STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155138	A. Building B. Wing	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brickyard Healthcare - Churchman Care Center	2860 Churchman Ave Indianapolis, IN 46203

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 35099 Based on observation, interview, and record review, the facility failed to ensure a self medication administration assessment was completed for 1 of 1 residents randomly observed with medications left at bedside. Finding includes: During an observation on 10/16/24 at 9:38 a.m., Resident 30 was sitting up on the side of the bed. The following items were observed sitting on top of table in front of television: - One medication bottle of Simbrinza Ophthalmic Suspension 1-0.2%, for the treatment of glaucoma. - One medication bottle of Lantanoprost Solution 0.0005%, for the treatment of glaucoma. During an observation on 10/17/24 at 8:38 a.m., a small plastic medication cup with multiple unidentified tablets and capsules were observed sitting on the table in front of the television. During an interview at that time, Resident 30 indicated that he had to eat breakfast before he could take his medication, so the nurse left them for him. During an observation on 10/21/24 at 10:50 a.m., the following was observed sitting on top of refrigerator in Resident 30's room: - One medication bottle of Simbrinza Ophthalmic Suspension 1-0.2%, for the treatment of glaucoma. - One medication bottle of Lantanoprost Solution 0.0005%, for the treatment of glaucoma. On 10/21/24 at 11:03 a.m., Resident 30's clinical record was reviewed. The clinical record lacked a self-administration medication assessment. During an interview on 10/21/24 at 10:55 a.m., Qualified Medication Aide (QMA) 5 indicated medications should not be left in resident rooms. During interview on 10/21/24 at 11:30 a.m., the Director of Nursing indicated that it was not acceptable for staff to leave medication in resident rooms. The DON indicated Resident 30 did not have a medication self-administration assessment. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/21/24 at 11:30 a.m., the Director of Nursing provided a policy titled Medication Administration Policy, dated 2024, and indicated it was the policy currently in use for the facility. The policy indicated, 18. Observe resident consumption of medication. 3.1-11(a)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 38466 Based on interview and record review, the facility failed to ensure that written Notice of Transfer and Discharge was provided to the resident's representative and to the Office of the State Long-Term Ombudsman for 1 of 6 residents reviewed for written transfer and discharge notification. (Resident 31) Finding includes: On 10/17/24, at 2:00 p.m., Resident 31's clinical record was reviewed. The diagnoses included, but were not limited to, congestive heart failure and type 2 diabetes. The face sheet indicated Resident 31 had a resident representative. The Annual Minimum Data Set (MDS) assessment, dated 8/22/24, indicated Resident 31 was cognitively intact. The clinical record's census tab indicated Resident 31 was transferred to the hospital emergency department on 8/5/24. The Notice of Transfer or Discharge document, dated 8/5/24, indicated Resident 31 was transferred to the hospital emergency department for a facility-initiated hospital transfer on 8/5/24. Resident 31 was provided a copy of the transfer document at the time of his transfer. On 10/21/24 at 1:45 p.m., the Administrator provided a copy of the facility's August 2024 monthly report submitted to the Office of the State Long-Term Ombudsman. The report indicated Resident 31 was transferred to the hospital on 8/5/24. The monthly report did not included a copy of Resident 31's Notice of Transfer and Discharge document. The monthly report lacked specific details for the transfer including the reason for transfer, bed hold policy, and appeal rights. The clinical record lacked documentation that the written Notice of Transfer and Discharge document was provided to the resident's representative and to the Office of the State Long-Term Ombudsman for the facility-initiated hospital transfer on 8/5/24. During an interview on 10/16/24 at 1:17 p.m., Resident 31 indicated he was transferred to the hospital this past August. During an interview on 10/18/24 at 8:43 a.m., the Director of Nursing Services (DNS) indicated Resident 31 was transferred to the hospital emergency department on 8/5/24. The facility lacked verification that the written Notice of Transfer and Discharge document was provided to the resident's representative and to the Office of the State Long-Term Ombudsman for the facility-initiated hospital transfer on 8/5/24. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/21/24 at 2:05 p.m., the Social Service Director indicated the Notice of Transfer and Discharge document was not included in the monthly report that was sent to the Ombudsman. The monthly report provided to the ombudsman only included the date and location of the transfer. On 10/21/24 at 9:12 a.m., the Regional Director of Clinical Operations provided a copy of the Transfer and Discharge (including AMA [Against Medical Advice]) policy, dated 2024, and indicated it was the current policy in use by the facility. A review of the policy indicated, .The facility's transfer/discharge notice will be provided to the resident and the resident's representative in a language and manner in which they can understand .copies of notices for emergency transfers to the Ombudsman . 3.1-12(a)(6)(A)(iii)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 36746 Based on observation, interview, and record review, the facility failed to implement the comprehensive care plan for 1 of 2 residents reviewed for falls. (Resident 7) Finding includes: On 10/16/24 at 10:00 a.m., observed Resident 7's in bed. The bed was observed to be elevated (approximately 4 feet from the floor) and was not in the the lowest position. On 10/17/24 at 11:23 a.m., observed Resident 7's in bed. The bed was observed to be elevated (approximately 4 feet from the floor) and was not in the lowest position. On 10/21/24 at 8:45 a.m., observed Resident 7 in bed. The bed was observed to be elevated and was not in the lowest position. During an interview on 10/21/24 at 8:45 a.m., RN 4 indicated Resident 7's bed should always be in the lowest position. On 10/21/24 at 9:30 a.m., the clinical record for Resident 7 was reviewed. The diagnosis included, but was not limited to, dementia. The Annual Minimum Data Set assessment, dated 9/11/24, indicated Resident 7 required extensive assist with bed mobility and transfers. A Care plan, dated 2/20/23, indicated Resident 7 was at risk for falls. The interventions included, but were not limited to, keep bed in low position, dated 9/18/24. On 10/21/24 at 9:05 a.m., the Regional Director of Clinical Operations provided a policy titled Comprehensive Care Plans, dated 2024, a review of the policy indicated Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident .3. The comprehensive care plan will describe, at minimum, the following . a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, .well being. 3.1-35(g)(2)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 45292 Based on interview and record review, the facility failed to document the drug dispositions for 1 of 3 closed record residents reviewed. (Resident 49) Finding includes: On 10/18/24 at 10:35 a.m., the clinical record of Resident 49 was reviewed. The diagnoses included, but were not limited to, paraplegia (paralysis of the legs and lower body), hepatitis C (a viral infection that affects the liver), and acquired absence of bilateral legs above the knee. A physician's order summary report of medications, dated for active orders as of 10/14/24, included, but were not limited to: - acidophilus probiotic blend 1 mcg (microgram) for probiotic - atorvastatin calcium 20 mg (milligram) for hyperlipidemia (high levels of fat in blood) - bacitracin ointment 500 unit/gm (gram) for wound care - benzocaine-menthol-zinc chloride gel 20-0.26-0.15 % for tooth pain - diazepam 5 mg for anxiety/seizures - docusate sodium 100 mg for constipation - ferrous sulfate 325 mg for iron supplementation - fluticasone propionate nasal suspension 93 mcg for nasal congestion - gabapentin 600 mg for pain - ibuprofen 400 mg for pain - Lidoderm patch 5 % for costochondritis (inflammation of the cartilage that connects your ribs to your breastbone) - linaclotide 145 mcg for irritable bowel syndrome - methadone hydrochloride 5 mg for substance abuse/pain - oxybutynin chloride extended release 5 mg for urinary incontinence - oxycodone hydrochloride 5 mg for spinal cord injury (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- oyster shell calcium 500 mg for supplement - sofosbuvir-Velpatasvir 400-100 mg for viral hepatitis C - trazodone hydrochloride 50 mg for depression - vitamin D3 1.25 mg for supplement A progress note, dated 10/14/24 at 5:47 p.m., indicated Resident 49 left the facility via bus and had been discharged with medication to home. Resident 49's record lacked documentation listing any name, type, or amount of medications that were sent home with the resident or resident's representative. During an interview on 10/18/24 at 10:50 a.m., the Regional Director of Clinical Operations (RDOC) indicated that the facility lacked documentation for drug dispositions for Resident 49. During an interview on 10/18/24 at 1:10 p.m., the RDOC indicated that the facility lacked a specific policy for drug dispositions. 3.1-25(s)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 36746 Based on observation, interview, and record review, the facility failed to ensure a medication cart was locked for 1 of 4 medication carts observed. (B Hall Medication Cart) Finding includes: On 10/16/24 from 9:25 a.m. until 9:40 a.m., observed an unlocked medication cart on the B hall. The cart was easily opened and no staff were visible in the area. The medication cart contained multiple resident's medications. The medications located inside the medication cart, included but was not limited to: - haloperidol 5 mg (milligram), a medication used to treat nervous, emotional and mental conditions. - metronidazol, a medication used to treat infections. - metoprolol 2.5 mg, a medication used to treat high blood pressure. - Eliquis 2.5 mg, a medication used to prevent blood clots from forming. During an interview on 10/16/24 at 9:45 a.m., the Medical Records Director indicated the medication cart should have been locked. On 10/17/24 at 10:53 a.m., the Regional Director of Clinical Services provided a policy titled Medication Storage, dated February, 2024, and indicated it was the current policy being used by the facility. A review of the policy indicated .1. a. All drugs and biologicals will be stored in locked compartments (i.e., medication carts .). 3.1-25(m)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 35099 Based on observation, interview, and record review, the facility failed to ensure food was prepared in a sanitary manner for 2 of 2 kitchen observations. Hair was not covered. (Dietary Manager) Findings include: On 10/16/24 from 9:08 a.m. to 10:00 a.m., observed the Dietary Manager in the kitchen food preparation area where food had been prepared for the morning meal and shipment of supplies were being put away. The Dietary Manager was observed to be lacking a hair net with hair measuring approximately one forth of an inch over the entire head. On 10/16/24 from 11:45 a.m. to 12:45 p.m., the Dietary Manager was observed in the kitchen assisting with food preparation for the noon meal. The Dietary Manager was observed to be lacking a hair net. During an interview on 10/16/24 at 12:45 p.m., the Dietary Manager indicated hair nets should be worn. During an interview on 10/17/24 at 2:58 p.m., the Regional Director for Clinical Operations indicated all kitchen staff preparing food should have been wearing hair nets. On 10/16/24 at 12:46 p.m., the Regional Director of Clinical Operations provided a copy of Food Safety requirement, dated 2024, and indicated it was the current policy in use by the facility. A review of the policy indicated, page 3 section 7.e . Hairnets should be worn when cooking, preparing, or assembling food, such as stirring pots or assembling the ingredients of a salad, . On 10/17/24 at 2:00 p.m., a review of the Indiana Food Establishment Sanitation Requirements, Title 410 IAC 7-24, effective November 13, 2004, indicated, (b)food employees shall wear hair restraints, such as hats, hair coverings or nets .that are designed and worn to effectively keep their hair from contacting . exposed food . 3.1-21(i)(2) 3.1-21(i)(3)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 45292 Based on interview and record review, the facility failed to ensure residents were provided a two-step Mantoux skin test (tool used for screening for tuberculosis) upon admission for 3 of 5 residents reviewed for tuberculosis skin tests. (Resident 32, Resident 33, and Resident 44) Findings include: 1. On 10/16/24 at 10:30 a.m., Resident 32's clinical record was reviewed. Resident 32's diagnoses included, but were not limited to, COPD, chronic kidney disease, and type 2 diabetes. Resident 32's clinical record lacked any documentation of a first step or a second step Mantoux skin test upon admission. 2. On 10/16/24 at 11:15 a.m., Resident 33's clinical record was reviewed. Resident 33's diagnoses included, but were not limited to, COPD, encephalopathy (a syndrome of brain dysfunction), and alcoholic liver disease. Resident 33's clinical record lacked any documentation of a first step or a second step Mantoux skin test upon admission. 3. On 10/16/24 at 11:00 a.m., Resident 44's clinical record was reviewed. Resident 44's diagnoses included, but were not limited to, chronic respiratory failure, tracheostomy status, and type 2 diabetes. Resident 44's clinical record lacked any documentation of a first step or a second step Mantoux skin test upon admission. During an interview on 10/18/24 at 1:40 p.m., the RDCO (Regional Director of Clinical Operations) indicated that Mantoux skin tests should be given upon admission. On 10/21/24 at 1:30 p.m., the Administrator provided an undated policy titled, Resident Screening for Tuberculosis, and indicated it was the policy currently in use by the facility. A review of the policy indicated that the facility screens for tuberculosis in accordance with state requirements and tuberculin skin tests must be completed within three months prior to admission or upon admission. 3.1-18(b)(1)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. 45292 Based on interview and record review, the facility failed to have residents sign the appropriate consent or refusal forms for pneumococcal vaccinations upon admission for 4 of 5 residents reviewed for immunization records. (Resident 3, Resident 32, Resident 33, and Resident 44) Findings include: 1. On 10/16/24 at 10:45 a.m., Resident 3's clinical record was reviewed. Resident 3's diagnoses included, but were not limited to, COPD (a lung disease that makes it difficult to breathe), chronic hepatitis C (a viral infection that affects the liver), and unspecified kidney injury. On 10/17/24 at 8:30 a.m., the DON (Director of Nursing), provided a copy of Resident 3's pneumococcal vaccine consent form. A review of the form indicated it was signed as verbal from POA [Power of Attorney] and was undated. 2. On 10/16/24 at 10:30 a.m., Resident 32's clinical record was reviewed. Resident 32's diagnoses included, but were not limited to, COPD, chronic kidney disease, and type 2 diabetes. On 10/17/24 at 8:30 a.m., the DON provided a copy of Resident 32's pneumococcal vaccine consent form. A review of the form indicated it was signed by the resident and was undated. 3. On 10/16/24 at 11:15 a.m., Resident 33's clinical record was reviewed. Resident 33's diagnoses included, but were not limited to, COPD, encephalopathy (a syndrome of brain dysfunction), and alcoholic liver disease. On 10/17/24 at 8:30 a.m., the DON provided a copy of Resident 33's pneumococcal consent form. A review of the form indicated it was signed by the DON for [Resident 33] and was dated 10/16/24. 4. On 10/16/24 at 11:00 a.m., Resident 44's clinical record was reviewed. Resident 44's diagnoses included, but were not limited to, chronic respiratory failure, tracheostomy status, and type 2 diabetes. On 10/17/24 at 8:30 a.m., the DON provided a copy of Resident 44's pneumococcal consent form. A review of the form indicated it was signed by two staff witnesses and was dated for 10/16/24. During an interview on 10/18/24 at 1:40 p.m., the RDCO (Regional Director of Clinical Operations) indicated that the forms should have been signed upon admission. The consent forms records were requested on 10/16/24 at the end of the first day of the survey and were provided on the morning of 10/17/24. All of the forms were dated for 10/16/24 or were undated, and the RDCO indicated that any undated areas on forms were also from 10/16/24. On 10/16/24 at 10:15 a.m., the DON provided an undated policy titled, Pneumococcal Vaccine (Series) and indicated it was the policy currently in use by the facility. A review of the policy indicated that each resident is to be assessed for pneumococcal immunizations upon admission and that a consent form shall be signed prior to the administration of the vaccine. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.1-13(a)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 45292 Based on interview and record review, the facility failed to have residents sign the appropriate consent or refusal forms for Covid-19 (SARS-CoV-2) vaccinations upon admission for 4 of 5 residents reviewed for immunization records. (Resident 3, Resident 32, Resident 33, and Resident 44) Findings include: 1. On 10/16/24 at 10:45 a.m., Resident 3's clinical record was reviewed. Resident 3's diagnoses included, but were not limited to, COPD (a lung disease that makes it difficult to breathe), chronic hepatitis C (a viral infection that affects the liver), and unspecified kidney injury. On 10/17/24 at 8:30 a.m., the DON (Director of Nursing), provided a copy of Resident 3's Covid-19 vaccine consent form. A review of the form indicated it was signed as verbal from POA [Power of Attorney] and was undated. 2. On 10/16/24 at 10:30 a.m., Resident 32's clinical record was reviewed. Resident 32's diagnoses included, but were not limited to, COPD, chronic kidney disease, and type 2 diabetes. On 10/17/24 at 8:30 a.m., the DON provided a copy of Resident 32's Covid-19 vaccine consent form. A review of the form indicated it was signed by the resident and was dated 10/16/24. 3. On 10/16/24 at 11:15 a.m., Resident 33's clinical record was reviewed. Resident 33's diagnoses included, but were not limited to, COPD, encephalopathy (a syndrome of brain dysfunction), and alcoholic liver disease. On 10/17/24 at 8:30 a.m., the DON provided a copy of Resident 33's Covid-19 consent form. A review of the form indicated it was signed by the DON for [Resident 33] and was dated 10/16/24. 4. On 10/16/24 at 11:00 a.m., Resident 44's clinical record was reviewed. Resident 44's diagnoses included, but were not limited to, chronic respiratory failure, tracheostomy status, and type 2 diabetes. On 10/17/24 at 8:30 a.m., the DON provided a copy of Resident 44's Covid-19 consent form. A review of the form indicated it was signed by two staff witnesses and was undated. During an interview on 10/18/24 at 1:40 p.m., the RDCO (Regional Director of Clinical Operations) indicated that the forms should have been signed upon admission. The consent forms records were requested on 10/16/24 at the end of the first day of the survey and were provided on the morning of 10/17/24. All of the forms were dated for 10/16/24 or were undated, and the RDCO indicated that any undated areas on forms were also from 10/16/24. (continued on next page)

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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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/16/24 at 10:15 a.m., the DON provided an undated policy titled, Covid-19 Vaccination and indicated it was the policy currently in use by the facility. A review of the policy indicated residents are to be offered immunizations for Covid-19 and that a consent form shall be signed prior to the administration of the vaccine.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155138	A. Building B. Wing	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brickyard Healthcare - Churchman Care Center	2860 Churchman Ave Indianapolis, IN 46203

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 36746 Based on observation, interview, and record review, the facility failed to ensure biohazard materials were stored behind a locked door for 1 of 1 biohazard rooms observed. (B Hall) Finding included: On 10/16/24 at 10:45 a.m., observed an unlocked biohazard room located on the B hall. No staff were present in the area. A sign posted on the door indicated caution biohazard materials, soiled utility, keep door locked. The door was unlocked and easily opened. Inside the room observed a large canister full of soiled linen. The room had a strong odor of urine. During an interview on 10/16/24 at 11:00 a.m., the Medical Records Director indicated the biohazard room should be locked. On 10/17/24 at 10:53 a.m., the Regional Director of Clinical Operations provided a copy of a policy titled Medical Waste, dated 2024, and indicated it was the current policy being used by the facility. A review of the policy indicated Policy: It is the policy of this facility to ensure that regulated medical waste is managed, handled, stored, and transported as per Federal, State and local guidance and regulations. 3.1-19(f)