STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155157	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brickyard Healthcare - Richmond Care Center	1042 Oak Dr Richmond, IN 47374

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure 2 of 5 residents reviewed for abuse (Resident D and Resident F) were free from sexual abuse from a resident with known inappropriate behaviors (Resident E), resulting in inappropriate touching (Resident D); and psychological harm of feeling upset and gross (Resident F). Finding included:1.The clinical record for Resident E was reviewed on 11/24/2025 at 4:20 p.m. The medical diagnoses included, but were not limited to, Wernicke's Encephalopathy and Substance Abuse Disorder. A Quarterly minimum data set assessment (MDS), dated [DATE], indicated Resident E was independent with transferring and walking. A care plan, dated 5/1/2025, indicated Resident E had behavioral issues of grabbing staff in appropriate areas, wanting to lay head on other residents' shoulders, and self-pleasuring in the room with his roommate present. Interventions included, but were not limit to, administer medications, monitor for effectiveness, anticipate the needs of the resident, to keep appropriate distance when communicating with the resident to allow space for the resident to remain focused on the conversation and redirect if the resident attempts to lay on a staff members shoulder, and to redirect the resident when attempting to grab/touch inappropriate areas. A care plan, dated 9/24/2025, indicated Resident E was at high risk of inappropriate behaviors of making loud inappropriate comments to staff and other residents. Interventions included encouraging Resident E to avoid making inappropriate comments and providing appropriate direction for resident to engage in activities that he enjoys. A behavior note, dated 8/7/2025, indicated Resident E was found self-pleasuring in the room with his roommate and yelling vulgarities. A behavior note, dated 8/7/2025, indicated Resident E was making inappropriate sexual comments in front of other residents. A behavior note, dated 8/7/2025, indicated Resident E had an intervention of being .moved to new room in which he can self-pleasure with privacy. A psychiatry progress note, dated 9/22/2025, indicate Resident E was asking other residents for fellatio (the practice of performing oral sex on a male). Per the facility census, Resident E had a roommate (Resident F) move-in on 10/30/2025. A social service progress note, dated 11/4/2025, indicated staff report Resident E was making .comments about kissing and going to another resident's room. A psychiatry visit note, dated 11/4/2025, indicated no new intervention for Resident E and .no concerns by staff . A Social Service note, dated 11/14/2025 at 9:50 a.m., indicated they met with .resident in his room as to address concerns reported by staff during smoke break. SSD educated resident on the importance in avoiding inappropriate verbal behaviors. Resident continued to make inappropriate comments to staff. SSD reminded resident to avoid verbal comments that are inappropriate in nature . A nursing progress note, dated 11/14/2025, indicate Resident E's roommate (Resident F) stated .he does not feel safe in same room with [Resident E], that he [Resident E] will ask him [Resident F] to suck his di*k, Resident E would watch him when toileting and make inappropriate comments regarding his butt, and roommate (Resident F) wants to be moved to another room. During an interview with SSD, on 11/24/2025 at 5:20 (continued on next page)

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 0600 Level of Harm - Actual harm Residents Affected - Few	p.m., she indicated she was not aware of Resident E's self-pleasure behaviors. She was not aware of any new interventions when Resident E obtained a roommate and did not increase supervision. She believed Resident E had a private room per his preference, not as a behavior management tool. During an interview with LPN 4, on 11/25/2025 at 11:30 a.m., she indicated she was unaware of any behavior management interventions for Resident E. If he had behaviors, she would use the baseline intervention of assuring his safety and then notify the DON/ED. She was unaware of needing to redirect, monitor, or keep distance when interacting with Resident E. During an interview with CNA 5, on 11/25/2025 at 1:30 p.m., she indicated she was unaware of any behavioral management interventions for Resident E. The clinical record for Resident F was reviewed on 11/24/2025 at 4:45 p.m. The resident's diagnosis included, but were not limited to, spinal stenosis and major depressive disorder. A Quarterly MDS Assessment, dated 10/6/2025, indicated Resident F was cognitively intact, needed partial/moderate assistance for dressing, was independent with chair transfer and locomotion with a manual wheelchair, and ambulation not attempted due to safety concerns.A care plan, dated 1/30/2024 and revised on 11/17/2025, indicated Resident F had depression and anxiety. The interventions included, but were not limited to, mental health services and nursing facility staff to provide supportive counseling.During an interview, on 11/24/2025 at 2:35 p.m., Resident F reported his former roommate (Resident E) was inappropriate with him. On three different occasions, Resident E had asked Resident F to show Resident E his penis. Resident F indicated Resident E would . make comments about my butt and try to watch me in the bathroom. These comments made Resident F upset and feel gross and .I don't want [Resident E] as my roommate.During an interview, on 11/25/2025 at 12:10 p.m., DON indicated there were no additional interventions put into place or increased supervision when Resident F was moved into Resident E's room on 10/30/2025. 2. A statement by Staff Member 7, dated 11/14/2025 (with no time documented), indicated that Resident E was observed to be acting suspicious around the center hall where Resident D's room was located. A nursing progress note, dated 11/14/2025, indicate two residents were yelling out. When the residents were asked why they were yelling out, resident Resident D indicated Resident E had touched him inappropriately. The clinical record for Resident D was reviewed on 11/25/2025 at 11:05 a.m. The medical diagnoses included intellectual disabilities and anxiety. A Quarterly MDS Assessment, dated 11/6/2025, indicated Resident D was cognitively impaired, needed partial to moderate assistance with dressing and transferring, and was independent with locomotion in a wheelchair. A care plan, dated 9/17/2025, indicated Resident D used medication to help manage a diagnosis of anxiety. The interventions included, but were not limited to, monitoring medication and psychiatry evaluation. A nursing progress note, dated 11/14/2025, indicated Resident D .indicated to staff that another resident had touched him inappropriately. The other resident was immediately removed from the situation and the accused resident placed on 1:1 [one staff to one resident supervision] immediately.A written statement, dated 11/14/2025, was signed by Resident D. The statement indicated, . [Resident E] came into his [Resident D's] room around 8 pm and touched him [Resident D] down there pointing to his private part. He touched me under my pants (clothes) with his hand. I told him to stop. A policy entitled, Abuse, Neglect, and Exploitation, was provided by the Director of Nursing on 11/25/2025 at 12:00 p.m. The purpose of the policy was to protect the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. The policy indicated the facility would work toward preventing abuse by, .Establishing a safe environment.identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors. The deficient practice was corrected on 11/14/2025, after the facility implemented a (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	systemic plan of staff education, auditing, and monitoring to ensure implementation of the in-servicing was monitored related to abuse. This citation relates to Intakes 2674247 and 2674760.3.1-27(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility staff failed to be knowledgeable of behavioral health interventions for 1 of 5 residents review for behavioral health management. (Resident E) Findings include: The clinical record for Resident E was reviewed on 11/24/2025 at 4:20 p.m. The medical diagnoses included Wernicke's Encephalopathy (neurological symptoms caused by biochemical lesions of the central nervous system) and Substance Abuse Disorder. A Quarterly MDS, dated [DATE], indicated Resident E was independent with transferring and walking. A care plan, dated 5/1/2025, indicated Resident E had behavioral issues of grabbing staff in appropriate areas, wanting to lay head on other residents' shoulders, and self-pleasuring in the room with his roommate present. The interventions included, but were not limited to, administer medications, monitor for effectiveness, anticipate the needs of the resident, to keep appropriate distance when communicating with the resident to allow space for the resident to remain focused on the conversation and redirect if the resident attempts to lay on a staff members shoulder, and to redirect the resident when attempting to grab/touch inappropriate areas. A care plan, dated 9/24/2025, indicated Resident E was at high risk of inappropriate behaviors of making loud inappropriate comments to staff and other residents. Interventions included encouraging Resident E to avoid making inappropriate comments and providing appropriate directions for the resident to engage in activities that he enjoys. A staff management solution system, provided on 11/25/2025 at 3:00 p.m., indicated the resident's behaviors interventions was for staff to do the educating Resident E to avoid inappropriate and/or sexual behaviors, arranging to receive mental health services, providing the opportunity to express mental health needs to staff, observation of mental health, providing opportunities to identify mental health needs, and to offer activities to redirect to activities. During an interview with SSD, on 11/24/2025 at 5:20 p.m., she indicated she was not aware of Resident E's self-pleasure behaviors. She was not aware of any new interventions when Resident E obtained a roommate and did not increase supervision. She believed Resident E had a private room per his preference, not as a behavior management tool. During an interview with CNA 3, on 11/25/2025 at 10:50 a.m., she indicated she had worked with Resident E often, but not always. She stated he had some behaviors that needed redirection, but she was not sure the last time he had them or what exactly they were. She had heard .other staff talk about. the behaviors. She was unaware of the interventions to keep distance when interacting with Resident E. During an interview with LPN 4, on 11/25/2025 at 11:30 a.m., she indicated she was unaware of any behaviors management interventions for Resident E. If he had behaviors, she would use the baseline intervention of assuring his safety and then notify the DON/ED. She was unaware of needing to redirect, monitor, or keep distance when interacting with Resident E. During an interview with CNA 5, on 11/25/2025 at 1:30 p.m., she indicated she had worked with Resident E the whole time he was here, but he did everything himself, so he didn't require much help. CNA 5 was unaware of any behavioral management interventions for Resident E to include redirecting and keeping distance when communicating to Resident E. A policy entitled, Behaviors Health Services, was provided by the Director of Nursing on 11/25/2025 at 12:00 p.m. The purpose of the policy was to ensure all residents received behavioral health services to assist in reaching and maintaining their highest level of mental and psychosocial function and well-being. The policy indicated to .utilize MDS and care area assessments.Assess and develop a person-centered care plan. and .share concerns to the intradisciplinary team.The deficient practice was corrected on 11/14/2025, after the facility implemented a systemic plan of staff education, auditing, and monitoring to ensure implementation of the in-servicing was monitored related to behaviors. This citation relates to Intakes (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2674247 and 2674760. 3.1-43(a)(1)