STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155687	A. BUILDING -- B. WING	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - MUNCIE CARE CENTER	2701 LYN-MAR DR MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/01/24 Facility Number: 000097 Provider Number: 155687 AIM Number: 100290970 At this Emergency Preparedness survey, Brickyard Healthcare-Muncie Care Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 117 and had a census of 99 at the time of this survey. Quality Review completed on 08/05/24	E 0000	Requesting desk review of our POC. Supporting documents of substaintial compliance is incldued with the POC.	
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: 08/01/24 Facility Number: 000097 Provider Number: 155687 AIM Number: 100290970 At this Life Safety Code survey, Brickyard Healthcare-Muncie Care Canter was found not in compliance with Requirements for Participation in	K 0000	Requesting desk review of our POC. Supporting documents of substaintial compliance is incldued with the POC.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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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	Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility was determined to be of Type V (111) construction and 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 117 and had a census of 99 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except for one detached garage that is used only for storage. Quality Review completed on 08/05/24			
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 staff interview, the facility failed to maintain the means of egress free from obstructions in 1 of 8 corridors within the facility. LSC 19.2.3.4(4) states, projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met:	K 0211	-what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Maintenance Director corrected the deficiencies immediately by removing the carts and replaced them with the	08/14/2024

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	(a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in. (1525 mm.) (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c) The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect approximately 16 residents, 4 staff and 2 visitors. Findings include: Based on observations made with the Maintenance Director, Maintenance Assistant, and the facility Executive Director on 08/01/24 during a tour the facility between 12:01 p.m. and 2:44 p.m. the following was noted: a) There was a small plastic three drawer chest holding personal protective equipment sitting outside resident room #209. This small three drawer chest was not on wheels. b) There was a small plastic three drawer chest holding personal protective equipment sitting outside resident room #213. This small three drawer chest was not on wheels. Based on interview with the Maintenance Director at the time of the observation, he acknowledged the chests in the corridor and added that he has found these items in the corridor before and that he has mentioned it to nursing staff, but they continue to forget about the necessity for the chests to be on wheels. This item was again discussed at the exit conference held on 08/01/24 at 2:16 p.m. with the		wheels. Maintenance Director/ Designee completed the inspection of all the hallways with isolation cart ensuring that carts have wheels. -how other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: Residents on the halls with isolation carts can be affected by the deficient practice. -what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; ED/Maintenance Director/ Designee will include the observation of isolation carts during daily rounds ensuring that the carts have appropriate wheels. -how the corrective action will be monitored to ensure that deficient practice will not recur; I.e., what quality assurance program will be put into place: ED/Maintenance director/	

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	Maintenance Director, Maintenance Assistant, and the facility Executive Director all present. 3.1-19(b)		Designee will include the observation of isolation cards during daily rounds and report in the TELS work orders for immediate correction of the deficient. ED/Maintenance director/ Designee will conduct weekly x 4 weeks and thereafter 1x monthly audit of the rooms with isolation carts and submit the report during QAPI meeting.	