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 _____	C 11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRICKYARD HEALTHCARE - CHURCHMAN CARE CENTER	**2860 CHURCHMAN AVE INDIANAPOLIS, IN 46203**

(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 Complaint IN00447653. This visit was in conjunction with a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on October 22, 2024. Complaint IN00447653 - Federal/State deficiencies related to the allegations are cited at F600. Survey date: November 21, 2024 Facility number: 000063 Provider number: 155138 AIM number: 100266210 Census Bed Type: SNF/NF: 68 Total: 68 Census Payor Type: Medicare: 1 Medicaid: 63 Other: 4 Total: 68 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed November 26, 2024.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation	F 600		

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

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F 600	Continued From page 1 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 protect the resident's right to be free from physical abuse by a QMA (Qualified Medication Aide) for 1 of 1 residents reviewed for abuse. (Resident D, QMA 4) Findings include: During an interview on 11/21/24 at 12:07 p.m., RN 2 indicated Resident D was hitting QMA 4 when QMA 4 picked up a chair for protection. QMA 4 then moved towards Resident D with the chair and put the chair against his neck. RN 2 told QMA 4 to stop, RN 2 notified the Director of Nursing (DON) immediately. During an interview on 11/21/24 at 12:13 p.m., Licensed Practical Nurse (LPN) 3 indicated she observed Resident D become upset. Resident D had begun to yell out and was hitting the wall at that time. QMA 4 approached Resident D to take him to his room when Resident D punched QMA 4. QMA 4 backed up and grabbed a folded metal chair and physically placed it onto Resident D's	F 600	Past noncompliance: no plan of correction required.	

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F 600	Continued From page 2	F 600		

upper chest just below his neck. LPN 3 yelled out to QMA 4 to stop and move away. LPN 3 then reported the incident to the DON immediately. LPN 3 indicated that all QMA 4 had to do was walk away from Resident D. LPN 3 indicated that QMA 4 had ample time to walk away, QMA 4 just wanted to show she was in control. LPN 3 indicated that QMA 4's actions stopped being self defense the minute she approached Resident D with the folded metal chair and pressed it against his upper torso and neck.

During an interview on 11/21/24 at 12:45 p.m., the DON and Executive Director (ED) indicated that nursing staff reported that QMA 4 had abused Resident D while trying to remove Resident D from the nurse's station. Resident D was hitting the wall and yelling and QMA 4 made physical contact with Resident D with a folded metal chair. The DON and ED indicated that all staff knew Resident D and his behaviors. The DON and ED further indicated all staff knew the proper steps to deescalate Resident D. The DON indicated the proper solution was for QMA 4 to just walk away. At that time, the DON and ED provided the facility reportable incident, dated 11/20/24. The reportable incident indicated on 11/20/24 QMA 4 placed a folding chair against Resident D's chest after QMA 4 was struck by Resident D. The DON and ED also provided an interview with QMA 4 conducted by the facility on 11/20/24 at 8:15 a.m. QMA 4 indicated on 11/20/24, Resident D was hitting the wall and knocked over a bedside table. QMA 4 indicated that Resident D was behind the nurses station and QMA 4 was trying to get Resident D away from the nurse's station. Resident D had begun hitting and kicking. QMA 4 then grabbed a folded metal chair to block Resident D's hits and kicks.

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F 600	Continued From page 3	F 600		

The clinical record for Resident D was reviewed on 11/21/24 at 1:33 p.m. The diagnoses included, but were not limited to, epilepsy, Bipolar Disorder, hypertension, intellectual disabilities, and dysphagia.

The Annual MDS (Minimum Data Set) assessment, dated 9/23/24, indicated Resident D was rarely understood and had severe cognitive impairment.

A Care Plan, revised 10/10/24, indicated Resident D had physical aggression towards staff, screaming/yelling out, and not allowing staff to put clothing up or other things off the floor. The interventions included, but were not limited to, allow resident time to calm down and reapproach.

On 11/21/24 at 1:11 p.m., a policy titled "Abuse, Neglect and Exploitation" with a revision date of February 2023, and indicated it was the current policy used by facility. Review of a current policy, indicated the following: "....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 certain resident to resident altercations. Abuse also includes deprivation by an individual, including a 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 facilitated or enabled through the use of technology...."

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F 600	Continued From page 4 This deficient practice was corrected on 11/20/24 after the facility implemented a systemic plan of correction that included the following actions: all staff were educated on the abuse policy with ongoing monitoring and audits. This citation relates to Complaint IN00447653. 3.1-27(a)(1)	F 600		