Thomas Johnson

PRINTED: 11/14/2024 FORM APPROVED OMB NO. 0938-039

11/11/2024

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SU | | | SURVEY | | |
|--|-----------------------|---|--------|----------|---|-------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | | ILDING | 00 | COMPL | |
| | | 155138 | B. WI | NG | | 10/22 | /2024 |
| NAME OF P | DOMDED OF CLIEBT TEL | | | STREET A | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF P | PROVIDER OR SUPPLIEF | C. | | 2860 CI | HURCHMAN AVE | | |
| | ARD HEALTHCARE | E - CHURCHMAN CARE CENTER | 1 | INDIAN | APOLIS, IN 46203 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | • | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | + | TAG | DEFICIENCY) | | DATE |
| F 0000 | | | | | | | |
| Bldg. 00 | | | | | | | |
| blug. 00 | | | F 00 | 100 | Preparation and/or execution | of | |
| | This visit was for a | Recertification and State | 1 00 | 100 | this plan do not constitute | OI . | |
| | | This visit included the | | | admission or agreement by th | e | |
| | | mplaint IN00444281. | | | provider that a deficiency exis | | |
| | | - | | | This response is also not to b | | |
| | Complaint IN00444 | 4281 - No deficiencies related to | | | construed as an admission of | | |
| | the allegations are o | eited. | | | by the facility, its employees, | | |
| | | | | | agents or other individuals wh | | |
| | Survey dates: Octo | ober 16, 17, 18, 21, and 22, 2024 | | | draft or may be discussed in t | | |
| | F 31. 1 A | 00062 | | | response and plan of correction | on. | |
| | Facility number: 0 | | | | This plan of correction is | | |
| | Provider number: 1002 | | | | submitted as the facility's cred | lible | |
| | Anvi number: 1002 | 200210 | | | allegation of compliance. | | |
| | Census Bed Type: | | | | | | |
| | SNF/NF: 75 | | | | | | |
| | Total: 75 | | | | | | |
| | | | | | | | |
| | Census Payor Type | : | | | | | |
| | Medicare: 2 | | | | | | |
| | Medicaid: 63 | | | | | | |
| | Other: 10 | | | | | | |
| | Total: 75 | | | | | | |
| | Thosa daffairer: | rofloata Stata Findings sited in | | | | | |
| | accordance with 41 | reflects State Findings cited in | | | | | |
| | accordance with 41 | v IAC 10.2-3.1. | | | | | |
| | Quality review com | apleted October 25, 2024. | | | | | |
| | , , | | | | | | |
| F 0554 | 483.10(c)(7) | | | | | | |
| SS=D | Resident Self-Adr | nin Meds-Clinically Approp | | | | | |
| Bldg. 00 | | | | | | | |
| | | | F 05 | 554 | Immediate action(s) taken fo | | 11/11/2024 |
| | | on, interview, and record | | | the resident(s) found to have | 9 | |
| | | failed to ensure a self | | | been affected include: Resident 30 has been deeme | d | |
| | | 1 residents randomly observed | | | safe and capable of | u | |
| | | 1 residents randomity observed | | | Saic and Capable Of | | |
| LABORATOR | Y DIRECTOR'S OR PRO | VIDER/SUPPLIER REPRESENTATIVE'S SIG | NATURE | | TITLE | | (X6) DATE |

Any defiency statement 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 disclodays 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: T24C11 Facility ID: 000063 If continuation sheet Page 1 of 18

Executive Director

PRINTED: 11/14/2024

| | T OF HEALTH AND HU! R MEDICARE & MEDIC | | | | | | RM APPROVED IB NO. 0938-039 |
|-----------|---|---|-----|---------|---|---------------------------------------|--------------------------------|
| | IT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155138 | l í | UILDING | onstruction 00 | (X3) DATE SURVEY COMPLETED 10/22/2024 | |
| NAME OF I | PROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP COD | | |
| BRICKY | ARD HEALTHCARE | - CHURCHMAN CARE CENTE | R | | NAPOLIS, IN 46203 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI | ATE | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | with medications le | ft at bedside. | | | self-administering meds. All | | |
| | TO 11 1 1 1 | | | | assessments and orders have | | |
| | Finding includes: | | | | been updated. Resident's car | | |
| | D | 10/1 <i>C</i> /2 <i>A</i> - 4.0.29 | | | plan has been updated as we | II. | |
| | 1 | ion on 10/16/24 at 9:38 a.m., ting up on the side of the bed. | | | Identification of other reside | 4- | |
| | | s were observed sitting on top | | | having the potential to be | ents | |
| | of table in front of t | | | | affected was accomplished | hv: | |
| | or table in front or t | CICVISIOII. | | | The facility determined that a | - | |
| | - One medication be | ottle of Simbrinza Ophthalmic | | | residents have the potential to | | |
| | | , for the treatment of glaucoma. | | | affected. | <i>3 6 6</i> | |
| | | ottle of Lantanoprost Solution | | | anostoa. | | |
| | | eatment of glaucoma. | | | An audit was completed to | | |
| | , | 5 | | | determine which residents are | 9 | |
| | During an observati | ion on 10/17/24 at 8:38 a.m., a | | | appropriate to be assessed for | | |
| | _ | ation cup with multiple | | | self-administration of | | |
| | | and capsules were observed | | | medications. All residents we | ere | |
| | | in front of the television. | | | evaluated for self-administeri | ng of | |
| | During an interview | at that time, Resident 30 | | | medication. | | |
| | indicated that he ha | d to eat breakfast before he | | | | | |
| | could take his medi | cation, so the nurse left them | | | Actions taken/systems put i | nto | |
| | for him. | | | | place to reduce the risk of | | |
| | | | | | future occurrence include: | | |
| | _ | ion on 10/21/24 at 10:50 a.m., | | | All clinical staff were in-service | | |
| | _ | bserved sitting on top of | | | regarding the facility policy fo | r | |
| | refrigerator in Resid | dent 30's room: | | | Resident Rights and Medicati | | |
| | | | | | Administration. Education wa | | |
| | | ottle of Simbrinza Ophthalmic | | | provided by DNS and DCE or | า | |
| | | , for the treatment of glaucoma. | | | 10-31-2024. | | |
| | | ottle of Lantanoprost Solution eatment of glaucoma. | | | How the corrective setimate | | |
| | 0.000570, for the tre | eaunent of graucoffia. | | | How the corrective action(s) will be monitored to ensure | | |
| | On 10/21/24 at 11:0 | 3 a.m., Resident 30's clinical | | | | uie | |
| | | d. The clinical record lacked a | | | practice will not recur: DNS or designee will audit all | new | |
| | | medication assessment. | | | admissions to ensure that the | | |
| | 5011-administration | modication assessment. | | | are assessed as appropriate | - | |

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.

the ability to self-administer their

medications. This audit will be

conducted 5 times weekly for 4 weeks, then 3 times weekly for 4

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE | | | | | |
|--|--|--|----------|---------|---|--------------|------------|
| AND PLAN | AND PLAN OF CORRECTION IDENTIFICATION NUMBER | | | JILDING | 00 | COMPLETED | |
| | | 155138 | B. W | ING | | 10/22/ | 2024 |
| NAME OF P | ROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP COD | | |
| | | | | | HURCHMAN AVE | | |
| BRICKY | AKD HEALTHCARE | E - CHURCHMAN CARE CENTER | | INDIAN | IAPOLIS, IN 46203 | | |
| (X4) ID | SUMMARY S | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION | \vdash | TAG | | | DATE |
| | | 10/21/24 at 11:30 a.m., the indicated that it was not | | | weeks, then monthly thereafte complete 6 months. Results of | | |
| | - | to leave medication in resident | | | audits will be reviewed monthl | | |
| | - | dicated Resident 30 did not | | | QAPI to identify any trends or | yaı | |
| | | elf-administration assessment. | | | patterns. If any issues are | | |
| | | | | | identified, will continue audits | | |
| | On 10/21/24 at 11:3 | 0 a.m., the Director of Nursing | | | based on IDT recommendation | n, | |
| | provided a policy ti | | | | otherwise will review on a PRI | 1 | |
| | | cy, dated 2024, and indicated it | | | basis. | | |
| | | ently in use for the facility. The | | | | | |
| | policy indicated, 18 | | | | | | |
| | consumption of med | dication". | | | | | |
| | 3.1-11(a) | | | | | | |
| F 0623 | 483.15(c)(3)-(6)(8) |) | | | | | |
| SS=D | Notice Requireme | | | | | | |
| Bldg. 00 | Transfer/Discharg | e | | | | | |
| | | | F 0 | 623 | Immediate action(s) taken fo | r | 11/11/2024 |
| | | and record review, the facility | | | the resident(s) found to have |) | |
| | | written Notice of Transfer | | | been affected include: | | |
| | | provided to the resident's | | | Notice of transfer/discharge se | ∍nt | |
| | _ | o the Office of the State sman for 1 of 6 residents | | | to Ombudsman and resident | | |
| | _ | r transfer and discharge | | | representative for Resident 31 | | |
| | notification. (Resid | _ | | | Identification of other reside | nte | |
| | notification: (resid | Sii 31) | | | having the potential to be | 11.5 | |
| | Finding includes: | | | | affected was accomplished by | ov: | |
| | C | | | | The facility has determined the | - | |
| | On 10/17/24, at 2:00 | 0 p.m., Resident 31's clinical | | | discharging residents have the | | |
| | record was reviewed | d. The diagnoses included, but | | | potential to be affected. | | |
| | | congestive heart failure and | | | | | |
| | type 2 diabetes. | | | | Audit completed of discharges | | |
| | | . ID 11 . 211 1 | | | past 30 days to ensure that all | | |
| | | eated Resident 31 had a | | | hospital transfers and discharge | jes | |
| | resident representati | ive. | 1 | | have notice of transfer and | | |
| | The Annual Minimu | ım Data Set (MDS) | | | discharge sent to resident representative and to | | |
| | | /22/24, indicated Resident 31 | | | Ombudsman. | | |
| | was cognitively inta | | | | Simpadoman. | | |

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Event ID:

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Facility ID: 000063

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|------------------------|-----------------------------------|-------|---------|--|-------|------------|
| | OF CORRECTION | IDENTIFICATION NUMBER | ì í | JILDING | 00 | COMPL | |
| | | 155138 | B. WI | | | 10/22 | |
| | | 1.55.55 | | | | .0,22 | |
| NAME OF P | ROVIDER OR SUPPLIE | R | | | ADDRESS, CITY, STATE, ZIP COD | | |
| | | | | | HURCHMAN AVE | | |
| BRICKY | ARD HEALTHCAR | E - CHURCHMAN CARE CENTER | | INDIAN | APOLIS, IN 46203 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | NCY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | ATF | COMPLETION |
| TAG | REGULATORY O | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | | | | | Actions taken/systems put i | nto | |
| | The clinical record | 's census tab indicated | | | place to reduce the risk of | | |
| | Resident 31 was tra | ansferred to the hospital | | | future occurrence include: | | |
| | emergency departn | nent on 8/5/24. | | | All licensed nursing staff and | | |
| | | | | | Director of Social Services we | ere | |
| | The Notice of Tran | sfer or Discharge document, | | | educated regarding the facility | y | |
| | dated 8/5/24, indica | ated Resident 31 was | | | policy for Transfer and Discha | arge | |
| | transferred to the h | ospital emergency department | | | and sending information to | - | |
| | for a facility-initiat | ed hospital transfer on 8/5/24. | | | Resident/Resident representa | ative | |
| | Resident 31 was pr | ovided a copy of the transfer | | | and Ombudsman on 10-31-20 | 024. | |
| | document at the tin | ne of his transfer. | | | | | |
| | | | | | | | |
| | On 10/21/24 at 1:4: | 5 p.m., the Administrator | | | How the corrective action(s) | | |
| | provided a copy of | the facility's August 2024 | | | will be monitored to ensure | the | |
| | monthly report sub | mitted to the Office of the State | | | practice will not recur: | | |
| | Long-Term Ombud | lsman. The report indicated | | | DNS or designee will audit all | | |
| | Resident 31 was tra | ansferred to the hospital on | | | discharges to ensure that writ | ten | |
| | 8/5/24. The month | ly report did not included a | | | notice of transfer and dischar | ge | |
| | copy of Resident 3 | 1's Notice of Transfer and | | | was provided to resident/resident | dent | |
| | Discharge docume | nt. The monthly report lacked | | | representative and to Office o | f the | |
| | specific details for | the transfer including the | | | State Long Term Ombudsma | n. | |
| | reason for transfer, | bed hold policy, and appeal | | | This audit will be conducted 5 | i | |
| | rights. | | | | times weekly for 4 weeks, the | n 3 | |
| | | | | | times weekly for 4 weeks, the | n | |
| | The clinical record | lacked documentation that the | | | monthly thereafter to complet | e 6 | |
| | written Notice of T | ransfer and Discharge | | | months. Results of all audits v | will | |
| | document was prov | vided to the resident's | | | be reviewed monthly at QAPI | to | |
| | representative and | to the Office of the State | | | identify any trends or patterns | s. If | |
| | Long-Term Ombud | Isman for the facility-initiated | | | any issues are identified, will | | |
| | hospital transfer on | 8/5/24. | | | continue audits based on IDT | | |
| | | | | | recommendation, otherwise w | vill | |
| | During an interview | w on 10/16/24 at 1:17 p.m., | | | review on a PRN basis. | | |
| | Resident 31 indicat | ted he was transferred to the | | | | | |
| | hospital "this past A | August." | | | | | |
| | . | 10/10/04 + 0.42 | | | | | |
| | _ | w on 10/18/24 at 8:43 a.m., the | | | | | |
| | _ | g Services (DNS) indicated | | | | | |
| | | ansferred to the hospital | | | | | |
| | | nent on 8/5/24. The facility | | | | | |
| | lacked verification | that the written Notice of | | | | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155138 | | (X2) MULTIPLE (A. BUILDING B. WING | | | | |
|--|--|--|--------------|---|----------------------|--|
| | PROVIDER OR SUPPLIEI | ₹ E - CHURCHMAN CARE CENTER | 2860 | T ADDRESS, CITY, STATE, ZIP COD CHURCHMAN AVE NAPOLIS, IN 46203 | | |
| (X4) ID PREFIX | | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | TAG | CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | DATE | |
| | to the resident's rep of the State Long-T facility-initiated ho During an interview Social Service Dire Transfer and Disch included in the mon the Ombudsman. | arge document was provided by resentative and to the Office of the Spital transfer on 8/5/24. Even on 10/21/24 at 2:05 p.m., the exter indicated the Notice of the arge document was not not not provided to the monthly report provided to the sign of the sign of the monthly report provided to the sign of the s | | | | |
| | Clinical Operations Transfer and Disch Medical Advice]) p indicated it was the facility. A review of facility's transfer/di to the resident and a language and man | 2 a.m., the Regional Director of a provided a copy of the arge (including AMA [Against policy, dated 2024, and a current policy in use by the policy indicated, "The scharge notice will be provided the resident's representative in mer in which they can of notices for emergency budsman" | | | | |
| F 0656 SS=D | 3.1-12(a)(6)(A)(iii) 483.21(b)(1)(3) Develop/Impleme | nt Comprehensive Care Plan | | | | |
| Bldg. 00 | review, the facility | on, interview, and record failed to implement the e plan for 1 of 2 residents (Resident 7) | F 0656 | Immediate action(s) taken f the resident(s) found to have been affected include: Resident 7's bed was immediated in low position | /e liately | |
| | | 00 a.m., observed Resident 7's in bserved to be elevated | | having the potential to be affected was accomplished The facility has determined to | - | |

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Event ID:

T24C11

Facility ID: 000063

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|------------------------|-----------------------------------|-------|----------|---|----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 00 | COMPL | ETED |
| | | 155138 | B. WI | ING | | 10/22/ | /2024 |
| | | | | STREET A | ADDRESS, CITY, STATE, ZIP COD | <u> </u> | |
| NAME OF P | ROVIDER OR SUPPLIER | 8 | | | HURCHMAN AVE | | |
| BDICK∨/ | | E - CHURCHMAN CARE CENTER | | | | | |
| DRICKYA | AND HEALTHUARE | - CHORCHIVIAN CARE CENTER | | INDIAN | APOLIS, IN 46203 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | (approximately 4 fe | et from the floor) and was not | | | residents at risk for falls have | the | |
| | in the the lowest po | sition. | | | potential to be affected. | | |
| | | | | | | | |
| | On 10/17/24 at 11:2 | 23 a.m., observed Resident 7's in | | | All residents were audited and | l fall | |
| | bed. The bed was of | bserved to be elevated | | | care plans were reviewed for | | |
| | (approximately 4 fe | et from the floor) and was not | | | residents at risk for falls and | | |
| | in the lowest position | on. | | | updated as needed by 11-11-2 | 2024. | |
| | | | | | | | |
| | | 5 a.m., observed Resident 7 in | | | Actions taken/systems put ir | nto | |
| | | bserved to be elevated and | | | place to reduce the risk of | | |
| | was not in the lowe | st position. | | | future occurrence include: | | |
| | | | | | All nursing staff were in-servic | ed | |
| | During an interview | on 10/21/24 at 8:45 a.m., RN 4 | | | regarding the facility policy for | | |
| | indicated Resident | 7's bed should always be in the | | | Comprehensive Care Plans ar | nd | |
| | lowest position. | | | | fall interventions. Education | | |
| | | | | | provided by DNS and DCE on | | |
| | | a.m., the clinical record for | | | 10-31-2024. | | |
| | Resident 7 was revi | ewed. The diagnosis included, | | | | | |
| | but was not limited | to, dementia. | | | All residents at risk for falls wil | I | |
| | | | | | have their care plans reviewed | t | |
| | The Annual Minim | um Data Set assessment, dated | | | updated quarterly, with signific | cant | |
| | 9/11/24, indicated F | Resident 7 required extensive | | | change, and as needed. | | |
| | assist with bed mob | oility and transfers. | | | | | |
| | | | | | How the corrective action(s) | | |
| | _ | 2/20/23, indicated Resident 7 | | | will be monitored to ensure t | he | |
| | | The interventions included, | | | practice will not recur: | | |
| | | d to, keep bed in low position, | | | DNS or designee will audit 3 | | |
| | dated 9/18/24. | | | | resident's fall care plans daily | | |
| | | | | | ensure completion. This audit | | |
| | | a.m., the Regional Director of | | | be conducted 5 days/week for | 4 | |
| | _ | provided a policy titled | | | weeks, then 3 times/week for | | |
| | _ | re Plans, dated 2024, a review | | | weeks, then monthly thereafte | | |
| | | ted "Policy: It is the policy of | | | complete 6 months. Results o | | |
| | - | lop and implement a | | | audits will be reviewed monthl | y at | |
| | | son-centered care plan for each | | | QAPI to identify any trends or | | |
| | | omprehensive care plan will | | | patterns. If any issues are | | |
| | | m, the following a. The | | | identified, will continue audits | | |
| | services that are to | be furnished to attain or | | | based on IDT recommendation | n, | |
| | maintain the resider | nt's highest practicable | | | otherwise will review on a PRI | N | |
| | nhysical well heir | nor " | l | | hacie | | ĺ |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

T24C11

Facility ID: 000063

If continuation sheet

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER | | X2) MULTIPLE CONSTRUCTION A. BUILDING O COMPLIANT A. WING A. | | | | | |
|---|---|---|----------------------------------|---------|--|--------------|------------|
| | | 155138 | B. WING 10/22/2024 | | | | |
| | PROVIDER OR SUPPLIEF | CHURCHMAN CARE CENTER | | 2860 CI | ADDRESS, CITY, STATE, ZIP COD HURCHMAN AVE APOLIS, IN 46203 | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIE | | ID PROVIDER'S PLAN OF CORRECTION | | | (X5) | |
| PREFIX | ` | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | 3.1-35(g)(2) | | | | | | |
| F 0755 | 483.45(a)(b)(1)-(3 | 3) | | | | | |
| SS=D | Pharmacy | /Dlagues a signt/D a goved a | | | | | |
| Bldg. 00 | Based on interview failed to document | /Pharmacist/Records and record review, the facility the drug dispositions for 1 of 3 ents reviewed. (Resident 49) | F 07 | 755 | Immediate action(s) taken for the resident(s) found to have been affected include: Disposition of medications confirmed with resident 49's representative. | | 11/11/2024 |
| | Resident 49 was revincluded, but were reparalysis of the leg (a viral infection the | 35 a.m., the clinical record of viewed. The diagnoses not limited to, paraplegia and lower body), hepatitis C at affects the liver), and f bilateral legs above the knee. | | | Identification of other resider having the potential to be affected was accomplished be affected was determined the discharging residents have the potential to be affected. | y: at all | |
| | A physician's order | summary report of | | | Audit completed of all discharg | ged | |
| | · · | for active orders as of | | | residents over the past 30 day | s to | |
| | 10/14/24, included, | but were not limited to: | | | ensure discharge medication | | |
| | :41.11 1.1 | -4:-1:11 1 (' | | | disposition was completed. | | |
| | for probiotic | otic blend 1 mcg (microgram) | | | Actions taken/ayatama mutim | ıto. | |
| | ioi piooiotic | | | | Actions taken/systems put in place to reduce the risk of | ilo | |
| | - atorvastatin calciu | ım 20 mg (milligram) for | | | future occurrence include: | | |
| | | gh levels of fat in blood) | | | All licensed nursing staff were | | |
| | | | | | in-serviced regarding the | | |
| | | nt 500 unit/gm (gram) for | | | documentation of drug | | |
| | wound care | | | | dispositions. Education provid | | |
| | hanzoosina manth | ool zine chlorida gal | | | by DNS and DCE on 10-31-20 | 24. | |
| | 20-0.26-0.15 % for | nol-zinc chloride gel tooth pain | | | All residents discharging will h | ave | |
| | 20 0.20 0.13 /0 101 | toom pain | | | their charts reviewed the follow | | |
| | - diazepam 5 mg fo | r anxiety/seizures | | | business day to ensure appropriate disposition of | 9 | |
| | - docusate sodium | 100 mg for constipation | | | medications was completed. | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

T24C11

Facility ID: 000063

If continuation sheet

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE SURVEY | | |
|--|------------------------|----------------------------------|------------|------------|--|----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 00 | COMPL | ETED |
| | | 155138 | B. WI | NG | | 10/22/ | /2024 |
| | | <u> </u> | | OTD FET | DDDEGG GITY GT TE TO GOT | <u> </u> | |
| NAME OF F | PROVIDER OR SUPPLIEF | ₹ | | | ADDRESS, CITY, STATE, ZIP COD | | |
| DDIG: 0:: | NDD | | | | HURCHMAN AVE | | |
| BRICKYA | ARD HEALTHCARE | E - CHURCHMAN CARE CENTER | | INDIAN | APOLIS, IN 46203 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | 1.5 | DATE |
| | - ferrous sulfate 32: | 5 mg for iron supplementation | | | How the corrective action(s) | | |
| | | | | | will be monitored to ensure t | he | |
| | - fluticasone propio | nate nasal suspension 93 mcg | | | practice will not recur: | | |
| | for nasal congestion | 1 | | | DNS or designee will audit all | | |
| | | | | | discharged residents' charts | | |
| | - gabapentin 600 m | g for pain | | | weekly x4 weeks to ensure | | |
| | | | | | documentation of drug dispos | tion | |
| | - ibuprofen 400 mg | for pain | | | is completed. Then 3 discharg | | |
| | | | | | residents monthly x5 months. | | |
| | | % for costochondritis | | | Results of all audits will be | | |
| | (inflammation of th | e cartilage that connects your | | | reviewed monthly at QAPI to | | |
| | ribs to your breastb | one) | | | identify any trends or patterns | . If | |
| | | | | | any issues are identified, will | | |
| | - linaclotide 145 mg | eg for irritable bowel syndrome | | | continue audits based on IDT | | |
| | | | | | recommendation, otherwise w | ill | |
| | 1 | chloride 5 mg for substance | | | review on a PRN basis. | | |
| | abuse/pain | | | | | | |
| | | | | | | | |
| | 1 | de extended release 5 mg for | | | | | |
| | urinary incontinenc | ee | | | | | |
| | | | | | | | |
| | 1 - | chloride 5 mg for spinal cord | | | | | |
| | injury | | | | | | |
| | , , , , , , , | 500 C 1 | | | | | |
| | - oyster shell calciu | m 500 mg for supplement | | | | | |
| | a of a alay! 37-1 | 2007 in 400 100 mg f1 | | | | | |
| | | asvir 400-100 mg for viral | | | | | |
| | hepatitis C | | | | | | |
| | trazadona hydraal | nloride 50 mg for depression | | | | | |
| | - u azouone nyuroci | morrae 50 mg tot acpression | | | | | |
| | - vitamin D3 1.25 n | na for sunnlement | | | | | |
| | - vitaiiiii D3 1.23 II | ng for supplement | | | | | |
| | A progress note da | ted 10/14/24 at 5:47 p.m., | | | | | |
| | | 49 left the facility via bus and | | | | | |
| | | d with medication to home. | | | | | |
| | nad occii disciiai ge | a with medication to nome. | | | | | |
| | Resident 40's recor | d lacked documentation listing | | | | | |
| | 1 100100111 7/0100011 | a raction decamentation nothing | 1 | | | | I |
| | | amount of medications that | | | | | |

| NAME OF PROVIDER OR SUPPLIER 155138 STRIET ADDRESS, CITY, STATE, ZIP COD 2860 CHURCHMAN AVE 10022/2024 | STATEMEN | T OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | r í | | ONSTRUCTION | (X3) DATE | |
|--|----------------|--|--|-------|---------|--|--------------------------------------|------------|
| NAME OF PROVIDER OR SUPPLER BRICKYARD HEALTHCARE - CHURCHMAN CARE CENTER IXIAMARY STATISHENT OF DEPICIENCIE (X4) ID PREFIX TAG REGULATORY OR ISC IDENTIFYING INFORMATION 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 on specific policy for drug dispositions. 3.1-25(s) 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 Itall 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 medications are to medications. The medications located inside the medication cart, included but was not limited to: - haloperidol 5 mg (milligram), a medication used to treat infections. - metronidazol, a medication used to treat infections. | AND PLAN | OF CORRECTION | | | | 00 | | |
| ROBIN COPPLOYIBER OR SUPPLIER BRICKYARD HEALTHCARE - CHURCHMAN CARE CENTER CAPID SUMMARY STATEMENT OF DEFICIENCE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG) PREFIX PROJECTION OF LIST OF MUST AND ADDITION OF LIST OF MUST ADDITION OF LIST OF MUST AND ADDITION OF L | | | 155138 | B. WI | NG | | 10/22/ | /2024 |
| PREFIX TAG REGILATORY OR LSC IDENTIFYING INFORMATION 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) F 0761 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 on the B hall. The cart 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. | | | | | 2860 CI | HURCHMAN AVE | | |
| 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) F 0761 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 ontained multiple resident's medications. - haloperidol 5 mg (milligram), a medication used to treat nervous, emotional and mental conditions. - metronidazol, a medication used to treat infections. | PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| - metoprolol 2.5 mg, a medication used to treat were in-serviced regarding the | F 0761 SS=D | representative. During an interview Regional Director of indicated that the fat for drug disposition. During an interview RDOC indicated that policy for drug disposition. 3.1-25(s) 483.45(g)(h)(1)(2) Label/Store Drugs Based on observation review, the facility cart was locked for observed. (B Hall Market Finding includes: On 10/16/24 from 9 observed an unlocked hall. The cart was evisible in the area. In multiple resident's multiple resi | on 10/18/24 at 10:50 a.m., the of Clinical Operations (RDOC) cility lacked documentation is for Resident 49. on 10/18/24 at 1:10 p.m., the part the facility lacked a specific cositions. and Biologicals on, interview, and record failed to ensure a medication 1 of 4 medication carts fedication Cart) or 25 a.m. until 9:40 a.m., ed medication cart on the Beasily opened and no staff were The medication cart contained medications. cated inside the medication ras not limited to: (milligram), a medication used totional and mental conditions. edication used to treat | F 07 | | the resident(s) found to have been affected include: Medication cart was immediat locked and audit was complete all carts in facility to ensure locking. Identification of other reside having the potential to be affected was accomplished to the facility has determined the all residents have the potential be affected. All medication carts audited to ensure their locking mechanis are functioning appropriately. Actions taken/systems put in place to reduce the risk of future occurrence include: All licensed nursing and QMA | ely ely ed of nts oy: at al to oms | |

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Event ID:

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Facility ID: 000063

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| | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE A. BUILDING 00 COMPLETED | | | | |
|-----------|--|---|---|--------|---|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | | ILDING | 00 | l | |
| | | 155138 | B. WI | NG | | 10/22/ | 2024 |
| NAME OF P | ROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP COD | | |
| BRICKYA | ARD HEALTHCARE | E - CHURCHMAN CARE CENTER | 2860 CHURCHMAN AVE INDIANAPOLIS, IN 46203 | | | | |
| (X4) ID | | STATEMENT OF DEFICIENCIE | | ID | | | (X5) |
| PREFIX | | CY MUST BE PRECEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | | COMPLETION |
| TAG | ` | LSC IDENTIFYING INFORMATION | | TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | DATE |
| | high blood pressure | | | | facility policy titled Medication | | |
| | | | | | Storage. Education provided | • | |
| | | medication used to prevent | | | DNS and DCE on 10-31-2024 | | |
| | blood clots from for | rming. | | | l | | |
| | During an interview | on 10/16/24 at 9:45 a.m., the | | | How the corrective action(s) will be monitored to ensure t | h a | |
| | Medical Records Di | | | | practice will not recur: | ne | |
| | | uld have been locked. | | | DNS or designee will audit all | | |
| | | | | | medication carts on a rotating | | |
| | | 3 a.m., the Regional Director of | | | basis on various shifts to ensu | re | |
| | _ | ovided a policy titled | | | that they are kept locked and | | |
| | _ | , dated February, 2024, and | | | medications are secure. This a | | |
| | | current policy being used by ew of the policy indicated "1. | | | will be conducted 5 times wee | • | |
| | • | logicals will be stored in | | | for 4 weeks, then 3 times wee for 4 weeks, then monthly | KIY | |
| | _ | ts (i.e., medication carts)." | | | thereafter to complete 6 month | ns. | |
| | 1 | , | | | Results of all audits will be | | |
| | 3.1-25(m) | | | | reviewed monthly at QAPI to | | |
| | | | | | identify any trends or patterns. | . If | |
| | | | | | any issues are identified, will | | |
| | | | | | continue audits based on IDT | ••• | |
| | | | | | recommendation, otherwise w review on a PRN basis. | III | |
| | | | | | leview off a FRIV basis. | | |
| | | | | | | | |
| F 0812 | 483.60(i)(1)(2) | | | | | | |
| SS=E | Food | | | | | | |
| Bldg. 00 | Procurement,Store | e/Prepare/Serve-Sanitary | | | | | 44/44/2024 |
| | Rosed on observation | on, interview, and record | F 08 | 312 | Immediate action(s) taken for the resident(s) found to have | | 11/11/2024 |
| | | failed to ensure food was | | | been affected include: | , | |
| | _ | ry manner for 2 of 2 kitchen | | | Hair nets were immediately pu | ıt on | |
| | | was not covered. (Dietary | | | by all staff cooking, preparing, | | |
| | Manager) | | | | assembling food. | | |
| | Findings include: | | | | Identification of other reside | nto | |
| | rmaings include: | | | | having the potential to be | ntS | |
| | On 10/16/24 from 9 | 2:08 a.m. to 10:00 a.m., observed | | | affected was accomplished b | ov: | |
| | | er in the kitchen food | | | The facility has determined the | - | |
| | | ere food had been prepared | | | residents have the potential to | | |

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Event ID:

T24C11

Facility ID: 000063

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| STATEMEN | T OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MU | JLTIPLE CO | NSTRUCTION | (X3) DATE | SURVEY |
|-----------|-----------------------|-----------------------------------|---------|------------|--|----------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | ILDING | 00 | COMPL | ETED. |
| | | 155138 | B. WII | NG | | 10/22/ | 2024 |
| | | | | CTDEET A | DDDFGG CITY CTATE ZID COD | | |
| NAME OF P | ROVIDER OR SUPPLIER | 8 | | | ADDRESS, CITY, STATE, ZIP COD | | |
| BB10107 | | CHURCHMAN CARE OFFITER | | | HURCHMAN AVE | | |
| BRICKY | ARD HEALTHCARE | - CHURCHMAN CARE CENTER | | INDIAN | APOLIS, IN 46203 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | '- | DATE |
| | for the morning me | al and shipment of supplies | | | affected. | | |
| | were being put awa | y. The Dietary Manager was | | | | | |
| | observed to be lack | ing a hair net with hair | | | Actions taken/systems put ir | ıto | |
| | measuring approxim | nately one forth of an inch over | | | place to reduce the risk of | | |
| | the entire head. | | | | future occurrence include: | | |
| | | | | | All dietary staff were in-service | ed | |
| | On 10/16/24 from 1 | 1:45 a.m. to 12:45 p.m., the | | | regarding the facility policy for | | |
| | | as observed in the kitchen | | | Food Safety. Education was | ļ | |
| | assisting with food | preparation for the noon meal. | | | provided by DNS and dietary | | |
| | The Dietary Manag | er was observed to be lacking | | | manager on 10-31-2024. | ļ | |
| | a hair net. | | | | - | | |
| | | | | | Visual aides and hair net supp | olies | |
| | During an interview | y on 10/16/24 at 12:45 p.m., the | | | placed at all entrances to kitch | nen. | |
| | Dietary Manager in | dicated hair nets should be | | | | | |
| | worn. | | | | How the corrective action(s) | | |
| | | | | | will be monitored to ensure t | :he | |
| | During an interview | v on 10/17/24 at 2:58 p.m., the | | | practice will not recur: | | |
| | Regional Director f | or Clinical Operations indicated | | | Dietary Manager or designee | will | |
| | all kitchen staff pre | paring food should have been | | | audit alternating shifts and dat | es | |
| | wearing hair nets. | | | | to ensure hair nets are being v | vorn. | |
| | | | | | This audit will be conducted 5 | | |
| | | 16 p.m., the Regional Director of | | | times weekly for 4 weeks, ther | า 3 | |
| | Clinical Operations | provided a copy of Food | | | times weekly for 4 weeks, ther | า | |
| | Safety requirement, | , dated 2024, and indicated it | | | monthly thereafter to complete | 2 6 | |
| | - | icy in use by the facility. A | | | months. Results of all audits w | ∕ill | |
| | | v indicated, page 3 section 7.e | | | be reviewed monthly at QAPI | | |
| | | be worn when cooking, | | | identify any trends or patterns | . If | |
| | | bling food, such as stirring | | | any issues are identified, will | | |
| | pots or assembling | the ingredients of a salad," | | | continue audits based on IDT | | |
| | | | | | recommendation, otherwise w | ill | |
| | | p.m., a review of the Indiana | | | review on a PRN basis. | ļ | |
| | | t Sanitation Requirements, | | | | | |
| | | , effective November 13, 2004, | | | | ļ | |
| | | employees shall wear hair | | | | ļ | |
| | · · | ats, hair coverings or nets | | | | ļ | |
| | _ | and worn to effectively keep | | | | ļ | |
| | their hair from cont | actingexposed food" | | | | ļ | |
| | | | | | | | |
| | 3.1-21(i)(2) | | | | | ļ | |
| | 3.1-21(i)(3) | | | | | | 1 |

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Event ID:

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Facility ID: 000063

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|----------------------------------|------------------------------------|-------|--------|--|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | ILDING | 00 | COMPL | ETED |
| | | 155138 | B. WI | NG | | 10/22/ | /2024 |
| | | | | CTDEET | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF I | PROVIDER OR SUPPLIE | R | | | CHURCHMAN AVE | | |
| BRICKY | ARD HEALTHCAR | E - CHURCHMAN CARE CENTER | | | NAPOLIS, IN 46203 | | |
| DINIONIA | | E - CHORCHWAN CARE CENTER | | INDIAN | | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | NCY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | .TE | COMPLETION |
| TAG | REGULATORY O | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| F 0880 | 483.80(a)(1)(2)(4 |)(e)(f) | | | | | |
| SS=D | Infection Preventi | | | | | | |
| Bldg. 00 | | | | | | | |
| | | | F 08 | 380 | Immediate action(s) taken fo | r | 11/11/2024 |
| | Based on interview | and record review, the facility | | | the resident(s) found to have | | |
| | failed to ensure res | idents were provided a | | | been affected include: | | |
| | two-step Mantoux | skin test (tool used for | | | All resident without TB test ha | ve | |
| | screening for tuber | culosis) upon admission for 3 | | | been given one and will be | | |
| | of 5 residents revie | ewed for tuberculosis skin tests. | | | followed by 2nd step. | | |
| | (Resident 32, Resid | dent 33, and Resident 44) | | | | | |
| | | | | | Identification of other reside | nts | |
| | Findings include: | | | | having the potential to be | | |
| | | | | | affected was accomplished I | oy: | |
| | 1. On 10/16/24 at 1 | 10:30 a.m., Resident 32's clinical | | | The facility has determined the | at all | |
| | record was reviewe | ed. Resident 32's diagnoses | | | residents that did not receive | the | |
| | included, but were | not limited to, COPD, chronic | | | Mantoux skin test, or have a | | |
| | kidney disease, and | d type 2 diabetes. | | | contraindication, have the pot | ential | |
| | | | | | to be affected. | | |
| | | cal record lacked any | | | | | |
| | | a first step or a second step | | | Audit completed of all residen | ts to | |
| | Mantoux skin test i | upon admission. | | | ensure all residents have | | |
| | | | | | appropriate Mantoux skin test | S | |
| | | 11:15 a.m., Resident 33's clinical | | | being done. | | |
| | | ed. Resident 33's diagnoses | | | | | |
| | | not limited to, COPD, | | | Actions taken/systems put in | nto | |
| | encephalopathy (a | - | | | place to reduce the risk of | | |
| | dystunction), and a | alcoholic liver disease. | | | future occurrence include: | | |
| | D 11 (22) | 1 11 1 1 | | | All licensed nursing staff were | | |
| | | cal record lacked any | | | in-serviced regarding the facili | • | |
| | | a first step or a second step | | | policy for Resident Screening | tor | |
| | Mantoux skin test i | upon admission. | | | Tuberculosis. Education was | ļ | |
| | 2 0 - 10/16/24 - 1 | 11.00 D:4 441 1' ' 1 | | | provided by DNS and DCE on | ı | |
| | | 11:00 a.m., Resident 44's clinical | | | 10-31-2024. | | |
| | | ed. Resident 44's diagnoses | | | All manifelants with and an in the | -: | |
| | | not limited to, chronic | | | All residents without an admis | | |
| | respiratory failure, 2 diabetes. | tracheostomy status, and type | | | TB test will have a TB test dor | ie | |
| | Z diabetes. | | | | by 11-11-2024 unless | | |
| | Dogidant 44la alini | cal record lacked any | | | contraindicated and risk | ļ | |
| | | a first step or a second step | | | assessment will be completed | | |
| I | | i mai atep of a second step | 1 | | | l. | I |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED | | | | | |
|---|---|--|--|----------------------------------|---|-----------------------------|------------|
| 155138 | | B. WING 10/22/2024 | | | | | |
| NAME OF PROVIDER OR SUPPLIER BRICKYARD HEALTHCARE - CHURCHMAN CARE CENTER | | | STREET ADDRESS, CITY, STATE, ZIP COD 2860 CHURCHMAN AVE INDIANAPOLIS, IN 46203 | | | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID PROVIDER'S PLAN OF CORRECTION | | | (X5) |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION |
| F 0883 SS=E Bldg. 00 | SS=E Influenza and Pneumococcal Immunizations | | F 08 | TAG | How the corrective action(s) will be monitored to ensure to practice will not recur: The IP nurse/DON/Designee will monitor all new admissions for 4 weeks then new admissions monthly x 5months. Results of all audit will be reviewed monthly at QAPI for no less than 6 mont to identify any trends or patterns. If any issues are identified, will continue audit based on IDT recommendatio otherwise will review on a Pf basis. Immediate action(s) taken for | 3 ths ts on, RN | 11/11/2024 |
| | failed to have reside consent or refusal for vaccinations upon a reviewed for immur Resident 32, Reside Findings include: 1. On 10/16/24 at 10 record was reviewed included, but were redisease that makes in hepatitis C (a viral in and unspecified kides. | | | | the resident(s) found to have been affected include: All residents were offered pneumococcal vaccine as appropriate. Identification of other reside having the potential to be affected was accomplished to the facility has determined that residents without appropriate vaccinations or contraindication have the potential to be affected. Audit completed of all resident ensure all residents have | nts py: at all pns ed. | |
| | On 10/17/24 at 8:30 | a.m., the DON (Director of | 1 | | appropriate pneumococcal | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | | |
|--|---|-----------------------------------|-------|--------------------|--|--------|------------|--|
| AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER | A. BU | JILDING | 00 | COMPL | ETED | |
| 155138 | | B. WING 10/22/202 | | | 2024 | | | |
| | | | | | | | | |
| NAME OF PROVIDER OR SUPPLIER | | | | | ADDRESS, CITY, STATE, ZIP COD | | | |
| | | | | 2860 CHURCHMAN AVE | | | | |
| BRICKYARD HEALTHCARE - CHURCHMAN CARE CENTER | | | | INDIAN | IAPOLIS, IN 46203 | | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
| PREFIX | (EACH DEFICIEN | NCY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE | TE | COMPLETION | |
| TAG | REGULATORY O | R LSC IDENTIFYING INFORMATION | | TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | 16 | DATE | |
| | Nursing), provided a copy of Resident 3's | | | | vaccinations offered, consents | are | | |
| | pneumococcal vaco | eine consent form. A review of | | | being signed and being given, | | | |
| | - | it was signed as "verbal from | | | if resident refuses, they are given | | | |
| | | torney]" and was undated. | | | education and refusal form is | | | |
| | - | | | | signed and education | | | |
| | 2. On 10/16/24 at 1 | 0:30 a.m., Resident 32's clinical | | | documented. | | | |
| | record was reviewe | ed. Resident 32's diagnoses | | | | | | |
| | | not limited to, COPD, chronic | | | Actions taken/systems put ir | nto | | |
| | kidney disease, and | | | | place to reduce the risk of | | | |
| | • | | | | future occurrence include: | | | |
| | On 10/17/24 at 8:30 | 0 a.m., the DON provided a copy | | | All licensed nursing staff were | | | |
| | | eumococcal vaccine consent | | | in-serviced regarding the facili | | | |
| | - | the form indicated it was signed | | | policy for Pneumococcal | | | |
| | by the resident and | _ | | | Vaccine. Education provided b | ογ | | |
| | | | | | DNS and DCE on 10-31-2024 | - | | |
| | 3. On 10/16/24 at 1 | 1:15 a.m., Resident 33's clinical | | | | | | |
| | record was reviewe | ed. Resident 33's diagnoses | | | All residents offered vaccines | and | | |
| | included, but were | not limited to, COPD, | | | were given, and consents sigr | ned | | |
| | encephalopathy (a | syndrome of brain | | | by 11-11-2024. If resident refe | | | |
| | dysfunction), and a | lcoholic liver disease. | | | they are given education ad re | | | |
| | | | | | form is signed and education | | | |
| | On 10/17/24 at 8:30 | 0 a.m., the DON provided a copy | | | documented. | | | |
| | of Resident 33's pn | eumococcal consent form. A | | | | | | |
| | review of the form | indicated it was signed by the | | | How the corrective action(s) | | | |
| | DON "for [Residen | at 33]" and was dated 10/16/24. | | | will be monitored to ensure t | :he | | |
| | | | | | practice will not recur: | | | |
| | 4. On 10/16/24 at 1 | 1:00 a.m., Resident 44's clinical | | | Executive Director or designed | e will | | |
| | record was reviewe | ed. Resident 44's diagnoses | | | audit new admissions to ensu | re | | |
| | included, but were | not limited to, chronic | | | that they are offered appropria | ate | | |
| | respiratory failure, | tracheostomy status, and type | | | Pneumonia vaccine upon | | | |
| | 2 diabetes. | | | | admission and consent form | | | |
| | | | | | signed and vaccination given | or | | |
| | On 10/17/24 at 8:30 a.m., the DON provided a copy | | | | refusal signed and education | | | |
| | of Resident 44's pneumococcal consent form. A | | | | documented. This audit will be | ÷ | | |
| | review of the form indicated it was signed by two | | | | conducted 5 times weekly for | 4 | | |
| | staff witnesses and was dated for 10/16/24. | | | | weeks, then 3 times weekly fo | | | |
| | | | | | weeks, then monthly thereafte | r to | | |
| | During an interview | v on 10/18/24 at 1:40 p.m., the | | | complete 6 months. Results o | | | |
| | | Director of Clinical Operations) | | | audits will be reviewed monthl | | | |
| | indicated that the fo | orms should have been signed | | | QAPI to identify any trends or | - | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | | |
|--|--|------------------------------------|-----------------------|--------------------|--|-----------|------------|--|
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER | | IDENTIFICATION NUMBER | A. BUILDING <u>00</u> | | | COMPLETED | | |
| | 155138 | | B. WING 10/22/20 | | | /2024 | | |
| | | | | | | <u> </u> | | |
| NAME OF P | ROVIDER OR SUPPLIER | t | | | ADDRESS, CITY, STATE, ZIP COD | | | |
| BRICKYARD HEALTHCARE - CHURCHMAN CARE CENTER | | | | 2860 CHURCHMAN AVE | | | | |
| BRICKY | ARD HEALTHCARE | E - CHURCHMAN CARE CENTER | | INDIAN | IAPOLIS, IN 46203 | | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE. | COMPLETION | |
| TAG | REGULATORY OR | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE | |
| | upon admission. Th | ne consent forms records were | | | patterns. If any issues are | | | |
| | requested on 10/16/ | 24 at the end of the first day of | | | identified, will continue audits | | | |
| | the survey and were | e provided on the morning of | | | based on IDT recommendatio | n, | | |
| | 10/17/24. All of the | forms were dated for 10/16/24 | | | otherwise will review on a PRI | N | | |
| | or were undated, an | d the RDCO indicated that any | | | basis. | | | |
| | undated areas on forms were also from 10/16/24. | | | | | | | |
| | | | | | | | | |
| | On 10/16/24 at 10:1 | 15 a.m., the DON provided an | | | | | | |
| | undated policy title | d, "Pneumococcal Vaccine | | | | | | |
| | (Series)" and indica | ited 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 th | e vaccine. | | | | | | |
| | 2 1 12(a) | | | | | | | |
| | 3.1-13(a) | | | | | | | |
| F 0887 | 483.80(d)(3)(i)-(vii | i) | | | | | | |
| SS=E | COVID-19 Immun | ization | | | | | | |
| Bldg. 00 | | | | | | | | |
| | | | F 08 | 387 | Immediate action(s) taken fo | r | 11/11/2024 | |
| | | and record review, the facility | | | the resident(s) found to have | } | | |
| | | ents sign the appropriate | | | been affected include: | | | |
| | consent or refusal for | | | | All residents offered, and obta | - | | |
| | , | ecinations upon admission for 4 | | | signatures on the the appropri | iate | | |
| | | wed for immunization records. | | | consent or refusal forms for | | | |
| | | nt 32, Resident 33, and | | | Covid-19 (SARS-CoV-2) vacc | ines. | | |
| | Resident 44) | | | | | | | |
| | | | | | Identification of other reside | nts | | |
| | Findings include: | | | | having the potential to be | | | |
| | 1 0 10/16/24 | 0.45 | | | affected was accomplished by | - | | |
| | | 0:45 a.m., Resident 3's clinical | | | The facility has determined the | | | |
| | | d. Resident 3's diagnoses | | | residents that are not up to da | | 1 | |
| | | not limited to, COPD (a lung | | | on COVID-19 vaccinations ha | ve | | |
| | | it difficult to breathe), chronic | | | the potential to be affected. | | | |
| | - | infection that affects the liver), | | | | | | |
| | and unspecified kid | ney injury. | | | Audit completed of all resident | ts to | | |
| | 0 10/15/01 000 |) A PONTO | | | ensure all residents have | | | |
| | On 10/17/24 at 8:30 | a.m., the DON (Director of | | | appropriate COVID-19 | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

T24C11

Facility ID: 000063

If continuation sheet Page 15 of 18

| STATEMENT OF DEFICIENCIES X1) | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | | |
|--|---|-----------------------------------|----------------------------|--|--|------------|------------|
| AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER | A. BU | JILDING | 00 | COMPLETED | |
| 155138 | | 155138 | B. WING | | | 10/22/2024 | |
| | | | | CTP FFT | IDDREGG CHTV CT TE TO COP | | |
| NAME OF P | ROVIDER OR SUPPLIER | t | | | ADDRESS, CITY, STATE, ZIP COD | | |
| BRICKYARD HEALTHCARE - CHURCHMAN CARE CENTER | | | | 2860 CHURCHMAN AVE INDIANAPOLIS, IN 46203 | | | |
| BRICKY | ARD HEALTHCARE | - CHURCHMAN CARE CENTER | | INDIAN | APOLIS, IN 46203 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OF | LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | Nursing), provided a copy of Resident 3's | | | | vaccinations are being offered | Ι, | |
| | Covid-19 vaccine c | onsent form. A review of the | | | consents are being signed and | | |
| | form indicated it wa | as signed as "verbal from POA | | | being given, and if resident | | |
| | [Power of Attorney |]" and was undated. | | | refuses, they are given educat | tion | |
| | | | | | and refusal signed and educat | tion | |
| | 2. On 10/16/24 at 1 | 0:30 a.m., Resident 32's clinical | | | documented. | | |
| | record was reviewe | d. Resident 32's diagnoses | | | | | |
| | included, but were i | not limited to, COPD, chronic | | | Actions taken/systems put ir | nto | |
| | kidney disease, and | type 2 diabetes. | | | place to reduce the risk of | | |
| | | | | | future occurrence include: | | |
| | On 10/17/24 at 8:30 | a.m., the DON provided a copy | | | All licensed nursing staff were | | |
| | of Resident 32's Co | vid-19 vaccine consent form. A | | | in-serviced regarding the facili | ty | |
| | review of the form | indicated it was signed by the | | | policy for Covid-19 | | |
| | resident and was da | ted 10/16/24. | | | Vaccine. Education provided b | ру | |
| | | | | | DNS and DCE on 10-31-2024 | | |
| | 3. On 10/16/24 at 1 | 1:15 a.m., Resident 33's clinical | | | | | |
| | record was reviewe | d. Resident 33's diagnoses | | | All residents offered vaccines, | | |
| | included, but were | not limited to, COPD, | | | consent forms are signed and | | |
| | encephalopathy (a s | syndrome of brain | | | vaccines given. If resident | | |
| | dysfunction), and a | lcoholic liver disease. | | | refuses, they are given educat | tion | |
| | | | | | and refusal form is signed and | l | |
| | | a.m., the DON provided a copy | | | education documented by | | |
| | | vid-19 consent form. A review | | | 11-11-2024. | | |
| | | ed it was signed by the DON | | | | | |
| | "for [Resident 33]" | and was dated 10/16/24. | | | How the corrective action(s) | | |
| | | | | | will be monitored to ensure t | :he | |
| | | 1:00 a.m., Resident 44's clinical | | | practice will not recur: | | |
| | | d. Resident 44's diagnoses | | | Executive Director or designed | | |
| | | not limited to, chronic | | | audit new admissions to ensu | re | |
| | | tracheostomy status, and type | | | that they are offered COVID-1 | 9 | |
| | 2 diabetes. | | | | vaccine upon admission and | | |
| | 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 | | | | consent form or refusal and | | |
| | | | | | education is documented. This | | |
| | | | | | audit will be conducted 5 times | | |
| | | | | | weekly for 4 weeks, then 3 tim | | |
| | witnesses and was undated. | | | | weekly for 4 weeks, then mon | • | |
| | | | | | thereafter to complete 6 montl | ns. | |
| | - | on 10/18/24 at 1:40 p.m., the | | | Results of all audits will be | | |
| | , - | Pirector of Clinical Operations) | | | reviewed monthly at QAPI to | | |
| | indicated that the fo | orms should have been signed | | | identify any trends or patterns | . If | |

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 10/22/2024 | | | ETED | | |
|--|--|---|--|--------------|--|---------------------------|--------------------|
| | PROVIDER OR SUPPLIER | - CHURCHMAN CARE CENTER | STREET ADDRESS, CITY, STATE, ZIP COD 2860 CHURCHMAN AVE INDIANAPOLIS, IN 46203 | | | | |
| (X4) ID PREFIX | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL | | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | (X5) COMPLETION |
| F 0921 SS=D Bldg. 00 | upon admission. The requested on 10/16/26 the survey and were 10/17/24. All of the or were undated, an undated areas on for On 10/16/24 at 10:1 undated policy titled indicated it was the facility. A review of are to be offered im that a consent form administration of the 483.90(i) Safe/Functional/Signature and the facility of the fa | anitary/Comfortable Environ on, interview, and record failed to ensure biohazard and behind a locked door for 1 of observed. (B Hall) 5 a.m., observed an unlocked ated on the B hall. No staff area. A sign posted on the on biohazard materials, soiled cked. The door was unlocked Inside the room observed a f soiled linen. The room had a cron 10/16/24 at 11:00 a.m., the arector indicated the biohazard | F 09 | TAG | any issues are identified, will continue audits based on IDT recommendation, otherwise w review on a PRN basis. Immediate action(s) taken for the resident(s) found to have been affected include: All biohazard room doors were immediately locked. Identification of other reside having the potential to be affected was accomplished to the facility has determined the residents have the potential to affected. All biohazard doors in facility was audited to ensure their locking mechanisms are functioning properly. Actions taken/systems put in place to reduce the risk of future occurrence include: | r e e nts oy: at all b be | 11/11/2024 |
| | On 10/17/24 at 10:53 a.m., the Regional Director of | | | | All staff were in-serviced regal | rdina | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

T24C11

Facility ID: 000063

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/14/2024 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155138 | | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING | | X3) DATE SURVEY COMPLETED 10/22/2024 | | | |
|--|--|--|--|--------------------------------------|--|--|----------------------------|
| NAME OF PROVIDER OR SUPPLIER BRICKYARD HEALTHCARE - CHURCHMAN CARE CENTER | | | STREET ADDRESS, CITY, STATE, ZIP COD 2860 CHURCHMAN AVE INDIANAPOLIS, IN 46203 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ATE | (X5) COMPLETION DATE |
| IAU | Clinical Operation titled Medical Was was the current po A review of the po policy of this facil medical waste is n | s provided a copy of a policy ste, dated 2024, and indicated it licy being used by the facility. licy indicated "Policy: It is the ity to ensure that regulated nanaged, handled, stored, and Federal, State and local | | IAU | the facility policy for Medical Waste and keeping biohazard materials secure. Education was provided by Di and DCE on 10-31-2024. How the corrective action(s) will be monitored to ensure practice will not recur: Executive Director or designe audit doors to ensure biohazar room doors remain locked. The audit will be conducted 5 time weekly on various shifts for 4 weeks, then 3 times weekly for weeks, then monthly thereafted complete 6 months. Results of audits will be reviewed month QAPI to identify any trends or patterns. If any issues are identified, will continue audits based on IDT recommendation otherwise will review on a PR basis. | the e will ird nis s or 4 er to of all ly at | DATE |

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: T24C11 Facility ID: 000063 If continuation sheet Page 18 of 18