

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

PRINTED: 08/30/2024  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155687</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>08/28/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRICKYARD HEALTHCARE - MUNCIE CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2701 LYN-MAR DR</b> <b>MUNCIE, IN 47304</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
{F 000}	<p>INITIAL COMMENTS</p> <p>This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 7/12/24. This visit included a PSR to the Investigation of Complaint IN00436684 completed on 7/12/24.</p> <p>This visit was in conjunction with a Investigation of Complaint IN00440922.</p> <p>Complaint IN00436684 - Corrected.</p> <p>Complaint IN00440922 - No deficiency related to the allegation is cited.</p> <p>Survey dates: 8/27/24 and 8/28/24</p> <p>Facility number: 000097 Provider number: 155687 AIM number: 100290970</p> <p>Census Bed Type: SNF/NF: 104 Total: 104</p> <p>Census Payor Type: Medicare: 4 Medicaid: 69 Other: 31 Total: 104</p> <p>Brickyard Healthcare - Muncie Care Center was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the PSR to the Recertification and State Licensure Survey and the PSR to the Investigation of Complaint IN00436684.</p>	{F 000}			

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155687	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  R-C 08/28/2024
NAME OF PROVIDER OR SUPPLIER  BRICKYARD HEALTHCARE - MUNCIE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  2701 LYN-MAR DR MUNCIE, IN 47304		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
{F 000}	Continued From page 1 Quality review completed August 29, 2024.	{F 000}			