STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155120	A. Building B. Wing	11/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brickyard Healthcare - Brandywine Care Center	745 N Swope St Greenfield, IN 46140

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 - 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. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155120	A. Building B. Wing	11/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brickyard Healthcare - Brandywine Care Center	745 N Swope St Greenfield, IN 46140

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 - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to protect the resident's right to be free from physical abuse by a resident for 1 of 3 resident's reviewed for abuse. (Resident C)Findings include: 1.a. The clinical record for Resident C was reviewed on 11/12/25 at 11:10 a.m. The resident's diagnosis included, but were not limited to, dementia and diabetes.A Quarterly Minimum Data Set (MDS) Assessment, completed 8/25/25, indicated she had severe cognitive impairment.Resident C's clinical record contained a general note, dated 11/3/25 at 5:33 p.m. The general note indicated a Certified Nursing Assistant (CNA) had come to get the nurse due to another resident slapping Resident C. The other resident also attempted to choke Resident C. The residents were separated. Resident C was sitting in her room. Resident C had redness to her right cheek and right side of her neck. Resident C stated the other resident had only slapped her and she did not think the choking had happened, but it all happened so fast. Resident C indicated she was okay and felt safe. 1.b. The clinical record for Resident D was reviewed on 11/12/25 at 11: 15 a.m. The resident's diagnosis included, but were not limited to, dementia and anxiety disorder.A Quarterly MDS Assessment, completed 8/29/25, indicated she had severe cognitive impairment. A care plan, initiated 9/26/25, indicated Resident D could experience being physically aggressive, grabbing others, lunging at others, express frustration, anger at others, screaming at others, and disruptive sounds. The goal was for her to demonstrate decreased frequency on any of the behaviors. The interventions were to ensure safety of resident, staff and others by removing others from the area and maintaining a safe distance, to speak in a soft, calm tone, and provide reassurance, and to use non-threatening body language and remain calm avoiding sudden movements. Resident D's clinical record contained a behavior charting note, dated 10/16/25 at 6:21 p.m., that indicated Resident D threw water on another resident. Resident D continued to be agitated and was very difficult to redirect. Resident D was able to calm down after staff sat with her in her room for about 15 minutes. Resident D was placed on 15-minute observations. The intervention attempted was to separate Resident D to a calm area while staff talked with her. Resident D's clinical record contained a general note, dated 11/3/25 at 6:20 p.m. The general note indicated a CNA had come to get the nurse due to Resident D slapping another resident. Another CNA indicated Resident D had also attempted to choke the other resident. Resident D came to sit in the dining room. Resident D was smiling, laughing, and talking to other residents in the dining room. Resident D could not give an answer when asked what had happened. On 11/12/25 at 1:38 p.m., the Executive Director (ED) provided a copy of an incident report, sent to the Indiana Department of Health on 11/3/25. The incident report indicated that on 11/3/25 at 5:40 p.m., Resident D had slapped Resident C while in the hallway. Resident D had also placed her hands around Resident C's neck. The immediate action taken was that the residents were separated by the staff. The ED, Director of Nursing, physician, and families were notified. Resident D was placed on 15-minute checks while asleep and one on one care when awake. The process was started for Resident D to be transferred to an inpatient hospital. The preventative measures taken were for psychiatric services to be provided to both residents and the care plans would be updated as needed. The follow up, dated 11/11/25, indicated Resident D remained at an inpatient psychiatric hospital. The facility would review and implement recommendations when Resident D readmitted and care plans would be updated as needed. During an interview on 11/13/25 at 2:43 p.m., CNA 5 indicated she had witnessed Resident D slap Resident C on 11/3/25. CNA 5 had been standing next to the unit shower room, looking down the hallway. Resident C and another resident were standing outside of the doorway to Resident C's room. Resident D had walked up to Resident C and began verbally arguing. Resident D then slapped Resident C on the right cheek. CNA 5 was able to hear the slap from where she was standing. CNA 5 had not witnessed Resident D attempting to choke Resident C. Another CNA had separated the residents while CNA 5 went to get the nurse. On 11/13/25 at 1:22 p.m., the Director of Nursing (DON) provided the current Abuse, Neglect and Exploitation policy, that read It is the policy of this facility to provide protection for 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. Definitions .Physical Abuse includes, but is not limited to hitting, slapping, punching, biting, and kicking. It also includes controlling behavior through corporal punishment .This citation relates to Intake 26597183.1-27(a)(1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155120	A. Building B. Wing	11/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brickyard Healthcare - Brandywine Care Center	745 N Swope St Greenfield, IN 46140

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155120	A. Building B. Wing	11/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brickyard Healthcare - Brandywine Care Center	745 N Swope St Greenfield, IN 46140

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review the facility failed to assess a resident's vitals and lung sounds after routine breathing treatments were administered for 1 of 3 residents reviewed for respiratory care. (Resident B)Findings include:The clinical record for Resident B was reviewed on 11/12/25 at 11:30 a.m. The diagnoses included, but were not limited to, hypertension (high blood pressure), atherosclerotic (plaque buildup in arteries) heart disease, Chronic Obstructive Pulmonary Disease (COPD), and stroke. A Quarterly Minimum Data Set (MDS) assessment, dated 6/19/25, indicated Resident B was cognitively intact. A care plan, dated 3/26/25, indicated the resident had COPD due to smoking. The interventions included but were not limited to the following: bronchodilators as ordered, monitor effectiveness, and head of bed elevated.A care plan, dated 3/26/25, indicated the resident had COPD due to smoking. The interventions included, but were not limited, administer aerosol or bronchodilators as ordered. Monitor and document any side effects and effectiveness, resident's head of bed elevated to relieve shortness of breath while lying flat related to COPD. A physician order, dated 7/18/25, indicated Resident B was to receive 3 milliliters of ipratropium-albuterol nebulizer treatment three times a day. The October 2025 Medication/Treatment Record (MAR/TAR) indicated Resident B had received the 3 milliliters of ipratropium-albuterol nebulizer treatments. The MAR lacked respiratory assessments, nor vitals obtained after the routine nebulizer treatments were administered. A physician order, dated 7/18/25, indicated the resident was to receive 2 puffs of 108 micrograms of an albuterol inhaler every 6 hours as needed (PRN) for wheezing and shortness of breath. The MAR indicated Resident B received 2 puffs of the PRN 108 micrograms albuterol inhaler on 10/19/25 at 7:00 a.m. The medication was documented as being effective for the PRN beathing treatment. An interview was conducted with the DON on 11/12/25 3:49 p.m. She indicated the staff should be conducting respiratory assessments after administration of all nebulizer treatments. An interview was conducted with Resident B's Representative on 11/13/25 at 9:08 a.m. He indicated Resident B was unavailable, but he recalled the resident's stay in the nursing facility. The breathing treatment and the inhaler were not working anymore. An interview was conducted with Nurse Practitioner (NP) 1 on 11/13/25 at 1:47 p.m. She indicated she had seen Resident B at the beginning of October. She was made aware of Resident B's complaints of shortness of breath on 10/19/25. She had spoken to the resident about smoking cessation. The resident was not compliant. The resident was assessed, and her vitals were stable at that time. NP 1 did have documentation, a facility staff member, had notified the on-call provider on 10/21/25 at 2:46 a.m., about Resident B with complaints of shortness of breath. The resident received an additional dose of the albuterol inhaler. NP 1 was notified later that morning by staff of Resident B's shortness of breath. Monitoring and Documentation of Respiratory Services/Response Staff should document, based on current professional standards of practice, the assessment and monitoring of the resident's respiratory condition, including response to therapy provided, and any changes in the respiratory condition. Depending on the type of respiratory services the resident receives, physician orders and the individualized respiratory care plan, documentation should include, as appropriate: Vital signs, including the respiratory rate; Chest movement and respiratory effort, and the identification of abnormal breath sounds; Signs of dyspnea, cyanosis, coughing, whether position affects breathing, characteristics of sputum, signs of potential infection, or the presence of behavioral changes that may reflect hypoxia including anxiety, apprehension, level of consciousness; and Instructions for the resident on how to participate/assist in the respiratory treatments as appropriate. The attending practitioner must be immediately notified of significant changes in condition, and the medical record must reflect the notification, response and interventions implemented to address the resident's condition. Also, refer to S483.10(g)(14) F580 for notification of physician, family of significant changes. Modalities/Respiratory Therapy/Care/Services A variety of respiratory therapy modalities and care may be provided in the nursing home, including coughing/deep breathing, therapeutic percussion/vibration and postural drainage, aerosol/nebulizers, humidification, and therapeutic gas administration, BiPAP or CPAP, tracheostomy care and tracheal suctioning, and mechanical ventilation and oxygenation support. Coughing/deep breathing, therapeutic percussion/vibration and bronchopulmonary drainage If a resident has written orders for postural drainage, chest percussion, and vibration to increase the mobility of pulmonary secretions, the care plan must include, based upon the resident's assessments and identified needs, the type of exercise, including when and how often provided. The resident's record should reflect how staff are monitoring the condition of the resident prior to, during and after the treatments, and, as appropriate, vital signs including the respiratory

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155120	A. Building B. Wing	11/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brickyard Healthcare - Brandywine Care Center	745 N Swope St Greenfield, IN 46140

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 0744 Level of Harm - Actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155120	A. Building B. Wing	11/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brickyard Healthcare - Brandywine Care Center	745 N Swope St Greenfield, IN 46140

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 0744 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to timely develop individualized plans of care for residents who displayed behaviors, document behavioral incidents in the clinical record, document effectiveness of interventions used to manage behaviors, review behaviors with an interdisciplinary team, and provide adequate supervision resulting in increased behaviors and resident-to-resident altercations. (Resident C, D, G, H, and J)Findings include: 1a. The clinical record for Resident D was reviewed on 11/12/25 at 11: 15 a.m. The resident's diagnosis included, but was not limited to, dementia and anxiety disorder.A physician's order, dated 8/18/25, indicated behavior monitoring for Depression every day and night shift for depression.A Quarterly MDS Assessment, completed 8/29/25, indicated she had severe cognitive impairment. She had exhibited physical and verbal behaviors directed toward others one to three days during the seven day look back period. She had displayed behaviors not directed toward others one to three days during the seven day look back period. She was able to walk with supervision for at least 150 feet. A care plan, last revised on 9/6/25, indicated Resident D was at risk for elopement and wandering related to being disoriented to place and impaired safety awareness. She wanders aimlessly and will wander into other resident rooms. The goal was for her safety to be maintained and that she would not leave the facility unattended. The interventions included to distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, and books. Identify pattern of wandering: Is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Offer interventions as appropriate. Intervene as appropriate. Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures, and memory boxes.A care plan, initiated 9/26/25, indicated Resident D could experience being physically aggressive, grabbing others, lunging at others, express frustration, anger at others, screaming at others, and disruptive sounds. The goal was for her to demonstrate decreased frequency on any of the behaviors. The interventions were to ensure safety of resident, staff and others by removing others from the area and maintaining a safe distance, to speak in a soft, calm tone, and provide reassurance, and to use non-threatening body language and remain calm avoiding sudden movements. A care plan, initiated 9/26/25, indicated Resident D might experience becoming sad and tearful. The goal was for her to verbalize when she is feeling sad and tearful. The interventions were to acknowledge and validate emotions, encourage resident to verbalize feelings rather than only expressing through crying, and to offer privacy when desired, but check in frequently to ensure safety and support.The September 2025 Medication Administration Record (MAR) did not contain information that Resident D had displayed any behaviors related to depression during the month of September. A general progress note, dated 10/6/25 at 5:06 p.m., indicated Resident D was having increased anxiety. Resident was crying and saying things like I don't know what to do and it's about my kids what should I do. Staff attempted redirection with snacks, activities, and one on one attention. Resident D remained tearful. Will continue to try redirection. A Psychiatric Progress Note, dated 10/8/25, indicated Resident D had been seen due to increased depressive symptoms. Over the past couple of weeks, staff report worsening depressive symptoms. Resident D had been increasingly tearful and emotionally labile. On that date, she was observed sitting in a chair crying and stated she just wishes God would take her. Staff report that Resident D becomes easily overwhelmed by other residents, loud noises, or excessive commotion, which often triggers crying and shut down episodes. During these times, she appears withdrawn and anxious, and her crying and anxiety levels become significantly exacerbated. Staff report that she becomes upset when another resident enters the area and began to hit herself in the head, saying I am stupid. When the other resident was removed and environment was quieted, Resident D calmed, stopped crying, and began joking with staff. The assessment/plan was to increase Resident D's sertraline (anti-depressant medication) to 75 milligrams (MG) daily, continue close monitoring for self-injurious behavior or suicidal ideations, provide calm, reassuring redirection during episodes of overstimulation, and to maintain supervision in common area to ensure safety. The non-pharmacological interventions were to implement environmental modifications to reduce over stimulation (quiet areas, limited crowding, and noise), and to encourage participation in structured, calming, and social activities as tolerated.The non-pharmacological interventions listed in the Psychiatric Progress Note were not added to Resident D's plan of care. Resident D's clinical record did not contain a care plan that addressed self-harm A care plan, initiated 10/17/25