DEPARTMENT OF HEALTH AND HUMAN SERVICES							
CENTERS FOR MEDICARE & MEDICAID SERVICES							
STATEMENT OF DEFICIENCIES	V1) DDOVIDED/CLIDDLIED/CLIA						

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155687	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/08/2023	
	ROVIDER OR SUPPLIER	- MUNCIE CARE CENTER		2701 L	ADDRESS, CITY, STATE, ZIP COD YN-MAR DR E, IN 47304		
(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 APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
E 0000	0000						
Bldg	conducted by the In accordance with 42 Survey Date: 06/08 Facility Number: 06 Provider Number: 1 AIM Number: 1002 At this Emergency 1 Brickyard Healthcar found not in compli Preparedness Requi Medicaid Participat CFR 483.73. The fa had a census of 106	20097 55687 290970 Preparedness survey, re- Muncie Care Center was ance with Emergency rements for Medicare and ing Providers and Suppliers, 42 acility has a capacity of 117 and at the time of this survey. 42 CFR, Subpart 483.73 is NOT by:	E 0	000	Preparation, submission and implementation of this Plan of Correction does not constitut admission or agreement with facts and conclusions set for survey report. Our Plan of Correction was prepared and executed as a means to continuously improve the quacare and comply with all applicable federal and state requirements. The facility respectfully require a desk review.	e an the th the	
E 0039 SS=F Bldg	S=F 441.184(d)(2), 482.15(d)(2), 483.475(d)(2),						

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

TITLE (X6) DATE

Kaushik Patel Executive Director 06/23/2023

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 155687		(X2) MULTIPLE CO A. BUILDING B. WING	COM	e survey pleted 8/2023		
	PROVIDER OR SUPPLIER	E - MUNCIE CARE CENTER	2701 L`	ADDRESS, CITY, STATE, ZIP CO YN-MAR DR E, IN 47304)D	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION
TAG	CMHCs at §485.9	20, RHCs/FQHCs at RD Facilities at §494.62]:	TAG	DEFICIENCE		DATE
	exercises to test t	acility] must conduct he emergency plan ility] must do all of the				
	(i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)					
	include, but is not (A) A second full-scommunity-based functional exercise (B) A mock disast (C) A tabletop exeled by a facilitator discussion using a clinically-relevant set of problem stamessages, or preto challenge an er (iii) Analyze the [famaintain documer exercises, and em	er drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a tements, directed pared questions designed				

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155687		î ´	ILTIPLE CO ILDING NG	COM	e survey pleted 18/2023			
	OF PROVIDER OR SUPPLIE	R E - MUNCIE CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 2701 LYN-MAR DR MUNCIE, IN 47304					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
	the patient's home conduct exercises plan at least annual the following: (i) Participate in a community based (A) When a community based functional (B) If the hospice man-made emerged of the emergency exempt from engascale community-facility-based functional exercise of this section is dinclude, but is not (A) A second full community-based functional exercise (B) A mock disass (C) A tabletop exeled by a facilitator discussion using clinically-relevant set of problem stamessages, or preto challenge an exercises to test to exercises to exercises.	espices that provide care in e. The hospice must is to test the emergency itally. The hospice must do a full-scale exercise that is a every 2 years; or inunity based exercise is not uct an individual facility exercise every 2 years; or experiences a natural or individual exercise or individual exercise or individual exercise following the individual exercise every 2 individual exercise every						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION A. BUILDING		NSTRUCTION	(X3) DATE SURVEY COMPLETED	
		155687	B. WING		_	06/08/	2023
	PROVIDER OR SUPPLIER	R - MUNCIE CARE CENTER	2	701 LY	DDRESS, CITY, STATE, ZIP COD 'N-MAR DR E, IN 47304		
					,		
(X4) ID		STATEMENT OF DEFICIENCIE		D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	T	AG	DEFICIENCE		DATE
		an annual full-scale exercise					
	that is community-based; or (A) When a community-based exercise is not						
	1 ' '	ict an annual individual					
		ctional exercise; or					
	· -	experiences a natural or					
	1 ' '	ency that requires activation					
		plan, the hospice is					
		aging in its next required					
		nity based or facility-based					
	functional exercise	e following the onset of the					
	emergency event. (ii) Conduct an additional annual exercise						
	that may include,	but is not limited to the					
	following:						
	1 ' '	-scale exercise that is					
	1	l or a facility based					
	functional exercise						
	(B) A mock disas						
		ercise or workshop led by a					
		udes a group discussion					
	using a narrated,						
		rio, and a set of problem					
		ted messages, or prepared					
	ı ·	ed to challenge an					
	emergency plan.	seeminale recommend to and					
	1 ' '	nospice's response to and					
		ntation of all drills, tabletop nergency events and revise					
		ergency plan, as needed.					
	the hospice's eme	ergency plan, as needed.					
	*[For PRFTs at §441.184(d), Hospitals at						
	§482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency						
	plan twice per year. The [PRTF, Hospital,						
	CAH] must do the						
		an annual full-scale exercise					
	that is community-based: or			l			

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CENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES			OM	B NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u></u>	COMPL	ETED
		155687	B. WING	06/08	/2023	
NAME OF I			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEI	K.		YN-MAR DR		
BRICKY	ARD HEALTHCARE	E - MUNCIE CARE CENTER	MUNCI	E, IN 47304		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG			TAG	DEFICIENCY)		DATE
	1 ' '	nunity-based exercise is not				
	accessible, conduct an annual individual,					
	-	ctional exercise; or				
	_ ' '	Hospital, CAH] experiences				
		or man-made emergency				
	· ·	ation of the emergency				
	plan, the [facility]	is exempt from engaging in				
	its next required f	ull-scale community based				
or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual						
	exercise or and that may include, but is not limited to the following:					
		-scale exercise that is				
	community-based	l or individual, a				
	facility-based fund	ctional exercise; or				
	(B) A mo	ock disaster drill; or				
	(C) A tableto	p exercise or workshop that				
	is led by a facilitat	tor and includes a group				
	discussion, using	a narrated,				
	clinically-relevant	emergency scenario, and a				
	set of problem sta	atements, directed				
	messages, or pre	pared questions designed				
	to challenge an e	mergency plan.				
	(iii) Analyze t	he [facility's] response to				
	and maintain doc	umentation of all drills,				
	tabletop exercises	s, and emergency events				
	and revise the [fa	cility's] emergency plan, as				
	needed.					
	*[For PACE at §4	60.84(d):1				
	-	PACE organization must				
		s to test the emergency				
	plan at least annu	5				
	organization must					
		an annual full-scale exercise				
	that is community					
	-					
	(A) When a community-based exercise is not		1			

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accessible, conduct an annual individual, facility-based functional exercise; or

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	, ,		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPI	
		155687	B. W	ING		06/08	/2023
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					/N-MAR DR		
BRICKY	ARD HEALTHCARE	E - MUNCIE CARE CENTER		MUNCI	E, IN 47304		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP	E RIATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		xperiences an actual natural					
		ergency that requires					
		mergency plan, the PACE					
		ngaging in its next required					
	full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.						
		gency event. In additional exercise every					
	1 ' '	the year the full-scale or					
		e under paragraph (d)(2)(i)					
		conducted that may include,					
but is not limited to the following:							
(A) A second full-scale exercise that is							
	community-based or individual, a facility						
	based functional e						
	(B) A mock disas						
		ercise or workshop that is					
	. , ,	and includes a group					
	discussion, using	a narrated,					
	clinically-relevant	emergency scenario, and a					
	set of problem sta	tements, directed					
	messages, or pre	pared questions designed					
	to challenge an er	mergency plan.					
	. , ,	PACE's response to and					
		ntation of all drills, tabletop					
		nergency events and revise					
	the PACE's emerg	gency plan, as needed.					
	*[For LTC Facilitie	es at §483.73(d):1					
	_	ity] must conduct exercises					
	_ ` ′ -	ency plan at least twice per					
		announced staff drills using					1
	the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not						
		ıct an annual individual,					
	facility-based fund	ctional exercise.					
	(B) If the [LTC fac	cility] facility experiences an					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155687			ILDING		COMPI 06/08	ETED	
	F PROVIDER OR SUPPLIEF	E - MUNCIE CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 2701 LYN-MAR DR MUNCIE, IN 47304				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE
	requires activation LTC facility is exe required a full-sca individual, facility- following the onse (ii) Conduct an activate may include, following: (A) A second full- community-based based functional et (B) A mock disas (C) A tabletop ex led by a facilitator discussion, using clinically-relevant set of problem sta messages, or pre to challenge an et (iii) Analyze the [I response to and r all drills, tabletop events, and revise emergency plan, at *[For ICF/IIDs at § (2) Testing. The IC exercises to test to twice per year. Th following: (i) Participate in a that is community (A) When a community (A) When a community (B) If the ICF/IID et natural or man-ma activation of the et	ter drill; or ercise or workshop that is includes a group a narrated, emergency scenario, and a stements, directed pared questions designed mergency plan. LTC facility] facility's naintain documentation of exercises, and emergency e the [LTC facility] facility's as needed. \$483.475(d)]: CF/IID must conduct the emergency plan at least the ICF/IID must do the an annual full-scale exercise					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155687		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/08/2023	
	PROVIDER OR SUPPLIE	R E - MUNCIE CARE CENTER		2701 LY	DDRESS, CITY, STATE, ZIP COD N-MAR DR E, IN 47304		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		nity-based or individual,					
		ctional exercise following the					
	onset of the emer						
	(ii) Conduct an additional annual exercise that may include, but is not limited to the following:(A) A second full-scale exercise that is						
	community-based						
	facility-based functional exercise; or (B) A mock disaster drill; or						
	1 ' '						
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group							
	discussion, using a narrated,						
	clinically-relevant emergency scenario, and a						
set of problem statements, directed							
		pared questions designed					
	to challenge an e	•					
	_	CF/IID's response to and					
	1 ' '	ntation of all drills, tabletop					
		nergency events, and revise					
		rgency plan, as needed.					
	and for AID 6 cine	igency plan, as needed.					
	*[For HHAs at §48	34.102]					
	(d)(2) Testing. Th	e HHA must conduct					
	exercises to test t	he emergency plan at					
	least annually. Th	e HHA must do the					
	following:						
	(i) Participate in a	full-scale exercise that is					
	community-based						
	` '	community-based exercise					
	· ·	conduct an annual					
	· ·	based functional exercise					
	every 2 years; or.						
		A experiences an actual					
		ade emergency that requires					
	activation of the emergency plan, the HHA is						
		aging in its next required					
		nity-based or individual,					
		ctional exercise following the					
	onset of the emergency event.						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 1.55687 NAME OF PROVIDER OR SUPPLIER BRICKYARD HEALTHCARE - MUNCIE CARE CENTER X3 ID SUMMAY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (I) Conduct an additional exercise or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-Scale exercise that is community-based or an individual, facility-based functional exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency senand, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. The OPO must do the following: (I) Conduct a paper-based, tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency plan. The OPO must do the following: (I) Conduct a paper-based, tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency plan, as needed.	STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
BRICKYARD HEALTHCARE - MUNCIE CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCE PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (CACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (CACH DEFICIENCY BY (CACH DEFICIENCY BY (CACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (CACH DEFICE AND OF CACH DEFICIENCY (A) A SECOND BY (CACH DEFICE AND OF CACH DEFICIENCY (A) A SECOND BY (CACH DEFICE AND OF CACH DEFICE (CACH DEFICE AND OF CACH DEFICE (CACH DE	AND PLAN	OF CORRECTION						
RRICKYARD HEALTHCARE - MUNCIE CARE CENTER RICHATORY OR ISC DEPTIFYING INFORMATION TAG REGILATORY OR ISC DEPTIFYING INFORMATION (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency plan, (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises to test the emergency plan, as needed. "[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercises or workshop at least annually. A tabletop exercises is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency plan as needed.			155687	B. W	ING		06/08	/2023
BRICKYARD HEALTHCARE - MUNCIE CARE CENTER XA ID					STREET A	ADDRESS, CITY, STATE, ZIP COD		
SUMMARY STATEMENT OF DEFICIENCIE DROUBLES NAMED CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LEXT DENTIFYING INFORMATION TAG PREFIX TAG COMPLETION DATE	NAME OF P	ROVIDER OR SUPPLIER	ę.		2701 LY	/N-MAR DR		
PREFIX TAG REGILATORY OR LSC IDENTIFYING INFORMATION (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency plan, as needed. "[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or	BRICKYA	ARD HEALTHCARE	E - MUNCIE CARE CENTER		MUNCI	E, IN 47304		
TAG REGULATORY OR LSC IDENTIFYING INFORMATION (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or		SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. "[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency, scenario, and a set of problem statements, directed messages, or		· ·			CROSS-REFERENCED TO THE APPROPRIATE		TE	
years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or	TAG			-	TAG	DEFICIENCY)		DATE
functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or		` '	-					
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relevant emergency scenario, and a set of problem statements, directed messages, or		_						
problem statements, directed messages, or			_					
		_	•					
prepared questions designed to challenge an		•	•					
			-					
emergency plan. If the OPO experiences an								
actual natural or man-made emergency that			- ·					
requires activation of the emergency plan, the								
		OPO is exempt from engaging in its next						
		required testing exercise following the onset						
of the emergency event.								
(ii) Analyze the OPO's response to and maintain documentation of all tabletop		, ,						

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155687	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION ;	(X3) DATE SURVEY COMPLETED 06/08/2023			
	PROVIDER OR SUPPLIEF	E - MUNCIE CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 2701 LYN-MAR DR MUNCIE, IN 47304					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE				
	the [RNHCI's and needed. *[RNCHIs at §403 (d)(2) Testing. The exercises to test to RNHCI must do the first of the exercises to test to the exercises of the exercises of the emergency produced to the exercises of the exe	e RNHCI must conduct the emergency plan. The ne following: er-based, tabletop exercise A tabletop exercise is a led by a facilitator, using a r-relevant emergency et of problem statements, s, or prepared questions enge an emergency plan. NHCI's response to and ntation of all tabletop nergency events, and revise rgency plan, as needed. view and interview, the facility tercises to test the emergency er year, including drills using the emergency TC facility must do the annual full-scale exercise that d; or ity-based exercise is not an annual individual, ional exercise. Ty experiences an actual natural gency that requires activation lan, the LTC facility is exempt ext required full-scale in a or individual, facility-based I exercise for 1 year following	E 0039	-039 What corrective action(s) will be accomplished for those residen found to have been affected by deficient practices: Education on the EPP policy of "after action report" for each full-scale community-based disasters drill, event and or tabletop exercise was complete by corporate maintenance direct to the Executive Director and Maintenance Director.	ts the			

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a. A second full-scale exercise that is

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potential to be affected by the

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155687		(X2) MULT A. BUILI B. WING	DING	NSTRUCTION	(X3) DATE SURVEY COMPLETED 06/08/2023	
AND PLA	NAME OF PROVIDER OR SUPPLIER BRICKYARD HEALTHCARE - MUNCIE CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		A. BUILI B. WING	DING STREET A 2701 LY	DDRESS, CITY, STATE, ZIP COD (N-MAR DR E, IN 47304 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) same deficient practice will be identified and what corrective actions will be taken: All residents residing at the fa have potential to be affected. What measures will be put into	COMPLETED 06/08/2023 (X5) COMPLETION DATE Cility
	maintain document exercises, and emer LTC facility's emer accordance with 42 deficient practice of Findings include: Based on records reand the Maintenance a.m., documentation exercise conducted This exercise did not response was analy were effective. Based records review, the Maintenance Direct for analyzing the L completed. This finding was records review, and the Maintenance Direct for analyzing the L completed.	ation of all drills, tabletop			place and what systemic char will be made to ensure that the deficient practice does not recompleted and procedures was completed and disaster drills will be accompated by an after-action report going forward. The drills will be audi in the EPP annual review by the ED and Maintenance to ensure compliance. How the corrective actions will monitored to ensure the defici practice will not recur, what quassurance program will be purplace: ED/Maintenance Director will submit the After-action report the QAPI meeting after each eand review with QAPI no less quarterly in perpetuity.	nges e cur: d nd all inied g tted he re I be ient uality t into

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155687		(X2) MULTIPLE (A. BUILDING B. WING	construction 	COMI	(X3) DATE SURVEY COMPLETED 06/08/2023	
	PROVIDER OR SUPPLIER ARD HEALTHCARE	E - MUNCIE CARE CENTER	2701	CADDRESS, CITY, STATE, ZI LYN-MAR DR CIE, IN 47304	P COD	
(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 (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TI DEFICIENCY	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
K 0000						
Bldg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Date: 06/08 Facility Number: 0 Provider Number: 1 AIM Number: 1002 At this Life Safety of Healthcare- Muncie compliance with Re Medicare/Medicaid Life Safety from Fi National Fire Protec Life Safety Code (I Health Care Occupa This one story facil Type V (111) const sprinklered. The fa with smoke detection to the corridors and detectors in the resi facility has a capaci 106 at the time of the All areas where the access were sprinkl facility services were	200097 255687 290970 Code survey, Brickyard Care Canter was found not in equirements for Participation in 42 CFR Subpart 483.90(a), re and the 2012 edition of the ction Association (NFPA) 101, 2SC), Chapter 19, Existing ancies and 410 IAC 16.2. The company of the control of the ction and was fully cility has a fire alarm system on in the corridors, areas open battery operated smoke dent sleeping rooms. The fity of 117 and had a census of his survey. The control of the customary ered. All areas providing	K 0000	Preparation, submis implementation of the Correction does not admission or agreer facts and conclusion survey report. Our P Correction was prep executed as a mean continuously improved care and comply with applicable federal arrequirements. The facility respect of a desk review.	nis Plan of constitute an ment with the ns set forth the Plan of pared and ns to e the quality of h all nd state	
K 0291 SS=F	NFPA 101 Emergency Lightii	ng				

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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 COMPLETED 01 B. WING 06/08/2023 155687 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2701 LYN-MAR DR BRICKYARD HEALTHCARE - MUNCIE CARE CENTER MUNCIE. IN 47304 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Bldg. 01 **Emergency Lighting** Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1. 19.2.9.1 Based on records review and interview, the facility K 0291 K-291 06/26/2023 failed to ensure 1 of 1 battery backup emergency light was tested annually for 90 minutes. Section 7.9.3.1.1 (1) requires functional testing shall be What corrective action(s) will be conducted monthly, with a minimum of 3 weeks accomplished for those residents and a maximum of 5 weeks between tests, for not found to have been affected by the less than 30 seconds, (3) Functional testing shall deficient practices: be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery The battery operated 90-minute powered and (5) Written records of visual emergency light test was inspections and tests shall be kept by the owner completed for all locations where for inspection by the authority having battery operated lights are located jurisdiction. This deficient practice could affect all by the Maintenance Director on residents in the facility. 6/20/23. The test was successful with no concerns noted. Findings include: Based on records review with the Maintenance Director on 06/08/23 at 11:15 a.m., annual testing How other residents having the for the battery backup emergency lights was potential to be affected by the unavailable. The Battery Operated Emergency same deficient practice will be Light Test Log indicated the annual 90 minute identified and what corrective actions will be taken: testing for the nine battery backup emergency lights was not conducting in the last 12 months. Based on an interview at the time of records All residents of the facility have review, the Maintenance Director stated the potential to be affected. annual 90 minute testing for the battery backup emergency light has not been conducted in the past 12 months. What measures will be put into This finding was reviewed with the Administrator place and what systemic changes and Maintenance Director at the exit conference. will be made to ensure that the deficient practice does not recur: 3.1-19(b) -minute emergency light test was

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155687	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	COMF	E SURVEY PLETED 3/2023
	ROVIDER OR SUPPLIER	- MUNCIE CARE CENTER	2701 L	ADDRESS, CITY, STATE, ZIP YN-MAR DR IE, IN 47304	COD	_
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	DRRECTION SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
				successfully complete applicable units. The testing date has been and it has been noted maintenance portal.	next annual scheduled	
				How the corrective ac monitored to ensure t practice will not recur quality assurance pro put into place:	he deficient , I.e., what	
				The annual testing da into maintenance port reviewed in QAPI for timely testing no less quarterly in perpetuity	tal and will be completion of than	
K 0920 SS=D Bldg. 01	Extens Electrical Equipme Extension Cords Power strips in a pused for compone patient-care-relate (PCREE) assembl assembled by qua the conditions of 1 the patient care vi non-PCREE (e.g., except in long-terr do not use PCREE meet UL 1363A or for non-PCREE in	ent - Power Cords and ent - Power Cords and ent - Power Cords and ent in the care vicinity are only ents of movable defectrical equipment es that have been lified personnel and meet 0.2.3.6. Power strips in cinity may not be used for personal electronics), en care resident rooms that E. Power strips for PCREE ELL 60601-1. Power strips the patient care rooms meet UL 1363. In				

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER 155687	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 06/08/2023	
	ROVIDER OR SUPPLIER ARD HEALTHCARE - MUNCIE CARE CENTER	2701 L	ADDRESS, CITY, STATE, ZIP COD YN-MAR DR E, IN 47304		
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 resident rooms did not used multi-plug adaptors as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects 1 resident. Findings include: Based on observation with the Maintenance Director on 06/08/23 at 1:50 p.m., resident room 150 contained a multi-plug adaptor powering computer equipment. Based on interview at the time of observation, the Maintenance Director	K 0920	-920 What corrective action(s) will be accomplished for those reside found to have been affected be deficient practices: The multiplug adaptor was removed upon discovery during survey by maintenance directed. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective.	oe onts y the or.	
	agreed a multi-plug adaptor was in use in room 150. The multi-plug adapter was removed at the time of discovery.		actions will be taken: All residents in the vicinity of to multi-plug adapter have the	he	
	This finding was reviewed with the Administrator and Maintenance Director at the exit conference.		potential to be affected. What measures will be put into		
	3.1-19(b)		place and what systemic chan will be made to ensure that the deficient practice does not rec	ges e	
			Maintenance Director/ Design	ee	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/27/2023 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		<u>01</u>	COMPLETED	
		155687	B. W	ING		06/08/	2023
NAME OF PROVIDER OR SUPPLIER BRICKYARD HEALTHCARE - MUNCIE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 2701 LYN-MAR DR MUNCIE, IN 47304				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	D 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	ΤF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					removed the multiplug adaptor from the resident during the survey. Maintenance Director/Designee has comple facility wide inspection multi pl adaptors and extension cords. Maintenance Director/Designe will observe 10 areas each monthly x 3 months for compliance How the corrective actions will monitored to ensure the deficie practice will not recur, I.e., what quality assurance program will put into place: The Maintenance Director will submit the report along with ar life safety issues and correction during the monthly QAPI meet no less than quarterly in perpetuity.	ted ug e be ent at be	

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