STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15E064	A. BUILDING -- B. WING	11/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROOKSIDE CARE STRATEGIES	505 N GAVIN ST MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 11/27/23 Facility Number: 000311 Provider Number: 15E064 AIM Number: 100285520 At this Emergency Preparedness survey, Brookside Care Strategies was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 42 and had a census of 23 at the time of this survey. Quality Review completed on 12/01/23 The requirements of 42 CFR, Subpart 483.73 are Not Met as evidenced by:	E 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulations. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of compliance effective January 5, 2024**. This facility respectfully requests consideration for paper compliance from this Plan of Correction.**	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727,			

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.

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BROOKSIDE CARE STRATEGIES	505 N GAVIN ST MUNCIE, IN 47303

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	CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of 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 accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.			

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	*[For Hospices at 418.113(d):] (2) Testing for hospices 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 accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:			

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	(i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging 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 that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or			

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	(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or			

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	(B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an			

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	actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (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 includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual 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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	full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (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 set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.			

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	(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop			

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	exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The 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 designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.			
	Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is	E 0039	**E039** It is the practice of Brookside Care Strategies to conduct exercises to test the emergency plan at least twice per year. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** All residents have the potential to be affected by the alleged deficient practice. A second drill will be conducted as required by 483.73 (Attachment A). **How other residents having the potential to be affected by the same deficient practice will be**	12/15/2023

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	community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on record review and interview with the Administrator on 11/27/23 at 12:30 p.m., no documentation of a second Emergency Preparedness (EP) annual exercise was available, but documentation of one annual exercise on 11/22/23 was available for review. Based on interview at the time of records review, the Administrator stated the facility did not participate in a second EP annual exercise but completed one facility based exercise within the last 12 months. This finding was reviewed with the Administrator at the exit conference.		**identified and what corrective actions will be taken?** All residents have the potential to be affected by the alleged deficient practice. Brookside Care Strategies will maintain continued efforts to ensure two drills/exercises are completed annually including unannounced drills. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** The Interdisciplinary Team will be inserviced on the requirements of the emergency preparedness plan related to required drills on December 13, 2023 (Attachment B). The IDT will review the training and testing requirements within the emergency preparedness plan 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 put into place?** The Administrator and/or designee will be responsible for scheduling the drills with the community-based exercise as well as the unannounced drills. If an actual natural disaster occurs this	

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			will be documented and used as an exercise. These drills will occur at least twice annually. The QAPI team will audit the inservice schedule to verify that the drills are included on the annual inservice schedule.	
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 facility has a capacity of 42 and had a census of 23 at the time of this survey.	K 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulations. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of compliance effective January 5, 2024. **This facility respectfully requests consideration for paper compliance from this Plan of Correction.**	

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	All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. This facility is certified for Medicaid only. The facility is not equipped with an emergency generator. Quality Review completed on 12/01/23			
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 4 corridor means of egresses were continuously maintained free of obstructions. This deficient practice affects 10 residents. Findings include: Based on observation during a tour of the facility with the Environmental Supervisor (ES) on 11/27/23 at 10:00 a.m., there was an easel located in the corridor in front of the Dining room means of egress door obstructing the exit. Based on an interview at the time of observations, the ES agreed an easel was obstructing the egress door in the Dining room. The ES moved the obstruction at the time of observation.	K 0211	**K211** It is the practice of Brookside Care to ensure all means of egresses 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 been affected by the alleged deficient practice had no negative outcome. This doorway was marked as an Exit in error as there is no means to reach a level, safe walking surface due to the	12/15/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15E064	A. BUILDING 01 B. WING	11/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROOKSIDE CARE STRATEGIES	505 N GAVIN ST MUNCIE, IN 47303

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	This finding was reviewed with the Administrator at the exit conference. 3.1-19(b)		railway on that side of the building. The exit sign has been removed (Attachment C) and the floor plan (Attachment D) has been updated with the correct exit pathways. All staff will be retrained on the new floor plan. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents have the potential to be affected by the alleged deficient practice. The exit sign has been removed and the floor plan has been updated with the correct exit pathways. All staff will be retrained on the new floor plan by December 13, 2023. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** All staff will be trained on the new floor plans and the correct exit pathways by December 13, 2023 (Attachment E). **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 designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15E064	A. BUILDING 01 B. WING	11/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROOKSIDE CARE STRATEGIES	505 N GAVIN ST MUNCIE, IN 47303

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			will be responsible for updating the floor plans if changes occur. Staff will be retrained if any changes are made to the means of egress. The Administrator and/or designee will complete daily life safety facility rounds (Attachment F) to check for obstructions daily five times a week for 4 weeks, weekly for a month, and then monthly for 3 months. If there are obstructions noted, the staff presently in the building will be reeducated.	
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 Based on observation and interview, the facility failed to ensure exit discharge to the back of the facility from the Dining room was provided with a level walking surface in accordance with NFPA 101 (2012 edition) section 7.7. This deficient practice could affect 10 residents that would use the back exit. Findings include: Based on observations with the Environmental Supervisor (ES) on 11/27/23 at 10:05 p.m., the exit discharge from the back of the facility from the Dining room leading outside discharged into the	K 0271	**K271** It is the practice of Brookside Care to ensure all means of egresses are free from obstruction and have a level walking surface. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** The 10 residents who could have been affected by the alleged	12/15/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15E064	A. BUILDING 01 B. WING	11/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROOKSIDE CARE STRATEGIES	505 N GAVIN ST MUNCIE, IN 47303

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	yard. Based on interview at the time of observation, the ES agreed the exit discharge from the Dining room was not a level walking surface. The finding was reviewed with the Administrator during the exit conference. 3.1-19(b)		deficient practice had no negative outcome. This doorway was marked as an Exit in error as there is no means to reach a level, safe walking surface due to the railway on that side of the building. The exit sign has been removed (Attachment C) and the floor plan (Attachment D) has been updated with the correct exit pathways. All staff will be retrained on the new floor plan. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents have the potential to be affected by the alleged deficient practice. The exit sign has been removed and the floor plan has been updated with the correct exit pathways. All staff will be retrained on the new floor plan by December 13, 2023. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** All staff will be trained on the new floor plans and the correct exit pathways by December 13, 2023 (Attachment E). **How the corrective action will be monitored to ensure the deficient practice will not**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15E064	A. BUILDING 01 B. WING	11/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROOKSIDE CARE STRATEGIES	505 N GAVIN ST MUNCIE, IN 47303

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			recur, i.e., what quality assurance program will be put into place? The Administrator and/or designee will be responsible for updating the floor plans if changes occur. Staff will be retrained if any changes are made to the means of egress. The Administrator and/or designee will complete daily life safety facility rounds (Attachment F) to check for obstructions and a level walking surface daily five times a week for 4 weeks, weekly for a month, and then monthly for 3 months.	
K 0291 SS=E Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on observation and interview, the facility failed to ensure 1 of 8 battery powered emergency lights were maintained in accordance with LSC 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. LSC 7.9.2.7 states the emergency lighting system shall be either continuously in operation or shall be capable of repeated automatic operation without manual intervention. This deficient practice could affect 10 residents that would use the exit door	K 0291	**K291** It is the practice of Brookside Care to ensure all means of egresses are free from obstruction and that emergency lighting shall be continuously in operation. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** The 10 residents who could have been affected by the alleged	12/15/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15E064	A. BUILDING 01 B. WING	11/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	from the Dining room. Findings include: Based on observation with the Environmental Supervisor (ES) on 11/27/23 at 10:00 a.m., the battery-operated emergency light outside of exit door from the Dining room did not work when tested. Based on interview at the time of the observation, the ES agreed the battery-operated emergency light failed to function when its respective test button was pushed. The finding was reviewed with the Administrator during the exit conference. 3.1-19(b)		deficient practice had no negative outcome. This doorway was marked as an Exit in error as there is no means to reach a level, safe walking surface due to the railway on that side of the building. The exit sign has been removed (Attachment C) and the floor plan (Attachment D) has been updated with the correct exit pathways. All staff will be retrained on the new floor plan. However, the battery in the emergency light has been replaced (Attachment G). **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents have the potential to be affected by the alleged deficient practice. The exit sign has been removed and the floor plan has been updated with the correct exit pathways. The battery in the emergency light that was not working has been replaced. All staff will be retrained on the new floor plan by December 13, 2023. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** All staff will be trained on the new floor plans and the correct exit pathways by December 13, 2023 (Attachment B).	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E064	A. BUILDING 01 B. WING	11/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROOKSIDE CARE STRATEGIES	505 N GAVIN ST MUNCIE, IN 47303

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			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 designee will be responsible for updating the floor plans if changes occur. Staff will be retrained if any changes are made to the means of egress. The 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 there are outages noted a top priority work order will be completed and the Maintenance Director will change the battery as soon as possible.	
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 Care to replace batteries in the	12/15/2023

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	15E064	A. BUILDING 01 B. WING	11/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROOKSIDE CARE STRATEGIES	505 N GAVIN ST MUNCIE, IN 47303

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	resident rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on records review with the Maintenance Director and Administrator on 11/27/23 at 12:50 p.m., no documentation for battery replacement of resident room battery operated smoke alarms was available for review. Based on interview at the time of review, the Maintenance Director stated there was no documentation available to show when the last battery replacement of the battery operated smoke detectors was completed. This finding was reviewed with the Administrator at the exit conference. 3.1-19(b)		battery-operated smoke detectors per manufacturers recommendations. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** All residents have the potential to be affected by the alleged deficient practice but had no negative outcome. All battery-operated smoke detectors are being checked weekly at this time. As a preventative maintenance function all batteries have been replaced and this was documented on 12/8/2023 (Attachment H). **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents have the potential to be affected by the alleged deficient practice. The batteries in all battery-operated smoke detectors have been replaced and this was documented on 12/8/2023. The battery-operated smoke detectors will continue to be tested weekly. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** The Maintenance Director and/or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E064	A. BUILDING 01 B. WING	11/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROOKSIDE CARE STRATEGIES	505 N GAVIN ST MUNCIE, IN 47303

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			designee will continue to test the battery-operated smoke detectors weekly. The requirement for replacement of batteries per the manufacturer's recommendations has been added to the audit sheet so that this can be easily referenced by the Maintenance Director and/or designee (Attachment I). **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 Maintenance Director and/or designee will be responsible for monitoring the battery-operated smoke detectors and the replacement of the batteries. This is now noted on his battery-operated smoke detector audit tool.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E064	A. BUILDING 01 B. WING	11/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROOKSIDE CARE STRATEGIES	505 N GAVIN ST MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on record review, observation and interview; the facility failed to ensure 1 of 1 kitchen fire suppression system was inspected semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.2.1 states Maintenance of the fire-extinguishing systems and listed exhaust hoods containing a constant or fire-activated water system that is listed to extinguish a fire in the grease removal devices. Hood exhaust plenums, and the exhaust ducts shall be made by properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction at lease every six months. This deficient practice could affect staff in the kitchen and 20 residents in the dining room. Findings include: Based on records review with the Administrator on 11/27/23 at 01:05 p.m., the only documentation of semiannual kitchen fire suppression system inspection available for review was dated 05/11/23. An inspection six months after 05/11/23 was not conducted. Based on interview at the time of record review, the Administrator stated the semiannual kitchen fire suppression system inspection documentation six months after	K 0324	**K324** It is the practice of Brookside Care to ensure the kitchen fire suppression system is inspected 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 negative outcome. Koorsen was called immediately, and they completed an inspection on the kitchen fire suppression system on November 30, 2023, with no deficiencies cited (Attachment J). **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents have the potential to	11/30/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15E064	A. BUILDING 01 B. WING	11/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROOKSIDE CARE STRATEGIES	505 N GAVIN ST MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	05/11/23 is not available. This finding was reviewed with the Administrator at the exit conference. 3.1-19(b)		be affected by the alleged deficient practice. Koorsen was called immediately, and they completed an inspection on the kitchen fire suppression system on November 30, 2023, with no deficiencies cited. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** All Maintenance Staff retrained on the requirement of the kitchen fire suppression system to be tested semi-annually. **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 Maintenance Director and/or designer will be responsible for the timeliness of the inspections completed by Brookside's provider. If the inspection is due and it has not been scheduled, he will call the provider to make sure they have it on the calendar.	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E064	A. BUILDING 01 B. WING	11/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROOKSIDE CARE STRATEGIES	505 N GAVIN ST MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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 failed to ensure 1 of 1 Break Room was provided with adequate coverage. NFPA 13, 2010 edition, section 8.6.2.2.1 which refers to the maximum allowable protection area of coverage for a sprinkler. Table 8.6.2.2.1(a) through Table 8.6.2.2.1(d) states the maximum spacing of sprinklers as 15 feet. This deficient practice could affect 3 staff in the break room and up to 5 residents in the vicinity of the break room. Findings include: Based on observation with the Environmental Supervisor (ES) on 11/27/23 at 09:35 a.m., in the break room there was only one sprinkler head in the room. Only part of the area was covered by the sprinkler due to the sprinkler placement 16 feet from one wall. The coverage area is 7.5 feet on each side of the sprinkler Based on interview at the time of observation, the ES stated she was unaware there was a problem with the sprinkler installation in the break room.	K 0351	**K351** It is the practice of Brookside Care to ensure sprinklers provide adequate coverage in each room and that a sprinkler wrench is available in the spare sprinkler box. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** All residents have the potential to be affected by the alleged deficient practice but had no negative outcome. Koorsen has provided a quote to install an extended coverage sprinkler with a new tee which is designed to cover a 20' x 20' room as well as to provide a sprinkler wrench for the spare	01/05/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E064	A. BUILDING 01 B. WING	11/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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(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
	The finding was reviewed with the Administrator at the exit conference. 3.1-19(b) 2. Based on observation, review and interview, the facility failed to ensure the installation of the sprinkler system met the requirements of NFPA 13. NFPA 13, Standard for the Installation of Sprinkler Systems, 2010 Edition; Section 6.2.9.6 states one sprinkler wrench as specified by the sprinkler manufacturer shall be provided in the cabinet for each type of sprinkler installed to be used for the removal and installation of sprinklers in the system. Annex A is not a part of the requirements but is included for informational purposes only. A.6.2.9.6 states one sprinkler wrench design can be appropriate for many types of sprinklers and should not require multiple wrenches of the same design. This deficient practice could affect all occupants within the facility. Findings include: Based on observation with the ES on 11/27/23 at 11:35 a.m., the spare sprinkler cabinet located in the sprinkler riser room did not contain a sprinkler wrench. Based on interview at the time of observation, the ES confirmed a specialized sprinkler wrench was not found in the spare sprinkler cabinet. This finding was reviewed with the Administrator at the exit conference. 3.1-19(b)		sprinkler box (Attachment K). **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents have the potential to be affected by the alleged deficient practice. Koorsen will be installing an extended coverage sprinkler in the breakroom and will be providing a sprinkler wrench for the spare sprinkler box. Administrator has reached out to Koorsen to schedule the work on the sprinkler head (Attachment L). **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** All Maintenance Staff retrained on the requirement of the sprinkler coverage and the sprinkler wrench being required in the sprinkler box (Attachment B). **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 Maintenance Director and/or designee will be responsible for educating his staff moving forward on the sprinkler system as well as	

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	15E064	A. BUILDING 01 B. WING	11/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROOKSIDE CARE STRATEGIES	505 N GAVIN ST MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			the sprinkler wrench requirement. If new staff are acquired, the Maintenance Director will educate them on the sprinkler system and the wrench requirement.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are			

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	15E064	A. BUILDING 01 B. WING	11/27/2023

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	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 failed to ensure 1 corridor door was provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 2 residents in resident room 11. Findings include: Based on observation with the Environmental Supervisor (ES) on 11/27/23 at 10:10 a.m., the corridor door to resident sleeping room 11 would not close and latch into the frame when tested. Based on interview at the time of observation, the ES agreed the corridor door to room 11 would not close and latch into the door frame. The finding was reviewed with the Administrator during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 2 of 40 corridor doors resist the passage of smoke and capable of resisting fire for 20 minutes. This deficient practice could affect 8 residents in one smoke compartment. Findings include:	K 0363	**K363** It is the practice of Brookside Care to ensure resident room doors latch effectively and that all corridor doors do not have holes in them. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** The 10 residents who could have been affected by the alleged deficient practice had no negative outcome. The Maintenance Director has fixed Resident Room 11's door (Attachment M) so that it latches effectively. Both the clean linen room door (Attachment N) and soiled linen room door (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**	12/15/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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	Based on observation with the ES on 11/27/23 between 09:40 a.m. and 09:45 a.m., the corridor door to the soiled linen room and clean linen room, had a half inch hole that went through the doors. Based on interview at the time of observation, the ES agreed there was a half inch hole in the soiled linen and clean linen doors. The finding was reviewed with the Administrator during the exit interview 3.1-19(b)		**actions will be taken?** All residents have the potential to be affected by the alleged deficient practice. The Maintenance Director has fixed Resident Room 11's door so that it latches effectively. Both the clean linen room door and soiled linen room door have had fire caulking placed in the holes so that there are no remaining holes. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** Maintenance Director will audit resident room doors for effective latching. This will be added to the preventative maintenance list (Attachment P). If changes are made to the corridor locks due to lock changes etc. that create a hole, the hole will be filled in at that time. **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 Maintenance Director will add the latching of resident doors to his preventative maintenance checklist. The Administrator will observe for holes in the corridor doors while completing daily	

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			facility rounds (Attachment F).	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 2 electrical wirings were protected. NFPA 70, 2011 Edition. Article 406.5 (F) Exposed Terminals, Receptacles shall be enclosed so that live wiring terminals are not exposed to contact. This deficient practice could affect 8 residents in the vicinity of the maintenance office and resident room 5. Findings include: Based on observation during a tour of the facility with the Environmental Supervisor (ES) on 11/27/23 between 09:55 a.m. and 10:10 a.m., in the maintenance office the ceiling light fixture had an electrical receptacle in it that had pulled away from it exposing the wires and in the corridor by room 5 there was an emergency light that had unprotected wires. Based on interview at the time of observation, the ES acknowledged the aforementioned conditions and confirmed that exposed wiring was visible. These findings were reviewed with the Administrator at the exit conference. 3.1-19(b)	K 0511	**K511** It is the practice of Brookside Care to ensure that no electrical wiring is exposed. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** The 8 residents who could have been affected by the alleged deficient practice had no negative outcome. The Maintenance Director has fixed the light in the maintenance office (Attachment Q) as well as the emergency light outside Room 5 (Attachment R) and there are no exposed wires at this time. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents have the potential to	12/15/2023

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			be affected by the alleged deficient practice. The Maintenance Director has fixed the light in the maintenance office as well as the emergency light outside Room 5 and there are no exposed wires at this time. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** The Preventive Maintenance (PM) checklist was reviewed and revised to include auditing for exposed wires when touring the facility (Attachment S). The Maintenance staff were re-educated on the revised PM checklist by the Maintenance Director (Attachment B). The Maintenance Director re-educated all staff on the importance of communicating exposed wiring to the Maintenance department in a timely manner. **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 Maintenance Director will add exposed wiring to his preventative maintenance checklist. The Administrator will observe for exposed wiring while completing	

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BROOKSIDE CARE STRATEGIES	505 N GAVIN ST MUNCIE, IN 47303

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			daily facility rounds (Attachment F).	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations 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 Care to ensure smoking areas are maintained by disposing cigarette	12/15/2023

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	cover devices. This deficient practice could affect 10 residents and staff in the smoking area. Findings include: Based on observation during a tour of the facility with Environmental Supervisor (ES) on 11/27/23 at 10:15 a.m., in the resident smoking area, there was combustible trash mixed in with cigarette butts in the self-closing metal container. Based on interview at the time of observation, the ES agreed cigarette butts and combustible trash were found in the self-closing metal container in the resident smoking area. This finding was reviewed with the Administrator at the exit conference. 3.1-19(b)		butts in a metal or noncombustible container with self-closing cover devices that have no combustible trash. **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 no negative outcome. All cigarette butts and trash were cleaned up in the smoking area. The Maintenance Director then provided a trash can for the combustible trash and 1 more self-closing device for the cigarette butts. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents have the potential to be affected by the alleged deficient practice. The Maintenance Director has provided a trash can for the combustible trash and 1 more self-closing cover device for the cigarette butts. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?**	

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			The Housekeeping Supervisor and/or Designee will be responsible for completing QAPI 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 months. All cigarette butts and trash have been removed and cleaned up, 1 new self-closing cover devices has been provided in the designated smoking area, as well as a trash can for combustible trash, and all staff have been educated on the policy as well as designated smoking area and the routine cleaning and monitoring schedule for the smoking area. **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 Housekeeping Supervisor/Designee will be responsible for completing QAPI audit tool Smoking Area Assessment 5x/week for the first month, 3x/week for the second month, and weekly for at least 6 months. If 100% compliance is not achieved an action plan will be developed. Findings will be submitted to the QAPI team.	
K 0754 SS=E	NFPA 101 Soiled Linen and Trash Containers			

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Bldg. 01	Soiled Linen and Trash Containers Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is less than or equal to 96 gallons unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7 Based on observation and interview, the facility failed to ensure trash receptacles in 2 of 3 corridors were maintained in accordance with 19.7.5.7. This deficient practice could affect staff and up to 10 residents in the vicinity of the clean linen room and the resident bathing room. Findings include: Based on observations during a tour of the facility with the Environmental Supervisor (ES) on 11/27/23 at 09:45 a.m. and 10:05 a.m., there was a 32-gallon soiled linen barrel and a 32 gallon trash barrel next to each other in the corridor by the clean linen room and again by the resident bathing room. Based on interview at the time of observation, the ES agreed there were two 32-gallon barrels, one a soiled linen and one a trash barrel totaling 64 gallons in a 64 square foot area by the clean linen room and by the resident	K 0754	**K754** It is the practice of Brookside Care to ensure trash receptacles were maintained in accordance with 19.7.5.7 **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** The 10 residents who could have been affected by the alleged deficient practice had no negative outcome. Trash barrels were separated. **How other residents having the potential to be affected by the**	12/15/2023

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	bathing room. These findings were reviewed with the Administrator during the exit conference. 3.1-19(b)		**same deficient practice will be identified and what corrective actions will be taken?** All residents have the potential to be affected by the alleged deficient practice. All staff inserviced on appropriate location of soiled linen and trash barrels as well as spacing required between them. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** All staff inserviced on appropriate location of soiled linen and trash barrels. QAPI tool titled Daily Life Safety Facility Rounds (Attachment F) will be completed weekly x 4 weeks, monthly x 6 months, and quarterly there after until compliance is achieved. Ongoing compliance with this corrective action will be monitored 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 quarterly there after until compliance is achieved. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put**	

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			into place? Ongoing compliance with this corrective action will be monitored 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 quarterly there after until compliance is achieved. If Threshold of 100% is not met, an action plan will be developed to ensure compliance.	