PRINTED: 12/20/2023 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES					OM	B NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<del></del>	COMPL	ETED
		15E064	B. WING		11/27/	/2023
			<del></del>			
NAME OF P	ROVIDER OR SUPPLIER	8		ADDRESS, CITY, STATE, ZIP COD		
				GAVIN ST		
BROOKS	SIDE CARE STRAT	EGIES	MUNC	IE, IN 47303		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDERIC BLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.IE	DATE
E 0000						
Bldg						
Diag.	An Emergency Pres	paredness Survey was	E 0000	The creation and submission	of	
	conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.		E 0000			
				this Plan of Correction does not		
				constitute an admission by thi		
	Survey Date: 11/27	7/23		provider of any conclusion set		
	Survey Date: 11/2/	1143		in the statement of deficiencie		
	Facility Number: 00	00311		of any violation of regulations.  provider respectfully requests		
	•			1		
	Provider Number: 15E064 AIM Number: 100285520			this 2567 Plan of Correction b		
	Allyl Number: 1002	283320	considered the Letter of Credible			
	A 4 41. 1. E	Allegation of compliance effective				
	At this Emergency Preparedness survey, Brookside Care Strategies was found not in			January 5, 2024. This facility		
				respectfully requests		
	-	nergency Preparedness		consideration for paper	_	
	-	Medicare and Medicaid		compliance from this Plan of	İ	
		ders and Suppliers, 42 CFR		Correction.		
	-	has a capacity of 42 and had a				
	census of 23 at the t	time of this survey.				
	Quality Review con	mpleted on 12/01/23				
	_	f 42 CFR, Subpart 483.73 are				
	Not Met as evidenc	ed by:				
E 0039		6.54(d)(2), 418.113(d)(2),				
SS=F	. , , ,	2.15(d)(2), 483.475(d)(2),				
Bldg	, , , ,	.102(d)(2), 485.625(d)(2),				
	` , ` , `	.727(d)(2), 485.920(d)(2),				
	` , ` , `	1.12(d)(2), 494.62(d)(2)				
	EP Testing Requir	rements				
	§416.54(d)(2), §4	18.113(d)(2), §441.184(d)(2),				
	§460.84(d)(2), §48	82.15(d)(2), §483.73(d)(2),				
	§483.475(d)(2), §4	484.102(d)(2), §485.68(d)(2),				
	§485.625(d)(2), §4	485.727(d)(2), §485.920(d)				
	(2), §491.12(d)(2)	, §494.62(d)(2).				
	, ,					
	*[For ASCs at §41	6.54, CORFs at §485.68,				
	OPO, "Organization	ons" under §485.727,				
						I

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

TITLE (X6) DATE

Ruth Fuchs Administrator 12/15/2023

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.

FORM CMS-2567(02-99) Previous Versions Obsolete S7T421 Facility ID: 000311 If continuation sheet

ENTERS FOI	R MEDICARE & MEDIC	AID SERVICES				ON	AB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMP	LETED
		15E064	B. W	ING	<u></u>	11/27	7/2023
		<u> </u>		CERTER S	DDDDGG GITTL GT : T		
NAME OF 1	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, Z	IP COD	
					BAVIN ST		
BROOKS	SIDE CARE STRAT	EGIES		MUNCI	E, IN 47303		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTIO	ON SHOULD BE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO T DEFICIENCY		DATE
		20, RHCs/FQHCs at					
	_	RD Facilities at §494.62]:					
	9491.12, and ESP	ND Facilities at §494.02].					
	(2) Testing The If	facility) must conduct					
		acility] must conduct					
		he emergency plan					
	1 -	ility] must do all of the					
	following:						
		full-scale exercise that is					
	community-based						
	(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-ma	ade emergency that requires					
	activation of the e	mergency plan, the [facility]					
		igaging in its next required					
		or individual, facility-based					
	1	e following the onset of the					
	actual event.						
		ditional exercise at least					
	1 ' '	posite the year the full-scale					
		cise under paragraph (d)(2)					
		, , ,					
	1 ''	s conducted, that may					
	· ·	limited to the following:					
	1 ' '	scale exercise that is					
	1	or individual, facility-based					
	functional exercise						
	(B) A mock disast						
	. ,	ercise or workshop that is					
	1	and includes a group					
	discussion using a	a narrated,					
	clinically-relevant	emergency scenario, and a					
	set of problem sta	tements, directed					
	messages, or pre	pared questions designed					
	to challenge an er	·					
	_	acility's] response to and					
		ntation of all drills, tabletop					
		nergency events, and revise					
	I cyclologo, and ell	iorgonoy evente, and revise	1				1

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the [facility's] emergency plan, as needed.

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<del></del>	COMPL	ETED
		15E064	B. W	ING		11/27	/2023
		1		CTDEET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIE	R			BAVIN ST		
BROOKS	SIDE CARE STRAT	EGIES			E, IN 47303		
DITOORC				WONON	L, IIV 47303		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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
	*[For Hospices at						
		spices that provide care in					
	the patient's home. The hospice must						
	conduct exercises to test the emergency						
	plan at least annually. The hospice must do						
	the following:						
	(i) Participate in a full-scale exercise that is						
	community based every 2 years; or (A) When a community based exercise is not						
	l ` '	•					
		ıct an individual facility exercise every 2 years; or					
	(B) If the hospice experiences a natural or man-made emergency that requires activation						
	_	plan, the hospital is					
		aging in its next required full					
		based exercise or individual					
		ctional exercise following the					
	onset of the emer						
		dditional exercise every 2					
	1 ' '	ie year the full-scale or					
	1 *	e under paragraph (d)(2)(i)					
		conducted, that may					
		limited to the following:					
		-scale exercise that is					
	1 ' '	l or a facility based					
	functional exercise	•					
	(B) A mock disas						
	(C) A tabletop ex	ercise or workshop that is					
	led by a facilitator	and includes a group					
	discussion using a	a narrated,					
	clinically-relevant	emergency scenario, and a					
	set of problem sta	tements, directed					
	messages, or pre	pared questions designed					
	to challenge an e	mergency plan.					
	(a) <del>-</del>						
	` '	spices that provide inpatient					
		hospice must conduct					
		he emergency plan twice					
	per year. The hos	spice must do the following:					

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CENTERS FOR MEDICARE & MEDICAID SERVICES				ON	IB NO. 0938-039	
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<del></del>	COMPI	LETED
		15E064	B. WING		11/27	/2023
		.0200.			,	, = 0 = 0
NAME OF P	ROVIDER OR SUPPLIER	3	STREET A	ADDRESS, CITY, STATE, ZIP COD		
TVI WILL OF T	ROVIDER OR SOLI EIEF		505 N C	GAVIN ST		
BROOKS	SIDE CARE STRAT	EGIES	MUNCI	E, IN 47303		
WAY ID	OLD O ( ) DV	OT A TEN OF DEFICIENCE				
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROP		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	(i) Participate in a	an annual full-scale exercise				
	that is community-	-based; or				
	(A) When a comm	nunity-based exercise is not				
	accessible, condu	ct an annual individual				
		ctional exercise; or				
	-	experiences a natural or				
		ency that requires activation				
	_	plan, the hospice is				
		aging in its next required				
	full-scale community based or facility-based functional exercise following the onset of the					
	emergency event.  (ii) Conduct an additional annual exercise					
	\ \frac{1}{2}	but is not limited to the				
	following:					
	(A) A second full-	scale exercise that is				
	community-based	or a facility based				
	functional exercise	e; or				
	(B) A mock disas	ter drill; or				
	(C) A tabletop ex	ercise or workshop led by a				
	, ,	udes a group discussion				
	using a narrated,					
	_	rio, and a set of problem				
		ed messages, or prepared				
	questions designe					
	emergency plan.	to challenge an				
		conicolo recononce to and				
	` '	ospice's response to and				
		ntation of all drills, tabletop				
		nergency events and revise				
	the hospice's eme	ergency plan, as needed.				
		l41.184(d), Hospitals at				
	§482.15(d), CAHs	at §485.625(d):]				
	(2) Testing. The [F	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					
	anacis community.	-basca, oi	1			

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPI	LETED
		15E064	B. W	ING		11/27	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R		1	SAVIN ST		
BROOKS	SIDE CARE STRAT	TEGIES		1	E, IN 47303		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	1	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI	E	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	(A) When a comn	nunity-based exercise is not					
		uct an annual individual,					
	facility-based fund	ctional exercise; or					
	(B) If the [PRTF,	Hospital, CAH] experiences					
	an actual natural	or man-made emergency					
	that requires activ	vation of the emergency					
	plan, the [facility]	is exempt from engaging in					
	its next required f	ull-scale community based					
	or individual, facil	ity-based functional exercise					
	following the onse	et of the emergency event.					
	(ii) Conduct an [additional] annual						
	exercise or and that may include, but is not limited to the following:  (A) A second full-scale exercise that is						
	community-based	d 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 facilita	tor and includes a group					
	discussion, using	- ·					
	_	emergency scenario, and a					
	1	atements, directed					
	1	pared questions designed					
	to challenge an e						
	_	the [facility's] response to					
	and maintain doc	umentation of all drills,					
	tabletop exercises	s, and emergency events					
		cility's] emergency plan, as					
	needed.						
	*[For PACE at §4	· / =					
	(2) Testing. The F	PACE organization must					
	conduct exercises	s to test the emergency					
	plan at least annu	ually. The PACE					
	organization mus	t do the following:					
	(i) Participate in	an annual full-scale exercise					
	that is community						
		nunity-based exercise is not					
	accessible, condu	uct an annual individual,					

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facility-based functional exercise; or

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	G	<u></u>	COMPL	ETED
		15E064	B. WING			11/27/	/2023
		<u> </u>	STRE	EET A	DDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			AVIN ST		
BROOKS	SIDE CARE STRAT	EGIES			E, IN 47303		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	X	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG		DEFICIENCY)		DATE
	1 ' '	periences an actual natural					
		ergency that requires					
		mergency plan, the PACE					
	is exempt from en						
	full-scale commun						
	1	tional exercise following the					
	onset of the emer						
	(ii) Conduct a						
	2 years opposite t functional exercise						
	of this section is c						
	but is not limited to						
	(A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or						
	(B) A mock disast						
	1 ' '	ercise or workshop that is					
	1 ' '	and includes a group					
	discussion, using	~ .					
	_	emergency scenario, and a					
	set of problem sta						
	messages, or prep	pared questions designed					
	to challenge an er	nergency plan.					
	(iii) Analyze the P	ACE's response to and					
	maintain documer	ntation of all drills, tabletop					
	exercises, and em	nergency events and revise					
	the PACE's emerg	gency plan, as needed.					
	*[For LTC Fooilitie	o at \$492 72/d\:1					
	*[For LTC Facilitie	ty] must conduct exercises					
	· · ·						
	_	ency plan at least twice per					
		announced staff drills using					
	ICF/IID] must do t	ocedures. The [LTC facility,					
		ne following. In annual full-scale exercise					
	that is community						
	1	nunity-based exercise is not					
	1 ' '	ct an annual individual,					
	facility-based fund						
	1	ility] facility experiences an					
		my racinty expendences an	1	l			

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-039
STATEME	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E064	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY  COMPLETED  11/27/2023	
	PROVIDER OR SUPPLIEF		505 N (	address, city, state, zip coi GAVIN ST IE, IN 47303	)	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APF DEFICIENCY)	CTION JLD BE PROPRIATE	(X5) COMPLETION DATE
	requires activation LTC facility is exe required a full-sca individual, facility-following the onse (ii) Conduct an act that may include, following:  (A) A second full-community-based based functional (B) A mock disas (C) A tabletop ex led by a facilitator discussion, using clinically-relevant set of problem stamessages, or preto challenge an er (iii) Analyze the [I response to and nall drills, tabletop events, and revise emergency plan, at [C) Testing. The IC exercises to test to twice per year. The following:  (i) Participate in a that is community (A) When a commaccessible, condutation and facility-based functions.	ter drill; or ercise or workshop that is includes a group a narrated, emergency scenario, and a tements, 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				

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natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<del></del>	COMPL	ETED
		15E064	B. W	ING		11/27	2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	₹			SAVIN ST		
BROOKS	SIDE CARE STRAT	FGIES			E, IN 47303		
Broone				IVIOITOI			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	REFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE CO		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		nity-based or individual,					
	1	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 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						
	I -						
	set of problem sta						
	to challenge an er	pared questions designed					
	_	CF/IID's response to and					
	1 ' '	ntation of all drills, tabletop					
		nergency events, and revise					
		rgency plan, as needed.					
	THE IOI /IID 3 CITICI	igency plan, as necaca.					
	*[For HHAs at §48	34.1021					
	_	e HHA must conduct					
		he emergency plan at					
		e HHA must do the					
	following:						
	_	full-scale exercise that is					
	community-based						
	(A) When a c	ommunity-based exercise					
	is not accessible,	conduct an annual					
	individual, facility-	based functional exercise					
	every 2 years; or.						
	(B) If the HH	A experiences an actual					
	natural or man-ma	ade emergency that requires					
	activation of the e	mergency plan, the HHA is					
	exempt from engaging in its next required						
	full-scale commun	nity-based or individual,					
	facility based fund	tional exercise following the					
	onset of the emergency event.						

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Event ID:

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Facility ID: 000311

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<del></del>	COMPLETED
		15E064	B. WING		11/27/2023
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD	
BBOOKS	SIDE CADE STRAT	ECIES		GAVIN ST	
DROOKS	SIDE CARE STRAT	EGIES	MUNC	CIE, IN 47303	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCE	DATE
	1 ' '	ditional exercise every 2 e year the full-scale or			
		e year the full-scale of or of the under paragraph (d)(2)(i)			
	of this section is c				
		limited to the following:			
	· ·	full-scale exercise that is			
	community-based	or an individual,			
	facility-based fund				
		isaster drill; or			
	. , ,	exercise or workshop that			
	1	or and includes a group			
	discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed				
	1	pared questions designed			
	to challenge an er	· · · · · · · · · · · · · · · · · · ·			
	_	HA's response to and			
	1 ' '	ntation of all drills, tabletop			
		nergency events, and revise			
	the HHA's emerge	ency plan, as needed.			
	*[For OPOs at §48	36.3601			
		e OPO must conduct			
	. , , ,	he emergency plan. The			
	OPO must do the	following:			
		er-based, tabletop exercise			
		ast annually. A tabletop			
	· ·	a facilitator and includes a			
	1 - '	using a narrated, clinically			
	_	cy scenario, and a set of			
	I '	its, directed messages, or is designed to challenge an			
	1	f the OPO experiences an			
		nan-made emergency that			
		of the emergency plan, the			
	OPO is exempt from engaging in its next required testing exercise following the onset				
	of the emergency	_			
	(ii) Analyze the Of	PO's response to and			
	maintain documer	ntation of all tableton			

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Event ID:

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Facility ID: 000311

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<del></del>	COMPL	ETED
		15E064	B. Wl	NG		11/27	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			GAVIN ST		
BROOKS	SIDE CARE STRAT	EGIES		MUNCI	E, IN 47303		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	DATE
	i	nergency events, and revise					
		OPO's] emergency plan, as					
	needed.	or o of omergency plan, as					
	*[ RNCHIs at §400	3.748]:					
	(d)(2) Testing. The	e RNHCI must conduct					
	exercises to test the emergency plan. The RNHCI must do the following:  (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, 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	E 00	020	E039		12/15/2023
		tercises to test the emergency		139			12/13/2023
	plan at least twice p				It is the practice of Brookside (	Care	
	_	drills using the emergency			Strategies to conduct exercise		
		C facility must do the		test the emergency plan at lea			
	following:	,			twice per year.		
	_	annual full-scale exercise that					
	is community-based				What corrective action will be	е	
	a. When a commun	ity-based exercise is not			accomplished for those		
		an annual individual,			residents found to have beer	1	
	facility-based funct	ional exercise.			affected by the deficient		
		y experiences an actual natural			practice?		
	-	gency that requires activation			All residents have the potentia		
		lan, the LTC facility is exempt			be affected by the alleged defi	cient	
		ext required full-scale in a			practice. A second drill will be		
		or individual, facility-based			conducted as required by 483.	.73	
		l exercise for 1 year following			(Attachment A).		
	the onset of the actual event.				l., "		
		itional exercise that may			How other residents having t		
		imited to the following:			potential to be affected by th		
	a. A second full-sca	ne exercise that is	1		same deficient practice will b	e	

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STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION  X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  15E064		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  11/27/2023	
	PROVIDER OR SUPPLIER		505 N (	ADDRESS, CITY, STATE, ZIP COD GAVIN ST IE, IN 47303	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R 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
	community-based of functional exercises. b. A mock disaster c. A tabletop exercifacilitator that inclusion and a set of problem messages, or prepare challenge an emerg (iii) Analyze the LT maintain document exercises, and emer LTC facility's emer accordance with 42 deficient practice of Findings include:  Based on record revadministrator on 1 documentation of a Preparedness (EP) but documentation 11/22/23 was available interview at the time Administrator state participate in a second completed one facilitate 12 months.	drill; or se or workshop that is led by a ides a group discussion, using y-relevant emergency scenario, in statements, directed red questions designed to ency plan.  The facility's response to and action of all drills, tabletop regency events, and revise the gency plan, as needed in CFR 483.73(d)(2). This build affect all occupants.  The facility with the facility at 12:30 p.m., no second Emergency annual exercise was available, of one annual exercise on able for review. Based on the facility did not and EP annual exercise but this based exercise within the viewed with the Administrator		identified and what corrective actions will be taken?  All residents have the potential be affected by the alleged defination practice. Brookside Care Strategies will maintain contine efforts to ensure two drills/exercises are completed annually including unannounce drills.  What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur?  The Interdisciplinary Team will inserviced on the requirement the emergency preparedness related to required drills on December 13, 2023 (Attachm B). The IDT will review the train and testing requirements with the emergency preparedness at least annually and anytime amendments are made.  How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be pinto place?  The Administrator and/or desivil be responsible for schedulthe drills with the community-based exercise as as the unannounced drills. If actual natural disaster occurs	al to ficient inued in the dead into inued in plan in

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

PRINTED: 12/20/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E064		A. BUILDING COMPL			E SURVEY PLETED 7/2023		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 505 N GAVIN ST MUNCIE, IN 47303				
(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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	ORRECTION N SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
				will be documented at an exercise. These do at least twice annuall team will audit the inschedule to verify the are included on the at inservice schedule.	drills will occur ly. The QAPI service at the drills		
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: 11/27/2023  Facility Number: 000311 Provider Number: 15E064 AIM Number: 100285520  At this Life Safety Code survey, Brookside Care Strategies was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.  This one story facility was determined to be of Type V(000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and battery operated smoke detectors in the resident sleeping rooms. The		K 0000	The creation and subthis Plan of Correction constitute an admiss provider of any conclination of any violation of resprovider respectfully this 2567 Plan of Conconsidered the Letter Allegation of complianuary 5, 2024. This respectfully request consideration for pacompliance from this Correction.	on does not ion by this lusion set forth eficiencies, or gulations. This requests that rrection be r of Credible ince effective is facility ts aper		

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CENTERS FO	R MEDICARE & MEDIC	AID SERVICES			OM	B NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E064		(X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVEY         A. BUILDING       01       COMPLETED         B. WING       11/27/2023			ETED	
	PROVIDER OR SUPPLIEI		505 N (	ADDRESS, CITY, STATE, ZIP COD GAVIN ST IE, IN 47303		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE SCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K 0211 SS=E Bldg. 01	All areas where the access were sprinkly facility services we certified for Medica. The facility is not engenerator.  Quality Review consumption of Egress Means of Egress Mea	residents have customary lered. All areas providing re sprinklered. This facility is aid only.  Equipped with an emergency empleted on 12/01/23  - General - General ays, corridors, exit locations, and accesses are the Chapter 7, and the means encously maintained free of full use in case of the seminary modified by 18/19.2.2  1. 1.10.1 con and interview, the facility of 4 corridor means of egresses	K 0211	K211  It is the practice of Brookside of to ensure all means of egressor are free from obstruction.  What corrective action will be accomplished for those residents found to have been affected by the deficient practice?  The 10 residents who could have	es e 1	12/15/2023
	interview at the tim	ructing the exit. Based on an see of observations, the ES sobstructing the egress door.  The ES moved the obstruction		been affected by the alleged deficient practice had no nega outcome. This doorway was marked as an Exit in error as	tive	

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at the time of observation.

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there is no means to reach a level, safe walking surface due to the

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

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, ´		r í		NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER  15E064	A. BUILDING <u>01</u> COMPLETED  B. WING 11/27/2023				
		102001	1		DDDEGG CITY CTATE ZID COD	, ,	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD SAVIN ST		
BROOKS	SIDE CARE STRAT	EGIES			E, IN 47303		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	l F	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
TAG		viewed with the Administrator		IAU	railway on that side of the build	dina	DATE
	at the exit conference				The exit sign has been remove	-	
					(Attachment C) and the floor p		
	3.1-19(b)				(Attachment D) has been upda		
					with the correct exit pathways.		
					staff will be retrained on the ne floor plan.	ew	
					πουτριαπ.		
					How other residents having t	he	
					potential to be affected by th		
					same deficient practice will b		
					identified and what corrective actions will be taken?	е	
					All residents have the potentia	l to	
					be affected by the alleged defi		
					practice. The exit sign has bee	en	
					removed and the floor plan ha		
					been updated with the correct		
					pathways. All staff will be retra on the new floor plan by Dece		
					13, 2023.	ilibei	
					What measures will be put in	to	
					place and what systemic		
					changes will be made to		
					ensure that the deficient practice does not recur?		
					All staff will be trained on the r	new	
					floor plans and the correct exit		
					pathways by December 13, 20	23	
					(Attachment E).		
					How the corrective action will	II	
					be monitored to ensure the		
					deficient practice will not		
					recur, i.e., what quality	-4	
					assurance program will be points place?	ut	
					into place?		
					The Administrator and/or design	nnee	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  15E064			A. BUILDING  B. WING	01	COMPLETED  11/27/2023
	ROVIDER OR SUPPLIER		505 N G	ADDRESS, CITY, STATE, ZIP COD GAVIN ST E, IN 47303	
(X4) ID PREFIX TAG	(EACH DEFICIENC	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 APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Ex Discharge from Ex Exit discharge is a 7.7, provides a lev the provisions of 7 changes in elevation discharge shall be travel surface. 18.2.7, 19.2.7 Based on observatio failed to ensure exit	its its rranged in accordance with el walking surface meeting .1.7 with respect to on and shall be maintained s. Additionally, the exit a hard packed all-weather  n and interview, the facility discharge to the back of the	K 0271	will be responsible for updating floor plans if changes occur. Similarly will be retrained if any change made to the means of egress. Administrator and/or designee complete daily life safety facility rounds (Attachment F) to check for obstructions daily five times week for 4 weeks, weekly for a month, and then monthly for 3 months. If there are obstruction noted, the staff presently in the building will be reeducated.	Staff s are The will by ok s a a a consection of the will by the state of the will be
	level walking surfact 101 (2012 edition) s	e in accordance with NFPA ection 7.7. This deficient 10 residents that would use		It is the practice of Brookside ( to ensure all means of egresse are free from obstruction and I a level walking surface.	es
	Findings include:  Based on observatio Supervisor (ES) on discharge from the b	ns with the Environmental 11/27/23 at 10:05 p.m., the exit back of the facility from the		What corrective action will be accomplished for those residents found to have been affected by the deficient practice?  The 10 residents who could have the second formula of th	1
	-	g outside discharged into the		been affected by the alleged	

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

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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 <u>01</u> COMPLETED B. WING 11/27/2023				
		15E064	B. WIN	√G		11/27/	2023
	PROVIDER OR SUPPLIER			505 N G	ADDRESS, CITY, STATE, ZIP COD BAVIN ST E, IN 47303		
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN REGULATORY OR yard. Based on inter observation, the ES the Dining room wa	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION EVIEW at the time of agreed the exit discharge from as not a level walking surface.	I			evel, e ding. ed alan ated All ew the e lito cient en s exit inned mber	(X5) COMPLETION DATE
					How the corrective action will be monitored to ensure the deficient practice will not	II	

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

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E064		(X2) MULTIPLE A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 11/27/2023	
	PROVIDER OR SUPPLIER		505 1	ET ADDRESS, CITY, STATE, ZIP COD N GAVIN ST ICIE, IN 47303	
(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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
				recur, i.e., what quality assurance program will be p into place?	put
				The Administrator and/or des will be responsible for updatir floor plans if changes occur. will be retrained if any change made to the means of egress Administrator and/or designed complete daily life safety facil rounds (Attachment F) to che for obstructions and a level walking surface daily five time week for 4 weeks, weekly for month, and then monthly for 3 months.	og the Staff es are . The e will ity ck es a a
K 0291 SS=E Bldg. 01	NFPA 101 Emergency Lightir Emergency Lightin Emergency lightin duration is provide accordance with 7 18.2.9.1, 19.2.9.1	ng g of at least 1-1/2-hour d automatically in			
	Based on observation failed to ensure 1 of lights were maintain LSC 7.9.2.6 states be lights shall use only batteries provided with maintaining them in	on and interview, the facility 8 battery powered emergency and in accordance with LSC 7.9. Battery operated emergency reliable types of rechargeable with suitable facilities for a properly charged condition. Ch lights or units shall be	K 0291	It is the practice of Brookside to ensure all means of egress are free from obstruction and emergency lighting shall be continuously in operation.	ses
	with NFPA 70 Nationstates the emergence either continuously capable of repeated manual interventions	ntended use and shall comply onal Electric Code. LSC 7.9.2.7 y lighting system shall be in operation or shall be automatic operation without . This deficient practice could hat would use the exit door		What corrective action will be accomplished for those residents found to have bee affected by the deficient practice?  The 10 residents who could he been affected by the alleged	n

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 15E064			(X3) DATE SURVEY COMPLETED 11/27/2023
	505 N GA\	VIN ST	•
	ID PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	OBE COMPLETION
	TAG	DEFICIENCY)	DATE
ation with the Environmental on 11/27/23 at 10:00 a.m., the emergency light outside of exit ining room did not work when a interview at the time of the ES agreed the battery-operated failed to function when its	or m th sa ra T (/-	utcome. This doorway wan arked as an Exit in error here is no means to reach afe walking surface due to allway on that side of the lithe exit sign has been rentattachment C) and the flow that attachment D) has been utith the correct exit pathwat aff will be retrained on the	as as as as a level, o the building. noved or plan updated ays. All e new
	th	ne emergency light has be	- I
	preserved and A both preserved	otential to be affected by ame deficient practice we dentified and what corrections will be taken?  Ill residents have the pote e affected by the alleged ractice. The exit sign has emoved and the floor planeen updated with the correctionathways. The battery in the mergency light that was revoking has been replaced taff will be retrained on the correlation by December 13.  What measures will be pullace and what systemic hanges will be made to nsure that the deficient ractice does not recur?  Ill staff will be trained on the correct of the systemic hanges and the correct of the systemic hanges and the correct of the systemic hanges will be trained on the correct of the systemic hanges and the correct of the systemic hanges and the correct of the systemic hanges and the correct of the systemic hanges will be trained on the correct of the systemic hanges and the correct of the systemic hanges and the correct of the systemic hanges will be trained on the correct of the systemic hanges will be trained on the correct of the systemic hanges will be trained on the correct of the systemic hanges will be trained on the correct of the systemic hanges will be trained on the correct of the systemic hanges will be trained on the correct of the systemic hanges will be trained on the systemic hanges will be trained to the systemic hanges will be trained to the systemic hanges w	y the vill be ctive ential to deficient been n has rect exit ne not d. All e new s, 2023.  ut into
PI R. All C Y S lee v ) dd bor e t con s	IDENTIFICATION NUMBER	IDENTIFICATION NUMBER 15E064  STREET ADD 505 N GAN MUNCIE, I  DETENTIFY THE PRECEDED BY FULL YOR LSC IDENTIFYING INFORMATION Groom.  Ge:  Wation with the Environmental O on 11/27/23 at 10:00 a.m., the demergency light outside of exit Dining room did not work when on interview at the time of the E ES agreed the battery-operated of failed to function when its outton was pushed.  BY THE PRECEDENCY OF THE PRE	IDENTIFICATION NUMBER 15E064  A. BUILDING B. WING  STREET ADDRESS, CITY, STATE, ZIP COD 505 N GAVIN ST MUNCIE, IN 47303  ARY STATEMENT OF DEFICIENCIE CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION Groom.  Deficient practice had no noutcome. This doorway was marked as an Exit in error there is no means to reach safe walking surface due to railway on that side of the demergency light outside of exit Dining room did not work when on interview at the time of the exit sagreed the battery-operated to failed to function when its outton was pushed.  A. BUILDING B. WING  STREET ADDRESS, CITY, STATE, ZIP COD 505 N GAVIN ST MUNCIE, IN 47303  PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDE ACTION SHOULD CROSS-REFERENCED TO THE APPRO

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

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	of correction (X1) Provider/Supplier/Clia (IDENTIFICATION NUMBER (15E064)	(X2) MULTIPLE CO A. BUILDING B. WING	01	DATE SURVEY COMPLETED 11/27/2023
	PROVIDER OR SUPPLIER SIDE CARE STRATEGIES	505 N	ADDRESS, CITY, STATE, ZIP COD GAVIN ST IE, 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
			How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?  The Administrator and/or designe will be responsible for updating th floor plans if changes occur. Staf will be retrained if any changes at made to the means of egress. Th Administrator and/or designee will complete daily life safety facility rounds (Attachment F) to check the functioning of the emergency lights five times a week for 4 weeks, weekly for a month, and then monthly for 3 months. If ther are outages noted a top priority work order will be completed and the Maintenance Director will change the battery as soon as	ee ff re e II
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on record review, interview, and observation, the facility failed to ensure documentation for the preventative maintenance of 40 of 40 battery operated smoke alarms in	K 0300	K300  It is the practice of Brookside Car to replace batteries in the	12/15/2023 e

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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 <u>01</u> COM		COMPLETED		
		15E064	B. W	ING		11/27/2023	
				CENTER	A DODDEGG CHTM CTATE THE COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
DD001/6	NDE CADE CEDAT				GAVIN ST		
BROOKS	SIDE CARE STRAT	EGIES		MUNCI	E, IN 47303		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(2	K5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPI	ETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DA	ΓΕ
	resident rooms was	complete. NFPA 101 in			battery-operated smoke detec	tors	
	4.6.12.3 states exist	ting life safety features obvious			per manufacturers		
	to the public, if not	required by the Code, shall be			recommendations.		
	maintained. NFPA	72, 29.10 Maintenance and					
	Tests. Fire-warning	equipment shall be maintained			What corrective action will b	•	
	and tested in accord	lance with the manufacturer's			accomplished for those		
	published instruction	ons and per the requirements			residents found to have beer	ı [	
	_	A 72, 14.2.1.1.1 Inspection,			affected by the deficient		
	_	nance programs shall satisfy			practice?		
	the requirements of this Code and conform to the				All residents have the potentia	l to	
	equipment manufacturer's published instructions.				be affected by the alleged defi	cient	
	This deficient practice could affect all residents,				practice but had no negative		
	staff, and visitors.				outcome. All battery-operated		
	Findings include:				smoke detectors are being		
					checked weekly at this time. A		
					preventative maintenance fund	l l	
		eview with the Maintenance			all batteries have been replace	ed .	
		nistrator on 11/27/23 at 12:50			and this was documented on		
	_	ation for battery replacement of			12/8/2023 (Attachment H).		
		ry operated smoke alarms was					
		v. Based on interview at the			How other residents having t		
		Maintenance Director stated			potential to be affected by th		
		nentation available to show			same deficient practice will be	l l	
		ry replacement of the battery			identified and what correctiv	9	
	operated smoke det	ectors was completed.			actions will be taken?		
					All residents have the potentia	l l	
		viewed with the Administrator			be affected by the alleged defi	cient	
	at the exit conferen	ce.			practice. The batteries in all		
	2.1.10(1.)				battery-operated smoke detec		
	3.1-19(b)				have been replaced and this v		
					documented on 12/8/2023. Th		
					battery-operated smoke detec	l l	
					will continue to be tested weel	ily.	
					Milest magazines will be used.		
					What measures will be put in	το	
					place and what systemic		
					changes will be made to		
					ensure that the deficient		
					practice does not recur?	/or	
	I		1		The Maintenance Director and	/OI	

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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STATEMENT OF DEFICIENCIES		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E064		ONSTRUCTION  01  ADDRESS, CITY, STATE, ZIP COD  GAVIN ST	(X3) DATE SURVEY COMPLETED 11/27/2023	
BROOKS	SIDE CARE STRAT	EGIES		E, IN 47303		
(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 APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
				designee will continue to test to battery-operated smoke detect weekly. The requirement for replacement of batteries per the manufacturer's recommendation has been added to the audit stored to the audit sto	he tors ne ons heet e  II  ut  l/or or od	
K 0324 SS=E Bldg. 01	Ventilation Contro Commercial Cook * residential cooking appliances such a toasters) are used	nt is protected in IFPA 96, Standard for I and Fire Protection of ing Operations, unless: ng equipment (i.e., small s microwaves, hot plates, I for food warming or limited ance with 18.3.2.5.2,				

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\* cooking facilities open to the corridor in

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E064		(X2) MUI A. BUI B. WIN	LDING	nstruction  01	(X3) DATE COMPL 11/27/	ETED		
		PROVIDER OR SUPPLIER			505 N G	DDRESS, CITY, STATE, ZIP COD SAVIN ST E, IN 47303		
	(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
		patients comply w 18.3.2.5.3, 19.3.2 * cooking facilities with 30 or fewer p conditions under Cooking facilities NFPA 96 per 9.2.3 enclosed as hazal be open to the coo 18.3.2.5.1 through through 19.3.2.5.5 Based on record revienterview; the facili kitchen fire suppres semiannually. NFP Ventilation Control Commercial Cookin states Maintenance systems and listed econstant or fire-acti listed to extinguish devices. Hood exha ducts shall be made and certified person having jurisdiction deficient practice co and 20 residents in  Findings include:  Based on records re on 11/27/23 at 01:0 of semiannual kitch inspection available 05/11/23. An inspect was not conducted. of record review, th semiannual kitchen	atients comply with 18.3.2.5.4, 19.3.2.5.4. protected according to 3 are not required to be redous areas, but shall not rridor.  18.3.2.5.4, 19.3.2.5.1  18.3.2.5.4, 19.3.2.5.1  19.9.2.3, TIA 12-2  19.19.2.2 riew, observation and ty failed to ensure 1 of 1 sion system was inspected A 96, 2011 Edition, Standard for and Fire Protection of and Operations, Section 11.2.1 of the fire-extinguishing exhaust hoods containing a vated water system that is a fire in the grease removal ust plenums, and the exhaust by properly trained, qualified, u(s) acceptable to the authority at lease every six months. This bull affect staff in the kitchen	K 03	24	It is the practice of Brookside to ensure the kitchen fire suppression system is inspect semiannually.  What corrective action will be accomplished for those residents found to have been affected by the deficient practice?  The 20 residents who could have been affected by the alleged deficient practice had no negatoutcome. Koorsen was called immediately, and they complet an inspection on the kitchen fit suppression system on Nover 30, 2023, with no deficiencies cited (Attachment J).  How other residents having a potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?  All residents have the potential	ed  e  ave tive ted re nber	11/30/2023

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15E064		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 11/27/2023	
	PROVIDER OR SUPPLIER		505 N	ADDRESS, CITY, STATE, ZIP COD GAVIN ST IE, IN 47303	
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	05/11/23 is not avai	lable.		be affected by the alleged def practice. Koorsen was called immediately, and they comple an inspection on the kitchen f suppression system on Novel 30, 2023, with no deficiencies cited.	ficient eted ire mber
				What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur? All Maintenance Staff retraine the requirement of the kitcher suppression system to be tes semi-annually.	ed on n fire
				How the corrective action we be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place?  The Maintenance Director and designer will be responsible for timeliness of the inspections completed by Brookside's provider. If the inspection is dand it has not been scheduled will call the provider to make a they have it on the calendar.	d/or or the ue d, he
K 0351 SS=E Bldg. 01	by construction ty	Installation  nd hospitals where required			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DAT	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING <u>01</u> COM	PLETED	
15E064 B. WING 11/2	7/2023	
STREET ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER  505 N GAVIN ST		
BROOKSIDE CARE STRATEGIES MUNCIE, IN 47303		
BIGGROUP OF THE GIVE		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX GEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY)	DATE	
sprinkler system in accordance with NFPA		
13, Standard for the Installation of Sprinkler		
Systems.		
In Type I and II construction, alternative		
protection measures are permitted to be		
substituted for sprinkler protection in specific		
areas where state or local regulations prohibit		
sprinklers.  In hospitals, sprinklers are not required in		
clothes closets of patient sleeping rooms		
where the area of the closet does not exceed		
6 square feet and sprinkler coverage covers		
the closet footprint as required by NFPA 13,		
Standard for Installation of Sprinkler		
Systems.		
19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4,		
19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)		
1. Based on observation and interview, the facility K 0351 K351	01/05/2024	
failed to ensure 1 of 1 Break Room was provided		
with adequate coverage. NFPA 13, 2010 edition,   It is the practice of Brookside Care		
section 8.6.2.2.1 which refers to the maximum to ensure sprinklers provide		
allowable protection area of coverage for a adequate coverage in each room		
sprinkler. Table 8.6.2.2.1(a) through Table and that a sprinkler wrench is		
8.6.2.2.1(d) states the maximum spacing of available in the spare sprinkler		
sprinklers as 15 feet. This deficient practice could box.		
affect 3 staff in the break room and up to 5		
residents in the vicinity of the break room.  What corrective action will be		
accomplished for those		
Findings include: residents found to have been		
Based on observation with the Environmental affected by the deficient practice?		
Based on observation with the Environmental practice? Supervisor (ES) on 11/27/23 at 09:35 a.m., in the All residents have the potential to		
break room there was only one sprinkler head in  break room there was only one sprinkler head in  be affected by the alleged deficient	1	
the room. Only part of the area was covered by  practice but had no negative		
the sprinkler due to the sprinkler placement 16 feet outcome. Koorsen has provided a		
from one wall. The coverage area is 7.5 feet on quote to install an extended		
each side of the sprinkler Based on interview at coverage sprinkler with a new tee	1	
the time of observation, the ES stated she was  which is designed to cover a 20' x		
unaware there was a problem with the sprinkler  20' room as well as to provide a	1	
installation in the break room.		

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		1	_				
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		15E064	B. W	NG		11/27	/2023
		1		STREET	ADDRESS, CITY, STATE, ZIP COD	1	
NAME OF P	PROVIDER OR SUPPLIE	R			GAVIN ST		
BROOKS	SIDE CARE STRAT	FGIFS			E, IN 47303		
שולטטונם	ADE OAKE STRAT			WIGHT			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					sprinkler box (Attachment K).		
		viewed with the Administrator					
	at the exit conferen	ce.			How other residents having		
					potential to be affected by t		
	3.1-19(b)				same deficient practice will		
					identified and what corrective	ve	
		ation, review and interview, the			actions will be taken?		
		sure the installation of the			All residents have the potenti		
		et the requirements of NFPA			be affected by the alleged de		
	· ·	ndard for the Installation of			practice. Koorsen will be insta	alling	
		2010 Edition; Section 6.2.9.6			an extended coverage sprink	ler in	
	states one sprinkler	wrench as specified by the			the breakroom and will be		
	sprinkler manufacti	urer shall be provided in the			providing a sprinkler wrench	for the	
	cabinet for each typ	be of sprinkler installed to be			spare sprinkler box. Administ	rator	
	used for the remova	al and installation of sprinklers			has reached out to Koorsen t	0	
	in the system.				schedule the work on the spr	inkler	
					head (Attachment L).		
	Annex A is not a pa	art of the requirements but is					
	included for inform	national purposes only.			What measures will be put i	nto	
	A.6.2.9.6 states one	e sprinkler wrench design can			place and what systemic		
	be appropriate for r	nany types of sprinklers and			changes will be made to		
	should not require i	multiple wrenches of the same			ensure that the deficient		
	design.				practice does not recur?		
	This deficient pract	tice could affect all occupants			All Maintenance Staff retraine	ed on	
	within the facility.				the requirement of the sprink	ler	
					coverage and the sprinkler w	rench	
	Findings include:				being required in the sprinkle	r box	
					(Attachment B).		
	Based on observation	on with the ES on 11/27/23 at					
	11:35 a.m., the spar	re sprinkler cabinet located in			How the corrective action w	ill	
	the sprinkler riser re	oom did not contain a sprinkler			be monitored to ensure the		
		interview at the time of			deficient practice will not		
	observation, the ES	confirmed a specialized			recur, i.e., what quality		
	sprinkler wrench w	as not found in the spare			assurance program will be p	out	
	sprinkler cabinet.				into place?		
	This finding was re	eviewed with the Administrator			The Maintenance Director an	d/or	
	at the exit conferen				designee will be responsible		
	at the exit comercin				educating his staff moving for		
	3.1-19(b)				on the sprinkler system as we		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		15E064	B. W	ING		11/27/	/2023
				CTDEET A	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	L.			ADDRESS, CITY, STATE, ZIP COD SAVIN ST		
BROOKS	SIDE CARE STRATI	EGIES			E, IN 47303		
טועסטועם	ADE OAKE OHVAH			WIGHT	L, 114 77 000		
(X4) ID	SUMMARY S	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 APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					the sprinkler wrench requirem	ent.	
					If new staff are acquired, the		
					Maintenance Director will edu		
					them on the sprinkler system	and	
					the wrench requirement.		
IV 0000	NEDA 46 :						
K 0363	NFPA 101						
SS=E	Corridor - Doors						
Bldg. 01	Corridor - Doors	.,					
		corridor openings in other					
	-	osures of vertical openings,					
		s areas resist the passage					
		made of 1 3/4 inch					
		wood or other material					
	-	ng fire for at least 20					
		fully sprinklered smoke					
		only required to resist the					
		e. Corridor doors and doors					
	to rooms containing	_					
		rials have positive latching					
		atches are prohibited by					
	_	hese requirements do not					
		spaces that do not contain					
	flammable or com						
		n bottom of door and floor					
		ceeding 1 inch. Powered					
		vith 7.2.1.9 are permissible					
	-	device capable of keeping					
		hen a force of 5 lbf is					
		no impediment to the					
	-	rs. Hold open devices that					
		door is pushed or pulled are					
		ed protective plates of					
	_	re permitted. Dutch doors					
	_	3 are permitted. Door					
		beled and made of steel or					
		compliance with 8.3,					
	unless the smoke	· · · · · · ·					
	sprinklered. Fixed	fire window assemblies are					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 15E064 B. WING 11/27/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 505 N GAVIN ST **BROOKSIDE CARE STRATEGIES** MUNCIE. IN 47303 (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 allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire 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. 1. Based on observation and interview, the facility K 0363 K363 12/15/2023 failed to ensure 1 corridor door was provided with a means suitable for keeping the door closed, had It is the practice of Brookside Care no impediment to closing, latching and would to ensure resident room doors resist the passage of smoke. This deficient latch effectively and that all practice could affect 2 residents in resident room corridor doors do not have holes in 11. them. Findings include: What corrective action will be accomplished for those Based on observation with the Environmental residents found to have been Supervisor (ES) on 11/27/23 at 10:10 a.m., the affected by the deficient corridor door to resident sleeping room 11 would practice? not close and latch into the frame when tested. The 10 residents who could have Based on interview at the time of observation, the been affected by the alleged ES agreed the corridor door to room 11 would not deficient practice had no negative close and latch into the door frame. outcome. The Maintenance Director has fixed Resident Room The finding was reviewed with the Administrator 11's door (Attachment M) so that during the exit conference. it latches effectively. Both the clean linen room door (Attachment 3.1-19(b) N) and soiled linen room door

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Findings include:

2. Based on observation and interview, the facility

failed to ensure 2 of 40 corridor doors resist the

residents in one smoke compartment.

passage of smoke and capable of resisting fire for 20 minutes. This deficient practice could affect 8

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(Attachment O) have had fire

caulking placed in the holes so

that there are no remaining holes.

How other residents having the

potential to be affected by the same deficient practice will be

identified and what corrective

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		r í		ONSTRUCTION	(X3) DATE SUF		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPLETE 44/27/20	
		15E064	B. Wl			11/27/20	۷۵
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
BDOOKS	SIDE CADE STRAT	ECIES			GAVIN ST		
DROOKS	SIDE CARE STRAT	EGIES		MONCI	E, IN 47303		
(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 DEFICIENCY)	TE C	OMPLETION
TAG	REGULATORY OR	LISC IDENTIFYING INFORMATION	+	TAG	actions will be taken?		DATE
	Rased on observation	on with the ES on 11/27/23			All residents have the potential	ol to	
		and 09:45 a.m., the corridor			be affected by the alleged def		
		nen room and clean linen			practice. The Maintenance	OCTIL	
		ch hole that went through the			Director has fixed Resident Ro	oom	
		erview at the time of			11's door so that it latches		
	observation, the ES	S agreed there was a half inch			effectively. Both the clean line	n	
	hole in the soiled lin	nen and clean linen doors.			room door and soiled linen roo		
					door have had fire caulking pla	aced	
					in the holes so that there are r	10	
	_	viewed with the Administrator			remaining holes.		
	during the exit inter	view					
	2.1.10/1				What measures will be put in	ito	
	3.1-19(b)				place and what systemic		
					changes will be made to ensure that the deficient		
					practice does not recur?		
					Maintenance Director will aud	it	
					resident room doors for effecti		
					latching. This will be added to		
					preventative maintenance list		
					(Attachment P). If changes are	•	
					made to the corridor locks due		
					lock changes etc. that create	a	
					hole, the hole will be filled in a	t	
					that time.		
					How the corrective action wi		
					be monitored to ensure the		
					deficient practice will not recur, i.e., what quality		
					assurance program will be p	ut	
					into place?	u.	
					The Maintenance Director will	add	
					the latching of resident doors	to	
					his preventative maintenance		
					checklist. The Administrator w	ill	
					observe for holes in the corrid	or	
					doors while completing daily		

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E064	· /	JILDING	ONSTRUCTION 01	(X3) DATE COMPI 11/27	LETED
	PROVIDER OR SUPPLIER SIDE CARE STRAT			505 N C	ADDRESS, CITY, STATE, ZIP COD GAVIN ST E, IN 47303		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Utilities - Gas and Equipment using complies with NFI Code, electrical w complies with NFI Code. Existing ins service provided r 18.5.1.1, 19.5.1.1 Based on observatir failed to ensure 2 el NFPA 70, 2011 Ed Terminals, Recepta live wiring termina This deficient pract the vicinity of the r room 5.  Findings include:  Based on observatir with the Environme 11/27/23 between 0 maintenance office electrical receptacle it exposing the wire there was an emerg unprotected wires. of observation, the aforementioned cor exposed wiring was	Electric gas or related gas piping PA 54, National Fuel Gas iring and equipment PA 70, National Electric stallations can continue in no hazard to life. , 9.1.1, 9.1.2 on and interview, the facility lectrical wirings were protected. ition. Article 406.5 (F) Exposed cles shall be enclosed so that ls are not exposed to contact. ice could affect 8 residents in naintenance office and resident  on during a tour of the facility ental Supervisor (ES) on 19:55 a.m. and 10:10 a.m., in the the ceiling light fixture had an e in it that had pulled away from es and in the corridor by room 5 ency light that had Based on interview at the time ES acknowledged the aditions and confirmed that s visible.	K 0		k511  It is the practice of Brookside to ensure that no electrical will is exposed.  What corrective action will be accomplished for those residents found to have bee affected by the deficient practice?  The 8 residents who could habeen affected by the alleged deficient practice had no negal outcome. The Maintenance Director has fixed the light in maintenance office (Attachmed Q) as well as the emergency outside Room 5 (Attachment and there are no exposed wind this time.  How other residents having potential to be affected by the same deficient practice will identified and what corrective actions will be taken?  All residents have the potential to be affected to the same deficient practice will identified and what corrective actions will be taken?	Care ring  oe  n  ve ative the ent light R) es at  the ne be ve	12/15/2023

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	T OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DEF CORRECTION IDENTIFICATION NUMBER  15E064	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 11/27/2023
	ROVIDER OR SUPPLIER IDE CARE STRATEGIES	505 N	ADDRESS, CITY, STATE, ZIP COD GAVIN ST IE, 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 BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE
			be affected by the alleged de practice. The Maintenance Director has fixed the light in maintenance office as well a emergency light outside Roc and there are no exposed withis time.  What measures will be put place and what systemic changes will be made to ensure that the deficient practice does not recur? The Preventive Maintenance checklist was reviewed and revised to include auditing for exposed wires when touring facility (Attachment S). The Maintenance staff were re-educated on the revised F checklist by the Maintenance Director (Attachment B). The Maintenance Director re-educall staff on the importance of communicating exposed wirithe Maintenance department timely manner.  How the corrective action where the deficient practice will not recur, i.e., what quality assurance program will be into place?  The Maintenance Director we exposed wiring to his prevent maintenance checklist. The	eficient the sthe m 5 res at into e (PM) or the cated ng to tin a vill put ill add tative
				r

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	INT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  15E064	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION (X3	3) DATE SURVEY COMPLETED 11/27/2023
	PROVIDER OR SUPPLIER SIDE CARE STRATEGIES	505 N	ADDRESS, CITY, STATE, ZIP COD GAVIN ST EIE, 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
			daily facility rounds (Attachment F).	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Shall be adopted and shall include not less than the following provisions:  (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking.  (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required.  (3) Smoking by patients classified as not responsible shall be prohibited.  (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision.  (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.  (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.  18.7.4, 19.7.4			
	Based on observation and interview; the facility failed to ensure 1 of 1 smoking areas was maintained by disposing cigarette butts with no combustible trash in the provided metal or noncombustible containers with self-closing	K 0741	K741  It is the practice of Brookside Ca to ensure smoking areas are maintained by disposing cigarette	

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

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	F CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E064	A. BUILDING B. WING	01	COMPLETED  11/27/2023
	OVIDER OR SUPPLIER  DE CARE STRATE	EGIES	505 N (	ADDRESS, CITY, STATE, ZIP COD GAVIN ST IE, IN 47303	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
		deficient practice could affect f in the smoking area.		butts in a metal or noncombus container with self-closing cov devices that have no combust trash.	er
	with Environmental 10:15 a.m., in the re combustible trash m the self-closing metainterview at the time cigarette butts and c in the self-closing m smoking area.	n during a tour of the facility Supervisor (ES) on 11/27/23 at sident smoking area, there was ixed in with cigarette butts in al container. Based on e of observation, the ES agreed ombustible trash were found tetal container in the resident riewed with the Administrator e.		What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The 10 residents and staff who could have been affected by the alleged deficient practice had negative outcome. All cigarette butts and trash were cleaned to the smoking area. The Maintenance Director then provided a trash can for the combustible trash and 1 more self-closing device for the cigar butts.  How other residents having to potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents have the potential be affected by the alleged defining practice. The Maintenance Director has provided a trash of for the combustible trash and more self-closing cover devices the cigarette butts.  What measures will be put in place and what systemic changes will be made to ensure that the deficient	n  one no e up in  arette  the e e il to cient can 1

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

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STATEMEN	TEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		15E064	B. WI	NG		11/27/	/2023
NAME OF F	PROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
DD COLC	NDE 04DE 075 : -	FO.150			GAVIN ST		
BROOKS	SIDE CARE STRAT	EGIES		MUNCI	E, IN 47303		
(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 APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					The Housekeeping Supervisor		
					and/or Designee will be		
					responsible for completing QA	·PΙ	
					audit tool Smoking Area		
					Assessment (Attachment T)		
					5x/week for the first month,		
					3x/week for the second month	,	
					and weekly for at least 6 mont	hs.	
					All cigarette butts and trash ha	ave	
					been removed and cleaned up	), 1	
					new self-closing cover devices	has	
					been provided in the designate	ed	
					smoking area, as well as a tra		
					can for combustible trash, and	all	
					staff have been educated on t	he	
					policy as well as designated		
					smoking area and the routine		
					cleaning and monitoring sched	dule	
					for the smoking area.		
					Llow the competive estion wi		
					How the corrective action wi	11	
					be monitored to ensure the		
					deficient practice will not recur, i.e., what quality		
					assurance program will be p		
					into place?	ut	
					The Housekeeping		
					Supervisor/Designee will be		
					responsible for completing QA	PI	
					audit tool Smoking Area		
					Assessment 5x/week for the fi	rst	
					month, 3x/week for the second		
					month, and weekly for at least		
					months. If 100% compliance is		
					achieved an action plan will be		
					developed. Findings will be	-	
					submitted to the QAPI team.		
K 0754	NFPA 101						
SS=E	Soiled Linen and	Trash Containers					

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED
		15E064	B. WING		11/27/2023
	PROVIDER OR SUPPLIER	EGIES	505 N (	ADDRESS, CITY, STATE, ZIP COD GAVIN ST IE, IN 47303	
(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 APPROPRIA	TE COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
Bldg. 01	shall not exceed 3 average density or room or space shat gallons/square feet capacity of 32 gall within any 64 squal linen or trash collect capacities greater located in a room area when not attered to be experimented to be experimented to be experimented to be experimented to see and containers for and listed as meet 6921 or equivalen 18.7.5.7, 19.7.5.7	sh collection receptacles 12 gallons in capacity. The 15 f container capacity in a 16 f container capacity in a 17 f container capacity in a 18 f container	K 0754	K754	12/15/2023
		h receptacles in 2 of 3			
		tained in accordance with		It is the practice of Brookside	
		ient practice could affect staff		to ensure trash receptacles we	
	-	nts in the vicinity of the clean		maintained in accordance with	1
	linen room and the	resident bathing room.		19.7.5.7	
	Findings include:			What corrective action will b accomplished for those	
		ons during a tour of the facility		residents found to have been	1
		ental Supervisor (ES) on		affected by the deficient	
		m. and 10:05 a.m., there was a		practice?	
		en barrel and a 32 gallon trash		The 10 residents who could ha	ave
		other in the corridor by the		been affected by the alleged	
		d again by the resident		deficient practice had no nega	itive
		d on interview at the time of		outcome. Trash barrels were	
		agreed there were two		separated.	
		ne a soiled linen and one a		l., ., ., ., .	.
	trash barrel totaling	64 gallons in a 64 square foot		How other residents having t	the

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area by the clean linen room and by the resident

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potential to be affected by the

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		15E064	B. W			11/27	
		1.02001		_		,,	
NAME OF F	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
					GAVIN ST		
BROOKS	SIDE CARE STRAT	EGIES		MUNCI	E, IN 47303		
(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 APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	bathing room.				same deficient practice will b	Эе	
					identified and what correctiv	е	
	These findings were	e reviewed with the			actions will be taken?		
	_	ng the exit conference.			All residents have the potentia	ıl to	
					be affected by the alleged def		
	3.1-19(b)				practice. All staff inserviced or		
	3.1 15(0)				appropriate location of soiled l		
					and trash barrels as well as	IIICII	
					spacing required between the	m	
					spacing required between the	111.	
					What measures will be put ir	ito	
					place and what systemic		
					changes will be made to		
					ensure that the deficient		
					practice does not recur?		
					All staff inserviced on appropr	iate	
					location of soiled linen and tra		
					barrels. QAPI tool titled Daily I		
					Safety Facility Rounds	LIIC	
						tod.	
					(Attachment F) will be comple		
					weekly x 4 weeks, monthly x 6		
					months, and quarterly there at	ter	
					until compliance is achieved.		
					Ongoing compliance with this		
					corrective action will be monitor		
					via facility QAPI program, with		
					meetings being held monthly,	and	
					is overseen by the Executive		
					Director. QAPI tool titled Daily	Life	
					Safety Facility Rounds will be		
					completed weekly x 4 weeks,		
					monthly x 6 months, and quar	terly	
					there after until compliance is	•	
					achieved.		
					How the corrective action wi	II	
					be monitored to ensure the		
					deficient practice will not		
					recur. i.e., what quality		

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assurance program will be put

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CENTERS FOR MEDICARE & MEDICAID SERVICE	S

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15E064	` ′	JILDING	ONSTRUCTION  01	(X3) DATE COMPI 11/27	LETED
	PROVIDER OR SUPPLIER			505 N C	ADDRESS, CITY, STATE, ZIP COD GAVIN ST E, IN 47303		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
					into place? Ongoing compliance with this corrective action will be monitivia facility QAPI program with meetings being held monthly a is overseen by the Executive Director. QAPI tool titled Daily Safety Facility Rounds will be completed weekly x 4 weeks, monthly x 6 months, and quar there after until compliance is achieved. If Threshold of 1009 not met, an action plan will be developed to ensure compliance.	ored and Life terly % is	

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