents for the most recent twelve morperiod. The portable fire extinguisher location was missits normally affixed maintenant tag to document monthly and annual inspections. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned portable fire extinguisher location had missimonthly inspection documents for the most recent twelve morperiod 1 The maintenance tag was replaced on the portable fire extinguisher in the A wing nursitation and all others were checked for appropriate tags. 2 The maintenance tag was replaced on the portable fire extinguisher in the A wing nursitation and all others were checked for appropriate tags. residents in the vicinity have the	ation nth sing ce e sing ation nth s ses	12/02/2024

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OM	B NO. 0938-039	
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	LDING	01	COMPLETED	
		155138	B. WIN	G		11/14/	2024
NAME OF	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP COD HURCHMAN AVE		
BRICKY	ARD HEALTHCARE	E - CHURCHMAN CARE CENTE	:R	INDIAN	IAPOLIS, IN 46203		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		aintenance Director during a			potential to be affected by the		
		from 12:00 p.m. to 1:50 p.m. on			alleged deficient practice.		
		mounted ABC type portable fire			3 A monthly inspection was		
	_	d in the Pantry at the A Wing			added to TELS to check all fire	•	
		missing monthly inspection			extinguishers		
		the most recent twelve month			4 Maintenance will report to		
		le fire extinguisher location			QAPI no less than quarterly in		
		mally affixed maintenance tag			perpetuity regarding life safety		
		aly and annual inspections.					
	Based on interview						
		faintenance Director agreed					
		portable fire extinguisher					
		g monthly inspection					
		the most recent twelve month					
	period.						
	These findings wer	e reviewed with the Executive					
	Director and the M	aintenance Director during the					
	exit conference.						
	3.1-19(b)						
	2. Based on observ	ation and interview, the facility					
	failed to ensure 1 o	f 20 portable fire extinguishers					
	was given maintena	ance at periods not more than					
	one year apart. NF	PA 10, the Standard for					
	Portable Fire Extin	guishers, at Section 7.3.1.1.1					
	requires that fire ex	tinguishers shall be subjected					
		ntervals of not more than 1					
	year, at the time of	hydrostatic test, or when					
	specifically indicate	ed by an inspection or					
		ion. Section 3.3.15 defines					
	extinguisher mainte	enance as a thorough					
		fire extinguisher that is					
		aximum assurance that a fire					
	extinguisher will of	perate effectively and safely					
	and to determine if	physical damage or condition					
	will prevent its ope	ration, if any repair or					
	_	essary, and if hydrostatic					

testing or internal maintenance is required.

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED	
		155138	B. WING		11/14/2024	
NAME OF D	DOWNED OF CURRINE		STREET	ADDRESS, CITY, STATE, ZIP COD	•	
	PROVIDER OR SUPPLIER			CHURCHMAN AVE		
BRICKYA	ARD HEALTHCARE	- CHURCHMAN CARE CENTER	INDIA	NAPOLIS, IN 46203		
(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		
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
		each fire extinguisher shall securely attached that				
	_	and year the maintenance was				
		es the person performing the				
	work, and identifies the name of the agency performing the work. This deficient practice could					
	affect over 10 reside	ents, staff and visitors in the				
	vicinity of the A Wi	ing nurse's station.				
	Findings include:					
	D 1 1	ad r				
		ons with the Executive Aintenance Director during a				
		rom 12:00 p.m. to 1:50 p.m. on				
		nounted ABC type portable fire				
		I in the Pantry at the A Wing				
	-	nissing annual inspection				
	documentation for t	he most recent twelve month				
		le fire extinguisher location				
	-	mally affixed maintenance tag				
		ual inspection. Based on				
		e of the observations, the				
		for agreed the aforementioned				
	annual inspection de	uisher location had missing				
	amaar inspection to	o o o o o o o o o o o o o o o o o o o				
	_	e reviewed with the Executive				
	Director and the Ma	aintenance Director during the				
	exit conference.					
	3.1-19(b)					
K 0363	NFPA 101					
SS=E	Corridor - Doors					
Bldg. 01	Raced on observation	on and interview, the facility	V 02/2	K363	12/02/2024	
		f over 50 corridor doors to	K 0363	Based on observations with the	12/02/2024	
		oms had no impediment to		Executive Director and the		
		g into the door frame and		Maintenance Director during a	a tour	
		sage of smoke. This deficient		of the facility from 12:00 p.m.		

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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	ILDING	01	COMPL	
		155138	B. WI	NG		11/14/	2024
	PROVIDER OR SUPPLIEI	R E - CHURCHMAN CARE CENTER		2860 C	ADDRESS, CITY, STATE, ZIP COD HURCHMAN AVE IAPOLIS, IN 46203		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	BROWDERIC DI ANI OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY 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 OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	1 ^	et over 10 residents, staff and			1:50 p.m. on 11/14/24, the cor	ridor	
	visitors in the vicin	ity of resident sleeping Room			door to resident sleeping Roor		
	6.				failed to fully close and latch in		
					the door frame when tested to		
	Findings include:				close multiple times. The latch	ing	
					mechanism on		
		ons with the Executive			the door failed to protrude into		
		aintenance Director during a from 12:00 p.m. to 1:50 p.m. on			latching plate on the door fram Based on interview at the time		
		dor door to resident sleeping			the observations, the Mainten		
		ally close and latch into the door			Director agreed the	al ice	
	frame when tested to close multiple times. The				aforementioned corridor door	had	
	latching mechanism on the door failed to protrude into the latching plate on the door frame. Based				an impediment to latching into		
					door frame and would not resi		
		time of the observations, the			the passage of smoke.		
	Maintenance Direc	tor agreed the aforementioned			1 The door latch to residen	t	
	corridor door had a	n impediment to latching into			room 6 was repaired to close	and	
	the door frame and	would not resist the passage			latch properly.		
	of smoke.				2 The door latch to residen		
					room 6 was repaired to close		
	_	e reviewed with the Executive			latch properly. All residents wi		
		aintenance Director during the			the same smoke compartmen		
	exit conference.				have potential to be affected b	'y	
	2.1.10(%)				the alleged deficient practice.	-le	
	3.1-19(b)				3 A monthly door latch che task was added to TELS to ch		
					for proper door latching.	ECK	
					Maintenance will report to QA	ΡI	
					no less than quarterly in perpe		
					regarding life safety	rearry	
			1				
K 0753	NFPA 101						
SS=E	Combustible Dec	orations					
Bldg. 01							
		on and interview, the facility	K 0'	753	K 753 Continued From page 1		12/02/2024
		f over 50 corridor doors were			753 Wing nurse's station. Find	_	
		rdance with 19.7.5.6. 19.7.5.6			include: Based on observation		
		decorations shall be prohibited			with the Executive Director an		
		occupancy, unless one of the			the Maintenance Director duri	-	
I	following criteria is	s met:	1		tour of the facility from 12:00 p	ı.m.	1

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OMB NO. 0938-039 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 11/14/2024 155138 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2860 CHURCHMAN AVE BRICKYARD HEALTHCARE - CHURCHMAN CARE CENTER INDIANAPOLIS, IN 46203 (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 (1) They are flame-retardant or are treated with to 1:50 p.m. on 11/14/24, approved fire-retardant coating that is listed and Christmas themed wrapping paper labeled for application to the material to which it is was affixed to 60% or more of the corridor side of the three corridor (2) The decorations meet the requirements of doors at the A Wing nurse's NFPA 701, Standard Methods of Fire Tests for station. In addition, wrapping Flame Propagation of Textiles and Films. paper was also affixed to more (3) The decorations exhibit a heat release rate not than 80% of the corridor side of exceeding 100 kW when tested in accordance with the corridor door to the closet NFPA 289, Standard Method of Fire Test for directly across from the A Wing Individual Fuel Packages, using the 20 kW nurse's station. Based on interview ignition source. at the time of the observations, the (4)*The decorations, such as photographs, Maintenance Director stated he paintings, and other art, are attached directly to didn't know if the wrapping paper the walls, ceiling, and non-fire-rated doors in was fire retardant, the wrapping accordance with the following: paper was not treated with fire (a) Decorations on non-fire-rated doors do not retardant material and agreed the interfere with the operation or any required affixed wrapping paper exceeded latching of the door and do not exceed the area 30 percent of the face of the limitations of 19.7.5.6(b), (c), or (d). corridor door to aforementioned (b) Decorations do not exceed 20 percent of the four rooms wall, ceiling, and door areas inside any room or All facility corridor doors space of a smoke compartment that is not were cleared of Christmas protected throughout by an approved automatic decorations to less than 30% of sprinkler system in accordance with Section 9.7. the surface area and treated with (c) Decorations do not exceed 30 percent of the fire retardant or was completely wall, ceiling, and door areas inside any room or removed. space of a smoke compartment that is protected All facility corridor doors 2 throughout by an approved supervised automatic were cleared of Christmas sprinkler system in accordance with Section 9.7. decorations to less than 30% of (d) Decorations do not exceed 50 percent of the the surface area and treated with wall, ceiling, and door areas inside patient fire retardant or was completely sleeping rooms having a capacity not exceeding removed. four persons, in a smoke compartment that is A weekly paper audit was protected throughout by an approved, supervised created to monitor and ensure automatic sprinkler system in accordance with staff and residents are compliant Section 9.7. with proper fire safety regarding

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(5)*They are decorations, such as photographs

and paintings, in such limited quantities that a

hazard of fire development or spread is not

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decorations until after the holiday

removed. ALL STAFF WILL BE

season décor is completely

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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	ILDING	01	COMPLETED	
		155138	B. WI	NG		11/14/	2024
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	8			HURCHMAN AVE		
BRICKY	ARD HEALTHCARE	- CHURCHMAN CARE CENTER			APOLIS, IN 46203		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	TRAINED ON PROPER HOLI	DAY	DATE
	present. This deficient pract	ice could affect over 10			DÉCOR.	DAT	
	-	visitors in the vicinity of the B			4 Maintenance will report to	,	
	Wing nurse's station	_			QAPI no less than quarterly in		
	S				perpetuity regarding life safety		
	Findings include:						
	Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 12:00 p.m. to 1:50 p.m. on 11/14/24, Christmas themed wrapping paper was affixed to 60% or more of the corridor side of the three corridor doors at the A Wing nurse's station. In addition, wrapping paper was also						
		n 80% of the corridor side of					
		the closet directly across from					
		station. Based on interview at					
	_	ervations, the Maintenance					
		lidn't know if the wrapping					
		dant, the wrapping paper was					
		e retardant material and agreed					
		g paper exceeded 30 percent of					
	four rooms.	dor door to aforementioned					
	_	e reviewed with the Executive					
		aintenance Director during the					
	exit conference.						
	3.1-19(b)						
K 0761	NFPA 101						
SS=F Bldg. 01		pection & Testing - Doors					
ыug. U I	Based on record rev	view, observation and	K 07	761	K 761 Continued From page 1	8 K	12/02/2024
		ity failed to ensure annual	IX U	, 01	761 documentation did not inc		12/02/2024
		ng of all fire door assemblies			the stairwell door to the basem		
	•	accordance with LSC			by the kitchen. Based on		
		nunicating openings in dividing			observations with the Executiv	e	
	fire barriers require	d by 19.1.1.4.1 shall be			Director and the Maintenance		

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	01	COMPL	ETED
		155138	B. W	ING		11/14/	/2024
				_			
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
					HURCHMAN AVE		
BRICKY	ARD HEALTHCARI	E - CHURCHMAN CARE CENTER		INDIAN	APOLIS, IN 46203		
(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	ATE.	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	permitted only in c	orridors and shall be protected			Director during a tour of the fa	ıcility	
	by approved self-cl	osing fire door assemblies.			from 12:00 p.m. to 1:50 p.m. o	on	
	(See also Section 8	.3.) LSC 8.3.3.1 Openings			11/14/24, the stairwell door to	the	
	required to have a fire protection rating by Table				basement near the kitchen wa	as	
	8.3.4.2 shall be protected by approved, listed,				equipped with a 90-minute fire	•	
	labeled fire door as	semblies and fire window			resistance rating label affixed		
	assemblies and their accompanying hardware,				the hinge side of the door.		
	including all frames, closing devices, anchorage,				1 A fire door inspection wa	s	
	_	nce with the requirements of			conducted on the stairwell do		
		l for Fire Doors and Other			the basement by the kitchen.		
		es, except as otherwise			2 A fire door inspection wa	s	
		ode. NFPA 80 5.2.1 states fire			conducted on the stairwell do		
	_	all be inspected and tested not			the basement by the kitchen.		
	less than annually, and a written record of the				residents in the adjacent area		
	1	signed and kept for inspection			have potential to be affected by		
	_	\$ 80, 5.2.4.1 states fire door			the alleged deficient practice.	. ,	
	1 -	visually inspected from both			3 A location log was sent to	0	
		overall condition of door			TELS to add all locations of th		
	assembly.				fire doors in a recurring annua		
					inspection of the fire doors		
	NFPA 80, 5,2,4,2 s	tates as a minimum, the			including the stairwell door to	the	
	following items sha				basement by the kitchen.	110	
	_	or breaks exist in surfaces of			4 Maintenance will report to	0	
	either the door or fi				QAPI no less than quarterly in		
		light frames, and glazing beads			perpetuity regarding life safety		
		rely fastened in place, if so			Perpetuity regarding life salety	<i>!</i> =	
	equipped.	or, rastelled in place, it so					
		e, hinges, hardware, and					
	` /	reshold are secured, aligned,					
		er with no visible signs of					
	damage.	or with no visione signs of					
	(4) No parts are mi	ssing or broken					
	_	s do not exceed clearances					
	listed in 4.8.4 and 6						
		g device is operational; that is,					
		npletely closes when operated					
	from the full open	•					
	1 1	is installed, the inactive leaf					
	closes before the ac						
	(8) Latching hardw	are operates and secures the	1				

CENTERS FO	R MEDICARE & MED	ICAID SERVICES				ON	MB NO. 0938-039	
STATEME	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	a. building <u>01</u>			COMPLETED	
155138		B. W	B. WING			11/14/2024		
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF	NAME OF PROVIDER OR SUPPLIER				HURCHMAN AVE			
BRICKY	ARD HEALTHCAF	RE - CHURCHMAN CARE CENTE	ER .	INDIAN	APOLIS, IN 46203			
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTI		(X5)	
PREFIX	(EACH DEFICI	ENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO) BE)PRIATE	COMPLETION	
TAG		OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		the closed position.						
		dware items that interfere or						
	prohibit operation	are not installed on the door or						
	frame.							
		difications to the door assembly						
	have been perform	ned that void the label.						
	(11) Gasketing ar	nd edge seals, where required, are						
	inspected to verif	y their presence and integrity.						
	This deficient pra	ctice could affect all residents,						
	staff and visitors.							
	Findings include:							
	Based on review	of Direct Supply TELS Logbook						
		Inspection-Latch and Gap"						
		ated 10/22/24 with the						
		ector during record review from						
		0 p.m. on 11/14/24, annual fire door						
		entation for all fire doors in the						
	_	e most recent twelve month						
	-	railable for review. The						
	_	nnual fire door inspection						
		d not include the stairwell door						
		y the kitchen. Based on						
		the Executive Director and the						
		ector during a tour of the facility						
		to 1:50 p.m. on 11/14/24, the						
	_	the basement near the kitchen						
	was equipped wit	h a 90-minute fire resistance						
		ed to the hinge side of the door.						
		ere reviewed with the Executive						
		Maintenance Director during the						
	exit conference.							
	3.1-19(b)							
K 0914	NFPA 101							

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Testing

Electrical Systems - Maintenance and

SS=E

Bldg. 01

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPL	COMPLETED	
		155138	B. WING		11/14	11/14/2024	
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER							
				2860 CHURCHMAN AVE INDIANAPOLIS, IN 46203			
BRICKYARD HEALTHCARE - CHURCHMAN CARE CENTER							
(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	ATE	COMPLETION
TAG	+	R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
		view, observation and	K 0914		K914		12/02/2024
	interview; the facility failed to ensure		Testing" 08/28/24		Based on review of "Receptacle Testing" documentation dated		
	nonhospital-grade electrical receptacles that failed						
	annual testing in 7 of over 50 resident rooms were				08/28/24 with the Maintenanc		
	replaced with hospital-grade receptacles. NFPA				Director during record review from		
		lectrical Code, 2011 Edition, at			9:05 a.m. to 12:00 p.m. on		
		tates each patient bed location			11/14/24, select electrical		
	shall be provided with a minimum of four				receptacles in outlet boxes in		
		hall be permitted to be of the			seven resident sleeping rooms		
		uadruplex type, or any			•	failed annual inspection and	
	combination of the three. All receptacles, whether				testing. Each of the receptacle		
		be listed "hospital grade" and			which failed annual inspection and		
		not intended that there be a			testing were listed as failing d	ue to	
		placement of existing			"Retention Force > 4 ounces"	. The	
		receptacles. It is intended,			August 2024 inspection and		
		hospital grade receptacles be			testing documentation did not		
	_	ital grade receptacles upon			indicate the receptacles which	า	
		e, renovation, or as existing			failed testing were replaced. I	n	
	receptacles need replacement. This deficient		addition, the 08/28/24 "Receptacle		tacle		
	practice could affect over 7 residents.			Testing" documentation was			
					itemized by room locations bu	ıt	
	Findings include:				receptacles within the room(s)	
					were not itemized to indicate		
		"Receptacle Testing"			which specific receptacles we	re	
		ed 08/28/24 with the			tested. The select receptacle		
		tor during record review from			outlet boxes in resident sleep	ing	
	9:05 a.m. to 12:00	p.m. on 11/14/24, select electrical			rooms identified in the August	t	
	receptacles in outle	t boxes in seven resident			2024 testing as failing were		
		ed annual inspection and			located in: a. Room 24. b. Ro	om	
		e receptacles which failed			26. c. Room 28. d. Room 32.		
		nd testing were listed as			Room 37. f. Room 54. g. Roo	m	
	_	ention Force > 4 ounces". The			58. Based on interview at the	time	
	August 2024 inspec	_			of record review, the Mainten	ance	
		not indicate the receptacles			Director stated the receptacle	s	
	which failed testing	g were replaced. In addition,			which failed testing have not	/et	
	the 08/28/24 "Rece	ptacle Testing" documentation			been replaced. Based on		
	was itemized by ro	om locations but receptacles			observations with the Executi	ve	
	within the room(s)	were not itemized to indicate			Director and the Maintenance	!	
	which specific rece	ptacles were tested. The select			Director during a tour of the fa	acility	
		oxes in resident sleeping rooms			from 12:00 p.m. to 1:50 p.m. o	-	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	a. Building <u>01</u>		COMPLETED		
		155138	B. WING		11/14/2024		
NAME OF PROVIDER OR SUPPLIER BRICKYARD HEALTHCARE - CHURCHMAN CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 2860 CHURCHMAN AVE				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
	identified in the August 2024 testing as failing			11/14/24, outlet boxes which t	failed		
	were located in:			08/28/24 testing in resident			
	a. Room 24.			sleeping rooms 28, 54 and 58			
	b. Room 26.			were not hospital-grade			
	c. Room 28.			receptacles. The other four			
	d. Room 32.			resident sleeping rooms did n	ot		
	e. Room 37.			have access due to the reside	ents		
	f. Room 54.			being under isolation precauti	ons		
	g. Room 58.			due to infectious disease			
	Based on interview	at the time of record review,		concerns.			
	the Maintenance D	irector stated the receptacles		1 All resident room electric	al		
	which failed testing	g have not yet been replaced.		receptacles were inspected a	nd		
	Based on observation	ons with the Executive		tested and recorded and each	1		
	Director and the M	aintenance Director during a		individual outlet was recorded	. All		
	tour of the facility t	from 12:00 p.m. to 1:50 p.m. on		receptacles that failed were			
	11/14/24, outlet box	xes which failed 08/28/24		replaced with "green dot"			
	testing in resident s	leeping rooms 28, 54 and 58		hospital-grade receptacles.			
	were not hospital-g	rade receptacles. The other		2 All resident room electric	al		
	four resident sleepi	ng rooms did not have access		receptacles were inspected a	nd		
	due to the residents	being under isolation		tested and recorded and each	ı		
	precautions due to	infectious disease concerns.		individual outlet was recorded	. All		
				receptacles that failed were			
	These findings wer	e reviewed with the Executive		replaced with "green dot"			
	Director and the M	aintenance Director during the		hospital-grade receptacles. Al	I		
	exit conference.			resident in the aforementioned	b		
				rooms have potential to be			
	3.1-19(b)			affected by the alleged deficie	nt		
				practice.			
				3 An annual receptacle			
				inspection and testing task wa	as		
				added to TELS and document			
				of the inspection is required to	be l		
				downloaded upon completion.			
				4 Maintenance will report to	I		
				QAPI no less than quarterly in			
				perpetuity regarding life safety			

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