STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155076	A. Building B. Wing	10/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brickyard Healthcare - Brookview Care Center	7145 E 21st Street Indianapolis, IN 46219

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a cognitively impaired resident, who was assessed by the facility as an elopement risk, did not exit the facility unsupervised, for 1 of 3 residents reviewed for elopement and elopement risk (Resident B). The resident was able to exit the secured memory care unit through a bathroom window without the knowledge of staff. The resident was found at a local gas station, located in a busy intersection, and later sent to a local hospital after involvement with local police and emergency medical services (EMS).The Immediate Jeopardy began on October 1, 2025, when a cognitively impaired resident with dementia exited the secured memory care unit through a bathroom window unsupervised into a potentially dangerous area, including a multiple lane, busy intersection, that the resident had to cross to get to the local gas station located approximately 0.3 miles away from the facility. The Executive Director, Director of Nursing, and the Corporate Nurse were notified of the Immediate Jeopardy on 10/6/25 at 4:27 p.m.Findings include:The clinical record for Resident B was reviewed on 10/6/25 at 10:15 a.m. The diagnoses included, but were not limited to, dementia with agitation and behavioral disturbances, sleep disorder, and diabetes. He was admitted to the facility's secured memory care unit on 8/7/25. An admission Minimum Data Set (MDS) assessment, completed 8/14/25, indicated Resident B had severely impaired cognition. He displayed wandering behaviors for one to three days during the assessment period. The wandering behaviors placed him at a significant risk for potential danger. An elopement risk assessment, dated 8/15/25, indicated Resident B had a history of elopement and/or attempted elopement while at home. He had a history of attempted leaving the facility without informing staff. He had verbally expressed the desire to go home, packed belongings to go home or stayed near an exit door. He had wandered with a goal-directed specific destination. His wandering behavior was likely to affect the safety and well-being of himself or others. He had been recently admitted or re-admitted (within the past 30 days) and was not accepting of the situation.A care plan, dated 8/15/25, indicated he was at risk for elopement from the facility related to attempts to leave the facility unattended and impaired safety awareness. The goal was for his safety to be maintained, and he would not leave the facility unattended. The interventions included distracting him from wandering by offering pleasant diversions, structured activities, food, conversation, television, and books. Identify patterns of wandering and intervene as appropriate. Leave of absences with supervision. Place his picture in the elopement binder. Provide structured activities, toileting, walking inside and outside, reorientation strategies including signs, pictures, and memory boxes. Resident resided on a secured unit. A care plan, dated 8/26/25, indicated he had the potential to be verbally or physically aggressive related to dementia with agitation, with recent episodes observed. The goal was for him to have no new episodes of physical aggression toward peers. The interventions included administering medications as ordered, assessing and anticipating his needs, provide physical and verbal cues to alleviate anxiety; give positive feedback, assisting with verbalization of source of agitation, assisting to set goals formore pleasant behavior, encourage seeking out of staff member when agitated, and psychiatric/psychogeriatric consult as indicated.A care plan, dated 8/26/25, indicated he was at risk for sleep pattern disturbance. The resident had an order or had used sleep medication and had periods of staying awake at night due to being a truck driver in the past. The goal was for him to exhibit no sleep related behavioral symptoms, such as restlessness, irritability, lethargy, or disorientation. The interventions included administering sleep medications as ordered by the physician, assessing for adverse side effects, and assisting him in establishing a daily routine with periods of rest and activity. Also, to maintain an environment conducive to sleep (quiet, comfortable temperature, dimmed lights). A Behavioral Health Diagnostic Assessment, dated 9/2/25, indicated the reason for Resident B's referral for treatment was anxiety disorders, agitation, neurocognitive disorders, feeding/eating or sleep/wake disorders. The clinical assessment indicated Resident B was alert and conversational but not oriented. He was only oriented to person. He thought [NAME] was the president and stated he was in his older 20s when asked about his age. Resident B reported some anxiety. He can be physically aggressive with others on the Memory Care Unit. A General Note, dated 10/1/25 at 2:15 a.m., indicated at the start of the shift, at 10:00 p.m., Resident B was in his bedroom in bed sleeping. At around 2:15 a.m., during rounding, Resident B was awake in his bedroom with no noted anxiety at that time. Resident B walked out of his bedroom and into the hallway, and then went back into the bedroom and closed the door. At 4:15 a.m., writer (writer of the General Note) was notified by CNA (Certified Nurse Aide) that