STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. Building B. Wing	01/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brickyard Healthcare - Merrillville Care Center	8800 Virginia Place Merrillville, IN 46410

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** 32664 Based on record review, observation, and interview, the facility failed to protect a cognitively impaired resident's rights to be free from physical abuse for 1 of 2 residents reviewed for abuse. (Residents B and C). This deficient practice resulted in Resident B sustaining swelling with discoloration injuries to the bilateral eyes and left wrist, a laceration on the right toe, and a laceration on the right ankle that required six sutures to repair. Finding includes: A Facility-Reported Incident (FRI), dated 12/29/24, indicated the following: .Incident date: 12/29/24 Incident time: 9:30 a.m. Description added -12/29/24 Nurse observed [Resident B] with blood on the foot part of the bed, with an open area noted to right ankle, 2 cm [centimeters] X 0.3 cm, right toe with open area 0.9 cm X 0.3 cm, right eye swollen, left eye discoloration noted, and swelling to left wrist noted upon full assessment. When asked [Resident B], BIM [Brief Interview of Mental Status] 5 [cognitively impaired] was asked what happened he pointed to roommate [Resident C], BIM 15 [cognitively intact]. Assessment completed of [Resident C] denies the allegation but bruising was noted to both of his hands. Action Taken added -- 12/29/2024 Residents put on 1 to 1 [one-to-one] until resident [Resident B] was sent to hospital for evaluation. Full assessment done on both residents, including neuro checks. Both doctors and families were notified . Type of injury added -- 12/29/2024 Injuries noted to [Resident B] as described and [Resident C] noted with bruising to hands upon assessment . Type of preventative measures added -- 12/29/2024 Investigation initiated: (continued on next page)

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	1 to 1 staff initiated with residents. Social services notified. Residents both deny any pain, discomfort and no signs and symptoms of psychosocial distress or changes. Manager on duty notified and follow up in place. Care plans to be updated. Police to be notified due to allegation. Interviews of staff and residents will be conducted. Safety precautions in place A local Police Department Report, dated 12/29/24, indicated the following: The Police Department responded to the facility on [DATE] at 10:38 a.m. for a battery report.Upon arrival I was met by the Nursing Manager [Alzheimer's Unit Director] who advised that they needed to report an attack on a patient [Resident B]. The [Alzheimer's Unit Director] reported that the attack was discovered that morning by [CNA 1] while making rounds. [Resident B] was transported by medics to [Hospital] at least an hour prior to notifying police and not currently on scene. [Resident B] is said to suffer from a stroke and dementia making him nearly nonverbal. [CNA 1] located [Resident B] with a pool of blood under his leg, observed a black eye and swelling to his forehead along with a knot on his wrist. She then observed what appeared to be a puncture wound near his ankle and a small laceration to his toe. Although [Resident B] is nonverbal they asked him who did this causing him to point at his roommate [Resident C]. They advised that [Resident C] claimed that he did not do anything but also did not know what happened. [Resident C] is said to not be able to walk however his bed was on the lowest setting to the floor and they observed what appeared to be bruising and redness to his palms. Although [Resident C] can not [sic] walk they believe that he is able to pull himself from his bed and back again without the use of his legs. The [Alzheimer's Unit Director] advised that she looked through [Resident C's] belongings and the only weapons she located was that of a small [NAME] folding pocket knife [sic] and a pair of scissors; both of which were collected by her and secured in her office before my arrival. Due to the time lapse, the scene was already cleaned up and the sheets were removed from [Resident B's] bed before my arrival. Prior to being transported staff took photographs of [Resident C's] injuries which were forwarded to my department mail and uploaded .I further took photographs of the room, [Resident C], and his hands. [Resident C] claimed he did not know what happened nor did he see anyone enter the room prior to [CNA 1] this morning. He also advised that he has been roommates with [Resident B] for approximately 2 months and only had issues with him being loud but nothing recently. I collected and photographed the knife and scissors from [Alzheimer's Unit Director]. Both were secured and placed in an evidence locker at the police station .I attempted to follow up with [Resident B] at hospital however nursing staff advised that he was medicated at this time and that he was not able to speak with me . The record review for Resident C was completed on 1/2/25 at 3:01 p.m. Diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease (COPD), heart failure, anxiety, dementia, and depression. The resident was admitted to the facility on [DATE]. The Quarterly Minimum Data Set (MDS) assessment, dated 12/2/24, indicated the resident was cognitively intact. The resident had no mood problems, behaviors, or indicators of psychosis. The resident had impairment on both sides of his lower extremities with functional limitation in range of motion (ROM). The resident was dependent on staff for transfers from his bed to his wheelchair. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A Care Plan, dated 10/22/24 and revised 11/4/24, indicated the resident had an activities of daily living (ADL) self-care performance deficit related to decreased mobility, COPD, dementia, anxiety, heart failure, and major depressive disorder. The resident required assistance with ADL care, transfers, and bed mobility. The resident would often stay in bed and decline to get up. The progress notes, assessments, and care plans, dated September 2024 through 12/29/24, did not include any documentation to indicate Resident C had any prior behaviors or altercations with Resident B. The record review for Resident B was completed on 1/3/25 at 12:04 p.m. Diagnoses included, but were not limited to, paranoid schizophrenia, hemiplegia (partial paralysis on one side of body) following a stroke, altered mental status, and vascular dementia with behavioral disturbance. The Quarterly MDS assessment, dated 9/23/24, indicated the resident was severely cognitively impaired for daily decision making. The resident had difficulty focusing attention, was easily distracted or had difficulty keeping track of what was said. There were no indicators of psychosis. The resident had an impairment on one side of his upper and both sides of his lower extremities with functional limitation in ROM. The resident was dependent for transfers from his bed and required a partial to moderate assistance for bed mobility. The resident had clear speech, was able to make self understood, and a clear comprehension ability to understand others. He had inattention behavior that was continuously present. A Care Plan, dated 10/11/24, indicated the resident had impaired cognitive function related to vascular dementia. An intervention included to ask yes or no questions in order to determine the resident's needs. A Care Plan, dated 10/14/21 and revised 4/10/24, indicated the resident had a physical functioning deficit related to mobility impairment, right dominant side hemiplegia. The resident preferred to stay in bed. The resident required assistance of one to two people for bed mobility and transfer assistance. A Progress Note, dated 12/29/24 at 8:35 a.m., indicated, .Writer was call [sic] into the room by other nurse on shift and CNA. Writer observed resident has a pool of blood by his feet, a cut to his right ankle approximately 2 cm x 0.5 cm, a cut on right foot to the small toe approximately 0.9 cm x 0.3 cm, right eye with some discoloration, left eye swollen with some discoloration, and left wrist warm to touch, discolored, and tender to touch. Resident was asked who did it. Resident pointed to the roommate [Resident C] .911 called, MD notified, PRN pain medication given, resident place on 1:1, Neuro checks implemented. An After Visit Summary from the Emergency Department, dated 12/29/24, indicated Resident B was seen in the emergency room after an assault. The resident had a CT (computed tomography, computerized x-ray) of his head, cervical spine and facial bones. There was no acute fracture or dislocation. The CT facial bones showed possible left periorbital and maxillary cellulitis; however, he had a black eye and no cellulitis. There was an x-ray completed of the left wrist and right hip. The wrist x-ray showed an old navicular fracture. The right hip x-ray did not show an acute fracture or discoloration. The foot x-ray was negative for acute fracture. There was a laceration to his right heel, and it was repaired with 6 sutures. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A follow up from the FRI from 12/29/24, dated 1/3/25, indicated the following: . [Resident B] had injuries sustained after an alleged assault from resident [Resident C]. There were no witnesses to the event. The police were called on 12/29/24 and a report was generated. [Resident C] was noted with bruising to his hands but denied the assault allegation. He stated the bruising was from a small chain that he swings around his hand. The [Resident C] is able to move out of bed but there have been no incidents with the [Resident C] that involved any type of abuse of assault. Both residents were sent to the hospital for evaluation and monitored 1:1 until they were moved. Both were put in separate rooms and ultimately [Resident B] was sent to another facility per families [sic] prior request. Witness statements were taken from staff and there were no reported abuse or witnesses from residents. Upon investigation [Resident C] appears to have been the perpetrator of the assault. The State surveyors are currently in the facility and reviewing this incident . During an interview on 1/3/25 at 9:09 a.m., the Administrator indicated she was called on 12/29/24 at 9:37 a.m. and told of Resident B's injuries. The nurse reported to her that Resident B was being sent out to the emergency department. CNA 1 did her rounds around 7:00 a.m., and Resident B was fine. CNA 1 then went back into the room at around 8:30 a.m. and saw Resident B had blood in his bed on his sheets and a had black eye. CNA 1 asked Resident B what happened and Resident B pointed to his roommate, Resident C. The Administrator then interviewed Resident B and asked him if Resident C did this, and Resident B pointed to Resident C. She asked if Resident C had ever touched him before and he shook his head no. She indicated CNA 1 told her the first time she did rounds, Resident C's bed was in a high position. The second time she came back in, Resident C's bed was in a low position. Resident B could not get out of bed by himself, but she believed that Resident C could transfer himself out of his bed and into his wheelchair independently. There were no prior incidents between Resident B and C that were reported to her. The Administrator interviewed Resident C and observed redness to his hands. He told her it was from a beaded chain that he would wrap around his hands. Resident C denied the allegations and said he did not know what happened. She told the resident they were going to have to find a different place for him. The resident told her he wanted to go to a different nursing home. The Administrator indicated an outside entity staff member had also interviewed Resident C. The outside entity staff member told the Administrator that Resident C said he had hit Resident B with a reacher (handheld tool designed to extend your reach allowing to grip objects out of arm's length). The Administrator interviewed other residents in the surrounding areas and no other residents heard or saw anything happen. She believed since the resident's bed was in a low position when CNA 1 came back into the room that Resident C had gotten out of bed and possibly assaulted Resident B since that was what he told the outside entity staff member. She was unsure why Resident C would assault Resident B since there were no prior incidents. There were no residents in the area who had behaviors or would have wandered into the room. Resident B was discharged to a different facility per the family's request and Resident C was on one-to-one supervision until he was discharged to a different facility. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 1/3/24 at 9:39 a.m., CNA 1 indicated she had made her first rounds around 6:45 a.m. Both Resident B and Resident C were in bed. Resident C's bed was in a high position. Resident C's wheelchair was about three feet away from his bed. She then came back around 8:00 a.m., to deliver the resident's breakfast trays. CNA 1 delivered Resident C's tray first. He was in his bed and awake. She then proceeded to give Resident B his tray. She saw Resident B's face swollen and bruised and blood all over the foot of the bed. Resident B appeared to have been crying. CNA 1 indicated there was so much blood on the bed, and she was unsure where it was coming from. She asked the resident who did this and Resident B then pointed to Resident C. She immediately called the nurse for help. CNA 1 indicated Resident B did not really communicate, he would be able to say yes or no but did not talk much. He mostly made sounds. She had not heard any sounds coming from the room prior to going in. Resident B would not be able to get in and out of bed on his own. Resident C could get out of bed on his own but rarely ever did. CNA 1 did not observe any blood on Resident C or his clothing, but indicated his palms had a blue discoloration. Resident C had a metal fidget [NAME] and plastic reacher with a a metal end on his bedside table. She did not observe any blood on the objects at the time. CNA 1 indicated she was not aware of any previous behavioral issues between the residents prior to the incident. During an interview on 1/3/24 at 9:51 a.m., CNA 2 indicated CNA 1 had called her to come into the room approximately around 8:25 a.m., while she was passing resident breakfast trays. Resident C was in his bed with the curtain closed. She did not observe any discolorations or blood on Resident C. Resident B was observed in bed with a black eye and blood on the bed towards his feet. When Resident B was asked how this happened to him, he pointed towards Resident C. CNA 2 did not work with Resident B or Resident C often and was unaware of any prior behavioral incidents between the two residents. The staff helped clean up Resident B before paramedics arrived. During an interview on 1/3/25 at 10:07 a.m., CNA 3 indicated she was called into the residents' room. CNA 1 was in the room. Resident B was in bed with discolorations on his face and blood on the bed. CNA 1 asked him who did this to him and Resident B pointed to Resident C. Resident C just had a blank face and didn't say anything. She didn't observe any discolorations or blood on Resident C. She indicated Resident C could get out of bed on his own if he wanted to. She was working on the opposite hall on the unit that morning and did not see anyone go into the room. CNA 3 indicated she was not aware of any previous behavioral issues between the residents prior to the incident. During an interview on 1/3/25 at 10:11 a.m., Dietary Aide 1 indicated he had delivered the room cart to the unit that morning. He did not see or hear anything out of the ordinary. During an interview on 1/3/25 at 10:51 a.m., LPN 1 indicated she was passing medications on the unit when she was called into the residents' room by RN 1. Resident B was lying in bed with a pool of blood by his feet. His face was discolored, and his eye was swollen. She indicated the resident didn't communicate and when asked what happened, he then pointed to his roommate Resident C. LPN 1 observed bruising on Resident C's hands but could not recall where on the hands. Resident C had a reacher on his bedside table, but she did not notice any blood on the reacher or on Resident C. LPN 1 had last been in the room at 7:00 a.m., and both residents were in bed. Resident B was asleep, and she could not recall if Resident C was awake or asleep. LPN 1 indicated she was not aware of any previous behavioral incidents with the residents prior to the incident. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 1/3/25 at 10:58 a.m., RN 1 indicated she was passing medications on a different hallway. She was not the residents' nurse that day, but CNA 1 called her at approximately 8:30 a.m. because LPN 1 was busy with another resident. When she walked into the room, she saw that Resident B had a lot of blood on the bed. He had a discoloration to his eye. She then called LPN 1 to come into the room. They assessed the resident, cleaned him up and asked who hurt him. Resident B then pointed to his roommate Resident C. RN 1 indicated the paramedics also asked Resident B who injured him, and Resident B pointed to Resident C. She asked Resident C what happened, and he indicated he did not know. She asked Resident B if anyone else came into the room and he said he didn't know. Resident C was assessed, and he had bruising observed on the palm side of his hands. RN 1 did not observe any blood on Resident C. She was unaware of any behavioral incidents with the residents prior to the incident. During an interview on 1/3/25 at 12:17 p.m., the Alzheimer's Unit Director ([NAME]) indicated she was the Manager on Duty when the incident occurred. She was made aware of the situation that happened. Resident B had already been sent to the hospital at that time. She asked if any of the staff had searched for any weapons in the room and they told her they had not. She then proceeded in to search the room. She asked Resident C if he had any weapons. He told her he had a pocketknife in his wallet in a drawer to his nightstand. The resident reached over and retrieved the wallet and gave her the knife. She did not observe any blood on the knife. There was also a pair of scissors in a shaving package underneath his television. The [NAME] retrieved them and there was no blood observed on the scissors. She did not observe any discolorations or blood on Resident C. She was in the room when the police arrived and questioned Resident C. The police asked him what happened to his roommate. Resident C said he did not know. The police officer asked him if anyone else came into their room and the resident indicated he didn't see anyone because his curtain was closed. The police officer then went and got pictures from the nurse, came back 15 minutes later and said he needed to take pictures of Resident C's hands because the nurse said he had bruising. The police officer did not say anything to her related to if he saw any bruising. The police officer took the pictures, the pocketknife and the scissors. The [NAME] was unaware of any behavioral problems with the residents prior to the incident. During an interview on 1/3/25 at 12:31 p.m., the Social Services Director (SSD) indicated Resident C was admitted to the facility several years ago. He was living with his sister and mother, and they could no longer provide care for him. He was unable to care for himself. He had been roommates with Resident B since September 2024 and the only problem she heard about was that Resident C was complaining that Resident B's television was too loud. The SSD provided Resident C with headphones and there were no further complaints. Resident C did receive psychiatric services in the past but would often refuse. Resident C indicated he did not like talking with the therapists and had not seen psychiatric services in a long time. The resident did not take any psychotropic medications and was not currently on any behavioral monitoring. There were no prior behavioral incidents of physical aggression that were reported for which precautions would have to be put into place prior to the incident with Resident B. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A facility policy titled, Abuse, Neglect and Exploitation and received as current from the Administrator on 1/3/25, indicated, .It is the policy of this facility to provide protections 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 . 1. The facility will develop and implement written policies and procedures that: a. Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property .V. Investigation of Alleged Abuse, Neglect and Exploitation . B. Written procedures for investigations include: . 2. Exercising caution in handling evidence that could be used in a criminal investigation (e.g., not tampering or destroying evidence) . This citation relates to Complaints IN00450120 and IN00450272. 3.1-27(a)(1)