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 08/31/2023

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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F 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00416202. This visit resulted in a Partially Extended Survey- Substandard Quality of Care-Immediate Jeopardy. Complaint IN00416202 - Federal/State deficiencies related to the allegations are cited at F689. Survey dates: August 29, 30, 31, 2023 Facility number: 000063 Provider number: 155138 AIM number: 100266210 Census Bed Type: SNF/NF: 68 Total: 68 Census Payor Type: Medicaid: 66 Other: 2 Total: 68 This deficiency reflects State Finding cited in accordance with 410 IAC 16.2-3.1. Quality review completed September 1, 2023.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate	F 689		

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

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F 689	Continued From page 1 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide supervision to prevent an elopement for 1 of 3 residents reviewed for elopement. A resident diagnosed with schizoaffective disorder bipolar type and dementia, had a history of elopement and attempted to leave the facility 12 days prior, left the facility. The resident's whereabouts were unknown for 2 days when the resident was located by a bystander. The resident was confused and physically and verbally combative with EMS (Emergency Medical Services), had to be restrained and required inpatient psychiatric treatment. (Resident B) This deficient practice resulted in an Immediate Jeopardy. The Immediate Jeopardy began on, 8/25/23 at approximately 4:30 p.m., when the facility failed to provide supervision to prevent an elopement. This resulted in a resident who left the facility without staff and the resident's whereabouts were unknown for 2 days. The Vice President and Director of Nursing were notified of the Immediate Jeopardy on 8/29/23 at 5:30 p.m. The Immediate Jeopardy was removed, and the deficient practice corrected, on 8/26/23, prior to the start of the survey and was therefore Past Noncompliance. Finding includes: During an interview on 8/29/23 at 8:38 a.m., the Vice President indicated Resident B left the facility, on 8/25/23 at 4:38 p.m. Resident B was located, on 8/27/23 at approximately 5:24 p.m.	F 689	Past noncompliance: no plan of correction required.	

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Resident B received a new debit card and got upset that he was not allowed to keep it per his guardian. The facility was notified by a bystander that Resident B was located. The facility sent 2 staff members to get Resident B, but once staff arrived to pick him up, Resident B refused to come back and became combative with the staff and started cursing. The police arrived, and Resident B was taken to a hospital.

During an interview on 8/29/23 at 2:15 p.m., RN 1 (Registered Nurse) indicated she was Resident B's nurse when he left the facility. CNA 1 (Certified Nursing Aide) took Resident B's dinner tray to his room and when CNA 1 went back to collect the tray, Resident B was not in his room. CNA 1 noticed the tray had not been touched. RN 1 was notified that Resident B could not be located at approximately 9:30 p.m. RN 1 called 911 because the staff was not sure how long Resident B had been gone. RN 1 indicated she was told he was seen walking across the street, on 8/25/23 at approximately 4:38 p.m.

During an interview on 8/29/23 at 2:32 p.m., CNA 1 indicated she delivered a meal tray to Resident B's room. Resident B was not in his room at that time. Just before CNA 1 delivered Resident B's meal tray, CNA 1 saw Resident B walking in the hall. When CNA 1 returned to Resident B's room to collect the meal tray she noticed the meal tray had not been touched and Resident B was not in his room. CNA 1 notified a QMA (Qualified Medication Aide) that CNA 1 was not able to locate Resident B. Then CNA 1 walked the halls of the inside of the facility but didn't see Resident B. CNA 1 thought since she reported this to the QMA, she did not need to do anything else, so CNA 1 went to provide other residents care. CNA

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1 started charting when she finished providing care and realized she hadn't seen Resident B. CNA 1 went to check Resident B's room again and Resident B was not there. CNA 1 notified RN 1 that CNA 1 was unable to locate Resident B. CNA 1 indicated she watched the video footage from earlier in the day. Resident B was sitting outside on the front (unsecured) patio. Several staff members walked past him while he was outside unattended. When another resident turned his wheelchair away from Resident B, Resident B stood up and walked across the street. On 8/27/23, the staff were told from now on residents need to use the courtyard to sit outside not the front porch.

The clinical record for Resident B was reviewed on 8/29/23 at 8:45 a.m. The diagnoses included, but were not limited to, schizoaffective disorder bipolar type, alcohol abuse, cocaine abuse, and cognitive communication deficit.

A Quarterly MDS (Minimum Data Set) assessment, dated 7/18/23, indicated Resident B was cognitively intact and had moderate signs of depression.

An Order Appointing Temporary Guardian, dated 12/7/22, indicated the welfare of Resident B required immediate action. Immediate and irreparable injury to Resident B could result before notice and a hearing could be held because of Resident B's need for immediate medical attention. Resident B lacked capacity to consent to such treatment.

A Psychiatric Admission History and Physical, dated 5/1/23 at 9:52 p.m., indicated Resident B was admitted for paranoid and delusional thinking

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on an EDO (Emergency Detention Order). The EDO stated "actively psychotic - continues to be paranoid and delusional, impulsive, agitated. He is labile, paranoid, and impulsive with poor insight and needed ongoing inpatient psychiatric care as he remained disorganized". Additionally, it was stated that there was reason to believe Resident B could harm himself or others. Resident B required locked restraints in the emergency room.

A Nurse Practitioner note, dated 7/6/23, indicated Resident B expressed frustration over being at the facility. Resident B wanted to be transferred to a "boarding house". Resident B had a lengthy inpatient psychiatric hospitalization for paranoid and delusional thinking. Resident B attempted suicide by overdose 3 times and set fire to a group home in April of 2023.

A psychotherapy progress note, dated 7/24/23, indicated target symptoms and current severity (measured on a scale of 0-10; 0 indicated no symptoms and 10 indicated maximum severity). Anxiety 6/10, depression 7/10, withdrawal/isolation 5/10, hopelessness 6/10, paranoia 0/10, delusions 0/10, auditory hallucination 5/10. Plan: continue treatment plan created, on 6/15/23.

A psychotherapy progress note, dated 8/7/23, indicated target symptoms and current severity. Anxiety 7/10 (more severe), depression 8/10 (more severe), withdrawal/isolation 6/10, paranoia 5/10, delusions 5/10, auditory hallucinations 7/10. Plan: continue treatment plan created, on 6/15/23. Each of these symptoms were more severe than the previous psychiatric progress note, dated 7/24/23.

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A progress note, dated 8/13/23 at 12:37 p.m., indicated Resident B was at the reception area and attempted to follow peers out the front door when redirected by receptionist. Resident B became agitated and started screaming at the receptionist. Resident B picked up a LOA (leave of absence) book and slammed it on counter and stated, "why can't I leave".

A progress note, dated 8/25/23 at 11:15 a.m., indicated writer informed (name of guardian service), in detail, regarding Resident B's financial issues with his debit card. Resident B received two additional debit cards and writer gave them to the Executive Director. Writer informed guardian service that Resident B was extremely frustrated and upset that he was unable to get a hold of his guardian to be able to spend his money on cigarettes, clothes, and other things that he would like.

A progress note, dated 8/25/23 at 10:00 p.m., indicated it was reported to this nurse Resident B was missing. Staff did room to room search at this time. Was last seen in courtyard at approximately 5:00 p.m., wearing jeans and a black shirt.

A progress note, dated 8/25/23 at 11:00 p.m., indicated writer called guardian services to report that Resident B left the facility and has not returned. Resident B was aware that he was unable to leave the facility without the guardians permission.

A progress note, dated 8/27/23 at 5:39 p.m., indicated writer received call from a financial service located approximately 3 miles from the facility. Resident B went there to withdraw money

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from his account. Writer arranged transportation for Resident B to be brought back to the facility.

A progress note, dated 8/27/23 at 5:49 p.m., indicated QMA 1 (Qualified Medication Aide) reported Resident B to be very combative at financial service location. 911 called and Resident B was transferred from financial service to a hospital.

On 8/29/23 at 1:00 p.m., a hospital emergency department note, dated 8/27/23 at 6:21 p.m., was reviewed. The note indicated Resident B presented to the ED (emergency department) by EMS for confusion and agitation. Resident B was reported to have eloped from a facility as he has a known diagnosis of dementia. Resident B had reportedly been walking the street for the past several days and was found by a bystander who requested EMS. EMS found Resident B to be quite combative both verbally and physically. Resident B required restraints to the ambulance stretcher for Resident B's increased safety. On arrival to the ED, Resident B was yelling profanities at staff, and verbally and physically aggressive. Resident B was placed in four-point restraints for Resident B's and staff's safety.

During an interview on 8/29/23 at 3:54 p.m., the DON (Director of Nursing) indicated Resident B should not have been outside on the front patio without supervision if he was an elopement risk.

On 8/29/23 at 5:30 p.m., the DON provided a copy of an undated facility policy, titled Elopements and Wandering Residents, and indicated this was the current policy used by the facility. A review of the policy indicated this facility ensures that resident who exhibit wandering

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F 689	Continued From page 7 behavior and or are at risk for elopement receive adequate supervision to prevent accidents. The past noncompliance Immediate Jeopardy began on 8/25/23. The Immediate Jeopardy was removed and the deficient practice corrected by 8/26/23 after the facility implemented a systemic plan that included the following actions: in-services related to procedures for elopements, leave of absences, care plans, and guardians. This Federal tag relates to Complaint IN00416202. 3.1-45(a)(2)	F 689		