STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155138	A. BUILDING 00 B. WING	02/10/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00451109 and IN00451364. Complaint IN00451109 - Federal/State deficiencies related to the allegations are cited at F609. Complaint IN00451364 - No deficiencies related to the allegations are cited. Survey date: February 10, 2025 Facility number: 000063 Provider number: 155138 AIM number: 100266210 Census Bed Type: SNF/NF: 74 Total: 74 Census Payor Type: Medicaid: 71 Other: 3 Total: 74 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed February 13, 2025.	F 0000		
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations Based on interview and record review, the facility failed to thoroughly report all known information regarding an allegation of abuse at the time the allegation was reported to the state health department for 2 of 3 residents reviewed for	F 0609	Tag Cited: F-609 §483.12(c)(1)(4) – Abuse Reporting Requirements Issue Cited:	03/07/2025

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

Sara Newsom 02/28/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	abuse. (Resident B, Resident C) Findings include: During an interview on 2/10/25 at 8:04 a.m., Resident B indicated a few weeks ago, Resident C was in bed and waved Resident B into Resident C's room. Resident B walked into Resident C's room, pulled his pants down and exposed himself to Resident C. During an interview on 2/10/25 at 8:17 a.m., the Director of Nursing (DON) indicated, on 1/12/25, during evening shift she received a phone call from LPN 1 that Resident B was found in Resident C's room. Resident B had his pants down and was receiving oral sex from Resident C. The state health department reportable incident regarding Resident C performing oral sex on Resident B was reviewed, on 2/10/25 at 11:21 a.m. The incident indicated, on 1/12/25 at 8:10 a.m., both residents were found making inappropriate contact. The follow-up to the incident report, dated 1/17/25, indicated the investigation concluded that inappropriate touching occurred between both residents. During an interview on 2/10/25 at 11:08 a.m., CNA 1 indicated she walked into Resident C's room and Resident B was standing with his back toward the door and his pants were down. When he turned toward the door, she saw Resident C performing oral sex on Resident B. CNA 1 reported what she saw to LPN 1. On 2/10/25 at 11:11 a.m., the Administrator provided the Abuse, Neglect and Exploitation policy, revised 2/2023. The policy indicated allegations of abuse were reported to the state		"Based on interview and record review, the facility failed to thoroughly report all known information regarding an allegation of abuse at the time the allegation was reported to the state health department for 2 of 3 residents reviewed for abuse. (Resident B, Resident C" Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. Immediate action(s) taken for allegations of abuse found to have been affected include: ·All new allegations of abuse are being reported thoroughly with all known information. Identification of other residents having the potential to be affected was accomplished by: ·The facility has determined that all residents involved in abuse	

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	survey agency. This citation relates to Complaint IN00451109. 3.1-28(c)		allegations have the potential to be affected. Seven days of been audited. Actions taken/systems put into place to reduce the risk of future occurrence include: ·An in-service education program was conducted by Regional Director of Clinical Operations or Designee with Administrator and Director of Nursing addressing circumstances that require reporting including appropriate timeframes. How the corrective action(s) will be monitored to ensure the practice will not reoccur: The or , will conduct a random audit of allegations weekly for four (8) consecutive weeks. Then monthly for 4 months. These residents will be assessed and interviewed to ensure that all information is reported properly. Findings of this audit will be discussed with the Resident Council. This plan of correction will be monitored at the monthly Quality Assurance meeting until such consistent substantial compliance has been met.	

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			Corrective action completion date: _____3-7-2025_____ ____.	