STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155076	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brickyard Healthcare - Brookview Care Center	7145 E 21st Street Indianapolis, IN 46219

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. 41129 Based on interview and record review, the facility failed to ensure a resident's right to be treated with respect and dignity by a staff member who forcefully attempted to get a resident with a decreased ability to perform activities of daily living (ADLs) to perform her own incontinent care for 1 of 3 residents reviewed for abuse. (Resident D) Findings include: The clinical record for Resident D was reviewed on 9/20/24 at 1:55 p.m. Her diagnoses included, but were not limited to, asthma, morbid obesity, and hypertensive urgency. A minimum data set assessment, dated 8/11/24, indicated Resident D was moderately cognitively impaired and was dependent on assistance for bathing/showering, dressing, and toileting. She required partial to moderate assistance with personal hygiene. An interview with Resident D was conducted on 9/20/24 at 2:27 p.m. She indicated, on 8/20/24, she required assistance with incontinent care and requested for two people to help her. When her nurse came in to assist, she grabbed her arm and placed a cold, wet towel in her hand and forcefully took her arm down to her pelvic area. She indicated the nurse said if her arm can reach down there then she can clean herself up and she didn't have any aliments with her arms. She indicated this interaction made her feel very upset, degraded, and humiliated. She indicated that she still feels sad about the incident and it was uncalled for. An interview with the Executive Director (ED) was conducted on 9/20/24 at 2:00 p.m. She indicated the incident was about a resident who needed assistance with incontinent care and stated she needed two people to assist her. According to her, she believed the physician's assistant and a certified nursing assistant were in the resident's room when the nurse came in to assist her. She indicated the nurse grabbed the resident's arm and guided her arm to her pelvic area to assist her with her rehabilitation efforts and for her to wipe herself. She indicated when she spoke with Resident D, she indicated the nurse was forceful. This citation is related to Complaint IN00442213. 3.1-3(a) (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	3.1-3(t)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 41129 Based on interview and record review, the facility failed to thoroughly investigate an allegation of abuse for 1 of 3 residents reviewed for abuse. (Resident D) Findings include: The clinical record for Resident D was reviewed on 9/20/24 at 1:55 p.m. Her diagnoses included, but were not limited to, asthma, morbid obesity, and hypertensive urgency. A minimum data set assessment, dated 8/11/24, indicated Resident D was moderately cognitively impaired and was dependent on assistance for bathing/showering, dressing, and toileting. She required partial to moderate assistance with personal hygiene. An interview with Resident D was conducted on 9/20/24 at 2:27 p.m. She indicated, on 8/20/24, she required assistance with incontinent care and requested for two people to help her. When her nurse came in to assist, she grabbed her arm and placed a cold, wet towel in her hand and forcefully took her arm down to her pelvic area. She indicated the nurse said if her arm can reach down there then she can clean herself up and she didn't have any aliments with her arms. She indicated this interaction made her feel very upset, degraded, and humiliated. She indicated she still felt sad about the incident and it was uncalled for. An interview with the Executive Director (ED) was conducted on 9/20/24 at 2:00 p.m. She indicated the incident was about a resident who needed assistance with incontinent care and stated she needed two people to assist her. According to her, she believed the physician's assistant (PA) and a certified nursing assistant (CNA) were in the resident's room when the nurse came in to assist her. She indicated the nurse grabbed the resident's arm and guided her arm to her pelvic area to assist her with her rehabilitation efforts and for her to wipe herself. She indicated when she spoke with Resident D, she indicated the nurse was forceful. An incident report, dated 8/20/24, was received on 9/20/24 at 3:41 p.m. It indicated, on 8/20/24 at 1:30 p.m., a CNA stated another employee was utilizing inappropriate language and made contact with Resident D's arm. The immediate action taken was the initiation of an investigation and a full skin assessment was completed. Preventive measures taken indicated the investigation was initiated, social services notified to follow for signs and symptoms of psychosocial distress, and care plans were reviewed and updated. The follow-up, dated 8/26/24, indicated all staff was educated on abuse prohibition. All interview able residents were interviewed, psychosocial wellbeing was completed with no signs of distress, and care plans were reviewed and updated as needed. The investigation file for the incident was received on 9/20/24 at 10:03 a.m. from the ED. The file did not contain a statement from the PA even though she was a witness to the incident. It did not contain a written statement from Resident D. The ED indicated she had spoken with the resident but did not get her statement in writing. There was no statement from the CNA that reported the incident. (continued on next page)

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	155076	A. Building B. Wing	09/20/2024

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Abuse, Neglect and Exploitation policy was received on 9/19/24 at 11:08 a.m., from the Director of Nursing Services. The policy 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 .Investigation of Alleged Abuse, Neglect and Exploitation . an immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur .Written procedures for investigations include .Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations .Providing complete and thorough documentation of the investigation. This citation is related to Complaint IN00442213. 3.1-28(a) 3.1-28(d)

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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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. 41129 Based on interview and record review, the facility failed to identify individualized approaches of care for a resident with a diagnosis of dementia with agitation and to prevent a resident's distress for 1 of 3 residents reviewed for abuse. (Resident C) Findings include: The clinical record for Resident C was reviewed on 9/20/24 at 10:00 a.m. His diagnoses included, but were not limited to, dementia with moderate agitation, cerebral amyloid angiopathy (a condition that causes bleeding inside the brain and damages brain tissue leading to the loss of the ability to think), and reactive emotional distress. He was admitted to the facility, on 7/18/24, and moved to the locked memory unit, on 7/24/24, per a physician's note. A physician's order to give one 25 mg (milligrams) tablet of quetiapine (medication used to treat psychosis, schizophrenia, bipolar disorder and depression) as needed every 12 hours for delirium was placed on 7/18/24. A physician's assistant (PA) progress note, dated 7/19/24 at midnight, indicated Resident C was admitted to the facility following a recent hospitalization for placement to an extended care facility. Neurological testing revealed moderate dementia with agitation and reactive emotional distress as well as REM (rapid eye movement) behavior disorder (a sleep disorder that involves abnormal movements, behaviors, emotions, perceptions and dreams that occur while falling asleep, sleeping, between sleep stages or during arousal from sleep). He had increased behavioral disturbances at home with agitation and aggression which was noted on his outpatient psychiatry appointment on 6/4/24. On 7/23/24, the order for Resident C's 25 mg of quetiapine, as needed every 12 hours, was discontinued. The PA progress note, dated 7/24/24 at midnight, indicated the reason for the acute visit was per staff's request as Resident C exhibited increased anxiety and was moved to the locked memory care unit. The clinical record did not contain any behavior notes until 7/26/24. A behavior note, dated 7/26/24 at 2:26 p.m., indicated Resident C was seen in the hall walking completely naked. When he was approached, he was visibly upset and started to swing at staff with closed fists. Resident C's baseline care plan did not reference his behaviors (swinging closed fists at staff), nor did it contain interventions to the behaviors. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The PA progress note, dated 7/30/24 at midnight, indicated Resident C was evaluated for intermittent behavior issues. Staff noted the resident was sometimes agitated and aggressive with staff and had displayed intermittent erratic behaviors throughout the day. He responded with some verbal antagonism to the instructions by staff and his aggression is concerning. No changes to his medication regime were attempted at the time but may consider the potential for an as needed medication for agitation/aggression if the behaviors persisted or worsened. On 8/2/24, a physician's order for 25 mg of quetiapine to be given at bedtime for depression and agitation was placed. The PA progress note, dated 8/2/24 at midnight, indicated per the family's request, Resident C's buspirone (used to treat anxiety) was discontinued, but resident will likely need another medication in its place to help manage mood/behaviors given continued breakthrough agitation and behavior issues per staff. On 8/11/24, Resident C's order for 25 mg of quetiapine at bedtime was discontinued. On 8/13/24, a physician's order was placed for Resident C. It indicated to give 25 mg of quetiapine every 12 hours as needed. The order was discontinued on 8/14/24. On 8/15/24, a physician's order was placed for Resident C to receive one 25 mg tablet of quetiapine at bedtime. The order was discontinued on 8/23/24. Resident C's care plan, dated 8/19/24, indicated he had a history of behaviors which included removing his cardiac monitor related to having dementia. The interventions included, but were not limited to, attempt interventions before the behavior begins, offer him something he liked as a diversion, and to speak to him in an unhurried, calm voice. The care plan did not indicate what he liked to be used as a diversion, nor did it indicate he was physically aggressive (swinging closed fists) or what made him agitated. A physician's progress note, effective date of 8/19/24 at midnight, indicated Patient has advanced dementia. He has associated psychotic symptoms with intermittent hallucinations. He also has episodes of agitation. There is also associated general anxiety and insomnia. A self-reported incident, dated 8/29/24, indicated at approximately 2:30 p.m., Resident C who had a severe cognitive deficit was in the common dining room on the reflections unit. Resident C was being re-directed from a behavior and made contact with Resident B's head with a closed hand. The residents were immediately separated. Resident C was placed on one-on-one observation until he was sent to the hospital for evaluation. Resident B was assessed, and no injuries were noted. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with QMA 3 (qualified medication assistant 3), conducted on 9/20/24 at 9:38 a.m., indicated she was the only staff member present when Resident C hit Resident B on 8/29/24. She indicated a group of female residents and Resident C (who is male) were in the common dining room talking and listening to music. She indicated she was tending to a resident just outside of the common dining room when she heard Resident C yell out SHHH really loud. She indicated the sound alerted her that something was wrong. She indicated she had told Resident C to come out of the dining room as to re-direct him and when she did Resident C banged his hand on table making a loud noise which startled the female residents. He proceeded to ask the female residents for their cups so he could throw it at QMA 3. QMA 3 indicated, Resident C had said something to the effect of 'someone give me something to throw at this b****'. She indicated he was all worked up and needed to call for help, so she had turned from Resident B (whom she had been assisting) and was just heading to the nursing office when she heard Resident B say 'OW, stop that! When she turned around, Resident C had grabbed both of Resident B's arms with his one hand and she saw him hit her. She stated, he hit her three times. She indicated she did not see the first hit but assumed that was why Resident B had yelled out ow. She did witness the second hit, and he had a closed fist and when he went to hit her, he drew his arm back to strike her and made contact. He hit her in the face/head. She indicated she ran over trying to get him to release her arms and that was when he hit her for the third time. She stated she finally got him off of her and told Resident B to go down the hallway and away from him. He then turned to the other ladies in the room, so she told them to get on other side of table. She wanted to let him focus on her so he wouldn't target the other residents. He was screaming and hollering. She managed to call for help and when help arrived, he was still physically aggressive. She indicated the loudness of the noise from them talking just triggered him. She knew this from a prior experience with Resident C. She indicated when he moved in, she was in Resident C's room talking to his wife when he did the shhh thing and his wife had stated he does that when things are too loud for him. Resident C's treatment administration record (TAR), for August 2024, indicated for behavior monitoring related to the use of psychotropic medications. There weren't any behaviors noted for the month nor were there any intervention attempts noted. An interview with the Director of Nursing Services (DNS) was conducted on 9/20/24 at 11:39 a.m. She indicated Resident C was seen by neurology at the Veterans Administration but did not know what/if any recommendations were indicated as his wife took him to those appointments. She indicated his care plan should have addressed his behaviors upon admission given he was admitted with dementia with agitation. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Behavioral Health Services policy was received on 9/20/24 at 11:53 a.m. It indicated, It is the policy of this facility to ensure all resident receive necessary behavioral health services to assist them in reaching and maintain their highest level of mental and psychosocial functioning .The facility will ensure that necessary behavioral health care services are person-centered and reflect the resident's goals for care, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety .The assessment and care plan will include goals that are person-centered and individualized .Staff will .obtain history from medical records, the resident, and as appropriate the resident's family and friends, regarding mental, psychosocial, and emotional health .Monitor the resident closely for expressions or indications of distress .Accurately document the changes, including the frequency of occurrence and potential triggers in the resident's record .Evaluate resident and care plan routinely to ensure the approaches are meeting the needs of the resident .The care plan shall .have interventions that are person-centered, evidence-based, trauma informed, and in accordance with professional standards of practice .be reviewed and revised as needed, such as when interventions are not effective or when the resident experiences a change in condition 3.1-37(a) 3.1-43(a)(2)