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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRICKYARD HEALTHCARE - MUNCIE CARE CENTER	**2701 LYN-MAR DR MUNCIE, IN 47304**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00401123, IN00401809, and IN00402249 . Complaint IN00401123 - Substantiated. Federal/State deficiencies related to the allegations are cited at F600 . Complaint IN00401809 - Substantiated. Federal/State deficiencies related to the allegations are cited at F600 and F607. Complaint IN00402249 - Substantiated. No deficiencies related to the allegations were cited. Survey dates: February 24, 27 and 28, 2023 Facility number: 000097 Provider number: 155687 AIM number: 100290970 Census Bed Type: SNF/NF: 103 Total: 103 Census Payor Type: Medicare: 4 Medicaid: 89 Other: 10 Total: 103 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed March 2, 2023.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1)	F 600		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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F 600	Continued From page 1 §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to prevent the physical abuse of a cognitively impaired resident (Resident G) by a staff member (CNA [Certified Nursing Aide] 17). The facility also failed to prevent sexually inappropriate behaviors when a cognitively intact resident (Resident F) touched a severely cognitively impaired resident (Resident E) inappropriately. Using the reasonable person concept, it is likely these deficient practices would lead to chronic or recurrent fear and anxiety. The deficient practice was corrected by February 15, 2023, prior to the start of the survey, and was therefore past noncompliance. The facility had completed assessments, audits, and education related to abuse. Findings include: 1. Review of a facility reportable, dated 2/14/2023, indicated the ED (Executive Director) was escorting a terminated employee from the	F 600	Past noncompliance: no plan of correction required.	

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facility. The terminated employee became vocal and stated "whoever punched [Resident G] in the face needed to be next." The facility had previously investigated a bruise under the resident's right eye, and determined it was from a previous fall. Once the allegation was made by the terminated employee the facility re-opened an investigation.

The clinical record for Resident G was reviewed on 2/24/2023 at 2:30 p.m.. Diagnoses included, type 2 diabetes, encephalopathy, anxiety disorder, hypertension, vascular dementia with behaviors and chronic pain.

Review of the most recent quarterly Minimum Data Set (MDS) assessment, dated 2/15/2023, indicated the resident was severely cognitively impaired.

Review of a care plan, dated 8/30/2022, indicated I sometimes have behaviors which include Rejection of care such as yelling and being combative with care. Interventions included, but were not limited to, please tell me what you are going to do before you begin; Speak to me unhurriedly and in a calm voice.

Review of a risk management report, dated 1/27/2023, indicated staff noted a purple bruise to the resident's right eye right measuring 4.8 centimeters (cm) long x 2.4 cm wide. Staff noted the bruise was observed on 1/27/2023 at 6:00 a.m., when the day shift began.

In a written statement, dated 2/15/2023, Employee 18 indicated CNA 4 and CNA 17 had provided care to the resident, and when they exited the room CNA 17 indicated the resident

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had elbowed her in the private area.

A written statement by the DON (Director of Nursing) indicated on 2/15/2023, CNA 17 was notified of suspension, pending investigation. CNA 17 had indicated the resident sustained a fall a few days prior, and then he had the bruise. CNA 17 indicated the resident was combative at times, but care was always completed with two staff members and "it wasn't that bad".

A written statement, dated 2/15/2023, by the ED and DON, indicated CNA 4 was re- interviewed regarding any incident on 1/25/2023. During the interview, CNA 4 stated "She did it. She hit him. I am sorry I haven't said anything sooner, but I was afraid that I would lose my job." CNA 4 and CNA 17 had been providing care to the resident. CNA 4 was holding the resident's hands and CNA 17 was standing behind the resident. The resident's hand slipped from CNA 4 and the resident's elbow hit CNA 17 in the private area. From behind the resident, CNA 17 swung out and hit the resident in the eye. CNA 4 indicated they were shocked and it happened so quickly.

During an interview, on 2/27/2023 at 11:13 a.m., CNA 4 indicated on 1/25/2023 while providing care for Resident G with CNA 17,the following had occurred: Dinner had just finished between 5:00 and 5:30 p.m. Usually they got people ready for bed, changed them, toileted them. She (CNA 17) asked for help with Resident G. CNA 4 was holding his hands and at first, the resident was ok. When CNA 17 started to pull the resident's pants down, he had started to shake. He had then pulled his hands free and hit her. CNA 4 didn't see where, but knew he had hit her. She was standing behind him, and just shot out and

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hit him on his face with a closed hand. When CNA 4 asked her why she did that, she said "I am sorry he just hit me in my (slang term for female private area)." CNA 4 was shocked and did not know how to react, so he just stayed away from her. He didn't tell anyone. He realized now he should have told someone. When the ED and DON asked him the previous week what had happened, he told them what had actually happened. He had never seen CNA 17 do anything like that before. She was one of the kinder aides, so he was really shocked.

During the survey, the facility attempted to contact CNA 17 for an interview, but were unsuccessful.

2. The clinical record for Resident E was reviewed on, 2/24/2023 at 1:47 p.m.. Diagnoses included, dementia, anxiety, visual hallucinations, and delusional disorder.

Review of the most recent admission Minimum Data Set (MDS) assessment, dated 2/2/2023, indicated the resident was severely cognitively impaired. The resident was admitted to the facility's memory care secured unit on 1/27/2023. Resident behaviors included wandering four to six days out of the assessment period.

A current care plan, dated 1/27/2023, indicated "I have a diagnosis of Alzheimer's or related dementia. Due to cognitive loss, diminished decision making capabilities and safety and security issues, placement in the secure Alzheimer's Care unit with programs designed for this population is needed as evidenced by: dx [diagnosis] of dementia".

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Review of a facility reportable incident, dated 2/7/2023, indicated on 2/6/2023 at 9:30 a.m., Housekeeper 2 observed Resident F with his hands down the back of Resident E's pants. The residents were in Resident E's room.

The clinical record for Resident F was reviewed on 2/24/2023 at 2:00 p.m. Diagnoses included, end stage renal disease with dependence on renal dialysis, obstructive sleep apnea, depressive disorder, vascular dementia, anxiety, and sexual dysfunction.

Review of the most recent quarterly MDS, dated 2/9/2023, indicated the resident was cognitively intact. Behaviors included, but were not limited to the following: Physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually)- occurred one to three days during the assessment period. Other behavioral symptoms not directed towards others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds)-occurred one to three days during the assessment period.

A current care plan, dated 4/1/2022, indicated I sometimes have behaviors which include kissing other residents, holding others [sic] resident's hands; inappropriate touching Dx: other sexual dysfunction not due to a sustance o [sic] know [sic] physiological condition.

Review of a Psychiatry Progress Note, dated 12/29/2022, indicated there were no sexually in appropriate behaviors during the visit. The

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gradual dose reduction for Paxil was declined since there had been a decrease in sexually inappropriate behaviors since receiving Paxil (antidepressant/antianxiety) 20 mg once a day.

Review of a Psychiatry Progress Note, dated 1/19/2023 indicated the resident was being seen for psychiatric follow up and medication management for dementia, depression, mood disorder, and sexual inappropriate behaviors. The noted indicated the resident had multiple noted behaviors of inappropriate gestures and touching of staff and other residents, but was stable. An order for Depo-Provera (hormone-suppressant) 150 mg/ml weekly-on Monday after dialysis and to monitor closely as written at this visit.

Review of a Psychiatry Progress Note, dated 2/2/2023 indicated the resident was being seen for acute increased sexually inappropriate behaviors towards staff and other residents. The resident had a new order for Depo-Provera 150 mg/ml intramuscular suspension one a day on Fridays. One dose had been administered at the time of the visit. The order was changed to Mondays after dialysis on 2/2/2023.

During an interview, on 2/24/2023 at 2:24 p.m., Housekeeper 2 indicated on 2/6/2023 she had entered Resident F's room, and observed him with his hands down the back of Resident E's pants. The housekeeper reported Resident E did not seem to know what was happening. "She just looked at me dumbfounded. It was like she was saying 'I don't know what to do'. She didn't seem to be on board with it."

During an interview, on 2/24/2023 at 3:17 p.m.,

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the DON indicated Resident F was no longer on the secured unit. He had been placed there because of his confusion and exit-seeking behaviors. After the incident, the resident was reassessed and moved off the unit. Resident E was new to the facility, and wandered in and out of other residents' rooms.

During an interview, on 2/27/2023 at 10:28 a.m., the DON indicated Resident F had a history of sexually inappropriate behaviors and had not moved from the secured unit due to his fluctuations in his cognitive state and exit-seeking behaviors. The facility felt he was safe to move off the unit, after the incident, because his BIMS (cognitive assessment) was 15 out of 15.

During an interview, on 2/27/2023 at 1:32 p.m., QMA (Qualified Medication Aide) 8 indicated she had never had any experience with Resident F's behaviors. But, she knew he could be "head strong" and had heard about his sexually inappropriate behaviors.

During an interview, on 2/27/2023 at 1:25 p.m. LPN 7 indicated Resident F was made a "care in pairs" (two-person) because he would fondle the staff during care.

Review of a current, undated facility policy, titled" Abuse, Neglect and Exploitation" was provided by the Assistant Director of Nursing on 2/24/2023 at 10:19 a.m. The policy indicated the following: "Policy: 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

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F 600	Continued From page 8 property...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 and certain resident to resident altercations. Abuse also includes the deprivation by any individual including caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse and mental abuse including abuse facilitated or enabled through use of technology...Willful" means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm...." This Federal tag relates to complaints IN00401123 and IN00401809.	F 600		
F 607 SS=D	3.1-27(a)(1) Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95,	F 607		

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F 607	Continued From page 9 §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure staff reported allegations of abuse to the Administrator in a timely manner for 1 of 4 residents reviewed for abuse (Resident G). The deficient practice was corrected by February 15, 2023, prior to the start of the survey, and was therefore past noncompliance. The facility had completed assessments, audits, and education related to abuse. Findings include: The clinical record for Resident G was reviewed on 2/24/2023 at 2:30 p.m. Diagnoses included type 2 diabetes, encephalopathy, anxiety disorder, hypertension, vascular dementia with behaviors, and chronic pain. Review of a risk management report, dated 1/27/2023, indicated staff noted a purple bruise to	F 607	Past noncompliance: no plan of correction required.	

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the resident's right eye, measuring 4.8 centimeters (cm) long x 2.4 cm wide. Staff noted the bruise was observed on 1/27/2023 at 6:00 a.m., when the day shift began.

In a written statement, dated 2/15/2023, the ED and DON indicated CNA 4 was re-interviewed regarding any incident on 1/25/2023. During the interview, CNA 4 stated "She did it. She it him. I am sorry I haven't said anything sooner, but I was afraid that I would lose my job." CNA 4 and CNA 17 had been providing care to the resident. CNA 4 was holding the resident's hands and CNA 17 was standing behind the resident. The resident's hand slipped from CNA 4 and the resident's elbow hit CNA 17 in the private area. From behind the resident, CNA 17 swung out and hit the resident in the eye. CNA 4 indicated they were shocked and it happened so quickly. CNA 4 did not report the incident to the facility until 21 days after the incident.

During an interview, on 2/27/2023 at 11:13 a.m., CNA 4 indicated on 1/25/2023, while providing care for Resident G with CNA 17, the following occurred: "We had just finished dinner between 5:00 -530 p.m.. Usually we get people ready for bed, change them, toilet them. She (CNA 17) asked me to help with Resident G. I was holding his hands. At first he was ok. When she started to pull his pants down he started to shake. He pulled his hands free and hit her. I didn't see where, I just know he hit her. She was standing behind him. She just shot out and hit him on his face with a closed hand. I asked her why she did that and she said 'I am sorry he just hit me in my (slang term for female private area)'. I was shocked. I did not know how to react. I just stayed away from her. I didn't tell anyone. I

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F 607	Continued From page 11	F 607		

realize now I should have told someone. When the ED and DON asked me last week what happened I told them just what I told you. I had never seen CNA 17 do anything like that before. She is one of the kinder aides, so I was really shocked."

Review of a facility reportable incident, dated 2/14/2023, indicated the ED (Executive Director) was escorting a terminated employee from the facility. The terminated employee became vocal and stated "whoever punched [Resident G] in the face needed to be next." The facility had previously investigated a bruise under the resident's right eye, and determined it was from a previous fall. Once the allegation was made by the terminated employee, the facility immediately re-opened an investigation.

Review of a current policy, dated 12/25/2017, titled" Investigation and Reporting of Alleged Violations of Federal and State Laws Involving Mistreatment, Neglect, Abuse, Injuries of Unknown Source and Misappropriation of Resident's Property"" was provided by the DON on 2/28/2023 at 12:23 p.m. The policy indicated the following: "... Reporting...All employees shall immediately report to the Executive Director all alleged violations; if the Executive Director is not immediately available, all alleged violations should be reported to the Designated Supervisor in charge, who will report to the Executive Director; Reportable allegations include: reasonable suspicion of a crime; allegations of mistreatment; neglect; abuse; injury of unknown source as defined above, or; misappropriation of resident property, by anyone furnishing services on behalf of the center/locations. ...."

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F 607	Continued From page 12 Cross reference F600. This Federal tag relates to complaint IN00401809. 3.1-28(c)	F 607		