

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155687	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2026
NAME OF PROVIDER OR SUPPLIER Brickyard Healthcare - Muncie Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2701 Lyn-Mar Dr Muncie, IN 47304	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>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 fumarate (antipsychotic) 25 mg by mouth at bedtime (1/16/26), and citalopram (antidepressant) 10 mg PO once daily (1/19/25), and hydroxyzine hydrochloride (anxiety) 10 mg by mouth every six hours as needed (1/18/25). 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</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>one to three days of the assessment period. The resident required a walker for mobility. He required substantial assistance from staff for dressing, sit-to-stand, and transfers. The resident was dependent on staff assistance for toileting, bathing, and personal hygiene. Resident B required supervision for walking. He had one fall with no injury since the prior assessment. The resident did not have any skin concerns. Resident B's care plans indicated the following: A problem of wandering and elopement risk related to wandering aimlessly and exit seeking in the afternoon/evening due to sundowning. The resident wandered around the unit at night and into other residents' rooms (10/22/25). Interventions included: Distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, and books. The resident preferred the newspaper, snacks, and country/rock music (10/22/25). A problem of physical aggression related to mild neurocognitive disorder due to a known physiological condition with behavioral disturbance, anger, dementia and poor impulse control. The resident has a history of harm to others (10/24/25). Interventions included: Analyze times of day, places, circumstances, triggers, and what de-escalates the behavior and document (10/24/25), When the resident becomes agitated: Intervene before agitation escalates (10/24/25). A problem of verbal aggression related to dementia, ineffective coping skills, and poor impulse control (10/24/25). Interventions included: When the resident becomes agitated, intervene before agitation escalates and guide away from the source of distress (10/24/25). A problem of behaviors such as putting himself on the floor and getting up by himself, wandering around the unit, getting mad at others, cursing staff, putting staff in the corner, packing items that belong to him and others, and throwing items at staff (10/28/25). Interventions included: The resident remains on 15-minute checks (1/18/26). Review of Resident B's progress notes indicated the following: A progress note, dated 1/6/26 at 6:00 p.m., indicated Resident B was wandering and out of other residents' rooms. The resident was encouraged to stay out of other residents' rooms and offered fluids and snacks. The intervention was effective. On 1/9/26 at 5:47 p.m., Resident B was wandering up and down the hall. The resident was offered to use the restroom, snacks, and something to drink. The intervention was ineffective. The resident went to his room on his own. On 1/14/26 at 2:27 a.m., the resident continued on 15-minute checks. On 1/14/26 at 2:42 a.m., Resident B was getting in and out of bed wandering the hall and wandered into another resident's room to urinate. The attempted intervention was food and drinks. It was not effective. The DON, supervisor, and family were notified. On 1/17/26 at 8:11 p.m., the resident continued with 15-minute checks and no adverse effects were noted from medication changes. On 1/18/26 at 8:51 a.m., Resident B and the resident across the hallway had a cursing match. Resident B grabbed the rail outside the other resident's when the resident across the hall became agitated that Resident B was close to his room. The intervention attempted was redirection of both residents. The effectiveness of the intervention included: No contact was made from either resident. On 1/18/26 at 8:42 p.m., the nurse was passing medications and heard a commotion from several rooms up. Upon investigation, Resident B was on the floor lying in a fetal position with his arms over his head and another resident was kicking him. A skin assessment, pain assessment, and neurological assessments were completed. Resident B had a hematoma to his right forehead, an abrasion to the left side of his face, and red areas on his back. His pain was rated five out of ten. The neurological assessment was within normal limits. The resident was transferred to the hospital for evaluation, with notifications completed. A progress note, dated 1/19/26 at 8:05 a.m., indicated the resident returned to the facility at approximately 12:00 a.m. Monitoring was continued. On 1/19/26 at 5:40 p.m., Resident B tried to wander behind the nurse station, he was yelling and getting in the CNA's face. He stated his food was behind the desk. The resident was redirected to the dining room and given his tray and fluids.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interventions were effective. On 1/20/26 at 9:52 a.m., Resident B was spoken to about the previous event, but the resident could not remember any event. He was participating in activities in the dining room. He was calm, cooperative, and pleasant during the interview. The resident did not report nor show any signs of distress. On 1/20/26 at 3:47 p.m., Resident B was wandering more than usual in and out of rooms including the room across the hallway. He was bossy with staff, telling them what to do and how to do it. The interventions included food and snacks. The interventions were ineffective as the resident kept wandering in and out of rooms. No notifications were listed. On 1/23/26 at 9:30 a.m., the Interdisciplinary Team met to discuss the resident's behavior related to restlessness and agitation. The resident was followed by social services and interventions were effective after a period of time. The psychiatric provider was notified of the behaviors. Gabapentin was increased to 300 mg by mouth three times daily. The plan of care was continued at this time. On 1/23/26 at 10:53 a.m., the resident continued on 15-minute checks. On 1/26/26 at 4:00 p.m., Resident B wandered in and out of other residents' rooms looking for his tools. The resident was redirected to his room and offered fluids and snacks. Staff assisted the resident and plugged in his phone. The resident watched television. Interventions were effective. On 1/27/26 at 3:52 p.m., the Interdisciplinary Team met to review Resident B's behaviors as well as interventions. Care plans were reviewed and updated. The psychiatric provider was notified with no new orders. Monitoring of behaviors continued at this time. The resident continued to be easily redirected. Review of Resident B's 15-minute checks included 15-minute checks in place from 1/1/26 through 1/27/26. Review of the facility investigation of an altercation between Resident B and Resident C, on 1/18/26 at 6:53 p.m., included the following information: The facility reported incident to the Indiana Department of Health Face Sheet, assessment, pertinent progress notes, and diagnoses of Resident B Face Sheet, assessment, pertinent progress notes, and diagnoses of Resident C Cognitive assessments for both residents. Emergency Department progress notes for both residents. Imaging reports from the Emergency Department for Resident B Skin assessments for 17 residents dated 1/23/26 Adult Protection Notice dated 1/18/26 at 9:28 p.m. Police report Written statements from LPN 3 and QMA 4 Inservice sign in for all staff and policies dated 1/18/26 titled abuse, neglect, exploitation, de-escalation, and non-pharmacological interventions The investigation was consistent with the information reported to the Indiana Department of Health. During an observation on 1/27/26 at 12:33 p.m., on the secured memory care unit, Resident B's and Resident C's rooms were directly across the hallway from each other. During an observation on 1/27/26 at 12:54 p.m., Resident B was in the dining room seated at a table with another male resident working on a puzzle during a scheduled activity. Activity Assistant 10 was present in the dining room. Resident B was dressed, non-skid footwear in place, and Resident B was seated in a standard chair with his rollator beside him. No skin impairments were present during the observation. No concerns of aggression were observed. During an observation on 1/27/26 at 4:07 p.m., Resident B walked out of his room and towards the dining room. A staff member followed close behind him. The resident walked to the dining room table and sat down next to Activity Assistant 10. Six other residents were in the dining room at that time and interacting with Activity Assistant 10 during the observation. No concerns of aggression were observed. Interviews indicated the following: During an interview on 1/27/26 at 3:43 p.m., LPN 9 indicated she was familiar with both Resident B and Resident C. Resident B was a wanderer and sometimes wandered in and out of other residents' rooms. Resident B got upset at times if things were not done his way. Resident B was known to be verbally aggressive with other residents. Resident B was typically easy to redirect. Staff redirect him from wandering or situations with other residents by offering him snacks, toileting, and activities. Resident B liked bingo, coloring, and watching television in his room.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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</p> <p>(continued on next page)</p>		

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