STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. Building B. Wing	02/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brickyard Healthcare - Golden Rule Care Center	2330 Straight Line Pike 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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on interview and record review, the facility failed to treat a resident with respect and dignity when requesting pain medications for 1 of 6 residents reviewed for dignity. (Resident E) Findings include:During an interview with Certified Nursing Assistant (CNA) 2 on 2/2/26 at 2:37 p.m., they indicated they witnessed Registered Nurse (RN) 5 not acknowledging Resident E when Resident E wanted to speak with them about their pain medication that was due. CNA 2 indicated Resident E came to the nurse's station to speak with RN 5 who was sitting at the desk. RN 5 would not look up or acknowledge that Resident E was standing in front of her. The CNA indicated Resident E then started pounding on the desk with her cane, kicking it, while holding her communication tablet in the other hand. Resident E used a tablet to communicate. The CNA told RN 5 that Resident E was trying to get her attention, and her reply was, I know, thanks captain obvious, I know how to do my job. CNA 2 indicated RN 5 continued not to acknowledge Resident E after that was said and continued to work. RN 5 did eventually respond back to Resident E, but did not look up at her. Resident E was very upset. The clinical record for Resident E was reviewed on 2/3/26 at 11:15 a.m. The resident's diagnoses included, but were not limited to, hemiplegia (paralysis affecting on side) and hemiparesis (weakness on one side) following cerebral infarction (blockage in a blood vessel causing brain death) to left side, and aphonia (total loss of voice). The Annual Minimum Data Set (MDS) assessment, dated 11/5/25, indicated Resident E was cognitively intact, had chronic pain syndrome, and used opioid pain medication. During an interview with CNA 3 on 2/3/26 at 10:02 a.m., they indicated they answered Resident E's call light around 6:00 a.m. Resident E wanted her prn (as needed) pain medication. CNA 3 indicated she told RN 5 that Resident E was requesting her prn pain medication, and RN 5 indicated she had it at 2:30 a.m. and was not due again until 8:30 a.m. The CNA went back to Resident E's room to inform her what RN 5 told her. The resident indicated that was incorrect because she had her last medication around midnight. CNA 3 indicated this had made Resident E very upset because Resident E knows when she needs her prn medications and when they are due. Resident E walked down to the nurse's station after that with her tablet and was standing in front of RN 5 who was sitting at the nurse's desk. CNA 3 indicated Resident E stood there for a few minutes, with RN 5 not acknowledging her, so Resident E began banging her cane on the desk and kicking the desk to get her attention. CNA 2 then alerted RN 5 that Resident E needed her attention and needed something. RN 5 indicated to CNA 2 that she could see that, captain obvious, rudely. RN 5 continued to not acknowledge the resident after that, then a few moments later, spoke to her without looking up from her computer. CNA 3 indicated Resident E was taken back to her room after that incident and was very upset. During an interview with Resident E on 2/3/26 at 10:15 a.m., the resident indicated a nurse gave her prn pain medication at 11 p.m. and refused to give her prn oxycodone (pain medication) at 5:00 a.m. The resident indicated she did not get her medications until 8:00 a.m. RN 5 withholds and prolongs giving her her pain medications frequently and not receiving her prn pain medications when she requests them, causes her to (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
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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have increased pain. Resident E indicated she will wait up to two hours for her prn pain medications and by then her pain was completely out of control. No other nurses will do that except RN 5 who has done this to her ever since she began working there in Sept. During an interview with Licensed Practical Nurse (LPN) 8 on 2/4/26 at 3:41 p.m., the LPN indicated they did their training with RN 5 and she would specifically make Resident E wait hours to get her prn pain medication, and did not know why. A plan of care, dated 12/9/22, indicated Resident E had a communication problem due to not being able to speak and will be able to make basic needs known. The interventions included, but were not limited to, allow calm, unhurried environment to encourage communication, answer questions as needed and repeat as necessary, listen carefully, and validate verbal and non verbal expressions. A plan of care, dated 12/9/22, indicated Resident E needed pain management related to chronic pain syndrome. The interventions included, but were not limited to, distraction techniques, imagery, music, and relaxation techniques. A Resident Right policy was provided by the Executive Director (ED) on 2/4/26 at 9:35 a.m. It indicated .Resident Rights: 4. Respect and dignity. The resident has a right to be treated with respect and dignity. This citation relates to intakes 2728759 and 2728476.3.1-9(a)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interview and record review, the facility failed to investigate and follow up with a resident related to a staff member not addressing needs and wants for 1 of 1 resident reviewed for grievances. (Resident E) Findings include:During an interview on 2/2/26 at 2:37 p.m., Certified Nursing Assistant (CNA) 2 indicated she filled out a grievance form for Resident E on 1/24/26 in relation to an incident that occurred that morning at the nurse's station between Resident E and Registered Nurse (RN) 5. The morning of 1/24/26, Resident E was at the nurse's station upset and wanting to speak with RN 5 regarding her pain medication and that she was due for them. RN 5 indicated it was not time for her prn (as needed) medicine. CNA 2 indicated RN 5 would not acknowledge Resident E when she was standing at the nurse's station, and Resident E, who communicated primarily by tablet use, was pounding her cane on the desk and kicking it attempting to get RN 5's attention. Resident E was completely aware of her medications, times they were given, and times they were due again. RN 5 would not acknowledge Resident E, and eventually responded to Resident E but did not look up at her while speaking. CNA 2 indicated Resident E was very upset and she assisted Resident E back to her room at that time. A grievance form was filled out that morning, which was a Saturday, and placed a copy under the Director of Nursing's (DON) and the Executive Director's (ED) doors. The clinical record for Resident E was reviewed on 2/3/26 at 11:15 a.m. The resident's diagnoses included, but were not limited to, chronic pain syndrome, cerebral infarction (blockage in a blood vessel, leading to brain tissue death from lack of oxygen), and anxiety. The Annual Minimum Data Set (MDS) assessment, dated 11/5/25, indicated Resident E was cognitively intact, had chronic pain syndrome, and frequently had pain. During an interview with CNA 2 on 2/3/26 at 9:45 a.m., they indicated no one followed up with her about the grievance. During an interview with Resident E on 2/3/26 at 10:15 a.m., Resident E indicated no one had come in to follow up with her about the grievance. A plan of care, dated 12/9/22, indicated Resident E had impaired neurological status related to cerebrovascular accident. The interventions included, but were not limited to, reassurance and patience when patient attempts to communicate. A plan of care, dated 12/9/22, indicated Resident E had communication problems due to not being able to speak (aphonia) and had a communication device. The interventions included, but were not limited to, answer questions as needed and repeat as necessary, communicate with resident using electronic communication device, listen carefully, validate verbal and non verbal expressions, and maintain eye contact. During an interview with the DON on 2/4/26 at 9:34 a.m., the DON indicated they had not followed up with Resident E about the grievance. After receiving a grievance from a staff member in regards to a resident, the facility should have investigated, talked to the resident and staff members involved. A Resident and Family Grievance policy was provided by the Administrator in Training (AIT) on 2/3/26 at 10:55 a.m. It indicated .8. Grievances may be voiced in the following forms: b. Written complaint to a staff member or Grievance Official.10. Procedure: e. The Grievance Official, or designee, will keep the resident appropriately apprised of progress towards the resolution of the grievances.g. In accordance with the resident's right to obtain a written decision regarding his or her grievance, the Grievance Official will issue a written decision on the grievance. The written decision will include at a minimum: ii. The steps taken to investigate the grievance.iii. A summary of the pertinent findings or conclusions regarding the resident's concerns.12. The facility will make prompt efforts to resolve grievances. This citation relates to intake 2728759.3.1-7(a)(2)

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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 - 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, interview, and record review, the facility failed to ensure residents were free from mental/verbal abuse and threats of seclusion resulting in fear, intimidation, and mental anguish for 2 of 6 residents reviewed for abuse (Resident B and Resident C). Using the reasonable person concept, it is likely this would lead to fear, confusion, anxiety, and intimidation for Resident B and Resident C.Findings include:1. Review of the clinical record of Resident B on 2/2/26 at 10:55 a.m., indicated the resident's diagnoses included, but were not limited to, bipolar disorder (a chronic mental health condition), anxiety, paranoid schizophrenia (a mental health condition characterized by intense, irrational delusions), dementia (a decline in mental abilities), and repeated falls. The quarterly Minimum Data Set (MDS) assessment for Resident B, dated 12/5/25, indicated the resident was cognitively intact for daily decision making. The resident did not exhibit any behaviors during these assessment time frame. The resident utilized a wheelchair for mobility. The change in condition progress note for Resident B, dated 1/6/26 at 4:32 a.m., indicated a new order was received to send the resident to hospital. The resident was paranoid, falsely accusatory toward staff, disoriented to situation, yelling and screaming in her room and in the hallway and was waking up other residents on the unit. The resident was threatening to beat up staff. The resident was rolling around in her wheelchair staring at staff and being intimidating. The resident cursed at staff. The resident believed staff knew her family and was conspiring against her to do evil things. Staff and other residents did not provoke resident in any way or respond to her behaviors except to reorient her to reality and ask her to lower her voice so other residents could sleep. Reoriented the resident to reality that it was the middle of the night and no one means her any harm, we just want her to quiet down to maintain a peaceful living environment for herself and other residents. The resident was transferred to the hospital via Emergency Medical Services (EMT). The progress note was electronically signed by RN 5. The EMT run report for Resident B, dated 1/6/26 at 4:22 a.m., indicated the medics were dispatched to a mental and emotional patient at the nursing home. Once the medics were on scene the nurse said the patient was schizophrenic that was also bipolar. The nurse said the resident had been refusing her medications and not acting herself. The patient refused to come near the EMT and was in a wheelchair rolling around the day room. The patient was alert and oriented and cognitively intact. The patient was saying the head nurse was dangerous and was trying to hurt her. After the medics talked to the resident from a distance for some time, a medic was able to convince the resident to go with them. The patient reported to the medics she wanted to talk to the doctor at the hospital about the nursing home staff. The patient was assisted onto the stretcher and secured in the ambulance. The resident said the people that work at the nursing home need stopped and then the resident fell asleep during transport to the hospital. The hospital note for Resident B, dated 1/6/26 at 4:54 a.m., indicated the resident was anxious and paranoid. The resident was sent from the Extended Care Facility (EFC) for reported agitation. The patient was calm and cooperative at this time. Discussed the case with psychiatry who was familiar with Resident B and felt that she was at her baseline. Psychiatry felt it was appropriate to discharge her back to the nursing facility as she did not meet criteria for acute hospitalization. During an interview with Certified Nurse Assistant (CNA) 6 on 2/2/26 at 5:11 p.m., the CNA indicated in January 2026 (unsure of exact date) she witnessed RN 5 being abusive to Resident B. Resident B (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	was having behaviors she was screaming and yelling. RN 5 requested CNA 5 to put the resident in the supply closet. CNA 5 refused to do it. The resident was sent to the hospital that night. Resident B tried to stand up from her wheelchair and RN 5 pushed her down and the resident fell to the floor. RN 5 told CNA 5 and CNA 6 not to say anything to anyone about what had happened. CNA 5 and CNA 6 stayed with Resident B until the EMT's came and got Resident B. CNA 6 indicated the Director of Nursing (DON) called her and the CNA reported to the DON about RN 5 trying to get the CNA's to put Resident B in the supply closet and about RN 5 causing the resident to fall. The DON indicated she would look into it and for the CNA to stay away from RN 5. During an interview with CNA 5, on 2/2/26 at 5:46 p.m., the CNA indicated on 1/6/26, RN 5 was being emotionally abusive to Resident B. Resident B was having behaviors yelling and screaming and RN 5 was not used to dealing with behaviors. RN 5 would not leave the resident alone and was antagonizing her. RN 5 seemed to be spiteful to the resident. All the staff know to leave Resident B alone when she was having behaviors and she would calm down on her own. RN 5 attempted to get the CNA to push Resident B's wheelchair into the supply closet while she held the door open. CNA 5 refused to put the resident in the supply closet and RN 5 indicated for CNA 5 to hold the door open to the supply closet and she would push her in there, CNA 5 refused to do this also and told RN 5 that they could not put the resident in the supply closet. CNA 5 indicated RN 5 grabbed Resident B's wheelchair and the resident fell. RN 5 instructed CNA 5 and CNA 6 not to help the resident, but CNA 6 assisted the resident up into her wheelchair. CNA 5 and CNA 6 took Resident B away from the nurse. CNA 5 indicated all she could do was keep the resident away from the nurse. Resident B went with EMT's when they arrived because she did not want to be around RN 5. CNA 5 indicated she reported the incident to the Unit Manager and the Unit Manger indicated she would report it to the DON. During an interview with RN 5, on 2/2/26 at 6:27 p.m., the RN indicated she was not aware of any resident abuse occurring in the facility. The RN was not aware of any resident's being physically restrained or attempted to be isolated. She just let the residents go and make sure they were safe when they were having behaviors. The RN was not sure of the exact date, but she had to send Resident B to the hospital for behaviors. RN 5 did not think the resident had a fall she was rolling up and down the hallway in her wheelchair. RN 5 did not know why Resident B was on a regular unit because she just blows up. She tried to stay out of view of the resident that night because for some reason the resident was irritated by the nurse. RN 5 indicated it was not a fun night; it was the worse [sic]. The staffing was low and it was horrible, Resident B was not redirectable and was waking up other residents. CNA 6 stayed with Resident B until EMT's came and got her on the stretcher to transport her to the hospital. The RN indicated she did not realize the facility had so my psychiatric residents with behaviors mixed in the with regular residents. During an interview with Licensed Practical Nurse (LPN) 8, on 2/2/26 at 3:41 p.m., the LPN indicated CNA 5 reported to her on 1/20/26 that RN 5 attempted to get her to put Resident B in involuntarily seclusion in the supply closet about a week prior. Resident B had behaviors of yelling out and had outburst, the staff would leave her alone and eventually she would calm down. RN 5 wanted to put her in the supply closet because she was worried the resident was going to wake up other residents. LPN 8 indicated that CNA 5 also reported to her that Resident B had a fall that same night behind the nursing station. LPN 8 provided a text that she sent to the DON on 1/20/26 at 4:43 a.m. and reported that RN 5 tried to get CNA 5 to get to involuntarily seclude Resident B in a room behind the nursing station. LPN 8 texted the DON that she did not know all the details, so she had CNA 5 and CNA 6 write out a statement and put it under the DON's door. The DON indicated to the LPN 8, on 1/20/26 at 4:41 p.m., that she had not received any statements, but would talk to the staff. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an observation with the Regional Director of Clinical Operations, on 2/4/26 at 10:20 a.m., the supply closet on the center unit where Resident B resided was located behind the nursing station and had two locked doors to the room, the key was kept at the nursing station. Located in the room was a crash cart with liquid oxygen, oxygen tubing, goggles, back board, and a suctioning machine. The room contained dressing supplies, nebulizers, gloves, call light system with wires, batteries for mechanical lifts, two sinks, a toilet, drug buster (a method of destroying medication utilizing charcoal to neutralize medications) and dishwasher cleaning pods. 2. During an interview with Resident C, on 2/2/26 at 11:28 a.m., she indicated RN 5 had been verbally abusive toward her. Resident C indicated she was in her room one night sitting in her chair and needed help repositioning, her medications, and assistance going back to bed. The resident indicated she could not find her call light, so she had to yell out for help. Resident C indicated RN 5 came into the room and said, I don't know what you're yelling about, but someone will be in to take care of it.it's late and now all of my residents are awake, then began yelling at her and telling her to be quiet. The RN 5 told her, if you can't be quiet, they need to find you a different floor. Resident C indicated RN 5 told her, .the next time I see you, it better not be on my floor, you need to grow up, you have all of these people who are sick and all you are worried about is yourself. Resident C indicated CNA 4 then came into the room and said to RN 5, excuse me, you are not going to talk to her that way, she needs help. Resident C indicated this interaction made her feel this big cinching fingers together. Resident C indicated she was crying and sobbing, her feelings were hurt, and this made her feel really low. The clinical record for Resident C was reviewed on 2/2/26 at 11:55 a.m. The resident's diagnoses included, but were not limited to, idiopathic pulmonary fibrosis (a chronic progressive, and typically fatal lung disease), migraines, and cirrhosis of liver (long term liver disease). The admission MDS assessment, dated 1/17/26, indicated Resident C was cognitively intact. A written statement by CNA 4 was provided by the Executive Director (ED) on 2/4/26 at 9:44 a.m. It indicated Resident C was screaming for help at 10:50 p.m. Resident C stated she had been waiting for someone to take her blood pressure so she could be transferred back to bed. CNA 4 indicated he yelled for RN 5 to come help and she started to lecture the resident saying she was being loud and disrupting the other residents. During an interview with LPN 8 on 2/4/26 at 3:41 p.m., she indicated CNA 4 reported to her on 1/25/26 at 11:20 p.m. that CNA 4 entered Resident C's room because she was yelling out and wanting her blood pressure taken so she could get her medications and go to bed. CNA 4 indicated RN 5 entered the room and was yelling at Resident C and telling her to be quiet because she was going to wake up the entire floor. CNA 4 asked RN 5 if they could get Resident C's blood pressure, so they could get her back to bed. RN 5 refused, then finally took the blood pressure when it was time to get Resident C back to bed. CNA 4 then asked RN 5 for assistance in getting Resident C back to bed. RN 5 refused, then finally assisted CNA 4. LPN 8 indicated she notified the ED immediately after CNA 4 reported this to her. The Abuse, Neglect, and Exploitation policy was provided by the ED on 2/2/26 at 10:42 a.m. It indicated .Definitions: Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse.Involuntary Seclusion refers to the separation of a resident from other residents or from his/her room or confinement to his/her room against the resident's will.Mental Abuse includes, (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	but is not limited to, humiliation, harassment, threats of punishment, or deprivation.Verbal Abuse means the use of oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents. This citation relates to intakes 2728759 and 2728476. 3.1-27(a)(b)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview, and record review the facility failed to report an allegation of abuse to the Executive Director immediately for 1 of 6 residents reviewed for abuse (Resident B). Finding include: Review of the clinical record of Resident B on 2/2/26 at 10:55 a.m., indicated the resident's diagnoses included, but were not limited to, bipolar disorder (a chronic mental health condition), anxiety, paranoid schizophrenia (a mental health condition characterized by intense, irrational delusions), dementia (a decline in mental abilities), and repeated falls. The quarterly Minimum Data Set (MDS) assessment for Resident B, dated 12/5/25, indicated the resident cognitively intact for daily decision making. The resident did not exhibit any behaviors during these assessment time frame. The resident utilized a wheelchair for mobility. During an interview with CNA 6 on 2/2/26 at 5:11 p.m., the CNA indicated in January 2026 (unsure of exact date) she witnessed RN 5 being abusive to Resident B. Resident B was having behaviors she was screaming and yelling. RN 5 requested CNA 5 to put the resident in the supply closet. CNA 5 refused to do it. Resident B tried to stand up from her wheelchair and RN 5 pushed her down and the resident fell to the floor. CNA 6 indicated the Director Of Nursing (DON) called her and she did report to her about RN 5 trying to get the CNA's to put Resident B in the supply closet and she caused the resident to fall. CNA 6 indicated the Executive Director was not aware of this incident, she had reported it to the DON. During an interview with CNA 5 on 2/2/26 at 5:46 p.m., indicated on 1/6/26, RN 5 was being emotionally abusive to Resident B. Resident B was having behaviors yelling and screaming and RN 5 was not use to dealing with behaviors. RN 5 would not leave the resident alone and was antagonizing her. RN 5 seemed to be spiteful to the resident. All the staff know to leave Resident B alone when she was having behaviors and she would calm down on her own. RN 5 attempted to get the CNA to push Resident B's wheelchair into the supply closet while she held the door open. CNA 5 refused to put the resident in the supply closet and RN 5 indicated for CNA 5 to hold the door open to the supply closet and she would push her in there, CNA 5 refused to do this also and told RN 5 that they could not put the resident in the supply closet. RN 5 grabbed Resident B's wheelchair and the resident fell to the floor. CNA 5 indicated she reported the incident to the Unit Manager and the Unit manger indicated she would report it to the DON. CNA 5 was not aware if the Executive Director (ED)was aware of the incident with Resident B. During an interview with the ED on 2/3/26 at 10:22 a.m., the ED indicated no staff had reported to him that on 1/6/26 RN 5 requested staff to put Resident B in the supply closet or that RN 5 had caused Resident B to fall. The abuse policy provided by the Executive Director on 2/2/26 at 10:42 a.m., indicated allegations of abuse were to be reported to the Executive Director immediately but not later than 2 hours after the allegation was made. This citation relates to Intake 2728749.3.1-28(c)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to complete an assessment after a fall for 2 of 3 residents reviewed for accidents (Resident B and Resident C). Findings include:1. Review of the clinical record of Resident B on 2/2/26 at 10:55 a.m., indicated the resident's diagnoses included, but were not limited to, dementia (a decline in mental abilities) and repeated falls. The care plan for Resident B, dated 3/2/25, indicated the resident was at risk for falls related to: a history of falls, use of medication, wandering, vitamin D deficiency, Alzheimer's disease and dementia. The resident had also had disorders of bone density. There were no interventions implemented since 4/27/2023. The quarterly Minimum Data Set (MDS) assessment for Resident B, dated 12/5/25, indicated the resident cognitively intact for daily decision making. The resident utilized a wheelchair for mobility. The change in condition progress note for Resident B, dated 1/6/26 at 4:32 a.m., indicated a new order was received to send the resident to hospital. The resident was paranoid, falsely accusatory toward staff, disoriented to situation, yelling and screaming in her room and in the hallway and was waking up other residents on the unit. The resident was threatening to beat up staff. The resident was rolling around in her wheelchair staring at staff and being intimidating. The resident cursed at staff. The resident believed staff knew her family and was conspiring against her to do evil things. Staff and other residents did not provoke resident in any way or respond to her behaviors except to reorient her to reality and ask her to lower her voice so other residents could sleep. Reoriented resident to reality that it was the middle of the night and no one means her any harm, we just want her to quiet down to maintain a peaceful living environment for herself and other residents. The resident was transferred to the hospital via Emergency Medical Services (EMT). The progress note was electronically signed by RN 5. There was no documentation about Resident B having a fall or an assessment of the resident after the fall. During an interview with Resident B on 2/2/26 at 11:25 a.m., the resident indicated she did have a fall at the nursing station about three weeks ago. The resident was unsure what caused the fall, she just lost her balance. There were 2 or 3 staff that seen her fall but she was unsure of their names. During an interview with CNA 6 on 2/2/26 at 5:11 p.m., the CNA indicated in January 2026 (unsure of exact date) she witnessed Resident B trying to stand up from her wheelchair and RN 5 pushed her down and the resident fell to the floor. RN 5 told CNA 5 and CNA 6 not to say anything to anyone about what had happened. CNA 5 and CNA 6 stayed with Resident B until the EMT's came an got Resident B. During an interview with CNA 5 on 2/2/26 at 5:46 p.m., the CNA indicated on 1/6/26, Resident B was having behaviors yelling and screaming and RN 5 was not use to dealing with behaviors. RN 5 grabbed Resident B's wheelchair and the resident fell. RN 5 instructed CNA 5 and CNA 6 not to help the resident, but CNA 6 assisted the resident up into her wheelchair. CNA 5 indicated she reported the incident to the Unit Manager and the Unit manger indicated she would report it to the DON. RN 5 had not assessed the resident. During an interview RN 5 on 2/2/26 at 6:27 p.m., indicated she was not sure of the exact date but (continued on next page)

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	155264	A. Building B. Wing	02/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brickyard Healthcare - Golden Rule Care Center	2330 Straight Line Pike Richmond, IN 47374

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she had to send Resident B to the hospital for behaviors (1/6/26). RN 5 did not think the resident had a fall that night she was rolling up and down the hallway in her wheelchair. During an interview with LPN 8 on 2/2/26 at 3:41 p.m., indicated CNA 5 reported to her on 1/20/26 that Resident B had fallen on 1/6/26 at the nursing station and RN 5 did not assess the resident and told staff to leave the resident on the floor. LPN 8 indicated there was nothing in report about Resident B falling and she would have never known the resident had a fall if CNA 5 had not reported it to her. During an observation on 2/3/26 at 2:30 p.m., Resident B was wheeling herself in her wheelchair up and down the hallway independently. 2. The clinical record for Resident C was reviewed on 2/2/26 at 11:55 a.m. The resident's diagnosis included, but was not limited to, generalized anxiety disorder. The admission Minimum Data Set (MDS) assessment, dated 1/17/26, indicated Resident C was cognitively intact, used a wheelchair for ambulation, was dependent with rolling side to side, sit to lying, lying to sitting, and partial/moderate assistance with chair/bed-chair transfers. A Fall Risk Evaluation, dated 1/9/26, indicated Resident C was at risk for falls. A progress note, dated 1/11/26 at 5:37 p.m., indicated Resident C was yelling out from her room, staff went to the room, and resident was lying on the floor against the wall. Resident C was crying out in pain with her left leg. Doctor notified and new order to send to the ER (Emergency Room). No post fall assessment was documented for Resident C. A Facility Reported Incident, dated 1/11/26, indicated Resident C informed staff member that she fell while attempting to get out of bed. The resident was evaluated by the nurse and sent to the hospital for additional care and treatment. A local hospital discharge summary note, dated 1/15/26, indicated Resident C had been admitted [DATE] following a mechanical fall resulting in a closed hip fracture and underwent surgery with nail and screw placement on 1/12/26. A plan of care, dated 1/12/26, indicated Resident C was at risk for falls due to history of falls, poor balance, and unsteady gait. During an interview with the Director of Nursing (DON) on 2/4/26 at 10:43 a.m., the DON indicated there was an IDT (Inter-Disciplinary Team) note about the fall in Resident C's Electronic Health Record (EHR), but there was no post fall assessment completed for Resident C after her fall on 1/11/26. The floor nurse was who was responsible to make sure that a post fall assessment was completed for every fall. The post fall evaluation/assessment included: fall details, contributing factors, medication changes, vitals, pain, skin, physical findings, and comments. A Fall Prevention Program policy was provided by the DON on 2/2/26 at 10:42 a.m. It indicated .9. When any resident experiences a fall, the facility will: a. Assess the resident b. Complete a post-fall assessment.f. Document all assessments and actions. This citation relates to intake 2728759 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-45(a)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. Based on observation, interview, and record review, the facility failed to ensure a resident with a major mental illness was treated appropriately and failed to implement individualized interventions resulting in a physical/mental altercation between a staff member and the residents for 1 of 6 residents reviewed for mental/psychosocial services. (Resident B). Using the reasonable person concept, the resident would likely have psychological harm of chronic or recurrent fear and anxiety from how RN 5 handled the interactions with Resident B. Findings include:Review of the clinical record of Resident B on 2/2/26 at 10:55 a.m., indicated the resident's diagnoses included, but were not limited to, bipolar disorder a chronic mental health condition), anxiety, paranoid schizophrenia (a mental health condition characterized by intense, irrational delusions), dementia (a decline in mental abilities), insomnia (persistent difficulty falling asleep or staying asleep) and Alzheimer's disease (progressive irreversible neurodegenerative brain disorder). The care plan for Resident B, dated 3/2/25, indicated the resident had depression and would become angry, make negative statements, tearful and withdrawn. The interventions included, but were not limited to, allow time to express her feelings and offer beverages/snacks. The care plan for Resident B, dated 3/2/25, indicated the resident had a history of making comments about not wanting to live, but had not voiced a plan. The interventions included, but were not limited to, encourage the resident to speak about her thoughts and feelings when she was sad or upset. The care plan for Resident B, dated 3/2/25, indicated the resident had behaviors which included, rejection of care, cursing at staff, wandering, verbalizing things that were not true, seeing things that were not there, physical aggression towards staff. The interventions included, but were not limited to, all me to have a specific staff member hold her hand, offer the resident a diversion, speak to the resident in a calm and unhurried voice. The care plan for Resident B, dated 3/2/25, indicated the resident was at risk for sleep pattern disturbance related to the diagnosis of insomnia. The interventions included, but were not limited to, assess for pain, maintain a quiet, comfortable temperature, dimmed lights, offer a back rub, play soft relaxing music, offer warm milk and food. The care plan for Resident B, dated 3/2/25, indicated the resident had social isolation due to her diagnosis of schizophrenia and bipolar. The resident forgot things, had altered sleep pattern, altered nutrition, falls, behaviors, depression and increased dependence on staff and social/activity isolation. The interventions included, but were not limited to, encourage the resident to express her feelings. The care plan for Resident B, dated 3/2/25, indicated the resident had mood indicators of feeling bad about herself, failure to her family, depressed, little interest in pleasure, anxious, agitated, speaking slowly, poor appetite, thoughts of hurting herself, little energy, trouble concentrating, trouble sleeping, rapid movements, insomnia and often isolates herself. The interventions included, but were not limited to, take the time to discuss my feelings when she was sad and encourage activities related to her interest. The care plan for Resident B, dated 6/10/25, indicated the resident was at risk for psychosocial (continued on next page)

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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 0742 Level of Harm - Actual harm Residents Affected - Few	well-being due to the diagnosis of bipolar disorder. The interventions included, but were not limited to, allow the resident time to answer questions and verbalize feelings and fears daily. The care plan for Resident B, dated 9/14/25, indicated the resident wanted to maintain her personal preference of going to bed when she was tired. The care plan for Resident B, dated 12/25/25, indicated the resident had a behavior problem of talking loudly to herself and yelling at others. The interventions included, but were not limited to, anticipate and meet the residents needs and if reasonable, discuss the resident's behavior of why the behavior was inappropriate or unacceptable to the resident. The quarterly Minimum Data Set (MDS) assessment for Resident B, dated 12/5/25, indicated the resident cognitively intact for daily decision making. The resident did not exhibit any behaviors during these assessment time frame. The change in condition progress note for Resident B, dated 1/6/26 at 4:32 a.m., indicated a new order was received to send the resident to hospital. The resident was paranoid, falsely accusatory toward staff, disoriented to situation, yelling and screaming in her room and in the hallway and was waking up other residents on the unit. The resident was threatening to beat up staff. The resident was rolling around in her wheelchair staring at staff and being intimidating. The resident cursed at staff. The resident believed staff knew her family and was conspiring against her to do evil things. Staff and other residents did not provoke resident in any way or respond to her behaviors except to reorient her to reality and ask her to lower her voice so other residents could sleep. Reoriented resident to reality that it was the middle of the night and no one means her any harm, we just want her to quiet down to maintain a peaceful living environment for herself and other residents. The resident was transferred to the hospital via Emergency Medical Services (EMT). The progress note was electronically signed by RN 5. During an observation and interview with Resident B on 2/2/26 at 11:25 a.m., the resident was lying in her bed and thanked me for stopping in and checking on her. During an interview with the Unit Manager, on 2/2/26 at 2:48 p.m., the Unit Manager indicated she was unsure if RN 5 knew how to deal with residents who had psychiatric issues. An example was RN 5 wanted to follow Resident B around, and the resident needed to be left alone. A couple weeks ago on third shift RN 5 reported to her that Resident B was acting out and the Unit Manager told RN 5 to leave her alone, but RN 5 continued to follow the resident around. The Unit Manager indicated she told RN 5 that the staff were not to do that with this resident. During an interview with CNA 6, on 2/2/26 at 5:11 p.m., the CNA indicated in January 2026 (unsure of exact date) Resident B was having behaviors she was screaming and yelling. RN 5 kept trying to give the resident medication and telling her to and told her to stop yelling and be respectful to the other residents. CNA 6 indicated it was very chaotic on the unit. RN 5 did not attempt any interventions for Resident B. CNA 6 and CNA 5 took the resident took the resident away from RN 5. During an interview with CNA 5, on 2/2/26 at 5:46 p.m., the CNA indicated on 1/6/26, Resident B was having behaviors yelling and screaming and RN 5 was not used to dealing with behaviors. RN 5 would not leave the resident alone and was antagonizing her. RN 5 seemed to be spiteful to the resident. All the staff know to leave Resident B alone when she was having behaviors and she would calm down on her own. (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	During an interview RN 5 on 2/2/26 at 6:27 p.m., the RN indicated she did not know why Resident B was on a regular unit because she just blows up. RN 5 indicated she did not realize the facility had so my psychiatric residents with behaviors mixed in the with regular residents. During an interview with LPN 8, on 2/2/26 at 3:41 p.m., the LPN indicated CNA 5 reported to her on 1/20/26 that RN 5 attempted to get her to put Resident B in involuntarily seclusion in the supply closet about a week prior. Resident B had behaviors of yelling out and had outburst, the staff would leave her alone and eventually she would calm down. RN 5 wanted to put her in the supply closet because she was worried, she was going to wake up other residents. The LPN noticed there were a lot of residents on the center station agitated with RN 5 and seemed like RN 5 was trying to make the residents angry. A Dementia policy was provided by the ED on 2/4/26 at 9:35 a.m. It indicated .It is the policy of this facility to provide the appropriate treatment and services to every resident who displays signs of, or is diagnosed with dementia, to meet his or her highest practicable physical, mental and psychosocial well-being.Definitions: Highest practicable physical, mental, and psychosocial well-being is defined as the highest possible level of functioning and well-being, limited to the individual's recognized pathology and normal aging process. Highest practicable is determined through the comprehensive resident assessment and by recognizing and competently and thoroughly addressing the physical, mental, or psychosocial needs of the individual. A Behavioral Health Services policy was provided by the ED on 2/4/26 at 9:35 a.m. It indicated .It is the policy of this facility to ensure all residents receive necessary behavioral health services to assist them in reaching and maintaining their highest level of mental and psychosocial functioning and well-being.Definitions: Mental Disorder is a syndrome characterized by a clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities.1. Behavioral health encompasses a resident's whole emotional and mental well-being.3. The facility will ensure that necessary behavioral health care services are person-centered and reflect the resident's goals for care, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety.5. Behavioral health care and services shall be provided in an environment that is conductive to mental and psychological well-being.6. Conditions that are frequently seen in nursing home residents and may require the facility to provide specialized services and supports based upon residents' needs.c. Schizophrenia- Is a serious mental disorder that may interfere with a person's ability to think clearly, manage emotions, make decisions and relate to others.d. Bipolar Disorder- Is a mental disorder that causes dramatic shifts in a person's mood or energy, and may affect the ability to think clearly.11. Facility staff will implement person-centered care approaches designed to meet the individual goals and needs of each resident, which includes non-pharmacological interventions to help meet behavioral health needs. This citation relates to intake 2728759 3.1-43(a)(1)