STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155834	A. Building B. Wing	07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brickyard Healthcare - Willow Springs Care Center	2002 West 86th Street Indianapolis, IN 46260

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to allow a resident to return to the facility where the resident had resided for several months without documentation of any needs or behaviors which were not previously present and could not be met by the facility for 1 of 3 residents reviewed for an inappropriate discharge. (Resident B)Findings include: An email from the local hospital, dated 7/10/25, indicated Resident B was sent to the emergency room due to alleged aggression at the facility where he resided. The psychiatric department cleared him while in the emergency room to return to the facility. The facility refused to accept him back. The clinical record for Resident B was reviewed on 7/22/25 at 1:15 p.m. The diagnoses included, but were not limited to, Parkinson's disease, dementia, metabolic encephalopathy, bipolar disorder, and the need for assistance with personal care.Resident B was admitted to the facility, on 3/24/25, from a psychiatric hospital.The nursing progress notes, dated 3/24/25 to 4/24/25, indicated Resident B had behaviors of cussing at the staff, being aggressive with the staff, refusing to take his medications, refusing to allow staff to change his wet bed linens, calling the staff the N word, and he was physically and verbally abusive toward the staff members. The nursing progress notes did not include any documentation Resident B was putting other residents in danger.A nursing progress note, dated 4/24/25, indicated Resident B was admitted to a psychiatric hospital for the behaviors he had been displaying. A nursing progress note, dated 5/1/25 at 7:22 p.m., indicated Resident B was re-admitted to the facility after a psychiatric hospital stay for behaviors. A Nurse Practitioner's (NP) note, dated 5/5/25, indicated the resident was being seen for a re-admission to the facility from a psychiatric hospital stay from 4/24/25 to 5/1/25. He was started on Divalproex (a medication used as a mood stabilizer for persons with a diagnosis of bipolar disorder) and his quetiapine (a medication used to treat psychosis, delusions and hallucinations) was increased during his stay at the hospital. The NP note lacked documentation Resident B's needs could not be met at this facility.The nursing progress notes, dated 5/1/25 to 5/7/25, indicated Resident B had behaviors of hitting and scratching staff members, using racial slurs to staff members and calling them the N word. He would spit out his medications. When Resident B attempted to get a female resident's attention, she dismissed him and he became angry, aggressive, and attempted to grab and scratched her right forearm. He yelled negative verbalizations at her in the hallway. When interventions were ineffective, the police were called, and Resident B attempted to punch a police officer. A physician's order was obtained to send him out for a psychiatric evaluation related to being a continued harm to himself and other people despite de-escalation and redirection. A progress nursing note, dated 5/14/25 at 3:33 p.m., indicated Resident B was re-admitted to the facility after a recent psychiatric hospital stay. A NP note, dated 5/15/25, indicated the resident was visited for re-admission back into the facility from a psychiatric hospital stay for behaviors. He was content with all male care givers and none of his psych medications were changed. The psychiatric team had questioned if his Sinemet (a medication used to treat Parkinson's disease) could have been the cause of his behaviors. A neurology consultation would be scheduled. The NP note lacked documentation Resident B's needs could not be met at this facility.The clinical record lacked documentation the facility had scheduled a neurology consultation or had tried to implement all male caregivers for Resident B's care. A physician's note, dated 5/16/25, indicated the resident was sent to a psychiatric hospital for being verbally and physically aggressive. Multiple attempts to redirect him failed and he was at risk to himself and to the staff. He had some changes completed for his mental health treatments. He calmed down some and was eventually transferred back to the facility for further care of his chronic medical conditions. He had his psychiatric medications increased during his hospital stay from 4/24/25 to 5/1/25. The physician's note lacked documentation Resident B's needs could not be met at this facility or documentation Resident B was putting other residents in danger.The nursing progress notes, dated 5/14/25 to 5/30/25, indicated Resident B was displaying behaviors of calling staff members the N word, using racial slurs toward staff members, and being aggressive and punching staff. He was touching the staff's private areas while they were providing personal care for him, telling the staff to suck his private parts, punching staff members in between their legs, verbalizing sexually inappropriate comments to the staff and being verbally abusive to staff. A nursing progress note, dated 5/30/25, indicated Resident B had new episodes of physical aggression, sexual inappropriateness, and used racial slurs throughout the day. A physician's order was received to send the resident out for an acute psychiatric episode.The nursing progress notes did not include any documentation Resident B was putting other residents in danger.A nursing progress note, dated 5/31/25, indicated Resident

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure a resident, the resident's representative, and the Office of the State LTC Ombudsman was notified, provided the necessary paperwork, and was involved in the discharge process before a resident was sent to the emergency room and was not permitted to return for 1 of 3 resident reviewed the for discharge process. (Resident B)Findings include:An email from the local hospital, dated 7/10/25, indicated Resident B was sent to the emergency room due to alleged aggression at the facility where he resided. The psychiatric department cleared him while in the emergency room to return to the facility. The facility refused to accept him back. The clinical record for Resident B was reviewed on 7/22/25 at 1:15 p.m. The diagnoses included, but were not limited to, Parkinson's disease, dementia, metabolic encephalopathy, bipolar disorder, and the need for assistance with personal care. Resident B was admitted to the facility, on 3/24/25, from a psychiatric hospital.A social worker progress note, dated 4/23/25 at 4:30 p.m., indicated she attempted to call Resident B's son to participate in a care plan meeting, but his children were unreachable. The resident needed a guardian. She would continue to contact his children. The clinical record did not indicate the attempts the facility had made to obtain a guardian for Resident B.A nursing progress note, dated 4/24/25, indicated Resident B was admitted to a psychiatric hospital for the behaviors he had been displaying. A nursing progress note, dated 5/1/25 at 7:22 p.m., indicated Resident B was re-admitted to the facility after a psychiatric hospital stay for behaviors. The nursing progress notes, dated 5/7/25, indicated a physician's order was obtained to send Resident B out for a psychiatric evaluation.A progress nursing note, dated 5/14/25 at 3:33 p.m., indicated Resident B was re-admitted to the facility after a recent psychiatric hospital stay.A nursing progress note, dated 5/31/25, indicated Resident B was sent out to a psychiatric hospital due to behaviors.A nursing progress note, dated 6/25/25 at 3:48 p.m., indicated Resident B was re-admitted back to the facility from the psychiatric hospital.A nursing progress note, dated 7/4/25, indicated Resident B kicked an aide in the middle of her chest, grabbed her arm, scratched her on the right upper arm, spit at her and said multiple racial slurs. The police were called, and a physician's order was given to send the resident out to a different psychiatric hospital. A nursing progress note, dated 7/7/25, indicated Resident B was re-admitted to the facility.A nursing progress note, dated 7/9/25, indicated the resident was discharged to the emergency room.Resident B's record lacked documentation he was allowed to return to the facility after he was sent to the emergency room on 7/9/25. A document, titled Admissions/Marketing Referral Intake Form, dated 7/9/25 and provided by the Director of Nursing on 7/23/25 at 12:30 p.m., indicated Resident B was hospitalized for behaviors. He had been a previous admission and had refused care.The document was dated the same day the resident was sent to the hospital and indicated the resident had been a previous admission and had refused care. The document did not indicate Resident B was a current resident.During an interview, on 7/23/25 at 12:31 p.m., the Director of Nursing indicated the Admissions/Marketing Referral Intake Form was an assessment completed by LPN 1 on Resident B which determined he could not come back to the facility. During an interview, on 7/22/25 at 3:21 p.m., the Director of Nursing indicated after the resident was sent to the hospital, on 7/9/25, the facility refused to accept him back because they could not meet his needs due to, he was in restraints at the hospital. The facility was seeking a new place for Resident B to stay due to his behavioral outbursts. On 6/25/25, he was supposed to be admitted to a sister facility with an all-male behavioral unit. While EMS was in route with Resident B, the facility was contacted and told the accepting facility was full, so Resident B was brought back to their facility. The facility worked to get placement for him at a sister facility. The hospital called the sister facility who indicated they had accepted him, but the next day they decided he could not come because he did not have a payor source. Throughout his admission at the facility, the social worker had tried many facilities to move him to because they were not able to meet his needs.During an interview, on 7/23/25 at 2:51 p.m., the Social Service Director indicated she did not play any role in the discharge planning for Resident B because his discharge was an unplanned discharge. She did not notify the family (his sons) regarding the unplanned discharge because they lived out of state. They did not return calls to the facility even when the facility left messages for them.During an interview, on 7/30/25 at 10:40 a.m., the LTC Ombudsman indicated the facility had never contacted her for assistance with Resident B's care or behaviors. Her job is to be a resource and an advocate. If the facility would have reached out, she would have helped find Resident B a facility more suitable to meet his needs and behaviors. There was no documentation in the medical record to indicate the facility had tried to obtain a guardian for the resident, had

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a person-centered, comprehensive care plan was reviewed by the Interdisciplinary team (IDT) and updated to reflect the behavior care needs for 1 of 3 residents reviewed for care plans. (Resident B)Findings include:The clinical record for Resident B was reviewed on 7/22/25 at 1:15 p.m. The diagnoses included, but were not limited to, Parkinson's disease, dementia, metabolic encephalopathy, bipolar disorder, and the need for assistance with personal care. Resident B was admitted to the facility on [DATE].A care plan, dated 3/25/25, indicated Resident B had behavioral symptoms related to bipolar disorder as evidence by racial slurs and derogatory comments directed at staff, verbal and physical aggression towards staff, making contact with others, throwing items, and refusing care at times. The interventions included, but were not limited to, 3/25/25, to administer medications as ordered and monitor/document for side effects and effectiveness, care in pairs, provide opportunity for positive interaction and attention, stop and talk with him, discuss the resident's behavior to him and explain and reinforce why his behavior was inappropriate and unacceptable, intervene as necessary to protect the rights and safety of others, approach and speak in a calm manner, divert his attention, remove him from the situation and take him to an alternative location as needed, monitor his behavior episodes and attempt to determine the underlying cause of the behavior, consider the location, time of the day, and the persons involved in the behavior, and document the behavior and the potential causes of that behavior. 5/8/25, give the resident his space as needed.A Nurse Practitioner's (NP) progress note, dated 5/5/25, indicated the resident was seen for a re-admission to the facility from a psychiatric hospital stay from 4/24/25 to 5/1/25.A NP's progress note, dated 5/15/25, indicated the resident was seen for a re-admission to the facility from a psychiatric hospital stay. He was content with all male care givers.A NP progress note, dated 6/26/25, indicated the resident was seen for re-admission after a psychiatric hospital stay.Resident B's clinical record lacked IDT progress notes after each re-admission from the psychiatric hospitalizations to indicate the care plan had been reviewed and revised with new or modified interventions for Resident B's behaviors to be effectively managed. During an interview, on 7/23/25 at 4:00 p.m., the Regional [NAME] President of Operations indicated the care plans were to be reviewed and updated upon re-admission to the facility if needed. A current facility policy, titled Care Plan Revisions Upon Status Change, undated and provided by the Director of Nursing on 7/23/25 at 3:45 p.m., indicated .The purpose of this procedure is to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change.The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change .Interdisciplinary Team will discuss the resident condition and collaborate on intervention options. c. The team meeting discussion will be documented in the nursing progress notes. d. The care plan will be updated with the new or modified interventions. e. Staff involved in the care of the resident will report resident response to new or modified interventions This citation relates to Complaint 1369834.3.1-35(e)