STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E064	A. Building B. Wing	09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookside Care Strategies	505 N Gavin St Muncie, IN 47303

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review and interview, the facility failed to ensure a cognitively impaired resident was free from staff-to-resident verbal abuse for 1 of 3 residents reviewed for abuse. (Resident B) Finding includes:Resident B's clinical record was reviewed on 9/25/25 at 11:49 a.m. Diagnoses included Asperger's syndrome, unspecified altered mental status, malignant neoplasm of parotid gland, and generalized anxiety disorder. An 8/26/25, significant change Minimum Data Set (MDS) assessment indicated Resident B was severely cognitively impaired. Behaviors included other behavioral symptoms not directed towards others and rejection of care. The resident quired substantial staff assistance for oral hygiene, toileting hygiene, bathing, upper and lower body dressing, and footwear assistance. He required set-up assistance from staff for ambulation and transfers. Resident B's current care plans included the following:A 6/7/23 problem of impaired safety awareness related to Asperger's syndrome. Interventions included calling family as/if needed. A 9/2/25 problem of potential for psychosocial wellbeing related to an allegation with staff. Interventions included allow the resident time to answer questions and verbalize feelings, perceptions and fears (9/2/25), observe/document the resident's usual response to problems: external- expects others to control problems or leaves to fate or luck, internal - how individual makes own changes(9/2/25), when conflict arises, move residents to a calm safe environment and allow the resident to share their feelings (9/2/25).A progress note, dated 9/2/25 at 11:31 a.m., indicated a maintenance staff member had a verbal altercation with Resident B on 8/29/25. The resident continued to deny any distress and continued with his daily routine. Review of a facility reported incident, dated 8/29/25 at 10:01 a.m. indicated the following: Description added On 8/29/25 it was reported to the Administrator that Resident B was in a verbal altercation with a maintenance staff member. No injury was noted. Follow up indicated the investigation was completed. The allegation was substantiated, and the involved staff member was terminated from employment.A review of the facility investigation file, provided by the facility after entrance on 8/25/25, contained the following information:A handwritten statement from QMA 2, dated 8/29/25 at 7:00 a.m., indicated QMA 2 was at the medication cart and Resident B was seated in the chair next to the door. Resident B was doing his repetitive verbalizations with multiple questions, stood up and reached out towards QMA 2 with open arms and palms. QMA 2 was in the process of redirecting Resident B by putting her arm up in a halting position, explained that it was inappropriate behavior, and he needed to sit down. Before QMA 2 could finish redirecting Resident B, the Maintenance Assistant 4 came from behind QMA 2 and got close to Resident B. Resident B then told Maintenance Assistant 4 to shut up. Maintenance Assistant 4 responded to Resident B by telling him to shut up. Maintenance Assistant 4 then told Resident B to touch me. The resident moved towards the Maintenance staff member then with open arms and palms open and extended. Maintenance Assistant 4 then told Resident B, If you touch me, I will put you on the ground. The resident understood it was a threat and quickly left. Maintenance Assistant 4 then turned to QMA 2 and said, See? He's smarter than that. He does his thing and then mouths off. He spoke poorly of Resident 8 in front of QMA 2 and other staff. A handwritten statement from LPN 3, dated 8/29/25, indicated Resident B was in the front lobby at approximately 6:40 a.m. Maintenance Assistant 4 was also in the front lobby and was provoking Resident 8 to approach Maintenance Assistant 4. When Resident B did approach Maintenance Assistant 4, Maintenance Assistant 4 told the resident, If you put your hands on me, I'll lay you on the floor. The resident told Maintenance Assistant 4 to shut up and Maintenance Assistant 4 told the resident to shut up. Resident 8 was removed from the situation and sat in the chair in the lobby with staff supervision before being taken to shower. A typed statement, dated 8/29/25, indicated the Maintenance Assistant 4 reported he was doing his early morning check at the facility. Resident B had the nurse cornered in the building and was grabbing her butt and breast. Maintenance Assistant 4 stepped in to intervene and asked the resident to stop. The resident made a step towards Maintenance Assistant 4 and Maintenance Assistant 4 stated, Don't come any closer or I will put you on the floor. Maintenance Assistant 4 felt the nurse was distressed and needed his intervention. Maintenance Assistant 4 stated he knew he should not have said that as soon as it came out of his mouth.A Termination Documentation Form, dated 8/29/25, indicated Maintenance Assistant 4 was terminated upon conclusion of an investigation regarding a verbal altercation with a resident.During an interview on 9/25/25 at 1:48 p.m., LPN 3 indicated she was at the nurse's station by the computer on the morning of 8/29/25 and witnessed the verbal altercation between Resident B and Maintenance Assistant 4. Resident B was up and as usual with his repetitive verbalizations near the medication cart in front of the nurse's station where QMA