CL. TERD TOR	THE WINDS	THE CERTICES				0.01	21.0.0,00	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	<u></u>	COMPLETED		
		155687	B. WI	B. WING			06/06/2025	
NAME OF P	ROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD			
55.6.6.			2701 LYN-MAR DR					
BRICKYA	ARD HEALTHCARE	- MUNCIE CARE CENTER		MUNCI	E, IN 47304			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	.TE	COMPLETION	
TAG	`			TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE	
E 0000								
Bldg								
Ŭ	An Emergency Pres	paredness Survey was	E 00	000	The following Plan of Correcti	on		
		diana Department of Health in		,00	constitutes our written allegati			
	accordance with 42	-			of compliance for the deficient			
	ascordance with 42	222 105.75.			cited. Submission of the Plan			
	Survey Date: 06/06	5/25			Correction is not an admission			
	Darvey Date. 00/00	,, <u>20</u>			that a deficiency exits or that			
	Facility Number: 0	00097			was cited correctly. This Plan			
	Provider Number:				Correction is submitted to me			
	AIM Number: 100290970							
	Alivi Nullioei. 100.	290970			requirements established by S and Federal law	siale		
	At this Emarganay	Dronoradnass survay			and rederal law			
		Preparedness survey,						
	-	re - Muncie Care Center was						
	found in compliance	- ·						
		rements for Medicare and						
	_	ing Providers and Suppliers, 42						
	CFR 483.73.							
	_	certified beds. At the time of						
	the survey, the cens	us was 98.						
	Quality Review con	npleted on 06/09/25						
K 0000								
K 0000								
Bldg. 01								
Blug. 01	A Life Sefety Cada	Decertification and State	17.0	200	The following Plan of Comest	on		
	-	Recertification and State	K 00	JUU	The following Plan of Correction			
	-	vas conducted by the Indiana			constitutes our written allegati			
	_	th in accordance with 42 CFR			of compliance for the deficient			
	483.90(a).				cited. Submission of the Plan			
	G 5				Correction is not an admission			
	Survey Date: 06/06	0/25			that a deficiency exits or that			
					was cited correctly. This Plan			
	Facility Number: 0				Correction is submitted to me			
	Provider Number:				requirements established by S	3tate		
	AIM Number: 100	290970			and Federal law			
	At this Life Safety	Code survey, Brickyard						

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

TITLE (X6) DATE

Kaushik Patel Executive Director 06/20/2025

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclodays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: N4HE21 Facility ID: 000097 If continuation sheet Page 1 of 8

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155687		(X2) MULTIPLE CO A. BUILDING B. WING	X3) DATE SURVEY COMPLETED 06/06/2025		
	PROVIDER OR SUPPLIER	- MUNCIE CARE CENTER	2701 L	ADDRESS, CITY, STATE, ZIP COD YN-MAR DR IE, IN 47304	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	(X5) COMPLETION DATE
K 0222	compliance with Re Medicare/Medicaid Life Safety from Fir National Fire Protect Life Safety Code (I Health Care Occupation of This one-story facil Type V (111) const facility has a fire also detection in the corrorridors, and batter in all resident sleep capacity of 117 and of this visit. All areas where resident services were sprinkled and services were sprinkled control of the control of th	the Care Center was found not in Equirements for Participation in 1, 42 CFR Subpart 483.90(a), and the 2012 edition of the etion Association (NFPA) 101, and a second 410 IAC 16.2. The second and 410 IAC 16.2. The second and fully sprinkled. The arm system with smoke endors, spaces open to the ry-operated smoke detectors ing rooms. The facility has a had a census of 98 at the time dents have customary access all areas providing facility steed.			
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors				
	failed to ensure the exit doors was read without a clinical disecurity measures. of egress shall not block that requires the egress side unless of 19.2.2.2.4. Door-lo permitted in accord-	on and interview, the facility means of egress for 1 of over 7 fily accessible for residents agnosis requiring specialized Doors within a required means be equipped with a latch or the use of a tool or key from the therwise permitted by LSC tocking arrangements shall be ance with 19.2.2.2.5.2. This could affect 5 staff and visitors, it the facility.	K 0222	1.What corrective actions will be accomplished for those resider found to have been affected by deficient practice. This deficient practice could has affected the residents, staff and visitors using the exit door. The maintenance director during the survey had corrected the defici practice by removing the code reposted it in a location where clearly visible and readable. 2. How other residents having the potential to be affected by the	tts the ve d e e e e and t is

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Event ID:

N4HE21 Facility ID: 000097

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>		COMPLETED	
		155687	B. W	ING		06/06/	/2025
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	R			YN-MAR DR		
BRICKY	ARD HEALTHCARE	E - MUNCIE CARE CENTER			E, IN 47304		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	PROVIDER'S DEAN OF CORRECTION	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					same deficient practice will be		
	Based on observation	on and interview with the			identified and what corrective		
Maintenance Supervisor (MS) and Assistant				actions will be taken.			
	Maintenance Direct	tor (AMD) and Executive			This deficient practice could a	ffect	
	Director (ED) on 0	6/06/25 at 12:35 p.m. during a			staff and visitors, when needir	ıg to	
	tour of the facility,	the kitchen exit door did not			exit the facility. Door code has	i	
	have the code poste	ed in a manner which was			been posted where it is easily		
	obvious and readab	le. The MS struggled to find			identified and readable for exi	i.	
	the code and then lo	ocated it on the side of the			3. What measures will be put	nto	
	door frame near the	e actuator panel. The			place and what systemic chan	ges	
		visor agreed that the code was			will be made to ensure that the)	
		nner which made it obvious and			deficient practice does not occ	ur.	
	agreed that this condition might also exist on				The Maintenance		
	other exit doors in t	the facility and stated he would			Director/designee will complet	.e	
	check them all and	post appropriately.			and audit of the entire facility t	.0	
					ensure all required codes have	е	
	This finding was ac	knowledged by the MS at the			been posted and easily identif	ied.	
	time of observation	and again at the exit			4. How the corrective actions	will	
	conference with the	e MS, AMD and ED all present.			be monitored to ensure the		
					deficient practice will not recui	,	
	3.1-19(b)				i.e., what quality assurance		
					program will be out into place.		
					The Maintenance		
					Director/designee will check		
					during rounds for all appropria	te	
					door code postings and submi	ıt	
					monitoring tool to the monthly		
					Quality Assurance Committee	for	
					review		
14 00= 1							
K 0271	NFPA 101						
SS=E	Discharge from E	xits					
Bldg. 01							
		on and interview, the facility	K 0	271	K 271		07/31/2025
		exit discharges had a level			1.What corrective actions will		
	_	ere free of obstructions, and			accomplished for those reside		
		packed all-weather travel			found to have been affected b	y the	
		ce with CMS Survey and			deficient practice.		
		05-38. This deficient practice			The exit discharge from the di		
	L could affect 17 resi	dents and staff outside the	1		hall into the courtvard, marked	las	I

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

PRINTED: 06/23/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	a. building <u>01</u>		COMPLETED			
		155687	B. WI	B. WING 06/06/20			2025		
			-	STREET A	ADDRESS, CITY, STATE, ZIP COD				
NAME OF P	PROVIDER OR SUPPLIER	t .			YN-MAR DR				
BRICKYA	ARD HEAI THCARE	E - MUNCIE CARE CENTER			E, IN 47304				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION		
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE		
	dining room.				facility exit, had large cracks in				
					the concrete and was uneven				
	Findings include:				the path of egress travel. The				
					has begun to repair the cracks				
		on and interview with the			the concrete and uneven surfa				
	_	visor (MS) and Assistant			by the facility maintenance cre				
		for (AMD) and Executive			and to be completed within the				
	` ′	5/06/25 at 12:50 p.m. during a			compliance date noted in POC				
	•	the exit discharge from the			2. How other residents having				
	~ ~	e courtyard, marked as a			potential to be affected by the				
		ge cracks in the concrete and			same deficient practice will be				
	-	oath of egress travel. Based on			identified and what corrective				
		ne of observation, the MS			actions will be taken.				
	-	the walkway was in need of			This deficient practice could a				
	_	nplete level walking surface			any residents and staff using t				
	-	hazards leading to the			path of egress from the dining				
	common way.				room. The leveling and sealing	-			
	TEN : 0" 1"				cracks and uneven surfaces w	/III			
	_	knowledged by the MS at the			be completed within the	00			
		and again at the exit			compliance date note in the P				
	conference with the	MS, AMD and ED all present.			3. What measures will be put i				
	2.1.10/1-)				place and what systemic chan	_			
	3.1-19(b)				will be made to ensure that the				
					deficient practice does not occ				
					Maintenance Director/Designe	ee			
					will monitor all egress exits to				
					ensure walkways are not a trip				
					hazard and will repair as need 4. How the corrective actions v				
					be monitored to ensure the	VVIII			
					deficient practice will not recu	-			
					i.e., what quality assurance	,			
					program will be out into place.				
					All results of monitoring will be				
					communicated to the monthly	,			
					Quality Assurance Committee	as			
					needed.	40			
K 0293	NFPA 101								
SS=E	Exit Signage								
	· ·		1		l				

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Event ID:

 $N4HE21 \qquad {\tt Facility\ ID:} \quad 000097$

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED	
		155687	B. WING		06/06/2025	
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD YN-MAR DR		
BRICKYA	ARD HEALTHCARE	- MUNCIE CARE CENTER	MUNCIE, IN 47304			
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	·	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE	
Bldg. 01	REGULATORT OR	LESC IDENTIFY TING INFORMATION	TAG		DATE	
Biag. 01	Based on observation	on and interview, the facility	K 0293	K 293	07/31/2025	
		1 riser room exit doors to the	12 02 9 5	1.What corrective actions will		
	outside of the facilit	ty were not mistaken as a		accomplished for those reside	nts	
	facility exit. LSC 7	.10.8.3.1 states any door,		found to have been affected b	y the	
		that is neither an exit nor a		deficient practice.		
		and that is located or arranged		The EXIT sign posted at the R	I	
		be mistaken for an exit shall		room door was removed durin		
		gn that reads as follows: NO		survey. Since then NO EXIT s	ign	
		IT sign shall have the word NO		was posted.	a l	
	in letters 2 inches high, with a stroke width of			2. How other residents having	tne	
	3/8ths inch, and the word EXIT below the word NO, unless such sign is an approved existing			potential to be affected by the		
	-	practice could affect 2 staff		same deficient practice will be identified and what corrective		
	sign. This deficient	practice could affect 2 staff		actions will be taken.		
	Findings include:			This deficient practice could a	ffect	
	i manigs merade.			staff and residents who are in		
	Based on observation	on and interview with the		activity room. The deficient		
	Maintenance Superv	visor (MS) and Assistant		practice was corrected during		
	-	or (AMD) and Executive		survey with new NO EXIT sign	n	
		5/06/25 at 11:55 a.m. during a		posted.		
	tour of the facility, t	the door to the outside from		3. What measures will be put	into	
	the Riser Room was	s marked as an exit on the door.		place and what systemic chan	iges	
	However, the door opened to a landing which did			will be made to ensure that the	e	
		ewalk or parking lot, it was		deficient practice does not occ	I	
		s. The MS agreed that the		Maintenance Director/Designe	I	
		t door, and the door was not		will audit all doors for appropri	ate	
	-	EXIT" sign. Based on		signage and change as neede		
		e of the observations, the MS		4. How the corrective actions	will	
		ot an exit to the public way		be monitored to ensure the		
	and acknowledged to the door should n	the Exit sign which was taped		deficient practice will not recui	Γ,	
	to the door should n	ioi be there.		i.e., what quality assurance		
	This finding was so	knowledged by the MS at the		program will be out into place.		
	-	and again at the exit		All results of monitoring will be		
		MS, AMD and ED all present.		communicated to the monthly Quality Assurance Committee	I	
	conference with the	MIS, AND and LD an present.		needed	as	
	3.1-19(b)			1100uou		

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Event ID: N4HE21

Facility ID: 000097

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDI	NG	<u>01</u>	COMPL		
		155687	B. WING				06/06/2025	
	PROVIDER OR SUPPLIER	R E - MUNCIE CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 2701 LYN-MAR DR MUNCIE, IN 47304					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID				(X5)	
PREFIX	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREF	TIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TA	G	DEFICIENCY)	IE	DATE	
K 0321	NFPA 101			ĺ				
SS=E	Hazardous Areas	- Enclosure						
Bldg. 01								
	Based on observation	on and interview, the facility	K 0321	İ	K 321		07/31/2025	
	failed to ensure 1 of	f over 6 hazardous area doors,			1.What corrective actions will I	be		
	such as storage room	ms, were provided with			accomplished for those reside	nts		
	properly working so			found to have been affected by the				
	deficient practice co	ould affect more than 10			deficient practice.			
	residents, as well as			The kitchen storage room leading into the kitchen containing				
	Findings include:			combustible supplies was not				
				equipped with a self-closing				
	Based on observation			device. A self-closing door clos	sure			
	Maintenance Super			will be installed on the door				
	Maintenance Direct			between the kitchen and the				
	Director (ED) on 06			storage room.				
	tour of the facility,	the Kitchen Storage Room			2. How other residents having	the		
	leading into the kito	chen, greater than 50 square			potential to be affected by the			
	feet, contained seve	eral combustible items, such			same deficient practice will be			
	as, paper, plastic, ar	nd more than 20 cardboard			identified and what corrective			
		r door to this room was not			actions will be taken.			
	equipped with a sel			The deficient practice could af	fect			
					more than 10 residents as wel			
	_	knowledged by the MS at the			staff and visitors. A self-closing	g		
		and again at the exit			door closure will be installed to	o the		
	conference with the	e MS, AMD and ED all present.			door.			
					3. What measures will be put i			
	3.1-19(b)				place and what systemic chan	-		
					will be made to ensure that the			
					deficient practice does not occ			
					Maintenance Director/Designe			
					will audit all doors to assess for			
					appropriate door closure and r	nake		
					changes as needed.			
					4. How the corrective actions \	WIII		
					be monitored to ensure the	_		
					deficient practice will not recur	,		
					i.e., what quality assurance			
					program will be out into place.			
	I				All results of monitoring will be	;	Ì	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155687		(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION G 01	COMP	(X3) DATE SURVEY COMPLETED 06/06/2025		
	ROVIDER OR SUPPLIER	- 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 CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE APPR	TION LD BE ROPRIATE	(X5) COMPLETION DATE	
				communicated to the mor Quality Assurance Comm needed.	•		
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors						
	failed to ensure all of passage of smoke. affect 2 residents and Findings include: Based on observation Maintenance Super Maintenance Direct Director (ED) on 06 tour of the facility, Room #224 would a the passage of smoke This finding was actime of observation	on and interview with the visor (MS) and Assistant or (AMD) and Executive 5/06/25 at 12:05 p.m. during a the corridor door to Resident not latch and would not resist	K 0363	It 363 1. What corrective actions accomplished for those refound to have been affect deficient practice. This deficient practice has the resident room #224 at been corrected since ther 2. How other residents has potential to be affected by same deficient practice widentified and what correct actions will be taken. This deficient practice couthe residents and staff in #224 A new latch plate hinstalled on the corridor diresident room #224. 3. What measures will be place and what systemic will be made to ensure the deficient practice does not Maintenance Director/Desident will audit all doors to ensure doors latch and correct as needed. 4. How the corrective active monitored to ensure the deficient practice will not incomposed to the place and what quality assurance program will be out into pall results of monitoring will result and the results of monitoring will result will result and the results of monitoring will result and the results of the results of the	esidents ted by the s affected and has aving the y the fill be ctive uld affect room has been coor by put into changes at the ot occur. signee ure all s fons will he recur, ce lace.	07/31/2025	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2025 FORM APPROVED OMB NO. 0938-039

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING 01			COMPLETED	
		155687	B. WING			06/06/2025		
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	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		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
					Quality Assurance Committee needed.	as		

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