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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155157	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brickyard Healthcare - Richmond Care Center	1042 Oak Dr Richmond, IN 47374

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36942 Based on interview and record review, the facility failed to ensure a resident who admitted to the facility with an identified skin concern received timely treatment and services that was later identified with an unstageable pressure ulcer that had worsened and became infected (Resident E) and failed to ensure a resident received treatment for incontinence associated dermatitis (IAD) who was later identified with a stage 3 pressure ulcer (Resident D) for 2 of 3 residents reviewed for skin integrity. The deficient practice was corrected on 2/1/24, prior to the start of the survey, and was therefore past noncompliance. The facility had completed full skin assessments on all of the residents, conducted in-service education for wound treatment management, documentation of wound treatments, skin assessments, changes in condition, and pressure injury prevention/management, conducted audits for residents with identified wounds, and conducted audits for new admissions for skin integrity and treatment initiation. Findings include: 1. The clinical record for Resident E was reviewed on 4/16/24 at 3:30 p.m. The diagnoses included, but were not limited to, bipolar disorder, major depressive disorder, malnutrition, muscle weakness, need for assistance with personal care, and rhabdomyolysis (a breakdown of skeletal muscle due to direct or indirect muscle injury). Resident E was admitted to the facility on [DATE]. A Braden Scale (a scale that assesses a patient's risk of developing a pressure ulcers), dated 1/4/24, indicated Resident E was at risk for pressure ulcer development. A care plan for activities of daily living (ADLs), initiated on 1/9/24, indicated Resident E had interventions listed for 2 staff person assist with bathing, bed mobility, dressing, and morning and bedtime routine. A care plan for skin, initiated on 1/31/24, indicated Resident E admitted to the facility with a pressure ulcer to the coccyx. The interventions included, but were not limited to, weekly assessment of the skin and treatments as ordered. A care plan for skin, initiated on 1/31/24, indicated Resident E admitted to the facility with a pressure ulcer to the lower, mid-back. The interventions included, but were not limited to, weekly assessment of the skin and treatments as ordered. (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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A progress note, type: Clinical Admission and dated for 1/3/24 at 10:11 p.m., indicated Resident E had an abrasion to his right knee. A progress note, type: Skin Only Evaluation and dated for 1/4/24 at 7:35 a.m., indicated Resident E had an abrasion to the right knee. There was documentation of Scabs on his right and left cheeks and chin. Skin tear on his lower back with 0.1 in diameter [sic]. There was no further description of the skin alterations for Resident E. A progress note, dated 1/7/24, indicated Resident E was admitted to the hospital. A hospital discharge summary, dated 1/10/24, indicated the following, .was admitted on [DATE] due to altered mental status and lethargy .Patient does have multiple Pressure ulcers of mid spine, left spine, left sacrum, right sacrum, and right metatarsal, all present upon admission. Patient will benefit from close outpatient follow-up with Wound Care, as well as frequent position change to avoid worsening of pressure ulcers A progress note, dated 1/10/24 at 7:45 p.m., indicated Resident E was readmitted to the facility from the hospital. A skin assessment was completed and noted resident still has skin tear on his sacrum, lower back and right foot. Dressing placed on his lower back & sacrum A Weekly Skin Review, dated 1/11/24, indicated skin tears that were Pre-existing were marked. The document indicated skin tears present to the coccyx, sacrum, and right foot. There were no further assessments that included measurements, condition of the wounds, etiology of the wounds, and/or treatment of such wounds. The electronic medication administration record (EMAR) and electronic treatment administration record (ETAR) of January of 2024 was reviewed and did not indicate any treatments for Resident E's skin upon admission to the facility on [DATE] and upon readmission to the facility on [DATE]. A wound assessment report, dated 1/16/24, indicated a stage 3 pressure ulcer to Resident E's coccyx that was Present on Admission. The treatment was listed as cleanse the area with wound cleanser, apply Triad paste, and leave open to air twice daily. A wound assessment report, dated 1/16/24, indicated a stage 3 pressure ulcer to Resident E's lower back that was Present on Admission. The treatment was listed as cleansing the area with wound cleanser, apply hydrogel, cover with bordered gauze, and change daily. The EMAR and ETAR of January of 2024 was reviewed and didn't note any treatment orders for Resident E's skin on 1/16/24. A physician order, dated 1/18/24, was noted to Resident E's mid-lower back to cleanse with normal saline and pat dry, apply collagen to wound bed and cover with bordered foam. A physician order, dated 1/18/24, was noted to Resident E's sacrum to cleanse with normal saline, pat dry, apply collagen to wound bed and cover with border foam. These orders were not consistent with the wound assessment report treatment plan from 1/16/24. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A physician order, dated 1/22/24, was noted to Resident E's mid-lower back to cleanse with wound cleanser and pat dry. Apply hydrogel to wound bed and covered with bordered gauze. Change daily and as needed. The order was discontinued on 1/28/24. A physician order, dated 1/22/24, was noted to Resident E's sacrum to cleanse with wound cleanser and pat dry. Apply Triad paste to wound bed and leave open to air. Complete BID (twice daily) and PRN (as needed). The order was discontinued on 1/28/24. The ETAR for January of 2024 indicated the Triad paste to Resident E's sacrum to be conducted twice daily but was signed off, as administered, on a daily basis from 1/23/24 to 1/28/24. A wound assessment report, dated 1/24/24, indicated a stage 3 pressure ulcer to Resident E's coccyx that was stable. The treatment was listed to cleanse the area with wound cleanser, apply Dakins moistened fluffed gauze ((Dakin's solution is a dilute solution of sodium hypochlorite (0.4% to 0.5%) and other stabilizing ingredients, traditionally used as an antiseptic, e.g. to cleanse wounds in order to prevent infection)), cover with bordered foam, and change daily. A wound assessment report, dated 1/24/24, indicated a stage 3 pressure ulcer to Resident E's lower back that was stable. The treatment was listed to cleanse the area with wound cleanser, apply Dakins moistened fluffed gauze, cover with bordered foam, and change daily. Physician orders, dated 1/28/24, was noted for Dakins soaked fluffed gauze treatment to Resident E's coccyx and mid-lower back daily. The orders were discontinued on 2/13/24. A wound assessment report, dated 1/31/24, indicated a stage 3 pressure ulcer to Resident E's coccyx. There was blue and green drainage noted. The treatment remained the same with Dakins moistened fluffed gauze daily. A wound assessment report, dated 1/31/24, indicated a stage 3 pressure ulcer to Resident E's lower back. There was blue and green drainage noted. The treatment remained the same with Dakins moistened fluffed gauze daily. A care plan for wounds, dated 1/31/24, indicated Resident E had a wound infection to the coccyx and lower back area. The interventions included, but were not limited to, treatments as ordered and obtain and monitor lab/diagnostic work as ordered. A progress note, dated 2/1/24, indicated Resident E's pressure ulcers were worsening and will order to get wound culture. A progress note, dated 2/5/24 at 10:05 p.m., indicated a wound culture was obtained of Resident E's sacrum and taken to the lab. A progress note, dated 2/7/24 at 12:36 a.m., indicated a wound culture was obtained and sent to the lab within the past 2 days. The lab called and stated that both times the specimen was sent in the wrong collection tubes. The facility did not have the correct specimen tubes. Someone needed to go get the tubes from the lab. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A wound assessment report, dated 2/7/24, indicated an unstageable pressure ulcer to Resident E's coccyx that had worsened and was malodorous (smelling very unpleasant). A wound assessment report, dated 2/7/24, indicated a stage 3 pressure ulcer to Resident E's lower back. The wound was stable and there were no changes to the treatment. A skin and wound note, dated 2/7/24 at 4:16 a.m., indicated the following, .lower back pressure ulcer stable noblue [sic] green drainage this week. Coccyx pressure ulcer now classified as unstageable, much worse than last week, new odor and measuring much larger in size. Patient absolutely would not let staff assess wounds properly, let alone debride wounds as they need to be debrided, patient was yelling, cursing and hitting staff .Noted WBC [white blood cell] elevated at almost 30k [30,000]. Wound culture was obtained by staff as previously recommended. Recommend to send patient to ER [emergency room] for further evaluation of coccyx wound due to abrupt worsening status A hospital document, dated 2/7/24, indicated the following, .Physical Exam .Musculoskeletal .Comments: Approximately 4 cm [centimeters] decubitus ulcer present near the left sacrum with malodorous drainage with tenderness. No significant erythema or warmth .ED [Emergency Department] Course .presenting from ECF [extended care facility] .concerns for infection of decubitus ulcer .Fournier's gangrene with in the right perineum extending from a decubitus ulcer and abscess .recommends transfer to a tertiary center for higher level of care 2. The clinical record for Resident D was reviewed on 4/16/24 at 2:45 p.m. The diagnoses included, but were not limited to, congestive heart failure, muscle weakness, chronic pain syndrome, and edema. A care plan for skin, revised 1/18/24, indicated Resident D was at risk for pressure ulcer development. The interventions included, but were not limited to, conduct weekly skin inspection and treatments as ordered. A Braden Scale, dated 12/5/23, indicated Resident D was at risk for pressure ulcer development. A Skin Only Evaluation, dated 12/16/23, indicated a laceration to the left buttock and excoriation to the perineal area. There were no physician orders for Resident D's skin for 12/16/23. A skin and wound note, dated 12/20/23, indicated incontinence associated dermatitis (IAD) was present to the left posterior thigh and left buttock. The plan was to cleanse both areas with water, pat dry, apply triad paste to the wound, leave open to air, and change twice daily. A skin and wound note, dated 12/27/23, indicated IAD was present to the left posterior thigh and left buttock. The treatment plan remained the same with triad paste to both areas, leave open to air, and change twice daily. There were no orders for triad paste in Resident D's EMAR and/or ETAR for December of 2023. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A skin and wound note, dated 1/3/24, indicated IAD to the left posterior thigh that was improving. The left buttock was previously classified as MASD [moisture-associated skin damage], progression into PU [pressure ulcer] with full thickness and listed as a stage 3. The treatment plan consisted of triad paste to the left posterior thigh and triad paste with hydrogel to the base of the wound located on the left buttock. There were no treatment orders to Resident D's buttocks and/or posterior thigh on the EMAR or ETAR for January of 2024. A progress note, dated 1/4/24, indicated Resident D was not feeling well and sent out to the hospital for a low hemoglobin (a protein containing iron that facilitates the transport of oxygen in red blood cells) level. Resident D didn't return to the facility. An interview conducted with the Director of Nursing (DON), on 4/17/24 at 12:10 p.m., indicated she had been the DON for a couple of months. When she started working at the facility she started reviewing residents' charts. When she reviewed the charts of the residents with identified skin concerns, she noticed the lack of either having wound assessments, orders for treatment to such wounds, and following the physicians' orders. So, an audit was conducted of the residents with wounds currently at that time and the Nurse Practitioner (NP) from the wound consulting company assisted with doing a full skin sweep of the facility. That was completed on 2/1/24. The facility brought the Assistant Director of Nursing (ADON) on board with being the primary person for the wound management program as the line of focus for them. A policy titled Pressure Injury Prevention and Management, revised 2/1/24, was provided by the DON on 4/17/24 at 8:35 a.m. The policy indicated the following, .2. The facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate .3. Assessment of Pressure Injury Risk .c. Licensed nurses will conduct a full body skin assessment on all residents upon admission/readmission, weekly, and after any newly identified pressure injury. Findings will be documented in the medical record .d. Assessments of pressure injuries will be performed by a licensed nurse, and documented on the N Adv Skin Only Evaluation. The staging of pressure injuries will be clearly identified to ensure correct coding on the MDS [minimum data set] .4. Interventions for Prevention and to Promote Healing .b. Interventions will be based on specific factors identified in the risk assessment, skin assessment, and any pressure injury assessment (e.g., moisture management, impaired mobility, nutritional deficit, staging, wound characteristics) .5. Monitoring .d. The effectiveness of current preventative and treatment modalities and processes will be discussed in accordance with the QAPI [Quality Assurance and Performance Improvement] Committee Schedule, and as needed when actual or potential problems are identified This citation relates to Complaints IN00428308 and IN00429661. 3.1-40(a)(1) 3.1-40(a)(2)