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	03/31/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on record review and interview, the facility failed to protect a resident's right to be treated with respect and dignity when a staff member made a derogatory statement about the resident within hearing distance of the resident for 1 of 3 residents reviewed for abuse. (Resident B) The deficient practice was corrected on 3/20/26, prior to the start of survey, and was therefore past noncompliance. Findings include:Resident B's clinical record was reviewed on 3/30/26 at 1:06 p.m. Diagnoses included moderate dementia in other diseases classified elsewhere with mood disturbance and cognitive communication deficit.An 11/11/25, admission, Minimum Data Set (MDS) assessment indicated the resident was severely cognitively impaired. A progress note, dated 2/23/26 at 3:00 p.m., indicated, on 2/20/26, a staff member made an inappropriate statement to a staff member about Resident B and in front of Resident B. The resident stated he did not hear the statement made and denied any psychosocial distress. A current care plan, dated 2/23/26, indicated the resident was at risk for psychosocial well-being problem related to an inappropriate statement made to another staff member in front of the resident. Interventions included removal of the resident to a calm safe environment allowing the resident to share feelings when conflict arises (2/23/26).During an interview on 3/31/26 at 10:12 a.m., QMA 4 indicated, on 2/20/26, she was at the nurses station and holding Resident B's hand when CNA 3 came from behind QMA 4. When CNA 3 was near the edge of the nurse station, CNA 3 told QMA 4 she should probably bleach her hands because she was holding Resident B's hand. This was said in front of Resident B, who was next to QMA 4. QMA 4 felt the statement was disrespectful and undignified. Resident B was cognitively impaired and may not have been able to process what CNA 3 said in front of him. Resident B was talking to QMA 4 when the statement was made, but it was said within distance that the resident could have heard it. If Resident B was cognitively intact, the statement would have hurt Resident B's feelings. QMA 4 reported the information to the Business Office Manager, DON, and the Administrator immediately. CNA 3 was removed from duty.On 3/31/26 at 1:16 p.m., CNA 3 indicated she walked up to the nurse's station on 2/20/26 and Resident B was touching QMA 4's hands and arms. CNA 3 muttered to QMA 4 that she would use bleach wipes after that. She meant after Resident B had his hands touching QMA 4. She did not intend for Resident B to hear what was said, but the resident was within hearing distance when she said it. CNA 3 was not sure if Resident B heard what was said, but he was next to QMA 4. CNA 3 did not believe her statement was humiliating or demeaning. CNA 3 was notified her employment was terminated for verbal abuse to the resident.On 3/31/26 at 2:19 p.m., the DON indicated she was notified on 2/20/26 in the morning before lunch about CNA 3 making a remark to QMA 4, who was holding Resident B's hand, that QMA 3 would wash her hands in bleach if she were QMA 4. The remark was made while in the presence of Resident B and had the potential to hurt Resident B's feelings. This should not have been said at all, and specifically not in the presence of the resident.On 3/31/26 at 3:07 p.m., the Administrator indicated Resident B was cognitively impaired. The DON obtained a statement from CNA 3. He believed the statement was disrespectful, undignified, and a form of verbal abuse. The facility had ongoing abuse education every month for all staff. They also included abuse in their quality assurance performance improvement plan.On 3/31/26 at 3:30 p.m., the Administrator (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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated the facility was specifically working on respect, dignity, and deescalation techniques in their Crisis Prevention Verbal Interventions Training. The first group of eight management staff received the training on 3/20/26. The next classes for CNAs, QMAs, and Nurses were scheduled for 4/8/26 and 4/9/26. Ancillary staff would receive the same training after all the clinical staff have completed the training.A facility reported incident submitted to Indiana Department of Health, on 2/20/26 at 11:30 a.m., indicated it was reported to the Administrator that a CNA made an inappropriate statement about Resident B to a staff member in front of the resident. No injury was noted. Immediate action taken: On 2/20/26 the Administrator, DON, physician, family and police were notified. The staff member involved was suspended pending investigation. Preventative measures taken: On 2/20/26 an investigation was initiated, statements were received, and interviews were completed. Social services were to provide psychosocial monitoring. The plan of care was reviewed and updated as needed. Follow up added: On 2/24/26 the facility investigation was completed. The allegation was substantiated and the staff member involved was terminated. Interviews were completed and no other residents were involved. Psychosocial monitoring will be provided as needed. The physician and family were notified.A facility investigation provided by the DON on 3/30/26 at 1:01 p.m. included the following:A handwritten interview with CNA 3 indicated she told another staff member in front of the resident that she would wash her hands probably with bleach after holding the resident's hand. The facility incident report regarding a staff to resident abuse incident on 2/20/26Resident B's updated care plan.On 2/23/26, thirty-seven resident questionnaires regarding abuse were conducted. No abuse concerns were identified.A facility abuse in-service sign-in sheet, dated 3/18/26, contained 58 signatures.Quality Assurance Performance Improvement Minutes, dated 3/31/26, indicated the facility was continuing Crisis Prevention Verbal Intervention Training for nurses and aides scheduled for 4/8/26 and 4/9/26. A facility document, dated 3/6/19, titled Resident rights, provided by the DON on 3/31/26 at 1:58 p.m., indicated the following: .(a) The resident has a right to a dignified existence. (1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. The deficient practice was corrected by 3/20/26 after the facility implemented a systemic plan that included a facility in-service regarding abuse on 3/18/26 and Crisis Prevention Verbal Intervention training started on 3/20/26.This citation relates to Intake 2779920.410 Indiana Administrative Code (IAC) 16.2-3.1-3(a)