

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 11/20/2025
Form Approved OMB
No. 0938-0391

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 08/22/2025
NAME OF PROVIDER OR SUPPLIER Brookside Care Strategies		STREET ADDRESS, CITY, STATE, ZIP CODE 505 N Gavin St Muncie, IN 47303	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. Based on interview and record review, the facility failed to ensure residents, for whom the facility managed funds, or their representatives, received quarterly funds statements for 2 of 3 residents reviewed for quarterly statements. (Residents F and H) Findings include: A current 8/19/25, facility Trail Balance resident funds statement indicated the facility managed personal funds for 32 residents. Residents E, F and H names were listed on the account list. Quarterly statements were requested of facility management for review for Residents E, F, and H. Residents F and H did not have quarterly statements for review. During an interview on 8/20/25 at 1:36 p.m., the Administrator and Business Office Manager both indicated that quarterly statements had not been given to residents who did not have a responsible party to receive them. This had been an error and residents should have received the statements themselves. A current, 2017, facility policy titled, Deposit of Resident Funds, provided by the Business Office Manager on 8/20/21 at 1:38 p.m., indicated The resident is provided a confidential quarterly statement on funds on deposit with the facility. This citation relates to Complaint 2588630. 3.1-6(g)		

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.

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

TITLE

(X6) DATE

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F 0570 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure the security of all personal funds of residents deposited with the facility. Based on interview and record review, the facility failed to provide a surety bond in sufficient amount to safeguard all resident funds. This deficient practice had the potential to impact 32 of 32 residents for whom the facility managed funds. Findings include: Review of a current 8/19/25, facility Trail Balance resident funds statement indicated the facility managed resident funds for 32 residents. Review of the facility's current, April 1, 2022, surety bond agreement indicated the resident funds were covered in liability surety for the amount of \$30,000.00 (thirty thousand dollars). A review of bank statements for July 2025 (7/1/25 to 7/31/25), June 2025 (5/31/25 to 6/30/25) and May 2025 (5/1/25 to 5/30/25) indicated 23 days had a daily ledger balance greater than \$30,000.00 as follows: 7/3/25 \$41,381.03, 7/7/25 \$41,422.03, 7/9/25 \$43,429.03, 7/13/25 \$42,740.03, 7/16/25 \$43,099.03, 7/21/25 \$31,950.82, 7/22/25 \$32,192.32, 7/23/25 \$31,869.32, 7/25/25 \$31,773.27, 7/28/25 \$30,109.89, 6/3/25 \$42,544.15, 6/4/25 \$48,374.65, 6/5/25 \$39,050.65, 6/6/25 \$37,644.65, 6/9/25 \$38,670.65, 6/11/25 \$38,802.65, 5/2/25 \$42,023.85, 5/7/25 \$42,188.85, 5/8/25 \$42,658.85, 5/9/25 \$47,217.85, 5/12/25 \$46,917.85, 5/14/25 \$46,096.55, and 5/21/25 \$30,107.55. During an interview on 8/20/25 at 9:30 a.m., the Business Office Manager indicated the facility did not complete the reviews to ensure the surety bond was sufficient for the coverage of the balance of resident funds. It was completed through the home office. A current, 2017, facility policy titled, Management of Residents' Personal Funds, provided by the Business Office Manager on 8/20/21 at 1:38 p.m., indicated .Should the facility manage the resident's funds, the facility will act as a fiduciary of the resident funds and hold, safeguard manage, and account for the personal funds of the resident. This citation relates to Complaint 2588630. 3.1-6(i)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review, the facility failed to notify a resident's representative regarding change in condition for 1 of 3 residents reviewed for change in condition. (Resident C) Finding includes: Resident C's record was reviewed on 8/19/25 at 12:31 p.m. Medical diagnoses included paranoid schizophrenia, hypertension, and gastro-esophageal reflux disease (acid reflux). A 5/27/25, quarterly, quarterly Minimum Data Set (MDS) indicated the resident was mildly cognitively impaired. A nurse's note, dated 7/22/25 at 12:39 p.m. indicated the resident was found cool, clammy, tachycardic (high heart rate), and hypertensive (high blood pressure). The resident was encouraged to take her blood pressure medication and drink fluids, but verbally refused and swatted at a cup containing the medication. The note lacked notification of family or the resident representative. A progress note dated 7/22/25 at 2:57 p.m. indicated the resident was excessively sweating, tachycardic, hypertensive, and tachypneic (high respiratory rate) and continued to refuse medications and fluids. The nurse practitioner (NP) was contacted and an order received to send the resident to the emergency room (ER). The resident's representative was informed of the transfer. During an interview with the Infection Preventionist (IP) on 8/20/25 at 1:56 p.m., she indicated Resident C was a very private person, but would often say hello to her during the day. On the morning of 7/22/25, the resident did not say hello to her and was not acting at her baseline. The IP noted the resident was cold, restless, and sweaty. The IP informed the DON, who attempted to get the resident to drink fluids and take her medication. The resident adamantly refused. Around approximately 2 p.m., a CNA approached the IP and indicated the resident remained altered, tachycardic, and more restless than previously. The IP called the NP, who told her to send the resident to the ER. During an interview with the DON, on 8/21/25 at 9:18 a.m., she indicated Resident C was a very private person and frequently refused her medications. On 7/22/25, the DON was approached by staff who indicated the resident was altered and had an elevated blood pressure. The DON attempted to give the resident her blood pressure medication, but the resident verbally refused and swatted at the medicine cup. The DON indicated later on that day, she was approached by the IP, who indicated the resident remained altered and was being sent to the hospital. During an interview with LPN 7 on 8/21/25 at 10:33 a.m., she indicated when a change of condition occurred, the resident would be assessed first, then depending on the condition of the resident, the provider and family would be contacted. During an interview with the DON on 8/21/25 at 10:40 a.m. she indicated when she worked with Resident C on 7/22/25, she was not acting at her baseline. When a change of condition was identified, staff were supposed to fill out an electronic interaction (e-Interact) form, which included notification of family or the resident representative. During an interview with the DON on 8/22/25 at 10:59 a.m., she indicated nursing staff were expected to contact family and resident representatives when a change of condition was identified and this would be charted in a progress note. A current facility policy, titled Change in a Resident's Condition or Status, and provided by the DON on 8/22/25 at 11:05 a.m. indicated the following, . Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., change in level of care, billing/payments, resident rights, etc.) . 4. Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: .b. There is a significant change in the resident's physical, mental, or psychosocial status; .e. It is necessary to transfer the resident to a hospital/treatment center This citation relates to Complaint 2588630.3.1-5(a)(2)3. 1-5(a)(3)		

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. (continued on next page)		

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review the facility failed to provide social services regarding financial management regarding the management of cash savings and spending down of resources to remain eligible for Medicaid for 2 of 3 residents reviewed for assistance to manage finances. (Resident C and D)Findings include:1.During an interview, Resident C's representative indicated the resident's funds had not been managed correctly. The resident had cash funds stored in the Social Service office, not the business office. There was no method to account for what funds had been spent. At the time of discharge, the representative was given cash in the amount of \$700 dollars, and the family thought their loved one should have more money. The facility staff informed them the resident purchased lots of snacks, when they questioned the amount of money returned to them.During an interview on 8/21/25 at 1:00 p.m., the Administrator indicated he had not known Resident C had cash in the Social Service office until he witnessed it being given to the family at the resident's discharge.During an interview on 8/21/25 at 1:08 p.m., the Social Services Director (SSD) indicated the following:She had stored Resident C's personal money in a locked file cabinet in the Social Service office. She had received \$900.00 in cash from the resident shortly after the resident's admission. The resident had a fear of banks. The SSD had not had the resident sign any form or paperwork indicating her money was stored in the SSD's office. The SSD had not kept a record of money the resident had received, nor had she had the resident sign any receipt for said money. The SSD had not talked to the resident's family member about the money being locked in the SSD office. She had not considered if the money would be covered by the surety bond or facility insurance. She had not developed any type of care plan for the resident regarding the safety and use of her money, which was stored in the SSD office. She had made purchases for the resident using said money. She had given the resident every receipt. The resident mostly purchased snacks. She was unsure if the Administrator was aware of said money being in the SSD office. She had given Resident C's family member \$700 dollars at the time of the resident's discharge.Resident C's clinical record was reviewed on 8/19/25 at 12:31 p.m. Diagnoses included paranoid schizophrenia and hypertension.A 5/27/25, quarterly, Minimum Data Set (MDS) assessment indicated Resident C was moderately cognitively impaired and required assistance with decision making.2. A current, facility, 8/19/25, Trail Balance resident funds statement indicated Resident D had a current balance of \$20, 619.36. A resident specific quarterly statement indicated Resident D received a deposit of \$22,466.00 in March 19, 2025. The facility was the resident's representative payee.Four letters addressed to Resident D, titled Resident Funds Balance Notification, dated April 30, 2025, May 30, 2025, June 30, 2025, and July 31, 2025 indicated the following: This letter is to notify you that your current Resident Funds Balance is within \$200.00 or exceeding what is allowed under Medical Assistance. Please contact your Social Worker within the next 7 days to discuss ways to assure continuance of Medicaid benefits. None of the 4 letters indicated the information had been verbally shared with the resident, nor did it indicated assistance had been offered. During an interview on 8/21/25 at 10:00 a.m., Resident D indicated he didn't believe he had any extra money to spend. If he had extra money, he'd really like to look into a different place to live. Additionally, if he had to stay at the facility, he'd spend his money on clothes and room decorations such as posters. During an observation at this time, the resident's room lacked any room decorations.Resident D's record was reviewed on 8/19/25 at 2:29 p.m. Current diagnoses included hypertension, diabetes, major depressive disorder, and unspecified dementia. The resident received Medicaid benefits.A 7/11/25, significant change, MDS assessment indicated the resident was moderately cognitively impaired and required assistance with decision making.A current 8/19/25 care plan indicated the resident had impaired decision making. The care plan originated 11/2024.A current 12/10/24 care plan indicated the resident had an alteration in mental functioning due to mental health diagnoses. The clinical record lacked documentation or plan of care regarding the resident's need to spend his money in order to remain eligible for Medicaid.During an interview on 8/21/2025 at 11:38 a.m., the Business Office Manager indicated the facility had no documentation of action taken to assist Resident D in spending his resources. The Corporate Director of Business Office Operation had told her because the resident had nine months to spend down his resources, the facility had not needed to assist the resident yet. The cooperate consultant hadn't assisted him yet and planned to come and start Monday, 8/25/25. This citation relates to Complaint 2588630. 3.1-34(a)		