STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15E064	A. BUILDING -- B. WING	10/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROOKSIDE CARE STRATEGIES	505 N GAVIN ST MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 10/07/24 Facility Number: 000311 Provider Number: 15E064 AIM Number: 100285520 At this Emergency Preparedness survey, Brookside Care Strategies was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 42 and had a census of 32 at the time of this survey. Quality Review completed on 10/11/24	E 0000	By submitting the following material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective 10/23/2024 to the state findings of the recent Life Safety Survey. We are requesting paper compliance.	
E 0025 SS=C Bldg. --	403.748(b)(7), 418.113(b)(5), 441.184(b) Arrangement with Other Facilities Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the development of arrangements with other ICF/IID facilities or other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to ICF/IID clients in accordance with 42 CFR 483.475(b)(7). This deficient practice could affect all occupants. Findings include: Based on record review and interview with the Maintenance Director (MD) on 10/07/24 between	E 0025	It is the practice of this facility to ensure emergency preparedness policies and procedures include the development of arrangements with other ICF/IID facilities or other providers. 1. What corrective actions will be accomplished for those residents found to be affected by the deficient practice. a. There were no residents affected by the alleged deficient practice.	10/14/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(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.

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K 0000 Bldg. 01	9:45 a.m. and 11:00 a.m., the emergency preparedness plan provided did not include policies and procedures for the development of arrangements with other ICF/IID facilities and other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to ICF/IID clients. Based on interview at the time of record review, the MD agreed the entitled" MUTUAL AID TRANSFER AGREEMENT" was blank and did not list any facility names. This finding was acknowledged by the Maintenance Director at the time of discovery and again with the Maintenance Director and Administrator present at the exit conference.		2. How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken. a. All residents have the potential to be affected by the alleged deficient practice. 3. What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur. a. The Administrator and/or Maintenance Director is responsible for ensuring that the disaster preparedness plan is accurate. Disaster plan updated with mutual aid agreements with other facilities.(attatchment 6) 4. How the corrective actions will be monitored to ensure the deficient practices will not occur. a. The Administrator and/or Designee will be responsible for ensuring that the disaster preparedness plan is appropriately reviewed and updated. The Quality Assurance Committee will review the disaster preparedness at a minimum of annually or more often if changes for compliance with recommendations as needed.	

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	15E064	A. BUILDING 01 B. WING	10/07/2024

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BROOKSIDE CARE STRATEGIES	505 N GAVIN ST MUNCIE, IN 47303

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	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: 10/07/24 Facility Number: 000311 Provider Number: 15E064 AIM Number: 100285520 At this Life Safety Code survey, Brookside Care Strategies was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery powered smoke detectors in all resident rooms. The facility has a capacity of 42 and had a census of 32 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. The facility is certified for Medicaid only. The facility is not equipped with an emergency powered generator. Quality Review completed on 10/11/24	K 0000	By submitting the following material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective 10/23/2024 to the state findings of the recent Life Safety Survey. We are requesting paper compliance.	

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K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Based on observation and interview, the facility failed to ensure 1 of 3 corridor means of egresses were continuously maintained free of obstructions. This deficient practice affects 16 residents. Findings include: Based on observations and interviews during a tour of the facility with the Maintenance Director on 10/07/24 between 11:20 a.m. and 1:00 p.m., in the East resident hall by laundry area there were two rolling racks used to hang up clothed parked in front of the corridor exit door. Based on an interview at the time of observations, the Maintenance Director stated they move the rolling racks into the corridor because the laundry room is crowded. This finding was acknowledged by the Maintenance Director at the time of discovery and again with the Maintenance Director and Administrator present at the exit conference. 3.1-19(b)	K 0211	It is the practice of this facility to ensure that the corridor means of egresses were continuously maintained free of obstructions. 1. What corrective actions will be accomplished for those residents found to be affected by the deficient practice. a. There were no residents affected by the alleged deficient practice. b. The laundry rolling racks were removed 10/08/2024 from the corridor. 2. How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken. a. All residents have the potential to be affected by the alleged deficient practice. b. The Maintenance Director completed rounds, and no other impediments were noted. 3. What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur. a. Staff were educated on 10-22-24 regarding the egress in the corridors.(attatchment 12) 4. How the corrective actions will	10/23/2024

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			be monitored to ensure the deficient practices will not occur. a. The Maintenance Director and/or Designee will monitor during facility rounds that the egress in the corridors are free of obstructions. If discrepancies are identified, then immediate action will be taken. The monitoring will 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 updated as needed.	
K 0325 SS=E Bldg. 01	NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) Based on observation and interview, the facility failed to ensure 1 of over 10 alcohol-based hand sanitizer dispensers were not installed over an ignition source. NFPA 101, Section 19.3.2.6(8) states dispensers shall not be installed in the following locations: (a) Above an ignition source within a 1-inch horizontal distance from each side of the ignition source (b) To the side of an ignition source within a 1-inch horizontal distance from the ignition source (c) Beneath an ignition source within a 1-inch vertical distance from the ignition source This deficient practice could affect 14 residents in one smoke compartment. Findings include:	K 0325	It is the practice of this facility to ensure alcohol-based hand sanitizer dispensers were not installed over an ignition source. 1. What corrective actions will be accomplished for those residents found to be affected by the deficient practice. a. All residents, staff members, and visitors have the potential to be affected by the alleged deficient practice. b. Alcohol-based hand sanitizer dispenser located above an electrical outlet were relocated. (Attachment #8)	10/15/2024

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	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 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 dispenser was installed on the wall directly above an electrical outlet. This finding was acknowledged by the Maintenance Director at the time of discovery and again with the Maintenance Director and Administrator present at the exit conference. 3.1-19(b)		2. How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken. a. All residents, staff members, and visitors have the potential to be affected by the alleged deficient practice. 3. What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur. a. Alcohol-based hand sanitizer dispenser located above an electrical outlet were located. (Attachment # 8) 4. How the corrective actions will be monitored to ensure the deficient practices will not occur. a. This is an ongoing program, should non-compliance be 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 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance 1. Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section	K 0345	It is the practice of this facility to ensure visual inspections shall be performed in accordance with being completed semi-annually. It	10/16/2024

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	14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all building occupants. Findings include: Based on record review and interview with the Maintenance Director on 10/07/24 between 9:45 a.m. and 11:00 a.m., no documentation could be provided regarding an itemized list of the facilities fire alarm appliances. The provided "in house" inspection documentation categorically reflected all appliances were inspected but failed to itemize the locations and specific appliances inspected. . This finding was acknowledged by the Maintenance Director at the time of discovery and again with the Maintenance Director and Administrator present at the exit conference. 2. Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm control panels was protected. NFPA 72, National Fire Alarm and Signaling Code Section 10.10.1 states a means for turning off activated alarm notification appliance(s) shall be permitted only if it complies with 10.10.3 through 10.10.7. Section 10.10.3 states the means shall be key-operated or located within		is the practice of this facility that the alarm control panels are protected from unauthorized use. 1. What corrective actions will be accomplished for those residents found to be affected by the deficient practice. a. There were no residents affected by the alleged deficient practice. b. The Maintenance Director has updated the inspection paperwork to include locations and specific appliances that were inspected. c. The key for the fire panel has been relocated. The staff have been educated on 10/09/2024 of the location of the key for the fire panel. (attachment 15,4) 2. How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken. a. All residents, staff, and visitors have the potential to be affected by the alleged deficient practice. 3. What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur. a. The Administrator and/or Designee will monitor the inspection/testing reports to ensure that the locations and specific appliances are included on the report.	

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	a locked cabinet, or arranged to provide equivalent protection against unauthorized use. This deficient practice could affect all occupants. Findings include: Based on observations and interviews during a tour of the facility with the Maintenance Director on 10/07/24 between 11:20 a.m. and 1:00 p.m., the fire alarm control panel (FACP) door was locked, and the key was left in the lock. The FACP is located in the nurses' station area. When asked if residents come into that area the nurse at the station replied "sometimes." This finding was acknowledged by the Maintenance Director at the time of discovery and again with the Maintenance Director and Administrator present at the exit conference. 3.1-19(b)		b. The key for the fire panel has been relocated. The staff have been educated on 10/08/2024 of the location of the key for the fire panel. 4. How the corrective actions will be monitored to ensure the deficient practices will not occur. a. The Maintenance Director and/or Designee will monitor inspections reports to ensure all required information is included. If discrepancies are identified, then immediate action will be taken. The monitoring will be an ongoing process. b. The Maintenance Director and/or Designee during daily rounds will monitor that the key is not in the fire panel. If discrepancies are identified, then immediate action will be taken. The monitoring will be an ongoing 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.	
K 0346 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Based on record review and interview, the facility failed to provide 1 of 1 correct written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system	K 0346	It is the practice of this facility to ensure a written policy for the protection of all residents indicating procedures to be	10/16/2024

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	has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants. Findings include: Based on record review and interview with the Maintenance Director on 10/07/24 between 9:45 a.m. and 11:00 a.m., the facility provided fire watch plan documentation but there were several versions of the plan, but no plan was complete. One version of the entitled "Fire Watch Policy and Procedures" listed names for previous administrators that no one in the room was familiar with. This finding was acknowledged by the Maintenance Director at the time of discovery and again with the Maintenance Director and Administrator present at the exit conference. 3.1-19(b)		followed in the event the fire alarm system must be placed out of service for four hours or more in a twenty-four period. 1. What corrective actions will be accomplished for those residents found to be affected by the deficient practice. a. All residents, staff members, and visitors have the potential to be affected by the alleged practice. b. The fire watch policy has been updated to include the required documentation. (Attachment #5) 2. How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken. a. All residents, staff members, and visitors have the potential to be affected by the alleged deficient practice. 3. What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur. a. The fire watch policy has been updated to include the required documentation. (Attachment#5) 4. How the corrective actions will be monitored to ensure the deficient practices will not occur. a. This is an ongoing program, should non-compliance be	

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			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 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on observation and interview, the facility failed to maintain the ceiling construction throughout the facility. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect 8 residents Findings include: 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 p.m., in the corridor near RR#20 there were a 1-inch unsealed gap in the ceiling. This condition could delay the activation of the sprinklers. Based on interview at the time of observation, the Maintenance Director agreed there was an unsealed gaps in the ceiling around RR # 20. This finding was acknowledged by the Maintenance Director at the time of discovery and again with the Maintenance Director and Administrator present at the exit conference. 3.1-19(b)	K 0353	It is the practice of this facility to maintain the ceiling construction throughout the facility. 1. What corrective actions will be accomplished for those residents found to be affected by the deficient practice. a. There were no residents affected by the alleged deficient practice. b. The unsealed gap in the ceiling corrected 10/16/2024.(attatchment #3) 2. How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken. a. All residents have the potential to be affected by the alleged deficient practice. b. The Maintenance Director completed rounds, and no other areas were identified. 3. What measures will be put in place and what systemic changes	10/16/2024

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			will be made to ensure that deficient practice does not recur. a. The Maintenance Director will 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 will be monitored to ensure the deficient practices will not occur. a. The Maintenance Director will 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 updated as needed.	
K 0354 SS=C Bldg. 01	NFPA 101 Sprinkler System - Out of Service Based on record review and interview, the facility failed to provide 1 of 1 correct written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants.	K 0354	It is the practice of this facility to provide a written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period.	10/16/2024

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	Findings include: Based on record review and interview with the Maintenance Director on 10/07/24 between 9:45 a.m. and 11:00 a.m., the facility provided fire watch plan documentation but there were several versions of the plan, no plan was completely complete. One version of the entitled "Fire Watch Policy and Procedures" listed names for previous administrators that no one in the room was familiar with. This finding was acknowledged by the Maintenance Director at the time of discovery and again with the Maintenance Director and Administrator present at the exit conference. 3.1-19(b)		1. What corrective actions will be accomplished for those residents found to be affected by the deficient practice. a. All residents, staff members, and visitors have the potential to be affected by the alleged deficient practice. b. The sprinkler fire patrol watch policy has been updated to include the required documentation. (Attachment #5,16) 2. How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken. a. All residents, staff members, and visitors have the potential to be affected by the alleged deficient practice. 3. What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur. a. The sprinkler fire patrol watch policy has been updated to include the required documentation. (Attachment #5,16) 4. How the corrective actions will be monitored to ensure the deficient practices will not occur. a. This is an ongoing program, should non-compliance be observed, corrective action shall	

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			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 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 4 of over 30 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 2 staff and 4 residents. Findings include: Based on observations and interviews during a tour of the facility with the Maintenance Director on 10/07/24 between 11:20 a.m. and 1:00 p.m., the (1) laundry room door into the corridor was held open with a sledgehammer. (2) RR# 17 failed to latch. (3) Kitchen door into the dining room , was equipped with a self-closing device but fFailed to self-close and latch. (4) The Dietary Kitchen door was missing a knob and had an approximate 3 inch hole through the door. This finding was acknowledged by the Maintenance Director at the time of discovery and again with the Maintenance Director and Administrator present at the exit conference. 3.1-19(b)	K 0363	It is the practice of this facility to ensure corridor doors have no impediment to closing and latching into the door frame. 1. What corrective actions will be accomplished for those residents found to be affected by the deficient practice. a. All residents and staff members have the potential to be affected by the alleged deficient practice. b. The laundry room door is closed. Staff have been instructed that door cannot be propped open. c. Resident Room #17 door has been fixed and latches appropriately. d. The kitchen door into the dining room self-closure has been repaired. e. The kitchen door with the missing knob has been repaired. (attachment 11,2,13) 2. How other residents having the potential to be affected by the same deficient practices will be	10/16/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E064	A. BUILDING 01 B. WING	10/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROOKSIDE CARE STRATEGIES	505 N GAVIN ST MUNCIE, IN 47303

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			identified and what corrective action will be taken. a. All residents and staff members have the potential to be affected by the alleged deficient practice. 3. What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur. a. The staff have been instructed to complete maintenance repair sheets for needed repairs. b. The Maintenance Director will complete monthly rounds to identify any maintenance repair issues. If any issues are identified, then repairs will be completed. This will be an ongoing monitoring process. 4. How the corrective actions will be monitored to ensure the deficient practices will not occur. a. The Maintenance Director will complete monthly rounds to identify any maintenance repair issues. If any issues are identified, then repairs will be completed. This will be an 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 updated as needed.	

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	15E064	A. BUILDING 01 B. WING	10/07/2024

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K 0927 SS=F Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage/transfer rooms was provided with a sign indicating that transferring is occurring. NFPA 99 11.5.2.3.1(3) states, the area is posted with signs indicating that trans-filling is occurring and that smoking in the immediate area is not permitted. This deficient practice could affect all residents. Findings include: Based on observations and interviews during a tour of the facility with the Maintenance Director on 10/07/24 between 11:20 a.m. and 1:00 p.m., the oxygen storage/transfer room did not have a posted sign indicating making a clear distinction between when transferring of oxygen is occurring in this location and when it is not. Based on interview at the time of observation, the Maintenance Director stated there was not a sign stating when trans-filling oxygen is occurring and when it is not but he understood the need form one. This finding was acknowledged by the Maintenance Director at the time of discovery and again with the Maintenance Director and Administrator present at the exit conference. 3.1-19(b)	K 0927	It is the practice of this facility to ensure oxygen storage/transfer rooms is provided with a sign indicating that transferring is occurring. 1. What corrective actions will be accomplished for those residents found to be affected by the deficient practice. a. All residents and staff members have the potential to be affected by the alleged deficient practice. b. A new oxygen in use sign has been posted on the door indicating oxygen filling in use. 2. How other residents having the 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 be affected by the alleged deficient practice. b. A new oxygen in use sign has been posted on the door indicating oxygen filling in use.(attatchment #14) 3. What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur. a. The staff will be educated on	10/16/2024

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	15E064	A. BUILDING 01 B. WING	10/07/2024

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			the new sign and how to operate properly during the oxygen filling process. 4. How the corrective actions will be monitored to ensure the deficient practices will not occur. a. The Maintenance Director shall periodically check/inspect and assure the sign is being used appropriately. b. 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.	