CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES	OMB NO. 093				
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155252	(X2) MULT A. BUILE B. WING		(X3) DATE SURVEY COMPLETED 06/23/2025		
	PROVIDER OR SUPPLIER	E - WOODLANDS CARE CENTE	STREET ADDRESS, CITY, STATE, ZIP COD 4088 FRAME RD ER NEWBURGH, IN 47630				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PRI	D PROVIDER'S PLAN OF CORE EFIX (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	IOULD BE COMPLETION		
E 0000							
Bldg	conducted by the In accordance with 42 Survey Date: 06/23 Facility Number: 0 Provider Number: 100 At this Emergency Brickyard Healthca found not in compli Preparedness Requi Medicaid Participat CFR 483.73	00155 155252 266830 Preparedness survey, re-Woodlands Care Center was ance with Emergency frements for Medicare and ing Providers and Suppliers, 42	E 0000	Preparation and submist Plan Of Correction does constitute any admission agreement of any kind facility of the truth of an conclusion set forth in the allegation. Accordingly, has prepared and submisted Plan of Correction sole requirement under State Federal Law that mand submission of a Plan of as a condition to particity Title 18 and 19 program provide the best possible our residents as possible.	es not on or by the ny this , the facility nits this ly as a te and lates a f Correction ipate in ns, and to ole care to		
E 0041 SS=F Bldg	the survey, the cens Quality Review cor The requirement at MET as evidenced 482.15(e), 483.73 Hospital CAH and Based on record rev failed to implement inspection, testing, found in the Health 110, and Life Safet; CFR 483.73(e)(2). 1. Based on record	npleted on 06/26/25 42 CFR, Subpart 483.73 is NOT	E 0041	E041F What corrective will be accomplished for residents found to have the deficient practice. The generator load perwill be recorded in the relational documentational bank test was confused by June 25, 2025. A professional processional	or those e been by ercentage monthly full ation and a ducted on		

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

(X6) DATE

TITLE

Maribeth Donaldson Executive Director 07/03/2025

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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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155252		l í	JILDING	ONSTRUCTION	(X3) DATE S COMPLI 06/23/2	ETED	
	PROVIDER OR SUPPLIEF	- WOODLANDS CARE CENTER		4088 FI	ADDRESS, CITY, STATE, ZIP COD RAME RD JRGH, IN 47630		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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)	TE	(X5) COMPLETION DATE
	generator during 12 Chapter 6.4.4.1.1.4 monthly testing of t emergency electrics with NFPA 110, the	or load testing for 1 of 1 of the past 12 months. (a) of 2012 NFPA 99 requires the generator serving the al system to be in accordance e Standard for Emergency and stems, Chapter 8. Chapter			routine maintenance and an annual diesel fuel test was conducted at that time by the emergency generator contract	tor.	
	6.4.4.2 of NFPA 99 inspection, perform repairs for the gene maintained and ava authority having jui	requires a written record of ance, exercising period, and			How other residents have th potential to be affected will be identified All residents have the potenti be affected		
	Findings include: Based on record review on 06/23/25 at 11:30 a.m. with the Maintenance Director present, there was no documentation on the generator monthly load test log for percentage of load for the past 12 month period. Based on interview at 11:30 a.m., the Maintenance Director confirmed there was no percentage of load documented on the monthly generator log for the past 12 month period. This finding was reviewed with the Maintenance Director during the exit conference.				What measures will be put in place or what systemic chang will be made to ensure that the deficient practice does not recompleted to include the load percentage on ameplate kw. Also, an annuload bank test, preventative remaintenance annually and an annual fuel test will be completed.	es e uur f al	
	facility failed to exemeet the requireme the Standard for En Systems, Chapter 8 generator sets in seconce monthly, for a one of the following (1) Loading that ma	review and interview, the creise the generator annually to ints of NFPA 110, 2010 Edition, hergency and Standby Powers 4.2. Section 8.4.2 states diesel creise shall be exercised at least minimum of 30 minutes, using g methods: Lintains the minimum exhaust recommended by the			How the corrective action wi monitored to ensure the defici practice will not recur, what Q program will be put into place. Maintenance will report to QA no less than quarterly in perper	ent A Pl	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155252		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/23/2025			
		ROVIDER OR SUPPLIER	E - WOODLANDS CARE CENTER	•	4088 FF	ADDRESS, CITY, STATE, ZIP COD RAME RD JRGH, IN 47630		
	(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY 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)	TE	(X5) COMPLETION DATE
	IAU	(2) Under operating not less than 30 per Power Supply) name Section 8.4.2.3 state installations that do 8.4.2 shall be exerce EPSS (Emergency) shall be exercised a loads (Load Bank Tof the EPS namepla minutes and at not land to the EPS namepla minutes and at not land to the EPS namepla minutes and at not land to the EPS namepla minutes and at not land to the EPS namepla minutes and at not land to the EPS namepla minutes and at not land to the EPS namepla minutes and at not land to the EPS namepla minutes and at not land to the EPS namepla minutes and at not land land particular to the EPS namepla minutes and the findings include: Based on record review with the Maintenan monthly load percent generator was not during 12 of the passinterview at the tim Maintenance Direct generator ran under was not sure if the 3 was achieved for 12 Additionally, the Macknowledged a load has not occurred with the Maintenance was reported to the maintenance and tenance an	g temperature conditions and at cent of the EPS (Emergency heplate kW rating. Hes diesel-powered EPS of not meet the requirements of fised monthly with the available Power Supply System) load and mually with supplemental fest) at not less than 50 percent the kW rating for 30 continuous less than 75 percent of the EPS fig for 1 continuous hour for a finot less than 1.5 continuous at practice could affect all belief. Friew on 06/23/25 at 11:30 a.m. the continuous for the diesel powered for the diesel powered for the diesel powered for acknowledged the fload on a monthly basis, but 30% of the name plate rating 20 of the past 12 month period. In a faintenance Director and bank test for the generator thin the past 12 month period.		IAU	Systemic changes will be completed by: July 14,2025 **Requesting paper compliance	·e**	DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155252		(X2) MULTIPL A. BUILDIN B. WING	LE CONSTRUCTION G	COM	E SURVEY PLETED 23/2025	
	PROVIDER OR SUPPLIER	- WOODLANDS CARE CENTER	408	EET ADDRESS, CITY, STATE, 88 FRAME RD WBURGH, IN 47630	ZIP COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFI TAG	CROSS-REFERENCED TO	TION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
	written schedule for operational testing of established. 8.3.4 m the EPSS inspection and repairs shall be available. 8.3.4.1 m shall include the fol maintenance report servicing personnel unsatisfactory cond taken, including par repair for the time a manufacturer. This all residents, staff a Findings include: Based on record rew with the Maintenance of the during the past 12 m routine maintenance generator was dated due. Based on interreview, the Mainter been no routine main on the emergency generator was dated due. Based on interreview, the Mainter been no routine main on the emergency generator was dated due. Based on interreview, the Mainter been no routine main on the emergency generator was dated due. Based on interreview, the Mainter been no routine main on the emergency generator during the 4. Based on record facility failed to enswaperformed for the NFPA 99, Health C Section 6.5.4.1.1.2 section 6.5.4.1.1	riew on 06/23/25 at 11:30 a.m. cee Director present, there was vailable to show the or has had routine maintenance months. The most recent export for the emergency 1 08/25/23, which was past review at the time of record nance Director said there has intenance service performed enerator within the past 12 viewed with the Maintenance				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155252		A. BUILDING B. WING		COMPLETED 06/23/2025		
	ROVIDER OR SUPPLIER	- WOODLANDS CARE CENTER	4088 FF	ADDRESS, CITY, STATE, ZIP COD RAME RD JRGH, IN 47630		
(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)	IVE ACTION SHOULD BE CED TO THE APPROPRIATE	
	6.4.4.1.1.3. Section shall be performed i Standard for Emergy Systems, 2010 Editi Section 8.3.8 states performed at least at by ASTM standards could affect all residusitors. Findings include: Based on record rew with the Maintenance no documentation of the diesel generate the past 12 month pethe time of record red Director said the last 08/25/23 according available.	in accordance with Section 6.4.4.1.1.3 states maintenance in accordance with NFPA 110, ency and Standby Power on, Chapter 8. NFPA 110, a fuel quality test shall be innually using tests approved in this deficient practice dents, as well as staff and siew on 06/23/25 at 11:30 a.m. the Director present, there was fan annual fuel quality test attor available for review during teriod. Based on interview at eview, the Maintenance it diesel fuel sample taken was to the documentation he had exit with the Maintenance exit conference.				
K 0000						
Bldg. 01	Licensure Survey w	00155 155252	K 0000	Preparation and submission or Plan Of Correction does not constitute any admission or agreement of any kind by the facility of the truth of any conclusion set forth in this allegation. Accordingly, the fact has prepared and submits this Plan of Correction solely as a requirement under State and Federal Law that mandates a	cility	

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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	COMPLETED	
		155252	B. WI	NG		06/23/	/2025
NAME OF P	ROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
BB1010/A		TANCORI ANDO CARE CENTER			RAME RD		
BRICKY	ARD HEALTHCARE	- WOODLANDS CARE CENTER		NEWBO	JRGH, IN 47630		
(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	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG DEFICIENCY)			DATE
	At this Life Safety	Code survey, Brickyard			submission of a Plan of Corre	ction	
	Healthcare-Woodla	nds Care Center was found			as a condition to participate in		
	not in compliance w	vith Requirements for			Title 18 and 19 programs, and		
	Participation in Med	dicare/Medicaid, 42 CFR			provide the best possible care		
	Subpart 483.90(a), 1	Life Safety from Fire and the			our residents as possible.		
	2012 edition of the	National Fire Protection			·		
	Association (NFPA) 101, Life Safety Code (LSC),					
	Chapter 19, Existing	g Health Care Occupancies and					
	410 IAC 16.2.	*					
	This one story facil	ity was determined to be of					
	Type V (000) const	ruction and was fully					
	sprinklered. The fa	cility has a fire alarm system					
	with hard wired sme	oke detectors in the corridors					
	and spaces open to	the corridors, plus battery					
	operated smoke det	ectors in all resident sleeping					
	rooms. The facility	has a capacity of 120 and had					
	a census of 103 at the	he time of this survey.					
		•					
	All areas where resi	idents have customary access					
	were sprinklered an	d all areas providing facility					
	services were sprinl	klered, except three detached					
	structures; one plast	tic shed, one wood framed					
	shed, and one wood	I framed garage with vinyl					
	siding used for facil	lity storage.					
	Quality Review con	npleted on 06/26/25					
K 0712	NFPA 101						
SS=F	Fire Drills						
Bldg. 01							
	Based on record rev	view and interview, the facility	K 0'	712	K712 corrective action will be		07/14/2025
	failed to provide qu	arterly fire drill documentation			accomplished for those reside	nts	
	for 1 of 3 shifts dur	ing 1 of 4 quarters, furthermore,			found to have been affected b	y the	
	the facility failed to	ensure fire drills were held at			deficient practice.		
	varied dates for 3 of	f 3 employee shifts during 4 of			Monthly fire drills will be		
	4 quarters during th	e past 12 month period. This			conducted once per shift per		
	deficient practice co	ould affect all residents in the			quarter at expected and		
	facility.				unexpected times under varyi	ng	
					conditions		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155252		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 06/23/2025				
	ROVIDER OR SUPPLIER	- WOODLANDS CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 4088 FRAME RD NEWBURGH, IN 47630					
(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 APPROPR DEFICIENCY)	(X5) COMPLETION DATE			
	Based on review of on 06/23/25 at 12:5 Director present, the a. There was no fir for the first shift (da (April, May, and Ju Based on interview acknowledged there available to review quarter of 2024, and b. 11 of 12 fire drill last five days of each the Maintenance Director of fire drills during	ls were performed during the h month. Based on interview, rector acknowledged the dates the last five days of each		-How will other residents who have the potential to be affect be identified? All residents have the potent be affected What measures will be put place or what systematic characters.	into			
	enough.	ne dates were not varied viewed with the Maintenance exit conference.		will be made to ensure that the deficient practice does not reach a quarterly review will be completed for each shift in rote to conduct a fire drill on each during each quarter with rotal days throughout the month	cur. tation shift			
				How will the corrective action be monitored to ensure the deficient practice will not and QA program will be put into place?	,			
				ED/Maintenance director will				

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155252		A. BUILDING 01 B. WING		COMPLETED 06/23/2025	
	ROVIDER OR SUPPLIER	- WOODLANDS CARE CENTER	4088 FF	ADDRESS, CITY, STATE, ZIP COD RAME RD JRGH, IN 47630		
(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)	(X5) COMPLETION DATE	
				monitor of fire drills monthly. Maintenance will report to QAI no less than quarterly in perperegarding life safety items		
K 0918	NFPA 101			Systematic changes will be completed by: July 14, 2025 ****requesting paper compliance for K712****		
SS=F Bldg. 01	1. Based on record facility failed to mai of monthly generator generator during 12 Chapter 6.4.4.1.1.4(monthly testing of the emergency electrica with NFPA 110, the Standby Powers Sys 6.4.4.2 of NFPA 99 inspection, performar repairs for the gener maintained and availanthority having juri	review and interview, the intain a complete written record or load testing for 1 of 1 of the past 12 months. a) of 2012 NFPA 99 requires the generator serving the 1 system to be in accordance Standard for Emergency and stems, Chapter 8. Chapter requires a written record of ance, exercising period, and rator to be regularly lable for inspection by the isdiction. This deficient it all residents, staff and	K 0918	K918 corrective action will be accomplished for those reside found to have been affected by deficient practice. The generator load percentage be recorded in the monthly full load testing documentation an load bank test was completed June 25, 2025. A professional routine maintenance was conducted by the emergency generator contractor, and an annual diesel test was conductedHow will other residents who may have the potential to be affected be identified? All residents have potential to be affected Will measures will be put into place.	y the e will d a on the	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155252		A. BUILI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/23/2025		
NAME	OF PROVIDER OR SUPPLIEF	- :			ADDRESS, CITY, STATE, ZIP COD		
BRIC	KYARD HEALTHCARE	- WOODLANDS CARE CENTE			RAME RD JRGH, IN 47630		
(X4) II		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		EFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAU		view on 06/23/25 at 11:30 a.m.	<u> </u>	IAU	what systematic changes will	be	DATE
		ce Director present, there was			made to ensure that the defici		
		on the generator monthly load			practice does not recur. A rev		
	test log for percenta	age of load for the past 12			of the monthly load testing of		
	month period. Base	ed on interview at 11:30 a.m.,			generator to include the load		
	the Maintenance Di	rector confirmed there was no			percentage of the nameplate I	ζW,	
	percentage of load	documented on the monthly			an annual load bank test, a		
	generator log for th	e past 12 month period.			professional preventative rout	ine	
					maintenance annually, and ar	l	
		viewed with the Maintenance			annual fuel test will be		
	Director during the	exit conference.			completedHow will the	_	
					corrective action(s) be monito		
	3.1-19(b)				to ensure the deficient practic		
	2 D 1				not and what QA program will		
		review and interview, the			put into place? ED/maintenar		
	-	ercise the generator annually to			director will review the monthly	У	
		nts of NFPA 110, 2010 Edition, nergency and Standby Powers			reports to ensure the load	!-	
		.4.2. Section 8.4.2 states diesel			percentage of the nameplate I		
		rvice shall be exercised at least			included Maintenance will rep QAPI no less than quarterly in		
	_	minimum of 30 minutes, using			perpetuity regarding life safety		
	one of the following				itemsSystematic changes		
		aintains the minimum exhaust			be completed by: July 14,	vviii	
		recommended by the			2025		
	manufacturer	J			****requesting paper compli	ance	
		temperature conditions and at			for F918****		
		cent of the EPS (Emergency					
	-	neplate kW rating.					
	•	es diesel-powered EPS					
	installations that do	not meet the requirements of					
		ised monthly with the available					
		Power Supply System) load and					
		nnually with supplemental					
		Test) at not less than 50 percent					
	•	ate kW rating for 30 continuous					
	•	less than 75 percent of the EPS					
		g for 1 continuous hour for a					
		f not less than 1.5 continuous					
	hours. This deficier	nt practice could affect all					
	L occuments in the tag	111TV	1				1

ZIP COD
F CORRECTION (X5) ION SHOULD BE THE APPROPRIATE THE APPROPRIATE THE APPROPRIATE THE APPROPRIATE TO MAKE THE APPROPRIATE THE APPROPRIAT
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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155252		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE S COMPLE 06/23/2	ETED	
	ROVIDER OR SUPPLIER	- WOODLANDS CARE CENTER	4088 F	ADDRESS, CITY, STATE, ZIP COD RAME RD URGH, IN 47630		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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)	ATE	(X5) COMPLETION DATE
	all residents, staff a	deficient practice could affect nd visitors.				
	with the Maintenand no documentation a emergency generated during the past 12 m routine maintenance generator was dated due. Based on interreview, the Maintenbeen no routine main on the emergency generator during the 3.1-19(b) 4. Based on record facility failed to enswas performed for INFPA 99, Health C Section 6.5.4.1.1.2 selectrical System) generator during the standard for Emerg Systems, 2010 Editi Section 8.3.8 states performed at least a by ASTM standards.	view on 06/23/25 at 11:30 a.m. ce Director present, there was available to show the or has had routine maintenance months. The most recent ereport for the emergency 108/25/23, which was past review at the time of record nance Director said there has intenance service performed enerator within the past 12 viewed with the Maintenance exit conference. The viewed with the Maintenance exit conference. The viewed with the Maintenance exit conference. The viewed with the Maintenance exit conference with July 10 to				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155252			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/23/2025	
	NAME OF PROVIDER OR SUPPLIER BRICKYARD HEALTHCARE - WOODLANDS CARE CENTER			4088 FF	ADDRESS, CITY, STATE, ZIP COD RAME RD JRGH, IN 47630		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	PRECEDED BY FULL PREFIX PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		E	(X5) COMPLETION DATE	
	with the Maintenann no documentation of for the diesel generathe past 12 month puthe time of record reductor said the last 08/25/23 according available.	riew on 06/23/25 at 11:30 a.m. ce Director present, there was if an annual fuel quality test ator available for review during eriod. Based on interview at eview, the Maintenance at diesel fuel sample taken was to the documentation he had viewed with the Maintenance exit conference.					

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