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	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brickyard Healthcare - Muncie Care Center	2701 Lyn-Mar Dr Muncie, IN 47304

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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 0600 Level of Harm - Minimal harm or potential for 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. Based on observation, record review, and interview, the facility failed to protect a resident's right to be free from abuse by failing to provide supervision to ensure a cognitively impaired resident who wandered (Resident B) was free from resident-to-resident physical abuse by a resident known to be aggressive towards others (Resident C) for 1 of 3 residents reviewed for abuse. The deficient practice was corrected on 1/26/26, prior to the start of survey, and was therefore past noncompliance. Findings include: Review of an Incident Report sent to the Indiana Department of Health indicated the following:On 1/18/26 at 6:53 p.m., Resident B and Resident C were in the dining room, following mealtime. Staff were assisting other residents to their rooms when they were alerted by yelling coming from the dining room. Resident B was on the ground and Resident C was kicking him. Resident C had a laceration to the lip and hematoma to the right side of the forehead. Action Taken, added 1/18/26, indicated both residents were immediately separated, the nurse called 911, and a head-to-toe assessment was completed on Resident B. Resident B complained of generalized pain and family requested an emergency room evaluation. Resident C remained aggressive, attempting to hit and kick staff and refused an assessment. The provider was notified and an order was received to send Resident C to the emergency room for a psychiatric evaluation. The residents' representatives were notified.Preventative Measures, added 1/28/26, indicated an investigation was initiated. Follow up, added 1/23/26, indicated an investigation was completed. Both residents were sent to the Emergency Department post-incident. Resident C returned to the facility with increased monitoring while asleep and one-on-one monitoring while awake until his discharge to a psychiatric facility on 1/19/26. Resident C remained out of the facility. Psychosocial follow up to be completed upon his return. Resident B returned to the facility and continued increased monitoring per usual. Psychosocial follow-ups were completed on Resident B with no signs or symptoms of psychosocial distress. Both resident care plans were reviewed and updated. Resident C's clinical record was reviewed on 1/27/26 at 11:18 a.m. Diagnoses included moderate vascular dementia with agitation, severe dementia in other diseases classified elsewhere with agitation, anxiety, and unspecified mood affective disorder.Current orders included the following: brexpiprazole (atypical antipsychotic) 4 mg by mouth once daily (1/17/26), quetiapine fumurate (antipsychotic) 25 mg by mouth at bedtime (1/16/26), and citalopram (antidepressant) 10 mg PO once daily (11/19/25), and hydroxyzine hydrochloride (anxiety) 10 mg by mouth every six hours as needed (11/18/25).A 11/12/25, admission Minimum Data Set (MDS) assessment indicated the resident was moderately cognitively impaired. Other behavioral symptoms occurred one to three days during the assessment period. No mobility devices were required. Resident C required partial assistance from staff for bathing, dressing, transfers, and walking.A current care plan, dated 11/7/25, indicated the resident is/has the potential to be aggressive related to dementia, ineffective coping skills, and poor impulse control. The resident can have behaviors of arguing with other residents, verbal aggression towards his son, yelling at others, talking about others standing by his (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 - Minimal harm or potential for actual harm Residents Affected - Few	door, name calling, obsession with another resident coming too close to his door, and physically aggressive when he feels others are somewhere they should not be. Interventions include: One-on-one supervision while the resident is awake and 15 minute checks while he is asleep (1/18/26); When the resident becomes agitated: Intervene before agitation escalates, guide away from source of distress, engage calmly in conversation, and if response is aggressive- staff walk calmly away and approach later (11/7/25), Intervene as necessary to protect the rights and safety of others. Divert attention. Remove the resident from the situation and take the resident to an alternate location as needed (11/12/25).Review of Resident C's progress notes indicated the following:A progress note, dated 1/16/26 at 12:14 p.m., indicated the resident was seen by the psychiatric provider. The resident was very paranoid and aggressive. Medication changes were made. On 1/18/26 at 7:32 a.m., Resident C became agitated when he thought the resident across the hall was in his room, when he was not. Interventions attempted: Both residents were redirected. The interventions were effective after cursing each other.On 1/18/26 at 9:35 a.m., Resident C was calm and engaging in activities. He was still concerned about the male resident going into his room. The resident kept getting up and looking down the hall to see where the male resident was at. Resident C was reassured that no one was going into his room. He was encouraged to participate with activities, coffee, and devotion. Exercise and snacks were given. The resident remained worried that a particular resident was going to go into his room. On 1/18/26 at 9:12 p.m., LPN 3 was in another room when she heard a commotion in the hallway. LPN 3 stepped into the hallway and observed Resident C down the hallway, kicking and stomping a male resident who was on the floor in a fetal position with his hands over his head. LPN 3 separated the residents, and Resident C began swinging and coming at LPN 3 and other staff. On 1/19/26 at 7:56 a.m., Resident C returned to the facility at approximately 11:00 p.m. The resident was placed on 15-minute checks at the time per protocol. The resident settled in and went to sleep shortly after his arrival from the hospital.On 1/19/26 at 11:41 a.m., the Interdisciplinary Team met and determined the resident should be sent for a psychiatric stay related to his recent aggressive behaviors. The provider and resident representative were notified and agreed with the plan of care. A referral was in progress.On 1/19/26 at 12:18 p.m., Resident C continued to get up during meals and activities to make sure his door was closed. He yelled down the hall when the door was not closed. The resident was assured no one was going in his room. He was redirected to activities and offered snacks and fluids. This was effective for short periods of time.Review of Resident C's monitoring indicated the resident was on 15-minute checks when he returned from the hospital early morning on 1/19/26 while sleeping and one-on-one monitoring while awake until he was discharged to the Psychiatric facility on 1/19/26.On 1/19/26 at 3:45 p.m., the resident was transported to the psychiatric facility. Resident C remained out of the facility during the survey. Resident B's clinical record was reviewed on 1/27/26 at 11:53 a.m. Diagnoses included severe vascular dementia with agitation, major depressive disorder, difficulty in walking, and other lower back pain.Current orders included the following: risperidone (antipsychotic) 2 mg by mouth at bedtime (11/12/25), tramadol hydrochloride (pain) 50 mg by mouth every six hours (1/7/26), sertraline hydrochloride (antidepressant) 50 mg by mouth once daily (11/25/25), gabapentin (pain) 300 mg by mouth three times daily (1/23/26), and lidocaine pain relief 4 % patch to the lower back topically in the morning (1/20/26). Monitor for side effects and report to the physician: antidepressant- agitation (11/11/25). Behavior monitoring for vascular dementia with agitation every shift for behavior monitoring (11/11/25). A 1/20/26, quarterly, Minimum Data Set (MDS) assessment indicated the resident was severely cognitively impaired. Resident B exhibited other behavioral symptoms not directed towards others one to three days of the assessment period. He exhibited wandering behavior (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident C was known to be aggressive, obsessive, and anxious that someone was going to go into his room while he was in the dining room. Resident C was known to be aggressive with residents and staff since he arrived at the facility. Sometimes Resident C was difficult to redirect. Resident C liked to color, watch movies in the dining room, and any food, coffee, and chocolate milk. At times, they must give him space and then reapproach Resident C. Resident B and Resident C's rooms were directly across from each other on the memory care unit. Approximately half of the residents on the unit wandered. The activities programming on the memory care unit typically ended at 4:00 p.m. On 1/27/26 at 4:10 p.m., CNA 12 indicated the evening shift typically had one nurse and two CNAs scheduled on the memory care unit. It was difficult in the evenings, with behaviors and wandering, to adequately redirect the residents. Due to behaviors on the unit on 1/26/26, she was finishing yesterday's showers. During a telephone interview on 1/27/26 at 6:32 p.m., QMA 4 indicated she was working on 1/18/26, the night of the altercation on the memory care unit, when an altercation between Resident B and Resident C took place around approximately 7:00 p.m. QMA 4 was in another resident's room with CNA 5 when LPN 3 yelled out for assistance. LPN 3 had just left the room she was in along with CNA 5 and QMA 4. CNA 14 had stepped off the memory care unit. CNA 5 was on the memory care unit to assist in place of CNA 14. When QMA 4 stepped out to the hallway, LPN 3 was trying to separate Resident C from Resident B. Resident B was on the floor in the hallway, on his right side, and near the dining room. Resident C was standing up and stomping on Resident B's left side rib area. Resident C was very persistent. The residents were separated. Resident B was taken to his room by LPN 3 while Resident C was monitored by QMA 4. Unit Manager 6 came to the memory care unit to assist after the residents were separated. Resident C did not like any residents near his room. Resident C was known to yell and be aggressive towards Resident B as their rooms were close. Resident C had been able to be redirected prior to this time. During a telephone interview on 1/27/26 at 7:10 p.m., CNA 5 indicated she was in the memory care unit assisting in another resident's room the evening of 1/18/26 along with LPN 3 when they heard Resident C cursing from the room they were in. LPN 3 immediately went out into the hallway. After CNA 5 assisted the other resident on the toilet, CNA 5 heard LPN 3 yelling stop. CNA 5 went to the hallway and LPN 3 was separating Resident C from Resident B. CNA 5 observed Resident B on the floor in the hallway near the dining room while Resident C kicked Resident B in the head and ribs. Resident B grabbed his rib area and had blood on his lip. CNA 5 reported the altercation Unit Manager 6, who indicated she was calling the DON simultaneously. CNA 5 returned to her scheduled unit. When she left, Resident C was trying to hit the staff who were with him and the nurse was with Resident B. During a telephone interview on 1/28/26 at 9:39 a.m., LPN 3 indicated she was in another resident's room on the memory care unit, along with QMA 4 and CNA 5, on 1/18/26 at approximately 7:00 p.m. when they heard a commotion. LPN 3 stepped out into the hallway and Resident B was on the ground in a fetal position with his hands over his head. Resident C was cursing, kicking, and stomping on Resident B's back, sides, and head. The beginning of the altercation was unwitnessed. It occurred in the hallway near the dining room. The residents were separated and QMA 4 toileted, and remained with, Resident C while LPN 3 remained with Resident B and completed his head-to-toe assessment. Resident B was alert but unable to describe what happened. The resident had pain in the rib area, red marks on the left side of his face, and a red mark on his forehead. The police were notified. Both residents were sent out to the Emergency Department for evaluation. Resident C was known to need intervention because he was obsessive about accusing Resident B of going into his room. Around breakfast time on 1/18/26, Resident B walked down the hallway and placed his hand on the rail in the hallway near Resident C's room with LPN 3 close to Resident B. Resident C got upset with Resident B and yelled (continued on next page)

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