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	10/24/2022

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: 10/24/22 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 35 at the time of this survey. Quality Review completed on 10/27/22	E 0000		
K 0000 Bldg. 01	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: 10/24/22 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	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jamey Kleva	HFA	11/28/2022

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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	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 35 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 10/27/22			
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants			

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	by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4			

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	ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure all doors were provided with only one latching mechanism to release the door and open. 33.2.2.5.7 refers to 7.2.1.5.10 which states a latch or other fastening device on a door leaf shall be provided with a releasing device that has an obvious method of operation and that is readily operated under all lighting conditions. 7.2.1.5.10.4 states the releasing mechanism shall open the door leaf with not more than one releasing operation. 7.2.1.5.10.1 states the releasing mechanism for any latch shall be located not less than 34 inches, and not more than 48 inches, above the finished floor. This deficient practice could affect 4 occupants. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director on 10/24/22 between 11:15 a.m. and 1:00 p.m., the (1) Nursing / HR Office and the (2) Activities Social Service Office, was equipped with two latching devices, a regular door handle with a turn latching mechanism and a separate keyed dead bolt locking latch. The Maintenance Director agreed that, when locked, to exit the Therapy area it would require two separate actions to open the door.	K 0222	The filing of the plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the requirements and continue to provide quality care. **The facility respectfully requests paper review for compliance.** 1. Maintenance Director removed deadbolt latch from inter works of lock, kept Outer casings to hide the hole, however replaced bottom Door Knob with a new self-latching hardware. 2. Maintenance Director Checked remaining doors for only one latch, no more found. 3.	11/28/2022

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	This finding was acknowledged by the Maintenance Director at the time of discovery and again with the Maintenance Director present at the exit conference. 3.1-19(b)			
K 0345 SS=E Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on observation and interview, the facility failed to ensure 1 of 4 manual fire alarm boxes were readily accessible. NFPA 72, The National Fire Alarm Code, 17.14.5 Manual fire alarm boxes shall be installed so that they are conspicuous, unobstructed, and accessible. This deficient practice affects staff, visitors and 15 residents near the central nurses station. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director on 10/24/22 between 11:15 a.m. and 1:00 p.m., the manual fire alarm pull station near the central front nurses' station was not readily accessible in that the pull station was being blocked by a cart. The Maintenance Director moved the cart during the tour, but when the surveyor accompanied by the Maintenance Director returned to the area later	K 0345	The filing of the plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the requirements and continue to provide quality care. **The facility respectfully requests paper review for compliance.** 1. Moved Med carts to another location when not in use. 2. Educated Nursing staff as to why the pull station can't be blocked. 3. Put up signage to remind staff the pull station can't be blocked. see exhibit 2	10/26/2022

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	during the survey, the cart was returned to the position obstructing access to the pull station. This finding was acknowledged by the Maintenance Director at the time of discovery and again with the Maintenance Director present at the exit conference. 3.1-19(b)			
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure 1 of 1 fire department connection sign was readable. NFPA 25 2010 edition states 13.7.1 fire department connections shall be inspected quarterly to verify the following: (1) The fire department connections are visible and accessible. (2) Couplings or swivels are not damaged and rotate smoothly. (3) Plugs or caps are in place and undamaged.	K 0353	The filing of the plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the requirements and continue to provide quality care. **The facility respectfully requests paper review for**	10/26/2022

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	(4) Gaskets are in place and in good condition. (5) Identification signs are in place. (6) The check valve is not leaking. (7) The automatic drain valve is in place and operating properly. (8) The fire department connection clapper(s) is in place and operating properly. This deficient practice could affect all residents. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director on 10/24/22 between 11:15 a.m. and 1:00 p.m., there was a sign at the fire department connection, but the sign was faded and was not legible. The Maintenance Director stated that the letters had faced so he painted over them. Based on interview at the time of the observations, the Maintenance Director agree the posted sign was faded and was hard to read and would need to be replaced. This finding was acknowledged by the Maintenance Director at the time of discovery and again with the Maintenance Director present at the exit conference. 3.1-19(b)		**compliance.** 1. Maintenance director painted sign to be more visible to Fire department for connection. 2. Put checking the sign on a yearly check list to be checked for visibility.	
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility	K 0355	The filing of the plan of correction	11/01/2022

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	failed to maintain 1 of 1 portable fire extinguishers in the kitchen cooking area in accordance with the requirements of NFPA 10. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, Section 5.5.5 states fire extinguishers provided for the protection of cooking appliances using combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. NFPA 10, 5.5.5.3 states a placard shall be placed near the extinguisher that states that the protection system shall be actuated prior to using the fire extinguisher. Since the fixed fire extinguishing system will automatically shut off the fuel source to the cooking appliance, the fixed system should be activated before using the portable fire extinguisher. In this instance, the portable fire extinguisher is supplemental protection. This deficient practice could affect five staff and visitors in the kitchen. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director on 10/24/22 between 11:15 a.m. and 1:00 p.m., a portable K Class fire extinguisher was located in the kitchen and a placard was not conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Based on interview at the time of observation, the Maintenance Director acknowledged a placard was not conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. A recent fire had occurred in the kitchen and the Maintenance Director stated that perhaps the signage had not been replaced. This finding was acknowledged by the Maintenance Director at the time of discovery and		does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the requirements and continue to provide quality care. **The facility respectfully requests paper review for compliance.** 1. Maintenance Director called Korsen to ordered the required sign. **2. Installed new signage near the K class fire extinguisher. See exhibit 4** 3. Educated Kitchen staff, that the fire suppression system needs to activated before using the K class extinguisher.	

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	again with the Maintenance Director present at the exit conference. 3.1-19(b)			
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire			

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	resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 2 of over 30 corridor doors would resist the passage of smoke. This deficient practice could affect 6 residents. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director on 10/24/22 between 11:15 a.m. and 1:00 p.m., the (1) door into the Therapy Office had approximately a 3.5-inch hole where the doorknob was missing. The Maintenance Director stated that it needed to be replaced. And (2) the corridor door to Resident Room # 13 had approximately 1 inch gap around the top of the door and would not resist the passage of smoke. This finding was acknowledged by the Maintenance Director at the time of discovery and again with the Maintenance Director present at the exit conference. 3.1-19(b)	K 0363	The filing of the plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the requirements and continue to provide quality care. **The facility respectfully requests paper review for compliance.** 1. Maintenance installed door knob into the therapy office. See Exhibit 5 **2. Maintenance adjusted door in room #13 to remove the gap.**	11/01/2022
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric			

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	Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 1. Based on observation and interview, the facility failed to ensure 4 of over 100 electrical outlets contained a cover plate and was protected from damage. NFPA 70, 2011 Edition. Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. NFPA 70, 2011 Edition. Article 406.5 (F) Exposed Terminals, Receptacles shall be enclosed so that live wiring terminals are not exposed to contact. This deficient practice could affect 8 residents. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director on 10/24/22 between 11:15 a.m. and 1:00 p.m., in the following locations there was an electrical outlet missing a cover plate and/or exposed wiring: A) In the Laundry Room near the Commercial Washer, the outlet box was hanging out from the wall. B) In Resident Room 22 an outlet cover was missing. C) In Resident Room 19 an outlet cover was missing. D) In Resident Room 14 an outlet cover was missing. E) In the Janitors Closet near Room #6 a light cover was missing. The Maintenance Director stated he wasn't sure what had happened to the covers.	K 0511	The filing of the plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the requirements and continue to provide quality care. **The facility respectfully requests paper review for compliance.** 1. Maintenance director replaced outlet covers in rooms 22, 19, 14, and janitors closet. See exhibit 6A & 6B 2. Educated staff as to if they see a missing cover to fill out a work order ASAP. 3. Called Korsen, setup request to come to building and fix the junction boxes in the attic on East and West hall. Appointment is made for them to come and install covers to junction boxes and complete and inspection to ensure the system is functioning properly.	12/05/2022

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	This finding was acknowledged by the Maintenance Director at the time of discovery and again with the Maintenance Director present at the exit conference. 2. Based on observation, the facility failed to ensure 2 of 2 electrical junction boxes in the East and West Hall were maintained in a safe operating condition. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 314.28(3) (c) states junction boxes shall be provided with covers compatible with the box and suitable for the conditions of use. Where used, metal covers shall comply with the grounding requirements of 250.110. This deficient practice could affect staff and up to 20 residents. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director on 10/24/22 between 11:15 a.m. and 1:00 p.m., electrical junction boxes in the attic on both the East and West Hall did not contain covers and had exposed electrical wiring. Based on interview at the time of the observations, the Maintenance Director acknowledged the electrical junction boxes were not provided with a cover and had exposed wires. This finding was acknowledged by the Maintenance Director at the time of discovery and again with the Maintenance Director present at the exit conference. 3.1-19(b)			

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BROOKSIDE CARE STRATEGIES	505 N GAVIN ST MUNCIE, IN 47303

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K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on record review, observation and interview; the facility failed to ensure documentation of electrical outlet receptacle testing at all resident rooms was available for review in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade at patient bed locations and in locations where deep sedation or general anesthesia shall be tested at intervals not exceeding 12 months. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.1	K 0914	The filing of the plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the requirements and continue to provide quality care. **The facility respectfully requests paper review for compliance.** **1. Purchased required testing**	11/04/2022

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	10/24/2022

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	states hospital-grade receptacles testing shall be performed after initial installation, replacement or servicing of the device. Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). Section 6.3.4.2.1.2 states, at a minimum, the record shall contain the date, the rooms or areas tested, and an indication of which items have met, or have failed to meet, the performance requirements of this chapter. This could affect all residents. Findings include: Based on record review and interview with the Maintenance Director on 10/24/22 between 9:45 a.m. and 11:15 a.m., an itemized listing of inspection and testing electrical outlet receptacles in in the facility within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Maintenance Director stated electrical receptacle testing has not happened. Based on observations with the Maintenance Director during a tour of the facility each resident sleeping room had multiple electrical receptacles installed at resident bed locations. This finding was acknowledged by the Maintenance Director at the time of discovery and again with the Maintenance Director present at the exit conference.		**device for the outlets.** 2. Maintenance Director performed test on outlets. See exhibit 8 3. Maintenance has set up a schedule for yearly test.	

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	3.1-19(b)			
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In 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 power strips in resident rooms were a UL rating of 1363A or 60601-1. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 feet beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 feet 6 inches above the	K 0920	The filing of the plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the requirements and continue to provide quality care. **The facility respectfully requests paper review for**	10/25/2022

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	floor. This deficient practice affects 2 residents. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director on 10/24/22 between 11:15 a.m. and 1:00 p.m., the power strip being used Resident Room #13 to power electrical equipment lacked a UL rating of 1363A or 60601-1 label. This finding was acknowledged by the Maintenance Director at the time of discovery and again with the Maintenance Director present at the exit conference. 3.1-19(b)		**compliance.** 1. Removed power strip from room 13 2. Educated staff that using a power strip must be cleared by the Maintenance Director first before being used.	