DEPARTMENT	OF HEALTH AND	HUMAN SERVICES
CENTERS FOR	MEDICARE & ME	DICAID SERVICES

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E064		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 10/07/2024	
	ROVIDER OR SUPPLIER			505 N G	ADDRESS, CITY, STATE, ZIP COD GAVIN ST E, IN 47303	<u> </u>		
(X4) ID PREFIX TAG E 0000	(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	
Bldg	conducted by the In accordance with 42  Survey Date: 10/07/  Facility Number: 00  Provider Number: 1002  At this Emergency I Brookside Care Strasubstantial compliant Preparedness Requi Medicaid Participat CFR 483.73. The fathad a census of 32 at Quality Review consumption of the conductive of the co	224  200311 25E064 285520  Preparedness survey, ategies was found in nee with Emergency rements for Medicare and ing Providers and Suppliers, 42 cility has a capacity of 42 and at the time of this survey.	E 00	000	By submitting the following material, we are not admitting truth or accuracy of any specifindings or allegations. We reserve the right to contest the findings or allegations as part any proceedings and submit the responses pursuant to our regulatory obligations. The farequests the plan of correction considered our allegation of compliance effective 10/23/20 the state findings of the recent Safety Survey. We are request paper compliance.	fic of nese cility n be 24 to t Life		
SS=C Bldg	failed to ensure eme and procedures inch arrangements with o providers to receive limitations or cessat the continuity of ser accordance with 42 deficient practice co Findings include:	Other Facilities  iew and interview, the facility orgency preparedness policies ude the development of other ICF/IID facilities or other residents in the event of ion of operations to maintain vices to ICF/IID clients in CFR 483.475(b)(7). This ould affect all occupants.	E 00	025	It is the practice of this facility ensure emergency prepared to policies and procedures include the development of arrangement with other ICF/IID facilities or oproviders.  1. What corrective actions will accomplished for those reside found to be affected by the deficient practice.  a. There were no residents affected by the alleged deficie practice.	emergency preparedness s and procedures include velopment of arrangements her ICF/IID facilities or other ers.  at corrective actions will be colished for those residents to be affected by the ht practice. The were no residents to by the alleged deficient		
LABORATOR	Y DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SI	GNATURI	<del></del>	TITLE		(X6) DATE	

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

(X6) DATE

Paul Stanley Administrator 10/26/2024 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 234J21 Facility ID: 000311 If continuation sheet Page 1 of 16

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

PRINTED: 10/30/2024 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E064	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	COME	E SURVEY PLETED 7/2024
	PROVIDER OR SUPPLIEI		505 N	ADDRESS, CITY, STATE, ZIP CO GAVIN ST EIE, IN 47303	OD	
	SIDE CARE STRAT  SUMMARY (EACH DEFICIENT REGULATORY OF 19:45 a.m. and 11:00 preparedness plan proposed arrangements with other providers to rotal finitations or certain the continuction of limitations or certain the continuction of limitations or certain the continuction. Based on its review, the MD agradid not list any facility of the finding was accommodated to the continuous of the co	STATEMENT OF DEFICIENCIE SCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION D a.m., the emergency provided did not include dures for the development of other ICF/IID facilities and receive residents in the event essation of operations to unity of services to ICF/IID interview at the time of record reed the entitled" MUTUAL AGREEMENT" was blank and	505 N	GAVIN ST	s having the by the swill be rective the potential leged be put in ic changes that not recur. Ind/or seg that the plan is a updated thents with ment 6) actions will be the not occur. Ind/or nsible for ter ppropriately the mittee will paredness lly or more	(X5) COMPLETION DATE
K 0000 Bldg. 01				with recommendations	as needed.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

234J21

Facility ID: 000311

If continuation sheet

Page 2 of 16

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01 COMPLETED			
		15E064	B. WING		10/07/2024	
	PROVIDER OR SUPPLIES		505 N (	ADDRESS, CITY, STATE, ZIP COD GAVIN ST		
BROOKS	SIDE CARE STRAT	EGIES	MUNCI	E, IN 47303		
(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	
		Recertification and State	K 0000	By submitting the following	41	
	-	vas conducted by the Indiana Ith in accordance with 42 CFR		material, we are not admitting the		
	483.90(a).	itii iii accordance witii 42 Ci K		truth or accuracy of any specifindings or allegations. We		
	403.70(a).			reserve the right to contest the	2	
	Survey Date: 10/07	/24		findings or allegations as part		
	, ,,,,			any proceedings and submit t		
	Facility Number: 0	000311		responses pursuant to our		
	Provider Number:	15E064		regulatory obligations. The fa	cility	
	AIM Number: 100	285520		requests the plan of correction	n be	
				considered our allegation of		
	At this Life Safety Code survey, Brookside Care Strategies was found not in compliance with			compliance effective 10/23/20		
				the state findings of the recen		
	Requirements for P	•		Safety Survey. We are reque	sting	
		, 42 CFR Subpart 483.90(a), re, and the 2012 edition of the		paper compliance.		
	-	ction Association (NFPA) 101,				
		LSC), Chapter 19, Existing				
		ancies and 410 IAC 16.2.				
	This one-story facil	ity was determined to be of				
		ruction and was fully				
	_	cility has a fire alarm system				
		on in the corridors, spaces				
	_	rs and battery powered smoke				
		dent rooms. The facility has a				
	of this survey.	had a census of 32 at the time				
	of this survey.					
	All areas where the	residents have customary				
		ered and all areas providing				
	_	re sprinklered. The facility is				
	certified for Medica	nid only.				
	The facility is not e powered generator.	quipped with an emergency				
	Quality Review cor	mpleted on 10/11/24				

Event ID: 234J21 Facility ID: 000311 If continuation sheet Page 3 of 16

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E064		(X2) MULTIPLE C A. BUILDING B. WING	construction <u>01</u>	(X3) DATE SURVEY  COMPLETED  10/07/2024	
	PROVIDER OR SUPPLIER		505 N	GAVIN ST CIE, IN 47303	
(X4) ID PREFIX TAG K 0211 SS=E	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION General	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
Bldg. 01	Based on observation failed to ensure 1 of were continuously robstructions. This of residents.  Findings include:  Based on observation tour of the facility won 10/07/24 between the East resident has two rolling racks us in front of the corridinterview at the time Maintenance Direct racks into the corriding crowded.  This finding was ac Maintenance Direct again with the Mainten	on and interview, the facility a corridor means of egresses maintained free of deficient practice affects 16 ons and interviews during a with the Maintenance Director in 11:20 a.m. and 1:00 p.m., in all by laundry area there were ed to hang up clothed parked dor exit door. Based on an e of observations, the or stated they move the rolling dor because the laundry room	K 0211	It is the practice of this facility the ensure that the corridor means egresses were continuously maintained free of obstructions.  1. What corrective actions will accomplished for those resider found to be affected by the deficient practice.  a. There were no residents affected by the alleged deficient practice.  b. The laundry rolling racks weremoved 10/08/2024 from the corridor.  2. How other residents having potential to be affected by the same deficient practices will be identified and what corrective action will be taken.  a. All residents have the potent obe affected by the alleged deficient practice.  b. The Maintenance Director completed rounds, and no other impediments were noted.  3. What measures will be put place and what systemic change will be made to ensure that deficient practice does not rectal. Staff were educated on 10-22-24 regarding the egress the corridors.(attatchment 12)	be nts  the er  the er  in ges  ur.  in

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

PRINTED: 10/30/2024 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION  A. BUILDING  01			(X3) DATE SURVEY COMPLETED	
		15E064	B. WI	NG		10/07	/2024
	PROVIDER OR SUPPLIE			505 N G	ADDRESS, CITY, STATE, ZIP COD GAVIN ST E, IN 47303		
(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)	NTE .	(X5) COMPLETION DATE
K 0325 SS=E Bldg. 01	Based on observatifailed to ensure 1 of sanitizer dispensers ignition source. NF states dispensers she following locations (a) Above an ignitic horizontal distance source (b) To the side of a 1-inch horizontal distance for Beneath an ignitic vertical distance from the side of the s	on source within a 1-inch from each side of the ignition  In ignition source within a istance from the ignition source tion source within a 1-inch om the ignition source ice could affect 14 residents in	K 03	325	be monitored to ensure the deficient practices will not occ a. The Maintenance Director and/or Designee will monitor during facility rounds that the egress in the corridors are freobstructions. If discrepancies identified, then immediate acti will be taken. The monitoring be an ongoing process.  b. Data will be presented at the quarterly Quality Assurance meeting to determine trends, patterns, and effectiveness of plan. The process will be upd as needed.  It is the practice of this facility ensure alcohol-based hand sanitizer dispensers were not installed over an ignition source.  1. What corrective actions will accomplished for those reside found to be affected by the deficient practice.  a. All residents, staff member and visitors have the potential be affected by the alleged defipractice.  b. Alcohol-based hand sanitized dispenser located above an electrical outlet were relocated (Attachment #8)	e of are ion will ne dated to ce.	10/15/2024

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

234J21

Facility ID: 000311

If continuation sheet

Page 5 of 16

i i		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	r í	(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING 01 COMPL			
		15E064	B. W			10/07/	/2024
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD GAVIN ST		
BROOKS	SIDE CARE STRAT	EGIES		MUNCI	E, IN 47303		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
		ons and interviews during a with the Maintenance Director			How other residents having potential to be affected by the	-	
		between 11:20 a.m. and 1:00			same deficient practices will b		
	p.m., an alcohol-based hand sanitizer dispenser was installed on the wall directly above an electrical outlet in the corridor by room #8. Based on interview at the time of observation, the MD confirmed the alcohol-based hand sanitizer				identified and what corrective action will be taken.		
					a. All residents, staff member	re	
					and visitors have the potentia		
					be affected by the alleged def		
		lled on the wall directly above			practice.		
	an electrical outlet.  3. What measures will be put in place and what systemic changes Maintenance Director at the time of discovery and again with the Maintenance Director and deficient practice does not recur.		in				
					1		
					1 .	Ü	
					deficient practice does not red	cur.	
	Administrator prese	ent at the exit conference.			a. Alcohol-based hand sanitize	zer	
					dispenser located above an		
	3.1-19(b)				electrical outlet were located.		
					(Attachment # 8 )		
					4. How the corrective actions	will	
					be monitored to ensure the		
					deficient practices will not occ		
					This is an ongoing program should non-compliance be	n,	
					observed, corrective action sh	nall	
					be taken, the observations an		
					any corrective actions taken v		
					be reviewed during Quality		
					Assurance Meeting and the p		
					of action adjusted accordingly	if	
					warranted.		
K 0245	NEDA 404						
K 0345 SS=F	NFPA 101	n Tooting and					
SS=F Bldg. 01	Fire Alarm Syster Maintenance	n - resung and					
Diag. 01		review and interview, the	K O	345	It is the practice of this facility	to	10/16/2024
		aintain 1 of 1 fire alarm systems	1,0	5 15	ensure visual inspections sha		10/10/2027
		NFPA 72, as required by LSC			performed in accordance with		
	101 Sections 19.3.4	4.5.1 and 9.6. NFPA 72, Section			being completed semi-annual		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		15E064	B. W	ING		10/07/2024	
		<u> </u>		CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			GAVIN ST		
PPOOK	SIDE CARE STRAT	ECIES			E, IN 47303		
BROOKS	SIDE CARE STRAT	EGIES		MONCI	E, IN 47303		
(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	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	14.3.1 states that ur	nless otherwise permitted by			is the practice of this facility th	at	
	14.3.2, visual inspe	ctions shall be performed in			the alarm control panels are		
	accordance with the schedules in Table 14.3.1, or				protected from unauthorized u	se.	
	more often if required by the authority having						
	jurisdiction. Table 14.3.1 states that the following				1. What corrective actions wil	l be	
	must be visually inspected semi-annually:				accomplished for those reside	nts	
	a. Control unit trou	ble signals			found to be affected by the		
	b. Remote annuncia	ators			deficient practice.		
	c. Initiating devices	(e.g. duct detectors, manual			a. There were no residents		
	fire alarm boxes, he	eat detectors, smoke detectors,			affected by the alleged deficie	nt	
	etc.)				practice.		
	d. Notification appliances				b. The Maintenance Director	has	
	e. Magnetic hold-open devices				updated the inspection paperv	vork	
	This deficient practice could affect all building				to include locations and specif	ic	
	occupants.				appliances that were inspected	d.	
					c. The key for the fire panel h	as	
	Findings include:				been relocated. The staff hav	е	
					been educated on 10/09/2024	of	
	Based on record rev	view and interview with the			the location of the key for the	fire	
	Maintenance Direct	tor on 10/07/24 between 9:45			panel. (attachment 15,4)		
	a.m. and 11:00 a.m.	., no documentation could be					
		an itemized list of the facilities			2. How other residents having	the the	
		es. The provided "in house"			potential to be affected by the		
		ntation categorically reflected			same deficient practices will b	е	
	~ ~	inspected but failed to itemize			identified and what corrective		
	the locations and sp	pecific appliances inspected			action will be taken.		
					a. All residents, staff, and visi	tors	
	This finding was ac				have the potential to be affect	ed	
		tor at the time of discovery and			by the alleged deficient practic	e.	
	_	ntenance Director and					
	Administrator prese	ent at the exit conference.			3. What measures will be put	in	
					place and what systemic chan	ges	
		ation and interview, the facility			will be made to ensure that		
		f 1 fire alarm control panels was			deficient practice does not rec	ur.	
	-	2, National Fire Alarm and			a. The Administrator and/or		
		etion 10.10.1 states a means for			Designee will monitor the		
	_	d alarm notification			inspection/testing reports to		
		e permitted only if it complies			ensure that the locations and		
	with 10.10.3 throug	gh 10.10.7. Section 10.10.3 states			specific appliances are include	ed	
	the means shall be l	kev-operated or located within			on the report		

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01  B. WING			(X3) DATE SURVEY  COMPLETED  10/07/2024			
	ROVIDER OR SUPPLIER			505 N G	ADDRESS, CITY, STATE, ZIP COD GAVIN ST E, IN 47303		
(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)	ΓE	(X5) COMPLETION DATE
	equivalent protection	rarranged to provide on against unauthorized use. ice could affect all occupants.			b. The key for the fire panel have been relocated. The staff have been educated on 10/08/2024 the location of the key for the fipanel.	e of	
	tour of the facility won 10/07/24 between fire alarm control pand the key was left located in the nurse residents come into station replied "som."  This finding was act Maintenance Direct again with the Maintenance control to the facility of the facility				4. How the corrective actions be monitored to ensure the deficient practices will not occur. The Maintenance Director and/or Designee will monitor inspections reports to ensure a required information is include discrepancies are identified, the immediate action will be taken. The monitoring will be an ongo process.  b. The Maintenance Director and/or Designee during daily rounds will monitor that the key not in the fire panel. If discrepancies are identified, the immediate action will be an ongo process.  c. Data will be presented at the quarterly Quality Assurance meeting to determine trends, patterns, and effectiveness of plan. The process will be updated as needed.	ur.  all d. If en . bing y is en . bing	
K 0346 SS=C Bldg. 01	NFPA 101 Fire Alarm System						
	failed to provide 1 of the protection of res	view and interview, the facility of 1 correct written policy for sidents indicating procedures e event the fire alarm system	K 03	346	It is the practice of this facility ensure a written policy for the protection of all residents indicating procedures to be	to	10/16/2024

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		15E064	B. W	ING		10/07/	/2024
		L		STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	8			GAVIN ST		
BROOKS	SIDE CARE STRAT	EGIES			E, IN 47303		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PROVIDER'S PLAN OF CORRECTION PREFIX GEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	*	t of service for four hours or			followed in the event the fire a	larm	
	more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants.				system must be placed out of		
					service for four hours or more	in a	
					twenty-four period.		
	Findings include:				What corrective actions will		
					accomplished for those reside	nts	
		view and interview with the			found to be affected by the		
		tor on 10/07/24 between 9:45			deficient practice.		
		, the facility provided fire watch			a. All residents, staff member		
	plan documentation but there were several versions of the plan, but no plan was complete.				and visitors have the potential	το	
	One version of the entitled "Fire Watch Policy				be affected by the alleged practice.		
	and Procedures" listed names for previous				b. The fire watch policy has b	een	
	administrators that no one in the room was familiar				updated to include the require		
	with.	no one in the room was familiar			documentation. (Attachment #		
	With.				documentation. (Attachment #	3)	
	This finding was ac	knowledged by the			2. How other residents having	the	
	Maintenance Direct	tor at the time of discovery and			potential to be affected by the		
	1 -	ntenance Director and			same deficient practices will b	е	
	Administrator prese	ent at the exit conference.			identified and what corrective		
					action will be taken.		
	3.1-19(b)				a. All residents, staff member		
					and visitors have the potential		
					be affected by the alleged def	cient	
					practice.		
					3. What measures will be put	in	
					place and what systemic chan		
					will be made to ensure that		
					deficient practice does not rec	ur.	
					a. The fire watch policy has b	een	
					updated to include the require		
					documentation. (Attachment#	5)	
					4. How the corrective actions	will	
					be monitored to ensure the		
					deficient practices will not occ	ur.	
					a. This is an ongoing program	١,	
					should non-compliance be		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 15E064 B. WING 10/07/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 505 N GAVIN ST **BROOKSIDE CARE STRATEGIES** MUNCIE. IN 47303 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE observed, corrective action shall be taken, the observations and any corrective actions taken will be reviewed during Quality Assurance meeting and the plan of action adjusted accordingly if warranted. K 0353 **NFPA 101** SS=E Sprinkler System - Maintenance and Testing Bldg. 01 Based on observation and interview, the facility K 0353 It is the practice of this facility to 10/16/2024 failed to maintain the ceiling construction maintain the ceiling construction throughout the facility. The ceiling traps hot air throughout the facility. and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. 1. What corrective actions will be NFPA 13, 2010 edition, 8.5.4.1.1 states the accomplished for those residents distance between the sprinkler deflector and the found to be affected by the ceiling above shall be selected based on the type deficient practice. of sprinkler and the type of construction. This a. There were no residents deficient practice could affect 8 residents affected by the alleged deficient Findings include: b. The unsealed gap in the ceiling corrected 10/16/2024.(attatchment Based on observations and interviews during a tour of the facility with the Maintenance Director (MD) on 10/07/24 between 11:20 a.m. and 1:00 2. How other residents having the p.m., in the corridor near RR#20 there were a potential to be affected by the 1-inch unsealed gap in the ceiling. This condition same deficient practices will be could delay the activation of the sprinklers. Based identified and what corrective on interview at the time of observation, the action will be taken. Maintenance Director agreed there was an a. All residents have the potential unsealed gaps in the ceiling around RR # 20. to be affected by the alleged deficient practice. This finding was acknowledged by the b. The Maintenance Director Maintenance Director at the time of discovery and completed rounds, and no other again with the Maintenance Director and areas were identified. Administrator present at the exit conference.

FORM CMS-2567(02-99) Previous Versions Obsolete

3.1-19(b)

Event ID:

234J21

Facility ID: 000311

If continuation sheet

3. What measures will be put in

place and what systemic changes

Page 10 of 16

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

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E064		IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 10/07/2024	
	PROVIDER OR SUPPLIER		505 N C	ADDRESS, CITY, STATE, ZIP COD GAVIN ST E, IN 47303		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC 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
				will be made to ensure that deficient practice does not rec a. The Maintenance Director complete monthly rounds to identify unsealed gaps. If any issues are identified, then immediate action will be taken This will be ongoing monitoring process.  4. How the corrective actions be monitored to ensure the deficient practices will not occ a. The Maintenance Director complete monthly rounds to identify unsealed gaps. If any issues are identified, then immediate action will be taken This will be ongoing monitoring process.  b. Data will be presented at the quarterly Quality Assurance meeting to determine trends, patterns, and effectiveness of plan. The process will be upd as needed.	will g will ur. will g	
K 0354 SS=C Bldg. 01	NFPA 101 Sprinkler System	- Out of Service				
	failed to provide 1 of the protection of rest to be followed in the has to be placed out more in a twenty fo	of 1 correct written policy for sidents indicating procedures e event the fire alarm system of service for four hours or ur hour period in accordance 0.6.1.6. This deficient practice is.	K 0354	It is the practice of this facility provide a written policy for the protection of residents indicati procedures to be followed in the event the fire alarm system has be placed out of service for for hours or more in a twenty four hour period.	ng ne is to ur	10/16/2024

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

PRINTED: 10/30/2024 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER  15E064	A. BUILDING B. WING	01	COM	PLETED 7/2024
	PROVIDER OR SUPPLIER		505 N	ADDRESS, CITY, STATE, ZIP COD GAVIN ST IE, IN 47303	•	
(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 CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ION D BE DPRIATE	(X5) COMPLETION DATE
	Maintenance Direct a.m. and 11:00 a.m. plan documentation versions of the plan complete. One vers Policy and Procedu administrators that with.  This finding was ac Maintenance Direct again with the Mair	view and interview with the for on 10/07/24 between 9:45, the facility provided fire watch but there were several, no plan was completely ion of the entitled "Fire Watch res" listed names for previous no one in the room was familiar knowledged by the for at the time of discovery and attenuance Director and ent at the exit conference.		1. What corrective actions accomplished for those refound to be affected by the deficient practice.  a. All residents, staff memand visitors have the poter be affected by the alleged practice.  b. The sprinkler fire patrol policy has been updated to include the required documentation. (Attachmet #5,16)  2. How other residents hapotential to be affected by same deficient practices widentified and what correct action will be taken.  a. All residents, staff memand visitors have the poter be affected by the alleged practice.  3. What measures will be place and what systemic of will be made to ensure the deficient practice does not a. The sprinkler fire patrol policy has been updated to include the required documentation. (Attachmet #5,16)  4. How the corrective action is an ongoing progshould non-compliance be observed, corrective actions.	sidents  abers, atial to deficient  watch  ent  ving the the vill be cive  abers, atial to deficient  put in changes t arecur. watch  o ent  ons will e occur. gram, e	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

234J21

Facility ID: 000311

If continuation sheet

Page 12 of 16

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E064		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 10/07/2024				
NAME OF PROVIDER OR SUPPLIER BROOKSIDE CARE STRATEGIES			STREET ADDRESS, CITY, STATE, ZIP COD 505 N GAVIN ST MUNCIE, IN 47303					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	ON (X5) BE COMPLETION DATE				
				be taken, the observations any corrective actions take be reviewed during Quality Assurance Meeting and the of action adjusted accordin warranted.	n will e plan			
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors							
	failed to ensure 4 of impediment to closi frame and would re This deficient pract residents.  Findings include:  Based on observation tour of the facility won 10/07/24 betwee (1) laundry room do open with a sledgeh latch. (3) Kitchen dequipped with a self-close and latch was missing a knob hole through the do  This finding was ac Maintenance Direct again with the Main		K 0363	It is the practice of this faciliensure corridor doors have impediment to closing and latching into the door frame.  1. What corrective actions accomplished for those restound to be affected by the deficient practice.  a. All residents and staff members have the potential affected by the alleged defipractice.  b. The laundry room door included by the laundry room door in that door cannot be propped. Resident Room #17 door been fixed and latches appropriately.  d. The kitchen door into the room self-closure has been repaired.  e. The kitchen door with the missing knob has been repelated to be affected by the affected by the affected by the alleged.	will be idents  If to be cient  s structed dopen. or has e dining e aired.			
				potential to be affected by t same deficient practices wi	l l			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

234J21

Facility ID: 000311

If continuation sheet

Page 13 of 16

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

PRINTED: 10/30/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E064		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 10/07/2024			
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD				
BROOKSIDE CARE STRATEGIES			505 N GAVIN ST MUNCIE, IN 47303				
	SIDE CARE STRAT		505 N (	GAVIN ST	be ont in ages cur. cted dair will will ur. will ur. will air		
				patterns, and effectiveness of plan. The process will be upd as needed.			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

234J21

Facility ID: 000311

If continuation sheet

Page 14 of 16

STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	a. building <u>01</u>		COMPLETED		
15E064		B. W	B. WING			10/07/2024	
NAME OF PROVIDER OR SUPPLIER BROOKSIDE CARE STRATEGIES			STREET ADDRESS, CITY, STATE, ZIP COD 505 N GAVIN ST MUNCIE, IN 47303				
(X4) ID	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	IE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
K 0927 SS=F Bldg. 01	SIDE CARE STRATEGIES SUMMARY STATEMENT OF DEFICIENCIE		K 0	927	It is the practice of this facility ensure oxygen storage/transferooms is provided with a sign indicating that transferring is occurring.  1. What corrective actions will accomplished for those reside found to be affected by the deficient practice. a. All residents and staff members have the potential to affected by the alleged deficie practice. b. A new oxygen in use sign heen posted on the door indictoxygen filling in use.  2. How other residents having potential to be affected by the same deficient practices will be identified and what corrective action will be taken. a. All residents and staff members have the potential to affected by the alleged deficie practice. b. A new oxygen in use sign heen posted on the door indictoxygen filling in use.(attatchmit #14)	to er  I be ents  be he has ating the e  be be ht has ating ent	10/16/2024
					What measures will be put place and what systemic chan will be made to ensure that deficient practice does not reca. The staff will be educated or the	ges ur.	

234J21

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

PRINTED: 10/30/2024 FORM APPROVED OMB NO. 0938-039

CLI. ILIKO I OIL	MEDICALLE & MEDIC	THE SERVICES				0	21.0.0,00
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		01	COMPL	LETED
		15E064	B. WI	NG		10/07/	/2024
		.0200.					
NAME OF P	ROVIDER OR SUPPLIER	3		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER			505 N GAVIN ST				
BROOKSIDE CARE STRATEGIES			MUNCIE, IN 47303				
(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 APPROPRIATE		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					the new sign and how to opera	ate	
					properly during the oxygen filli	ng	
					process.		
					·		
			4. How the corrective a			will	
			be monitored to ensure the				
					deficient practices will not occ	ıır	
					a. The Maintenance Director		
					periodically check/inspect and		
					assure the sign is being used		
					1		
					appropriately.		
					b. Data will be presented at the	ie	
					quarterly Quality Assurance		
					meeting to determine trends,		
					patterns, and effectiveness of		
					plan. The process will be upd	ated	
					as needed.		
							1

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 234J21 Facility ID: 000311 If continuation sheet Page 16 of 16