STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155157	A. Building B. Wing	09/13/2024

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 45291 Based on interview, observations, and record review, the facility failed to ensure Resident 44 had a self-administration of medications assessment completed for 1 of 1 resident reviewed for self-administration of medications. Findings include: The clinical record for Resident 44 was reviewed on 9/11/2024 at 11:20 a.m. The medical diagnoses included chronic respiratory failure and chronic obstructive pulmonary disease. A Quarterly Minimum Data Set (MDS) assessment, dated 8/29/2024, indicated Resident 44 was cognitively intact and did not have behaviors. A self-administration care plan, initiated on 9/10/2024, indicated an intervention of completing a self-administration assessment per the facility's protocol. During an interview and observation, on 9/5/2024 at 11:21 a.m., indicated Resident 44 had two medication nasal sprays. Resident 44 indicated they kept the two medicated nasal sprays on the over-bed table, staff knew about the medicated nasal sprays, and staff told them to just keep the medicated nasal sprays in one spot. During an interview on 9/5/2024 at 11:30 a.m., QMA 6 indicated Resident 44 utilized over the counter nasal sprays that the family provided, and Resident 44 kept at the bedside. During an observation on 9/10/2024 at 1:55 p.m., Resident 44 had two medicated nasal sprays on the bedside table. A self-administration assessment, dated 9/10/2024 at 6:29 p.m., indicated that Resident 44 was fully capable of self-administration for nasal decongestants. A policy entitled, Resident Self-Administration of Medications, was provided by the Director of Nursing Services on 9/12/2024 at 9:40 a.m. The policy indicated, .A resident may only self-administer medications after the facility's intradisciplinary team has determined which medications may be self-administered safely . the opportunity to self-administer medications during the routine assessment . 3.1-11(a)

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 25054 Based on observation, interview, and record review, the facility failed to provide fresh water daily for 1 of 1 resident reviewed for hydration. (Resident C) Findings include: During an observation and interview with Resident C on 9/9/24 at 11:30 a.m., the resident had two cups of thickened juice on the bedside table and no water. Resident C indicated she liked juice but would like to have fresh water every day also. During an observation on 9/10/24 at 1:59 p.m., Resident C had a cup of thickened coffee and a cup of thickened juice. The resident did not have any water. During an observation and interview with Resident C on 9/11/24 at 2:52 p.m., the resident had a cup of thickened coffee and juice. The resident did not have any water. Resident C indicated she had not had any water in the last five days. During an observation on 9/12/24 at 1:17 p.m., Resident C had a cup of thickened coffee and a cup of thickened juice. The resident did not have any water. Review of the clinical record of Resident C, on 9/11/24 at 2:15 p.m., indicated the diagnoses included, but were not limited to, congestive heart failure, pneumonia, dementia, chronic obstructive pulmonary disease, hypertension, anxiety, dysphagia, and history of pressure ulcer to the right buttock. A physician order for Resident C, dated September 2024, indicated the resident was to be up in a chair for all meals. The resident was ordered a regular diet and thickened liquids with nectar/mildly thick consistency. The plan of care for Resident C, dated 8/11/23, indicated the resident was at risk for constipation. The interventions included, but were not limited to, encourage fluids. The plan of care for Resident C, dated 8/11/23, indicated the resident had alteration in elimination of bowel and bladder. The interventions included, but were not limited to, encourage fluids. During an interview with the Director of Nursing Services on 9/12/24 at 2:00 p.m., they indicated the nursing staff were responsible to ensure Resident C had fresh water daily. The hydration policy provided by the Executive Director, on 9/13/24 at 1:00 p.m., indicated the facility offers each resident sufficient fluid, including water and other liquids, consistent with resident needs and preferences to maintain proper hydration and health. 3.1-3(v)(1)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 50436 1. Based on observation, interview, and record review, the facility failed to follow physician orders for obtaining daily and monthly weights for 2 of 2 residents reviewed for weights. (Resident 6 and 44). 2. Based on observation, interview, and record review, the facility failed to have accurate skin assessments, follow physician orders for no brief while in bed, and have heels floated for 1 of 3 residents reviewed for skin. (Resident C) Findings include: 1. The clinical record for Resident 6, reviewed on 9/9/24 at 2:19 p.m., indicated diagnoses included, but were not limited to, schizophrenia, muscle weakness, cognitive communication deficit, diabetes mellitus, and abnormal weight loss. During an observation on 9/9/24 at 11:47 a.m., Resident 6 was lying back in bed. Her legs were uncovered, and they were red and swollen. A quarterly Minimum Data Set (MDS) assessment, dated 7/31/24, indicated Resident 6 was cognitively intact, had limited extremity impairment to both lower extremities, and required a wheelchair for mobility. A physician order, dated 2/23/24, indicated a monthly weight to be obtained on the 16th of every month. A progress note, dated 3/14/24, indicated Resident 6 asked about the swelling in her legs and lack of leg strength and there was minimal swelling to both lower legs. A review of weights was obtained and documented 2/29/24- 172.6 pounds (lbs.), 7/10/24- 178.2 lbs., 7/31/24- 178.2 lbs., 8/1/24- 189.4 lbs., and 9/10/24- 179 lbs. This indicated Resident 6 was not weighed for four months and a re-weigh was not obtained after an abnormal weight was obtained, on 8/1/24. A progress note, dated 8/3/24 at 7:16 a.m., by Registered Dietician (RD) 7 indicated a weight of 189.4 reviewed with a 6.3 % weight increase. MD [Medical Director] and family notified. Suspect outlier weight, rec [recommend] re-weigh for verification. A progress note, dated 8/12/24 at 3:45 p.m., by RD 9 indicated weight gain may be due to edema and to observe Resident 6 for weight increase and decrease with the absence and /or presence of edema. A progress noted, dated 9/10/24 at 5:41 p.m., by the Director of Nursing Services (DNS) indicated a re-weight was collected and ace wraps (a compression bandage) were to be on bilateral lower extremities every morning and off at bedtime. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A care plan provided by the DNS, on 9/12/24 at 11:12 a.m., indicated Resident 6 had a history of significant weight changes with interventions, dated 9/11/22, for weights as ordered. During an interview with the DNS on 9/12/24 11:15 a.m., indicated she delegates to the certified nurse aides (CNAs) to obtain weights for residents as ordered by the physician. The DNS indicated when an abnormal weight was obtained, a re-weight was done. 45291 2. The clinical record for Resident 44 was reviewed on 9/11/2024 at 11:20 a.m. The medical diagnoses included chronic respiratory failure and chronic obstructive pulmonary disease. A Quarterly MDS assessment, dated 8/29/2024, indicated Resident 44 was cognitively intact, did not have behaviors, and received diuretics in the seven days prior to the assessment. A dehydration care plan, initiated on 7/9/2024, indicated Resident 44 was at risk for fluid imbalance due to diuretic use. An intervention indicated to record Resident 44's weight per order and notify physician of weight gains/losses. A physician order, dated 5/5/2024, indicated to notify Resident 44's provider of a weight gain of three pounds in 24 hours or a weight gain of five pounds in one week. A physician order, dated 5/15/2024, indicated to obtain daily weights for Resident 44 before eating or drinking. Resident 44's weight record, dated 8/1/2024 through 9/12/2024, indicated a weight gain of three of more pounds within 24 hours 11 times. Review of the progress notes, on 9/12/2024, indicated Resident's 44 provider was notified three times a weight gain of three or more pounds between 8/1/2024 through 9/12/2024. During an interview, on 9/12/2024 at 2:30 p.m., the DNS indicated they could not locate where a provider was notified of Resident 44's weight gain for eight incidents between 8/1/2024-9/12/2024. The DNS indicated the direct care nursing staff were responsible for obtaining daily weights and notifying appropriate providers if indicated. During an interview on 9/12/2024 at 3:00 p.m., the DNS indicated physician orders should be followed as written unless clinically contraindicated. A policy entitled, Weight Monitoring, was provided by the DNS on 9/12/2024 at 9:48 a.m. The policy indicated unless ordered at an increased frequency based on clinical needs, all residents would be weighed monthly. 25054 3. During an observation on 9/9/24 at 11:35 a.m., Resident C was lying in bed, the bilateral heels were flat on the bed, and the resident had a brief on. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 9/9/24 at 2:29 p.m., Resident C was lying in bed, the bilateral heels were flat on the bed, and the resident had a brief on. During an observation and interview with Resident C on 9/10/24 at 1:59 p.m., the resident was lying in bed, the bilateral heels were flat on the bed, and the resident had a brief on. Resident C indicated she was not supposed to wear a brief in bed because she had skin issues on her bottom. During an observation on 9/11/24 at 2:52 p.m., Resident C was lying in bed, the bilateral heels were flat on the bed, and the resident had a brief on. During an observation and interview with Resident C on 9/12/24 at 1:17 p.m., the resident was lying in bed, the bilateral heels were flat on the bed, and the resident had a brief on. The resident indicated her feet hurt and she would like to have cushioned boots on. During an observation and interview on 9/12/24 at 1:20 p.m., CNA 2 lifted Resident C's heels off the bed and there was no redness. CNA 2 provided incontinent care to the resident and the resident's bottom had a red rash covering the entire buttocks region. CNA 2 indicated they had been applying the house cream on the resident's bottom. During an interview with Registered Nurse (RN) 1 on 9/12/24 at 1:29 p.m., they indicated Resident C had returned from the local hospital with the rash and the facility had been applying the house cream to it. Review of the clinical record of Resident C, on 9/11/24 at 2:15 p.m., indicated the diagnoses included, but were not limited to, congestive heart failure, pneumonia, dementia, chronic obstructive pulmonary disease, hypertension, anxiety, dysphagia, and history of pressure ulcer to the right buttock. The plan of care for Resident C, dated 8/11/23, indicated the resident was at risk for skin impairment. The interventions included, but were not limited to, float heels at all times while in bed. A physician order for Resident C, dated September 2024, indicated the resident was not to have a brief on while in bed. The resident was to have a weekly skin review every Monday, on day shift, with a full set of vital signs. A Quarterly MDS assessment for Resident C, dated 7/13/24, indicated the resident was moderately impaired for daily decision making. The resident was always incontinent of her bladder and bowels. A skin assessment for Resident C, dated 7/29/24, indicated the resident had a pre-existing rash. A skin assessment for Resident C, dated 8/5/24, was not completed and was blank. A skin assessment for Resident C, dated 8/12/24, indicated a rash like skin issue. A skin assessment for Resident C, dated 8/19/24, indicated a rash like skin issue. A skin assessment for Resident C, dated 8/26/24, indicated skin intact. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A skin assessment for Resident C, dated 9/2/24, indicated skin intact. A skin assessment for Resident C, dated 9/9/24, indicated the resident had a rash. During an interview with the DNS on 9/12/24 at 2:00 p.m., they indicated the nurses were responsible to ensure pressure relieving devices for Resident C's heels were in place. The DNS indicated Resident C was not to have a brief on while in bed and was communicated to the CNAs by the resident's Kardex. The Kardex for Resident C provided by the DNS, on 9/12/24 at 3:00 p.m., indicated the resident was to have heels floated at all times while in bed and not to have a brief on while in bed. During an interview with Licensed Practical Nurse (LPN) 4 on 9/13/24 at 1:15 p.m., they indicated, 7/23/24, was the last day of treatment for Resident C's rash. LPN 4 would have the Nurse Practitioner (NP) look at it today for a treatment. LPN 4 provided the last treatment order for Resident C. A physician order for Resident C, dated 7/23/24, indicated the resident was ordered clotrimazole-betamethasone 1-0.05 % cream (antifungal cream) to be applied two times a day to the buttocks for a rash for 14 days. This indicated the resident had not a treatment implemented for her rash since 8/6/24. This citation relates to Complaint IN00440948. 3.1-37(a)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 30344 Based on observation, interview, and record review, the facility failed to don personal protective equipment (PPE) prior to entering the room of a resident in contact isolation for 1 of 2 residents reviewed for transmission-based precautions (TBP). (Resident 36) Findings: The clinical record for Resident 36 was reviewed on 9/6/24 at 11:35 a.m. The diagnoses included, but were not limited to, hypertension, anxiety, and major depressive disorder. The physician's orders indicated contact precautions during care every shift for ringworm, starting 7/5/24. An observation was made on 9/6/24 at 11:40 a.m. There was a sign on Resident 36's door to her room indicating she was in contact precautions and to perform hand hygiene as well as don a gown and gloves prior to entering the room. Certified Nurse Aide (CNA) 11 entered the room at that time with no gown or gloves and shut the door. An interview was conducted with CNA 11, on 9/6/24 at 11:55 a.m., after she exited Resident 36's room. She indicated she cared for Resident 36 with no gown or gloves, because, to her knowledge, Resident 36 was not in contact isolation. CNA 11 was unsure why the contact isolation sign was on the door and suggested inquiry with management. On 9/6/24 at 2:17 p.m., an interview was conducted with Licensed Practical Nurse (LPN) 4, the unit manager of the unit where Resident 36 resided. She indicated Resident 36 was indeed in contact isolation. The nurse practitioner wanted her to remain in it until seen by the dermatologist. LPN 4 clarified with CNA 11 earlier that Resident 36 was in contact isolation. LPN 4 educated CNA 11 as well as other nursing staff in regards to contact isolation. On 9/6/24 at 2:19 p.m., an observation was made. CNA 13 was observed to assist Resident 36 in her wheelchair into her room and position her next to her bed. CNA 13 adjusted Resident 36's feet and pushed her bedside table in front of her. The contact isolation sign remained on Resident 36's door, but CNA 13 was not wearing a gown or gloves. An interview was conducted with CNA 13, on 9/6/24 at 2:19 p.m., after she exited Resident 36's room. She indicated she did not think Resident 36 was in contact isolation, as she just brought her back from therapy. An interview was conducted with the Director of Nursing Services (DNS) on 9/9/24 at 12:25 p.m. She indicated they'd tried four different treatments to what they thought was ringworm, but none of them worked. Resident 36 had a dermatology appointment scheduled for December 2024, because that was the soonest appointment they could get. The nurse practitioner discontinued contact isolation for Resident 36 this morning, because the nurse practitioner didn't realize her appointment was three months away. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 9/9/24 nurse practitioner note read, .acute visit for skin rashes to bilateral elbows. Patient was treated with hydrocortisone cream, terbinafine cream, butenafine cream for ringworm since May of this year with no improvement, so referral made to dermatology but patient agreed at one time and then refused again. Today patient stated that she is using her own cream and area appear [sic] better. Denies itching. Staff relates no other concern .Assessments and Plans .Dermatophytosis, unspecified: Started treating both elbows since May with no efficacy. Area appear [sic] to be not ringworm as it responded OTC [over the counter] cream with no itching. Discontinue Isolation. The Transmission-Based (Isolation) Precautions policy was provided by the DNS on 9/12/24 at 9:40 a.m. It read, It is our policy to take appropriate precautions to prevent transmission of pathogens, based on the pathogens' modes of transmission .Contact precautions refer to measures that are intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or the resident's environment .Contact Precautions- a. Intended to prevent transmission of pathogens that are spread by direct or indirect contact with the resident or the resident's environment .c. Healthcare personnel caring for residents on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment. d. Donning personal protective equipment (PPE) upon room entry and discarding before exiting the room is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination . 3.1-18(b)(2)