STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155687	A. BUILDING -- B. WING	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - MUNCIE CARE CENTER	2701 LYN-MAR DR MUNCIE, 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 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: 06/06/25 Facility Number: 000097 Provider Number: 155687 AIM Number: 100290970 At this Emergency Preparedness survey, Brickyard Healthcare - Muncie Care Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 117 certified beds. At the time of the survey, the census was 98. Quality Review completed on 06/09/25	E 0000	The following Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. Submission of the Plan of Correction is not an admission that a deficiency exits or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law	
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: 06/06/25 Facility Number: 000097 Provider Number: 155687 AIM Number: 100290970 At this Life Safety Code survey, Brickyard	K 0000	The following Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. Submission of the Plan of Correction is not an admission that a deficiency exits or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kaushik Patel	Executive Director	06/20/2025

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155687	A. BUILDING 01 B. WING	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - MUNCIE CARE CENTER	2701 LYN-MAR DR MUNCIE, 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Healthcare - Muncie Care Center 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 (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery-operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 117 and had a census of 98 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review completed on 06/09/25			
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Based on observation and interview, the facility failed to ensure the means of egress for 1 of over 7 exit doors was readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect 5 staff and visitors, when needing to exit the facility. Findings include:	K 0222	1.What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. This deficient practice could have affected the residents, staff and visitors using the exit door. The maintenance director during the survey had corrected the deficient practice by removing the code and reposted it in a location where it is clearly visible and readable. 2. How other residents having the potential to be affected by the	07/31/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155687	A. BUILDING 01 B. WING	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - MUNCIE CARE CENTER	2701 LYN-MAR DR MUNCIE, 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on observation and interview with the Maintenance Supervisor (MS) and Assistant Maintenance Director (AMD) and Executive Director (ED) on 06/06/25 at 12:35 p.m. during a tour of the facility, the kitchen exit door did not have the code posted in a manner which was obvious and readable. The MS struggled to find the code and then located it on the side of the door frame near the actuator panel. The Maintenance Supervisor agreed that the code was not posted in a manner which made it obvious and agreed that this condition might also exist on other exit doors in the facility and stated he would check them all and post appropriately. This finding was acknowledged by the MS at the time of observation and again at the exit conference with the MS, AMD and ED all present. 3.1-19(b)		same deficient practice will be identified and what corrective actions will be taken. This deficient practice could affect staff and visitors, when needing to exit the facility. Door code has been posted where it is easily identified and readable for exit. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not occur. The Maintenance Director/designee will complete and audit of the entire facility to ensure all required codes have been posted and easily identified. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be out into place. The Maintenance Director/designee will check during rounds for all appropriate door code postings and submit monitoring tool to the monthly Quality Assurance Committee for review	
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Based on observation and interview, the facility failed to ensure all exit discharges had a level walking surface, were free of obstructions, and constructed of hard packed all-weather travel surface in accordance with CMS Survey and Certification Letter 05-38. This deficient practice could affect 17 residents and staff outside the	K 0271	K 271 1.What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. The exit discharge from the dining hall into the courtyard, marked as	07/31/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155687	A. BUILDING 01 B. WING	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - MUNCIE CARE CENTER	2701 LYN-MAR DR MUNCIE, 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	dining room. Findings include: Based on observation and interview with the Maintenance Supervisor (MS) and Assistant Maintenance Director (AMD) and Executive Director (ED) on 06/06/25 at 12:50 p.m. during a tour of the facility, the exit discharge from the dinging hall into the courtyard, marked as a facility exit, had large cracks in the concrete and was uneven in the path of egress travel. Based on interviews at the time of observation, the MS acknowledged that the walkway was in need of repair to have a complete level walking surface that was free of trip hazards leading to the common way. This finding was acknowledged by the MS at the time of observation and again at the exit conference with the MS, AMD and ED all present. 3.1-19(b)		facility exit, had large cracks in the concrete and was uneven in the path of egress travel. The work has begun to repair the cracks in the concrete and uneven surface by the facility maintenance crew and to be completed within the compliance date noted in POC 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken. This deficient practice could affect any residents and staff using the path of egress from the dining room. The leveling and sealing of cracks and uneven surfaces will be completed within the compliance date note in the POC. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not occur. Maintenance Director/Designee will monitor all egress exits to ensure walkways are not a trip hazard and will repair as needed. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, 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.	
K 0293 SS=E	NFPA 101 Exit Signage			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155687	A. BUILDING 01 B. WING	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - MUNCIE CARE CENTER	2701 LYN-MAR DR MUNCIE, 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Bldg. 01	Based on observation and interview, the facility failed to ensure 1 of 1 riser room exit doors to the outside of the facility were not mistaken as a facility exit. LSC 7.10.8.3.1 states any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT. The NO EXIT sign shall have the word NO in letters 2 inches high, with a stroke width of 3/8ths inch, and the word EXIT below the word NO, unless such sign is an approved existing sign. This deficient practice could affect 2 staff Findings include: Based on observation and interview with the Maintenance Supervisor (MS) and Assistant Maintenance Director (AMD) and Executive Director (ED) on 06/06/25 at 11:55 a.m. during a tour of the facility, the door to the outside from the Riser Room was marked as an exit on the door. However, the door opened to a landing which did not connect to a sidewalk or parking lot, it was surrounded by grass. The MS agreed that the door was not an exit door, and the door was not posted with a "NO EXIT" sign. Based on interview at the time of the observations, the MS stated the door is not an exit to the public way and acknowledged the Exit sign which was taped to the door should not be there. This finding was acknowledged by the MS at the time of observation and again at the exit conference with the MS, AMD and ED all present. 3.1-19(b)	K 0293	K 293 1.What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. The EXIT sign posted at the Riser room door was removed during the survey. Since then NO EXIT sign was posted. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken. This deficient practice could affect staff and residents who are in the activity room. The deficient practice was corrected during survey with new NO EXIT sign posted. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not occur. Maintenance Director/Designee will audit all doors for appropriate signage and change as needed. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, 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	07/31/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155687	A. BUILDING 01 B. WING	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - MUNCIE CARE CENTER	2701 LYN-MAR DR MUNCIE, 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Based on observation and interview, the facility failed to ensure 1 of over 6 hazardous area doors, such as storage rooms, were provided with properly working self-closing devices. This deficient practice could affect more than 10 residents, as well as staff and visitors. Findings include: Based on observation and interview with the Maintenance Supervisor (MS) and Assistant Maintenance Director (AMD) and Executive Director (ED) on 06/06/25 at 12:50 p.m. during a tour of the facility, the Kitchen Storage Room leading into the kitchen, greater than 50 square feet, contained several combustible items, such as, paper, plastic, and more than 20 cardboard boxes. The corridor door to this room was not equipped with a self-closing device. This finding was acknowledged by the MS at the time of observation and again at the exit conference with the MS, AMD and ED all present. 3.1-19(b)	K 0321	K 321 1.What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. The kitchen storage room leading into the kitchen containing combustible supplies was not equipped with a self-closing device. A self-closing door closure will be installed on the door between the kitchen and the storage room. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken. The deficient practice could affect more than 10 residents as well as staff and visitors. A self-closing door closure will be installed to the door. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not occur. Maintenance Director/Designee will audit all doors to assess for appropriate door closure and make changes as needed. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be out into place. All results of monitoring will be	07/31/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155687	A. BUILDING 01 B. WING	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - MUNCIE CARE CENTER	2701 LYN-MAR DR MUNCIE, 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			communicated to the monthly Quality Assurance Committee as needed.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure all corridor doors would resist the passage of smoke. This deficient practice could affect 2 residents and 2 staff. Findings include: Based on observation and interview with the Maintenance Supervisor (MS) and Assistant Maintenance Director (AMD) and Executive Director (ED) on 06/06/25 at 12:05 p.m. during a tour of the facility, the corridor door to Resident Room #224 would not latch and would not resist the passage of smoke. This finding was acknowledged by the MS at the time of observation and again at the exit conference with the MS, AMD and ED all present. 3.1-19(b)	K 0363	K 363 1.What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. This deficient practice has affected the resident room #224 and has been corrected since then. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken. This deficient practice could affect the residents and staff in room #224.. A new latch plate has been installed on the corridor door by resident room #224. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not occur. Maintenance Director/Designee will audit all doors to ensure all doors latch and correct as needed. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be out into place. All results of monitoring will be communicated to the monthly	07/31/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155687	A. BUILDING 01 B. WING	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - MUNCIE CARE CENTER	2701 LYN-MAR DR MUNCIE, 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Quality Assurance Committee as needed.	