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	12/08/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview and record review, the facility failed to ensure fluids were available and within reach and failed to ensure call lights were within reach for 3 of 3 residents reviewed for accommodation of needs (Resident 41, Resident 10 and Resident 5). Findings include:1. During an observation and interview on 12/02/2025 at 2:08 p.m., Resident 41 was lying in bed. The resident's call light was out of reach, on recliner underneath a blanket. The call light was activated for a test. CNA 2 came in the room and indicated he was responsible to ensure Resident 41 had her call light within reach. CNA 2 indicated he assisted Resident 41 to lay down and the roommate requested something and he forgot to give Resident 41 her call light. CNA 2 provided the resident with her call light. During the observation Resident 41 had no fluids available in her room. During an observation on 12/03/2025 at 2:33 p.m., Resident 41 had no fluids available in room. Resident 41's mouth and lips were dry and her lips were sticking to her teeth. Resident 41 indicated she would like to have something to drink, sometimes the staff gave her fluids and sometimes they did not. Resident 41 activated her call light. During an observation and interview on 12/03/2025 at 2:40 p.m., CNA 1 came into Resident 41's room, the resident requested something to drink. CNA 1 indicated she did not know why the resident did not have fluids available. CNA 1 provided the resident with a Styrofoam cup of ice water with a straw. Resident 41 took two large drinks of the water independently and indicated it tasted good. Review of the clinical record of Resident 41, on 12/04/2025 at 11:26 a.m., indicated the resident's diagnoses included, but were not limited to, history of urinary tract infection, muscle weakness, age related debility, chronic kidney disease, constipation and major depression. The physician's recapitulation for Resident 41, dated December 2025, indicated the resident diet order was thin liquids and encourage fluids as allowed by resident every shift (original date 11/25/25). The care plan for Resident 41, dated 11/26/25, indicated the resident had a urinary tract infection and was on antibiotics. The interventions included, but were not limited to, encourage adequate fluid. The care plan for Resident 41, dated 12/4/25, indicated the resident had the potential for dehydration related to diuretic medication use. The goal was to maintain moist mucous membranes. 2. During an observation and interview on 12/02/2025 at 2:36 p.m., Resident 10 was lying in her bed, the call light was behind the head board of her bed on the floor. The roommates call light was activated. CNA 2 came into the resident's room and indicated CNA 5 was taking care of Resident 10 and was on break. CNA 2 indicated he told CNA 5, before she went on break, to ensure all the residents she was caring for had their call lights available. CNA 2 provided Resident 10 with her call light. Resident 10 did not have water available, she had a cup of coffee on her bedside table out of reach. During an observation on 12/05/2025 at 1:23 p.m., Resident 10 was eating an drinking independently. During an interview with Resident 10 on 12/08/2025 at 10:47 a.m., the resident indicated it happened frequently that she did not have water available and sometimes her call light was out of reach. Resident 10 indicated when this happened she would have her roommate use her call light for her, if her roommate was in the room when that happened. The resident was observed to not have fluids in her room at this time except for a small medication cup with water in it. Review of the clinical record for Resident 10 on 12/08/2025 at 10:51 a.m., indicated the resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease, anemia, anxiety, arthritis, hypertension, muscle weakness and (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dementia. The quarterly Minimum Data Set (MDS) for Resident 10, dated 11/1/25, indicated the resident was moderately impaired for daily decision. The resident required set up only for drinking. The bowel care plan for Resident 10, dated 5/19/25, indicated the resident was at risk for constipation related to medication use and decrease mobility at times. The interventions included, but were not limited to, call bell in within reach, remind to use as needed and encourage fluids. The bowel and bladder care plan for Resident 10, dated 5/19/25, indicated the resident was at risk for alteration in elimination of bowel and bladder related to urinary and bowel incontinence. The interventions included, but were not limited to, call bell within reach, remind to use call bell as needed and encourage fluids. The hydration care plan for Resident 10, dated 5/19/25, indicated the resident was at at risk for alteration in hydration related to needing some set up with fluids, required reminded at times to increase fluids. The intervention included, provide, encourage and assist with fluids as needed. 3. During an observation and interview on 12/03/2025 at 10:40 a.m., Resident 5 did not have fluids available in his room. The resident indicated it happened occasionally that staff did not provide fluids to him. The resident activated his call light and requested something to drink from the staff. Review of the clinical record of Resident 5 12/05/2025 at 10:24 a.m., indicated the resident's diagnoses included, but were not limited to, depression, muscle weakness, diabetes, anxiety and vitamin deficiency. The physician's order for Resident 5, dated December 2025, indicated the resident was to receive a regular diet with thin liquid. The quarterly MDS assessment for Resident 5, dated 10/31/25, indicated the resident was cognitively intact for daily decision making. The resident was consistent and reasonable. The resident required set up for eating and drinking fluids. During an observation on 12/5/25 at 12:50 p.m., Resident 5 was drinking independently in his room. The hydration policy provided by the Director Of Nursing (DON) on 12/8/25 at 10:20 a.m., indicated the facility would offer each resident sufficient fluid, including water and other liquids, consistent with resident needs and preferences to maintain proper hydration and health. The protocol included, but were not limited to, ensure beverages were available and within reach. The call light policy provided by the DON on 12/8/25 at 10:25 a.m., indicated the facility would ensure a call light was at each residents bedside. Staff would ensure the call light was within reach of the resident and secured. The call system would be accessible to residents while in their bed. 3.1-3(v)(1)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interview and record review, the facility failed to file a grievance for a resident with missing clothing for 1 of 1 resident reviewed for grievances. (Resident 34)Findings include:The clinical record for Resident 34 was reviewed on 12/4/25 at 2:34 p.m. The diagnoses included, but were not limited to, hemiplegia (paralysis affecting one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (brain tissue death caused by a blockage in a blood vessel) affecting right dominant side and dry eye syndrome.The Quarterly Minimum Data Set (MDS) assessment, dated 10/20/25, indicated Resident 34 was cognitively intact for daily decision making.During an interview on 12/3/25 at 11:45 a.m., Resident 34 indicated he had two sweaters that came up missing approximately three months ago. One sweater was gray, had cost over $100.00, and meant a lot to him because his step-daughter had given it to him. The other sweater was green and he had gotten it last Christmas. Resident 34 indicated he told the Executive Director (ED) about a month ago and was told that they would look for them and get back with him and if he had to, they would be replaced. Resident 34 indicated no one had been back in to follow up on the missing items.Grievances were reviewed for the last six months and no grievances were filed for Resident 34's missing sweaters.During an interview with the ED on 12/4/25 at 2:18 p.m., The ED indicated Resident 34 had mentioned something to him about missing sweaters as he was passing by one day. The ED indicated Resident 34 told him he spoke with Laundry/Housekeeping Aide 2 about the missing sweaters and indicated Laundry/Housekeeping Aide 2 told him she spoke with Resident 34's wife, so I figured it was handled. The ED indicated he did not follow up with Resident 34 and indicated he should have filled out a grievance for these missing items.During an interview with Laundry/Housekeeping Aide 2 on 12/4/25 at 2:27 p.m., they indicated Resident 34 did tell them that he had missing sweaters and his wife went into the laundry room with her and they still could not be found. Laundry/Housekeeping Aide 2 indicated she spoke with the ED and he indicated to her he would follow up with Resident 34. Laundry/Housekeeping 2 indicated she never heard anything else about the missing sweaters after that and indicated she should have filled out a grievance form when she was first told about the missing items.The Resident and Family Grievances policy was provided by the ED on 12/4/25 at 2:50 p.m. It indicated,.8. Grievances may be voiced in the following forums: a. Verbal complaint to a staff member.10. Procedure:.b. The staff member receiving the grievance will record the nature and specifics of the grievance on the designated grievance form or assist the resident or family member to complete the form.c. Forward the grievance form to the Grievance Official as soon as possible.e. The Grievance Official, or designee, will keep the resident appropriately apprised of progress towards resolution of the grievances.12. The facility will make prompt efforts to resolve grievances. 3.1-7(a)(2)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview and record review, the facility failed to ensure care plan interventions were implemented for a resident's call light to be within reach and failed to implement a touch call light for a resident at high risk for falls for 1 of 2 residents reviewed for care plan implementation of interventions. (Resident 41). Finding include:During an observation and interview on 12/02/2025 at 2:08 p.m., Resident 41 was lying in bed, the resident's call light out of reach, on recliner underneath a blanket, the call light was activated for a test. CNA 2 came in the room and indicated he was responsible to ensure Resident 41 had her call light within reach. CNA 2 indicated he assisted Resident 41 to lay down and the roommate requested something and he forgot to give Resident 41 her call light. CNA 2 provided the resident with her call light. During an observation and interview on 12/04/2025 at 2:34 p.m., Resident 41 was lying in bed with her call light. CNA 3 verified Resident 41 did not have a pad touch call light. Review of the record of Resident 41 on 12/04/2025 at 11:26 a.m., indicated the resident's diagnoses included, but were not limited to, history of urinary tract infection, muscle weakness, age related debility, chronic kidney disease, constipation and major depression. The fall care plan for Resident 41, dated 8/5/25, indicated the resident was at risk for falls related to deconditioning and history of falls. The interventions included, but were not limited to, be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance and touch pad call light. The quarterly Minimum Data Set (MDS) assessment for Resident 41, dated 10/15/25, indicated the resident was moderately impaired for daily decision making. The resident required substantial/maximal assistance with transfers, the resident did not ambulate. The resident had one fall with injury since prior assessment. The fall risk assessment for Resident 41, dated 11/9/25, indicated the resident was at high risk for falls. The fall prevention policy provided by the Director Of Nursing (DON) ON 12/8/25 at 10:20 a.m., indicated the resident would be assessed for fall risk and receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. The protocol included, but were not limited to call light and frequently used items were within reach, provide interventions that address unique risk factors and alternate call system access. 3.1-35(b)(1)

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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. Based on interview and record review, the facility failed to initiate the continuation of care, related to the administration of a resident's comfort eye drops, for 1 of 1 resident reviewed for Quality of Care. (Resident 9) Findings include: The clinical record for Resident 9 was reviewed on 12/2/25 at 2:00 p.m. Her diagnosis included, but was not limited to, cataracts. The impaired visual function care plan, revised 7/6/25, indicated the goal was for the resident to have no indications of acute eye problems through the next review date. An intervention was to arrange consultation with the eye care practitioner as required. The physician's orders indicated she may see an ophthalmologist and/or optometrist, starting 9/4/25. An interview was conducted with Resident 9 on 12/2/25 at 2:01 p.m. She indicated she saw the optometrist a couple of weeks ago, who ordered eye drops for her, but she had not yet begun receiving them. The Plan section of the optometry consultation note, dated 11/14/25, indicated the resident received a new medication order for Refresh Dry Eye Therapy solution, one drop in both eyes, twice daily for indefinitely. The Action Required By Nursing Home Staff section of the note indicated there were new orders. The physician's orders in the clinical record did not include an order for Refresh eyedrops. An interview was conducted with the SSD (Social Services Director) on 12/4/25 at 1:05 p.m. She indicated she was responsible for residents seeing the eye doctor. Their provider last came on 11/14/25. The SSD reviewed Resident 9's 11/14/25 optometry consultation note and orders from the electronic health record. She indicated she was unsure what happened with the Refresh eyedrops, as she did not see an order for them. Nursing were responsible for administering them. An interview was conducted with the DON (Director of Nursing) on 12/4/25 at 1:16 p.m. She indicated nursing did not receive orders or consultation notes from the eye doctor. Only social services received them. She did not generally know who the eye doctor saw when they came. An interview was conducted with UM (Unit Manager) 5 on 12/4/25 at 1:24 p.m. She indicated the eye doctor gave orders to the SSD, who gave the orders to nursing. She was unaware of the Refresh eye drop orders for Resident 9. An interview was conducted with Resident 9 on 12/4/25 at 1:21 p.m. She indicated she still hadn't begun receiving the eye drops. Her eyes felt like they had sand in them. The Hearing and Vision Services policy was provided by the DON on 12/4/25 at 1:38 p.m. It indicated, The facility will utilize the comprehensive assessment process for identifying and assessing a resident's vision and hearing abilities in order to provide person-centered care. This process includes: a. Obtaining history from medical records, the family, and the resident regarding hearing and vision abilities.c. Ongoing monitoring of sensory problems; d. Care plan development and implementation. 3.1-37(a)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, interview, and record review, the facility failed to offer a resident his elbow splint, per the restorative nursing plan, for 1 of 2 residents reviewed for positioning and mobility. (Resident 1)Findings include:The clinical record for Resident 1 was reviewed on 12/2/25 at 2:10 p.m. His diagnoses included, but were not limited to, contractures and right-side hemiplegia. The Restorative Nursing PROM (Passive Range of Motion) program care plan, dated 1/3/24 and revised 12/2/25, indicated the resident participated in the program due to contractures and decreased range of motion. The goal was for him to tolerate PROM to his RUE (right upper extremity) and PROM/Stretch of his right upper extremity elbow and hand, for three sets of up to 15 repetitions in preparation for donning splint. An intervention indicated, Splint/Brace: Assistance with Splint or brace (Splint to elbow, carrot or palm guard) The resident was to wear the orthotic elbow extension splint and carrot or palm to RUE for up to 2 or more hours daily, 6 days per week. The staff responsible for this intervention was the RNA (restorative nurse aide.) The tasks section of the electronic health record indicated the above intervention was not completed eight of the last 30 days. There was no documentation to indicated he refused or was unavailable.An observation and interview with Resident 1 were conducted in his room on 12/4/25 at 2:28 p.m. He was not wearing an elbow splint. He indicated he did not use an elbow splint, only the carrot for his hand. There was no elbow splint visible in his room.An interview was conducted with UM (Unit Manager) 5 on 12/4/25 at 2:35 p.m. She indicated the therapy department was responsible for implementing the restorative nursing program, including PROM and splint application. The TD (Therapy Director) created the program and RNA 8 implemented it. An interview was conducted with the TD on 12/4/25 at 2:38 p.m. The TD indicated therapy oversaw the restorative nursing/PROM program at the facility, and RNA 8 implemented it. An interview was conducted with RNA 8 on 12/4/25 at 2:38 p.m. She indicated she began working at the facility as the restorative aide in March, 2025. Resident 1 had a carrot and palm protector for his right hand. He liked the carrot better than the palm protector and he used it about four hours a day, six days a week. He did not use any splints at all, and she did not offer an elbow splint to Resident 1, as she was unaware that he had one. An observation of Resident 1 and his belongings was made in his room with the TD and RNA 8 on 12/4/25 at 2:38 p.m. The TD retrieved Resident 1's elbow splint from a nightstand behind Resident 1's bed.The Restorative Nursing Programs policy was provided by the DON (Director of Nursing) on 12/5/25 at 9:50 a.m. It indicated, Residents, as identified during the comprehensive assessment process, will receive services from restorative aides when they are assessed to have a need for restorative nursing services. These services may include: b. Splint or brace assistance.The Restorative Nurse is responsible for maintaining a current list of residents who require restorative nursing services, and for ensuring that all elements of each resident's program are implemented.The discharging therapist, Restorative Nurse, or designated licensed nurse will communicate to the appropriate restorative aide, the provisions of the resident's restorative nursing plan, providing any necessary training to carry out the plan.3.1-42(a)(2)

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on observation, interview and record review the facility failed to provide routine dental service for a resident with improper fitting dentures for 1 of 3 residents reviewed for dental services (Resident 5). Finding include:During an observation and interview on 12/03/2025 at 10:49 a.m., Resident 5 indicated he had dentures but they were too big and they were in his bathroom. The resident indicated he would like to have dentures that fit. He did not have problems with eating but did miss things like corn on the cob that he could not eat due to not having dentures that fit. The resident did not remember the last time he wore his dentures and they had not fit him for a long time. The resident's dentures were observed in the bathroom in a denture cup with the resident's name on them, the resident was observed with no dentures in his mouth. Review of the clinical record for Resident 5 on 12/05/2025 at 10:24 a.m., indicated the resident's diagnoses included, but were not limited to, depression, muscle weakness, diabetes, anxiety and vitamin deficiency. The last dental note for Resident 5, dated 11/2/23, indicated the resident was edentulous, had poor oral hygiene and was recommended for routine dental exams. The annual Minimum Data Set (MDS) assessment for Resident 5, dated 5/27/25, indicated the resident had no natural teeth and was edentulous. The quarterly MDS assessment for Resident 5, dated 10/31/25, indicated the resident was cognitively intact for daily decision making. The resident was consistent and reasonable. The resident required set up for eating and drinking fluids. The care plan for Resident B, dated 11/25/25, the resident has potential for oral problems related to edentulous status. The interventions included, but were not limited to, coordinate arrangements for dental care, transportation as needed/as ordered. The physician recapitulation for Resident 5, dated December 2025, indicated the resident may see the dentist. During an interview with the Social Service Director (S.S.D.) on 12/4/25 at 3:32 p.m., she indicated she was responsible to ensure Resident 5 was seen by a dentist. see ancillary services. During an interview with the S.S.D. on 12/5/25 at 9:55 a.m., she indicated she was unable to find any documentation that Resident 5 had seen a dentist since 11/2/23. The S.S.D. was going to contact the dental company to see if they had any further documentation. During an interview with S.S.D. on 12/5/25 at 2:04 p.m., she indicated there was no documentation that the facility had contacted the dentist to schedule an appointment for Resident 5 after his last dental appointment in November 2023. The dental service policy provided by the Director Of Nursing (DON) on 12/8/25 at 10:15 a.m., the DON indicated the facility would assist residents in obtaining routine and emergency dental services. Routine dental services meant an annual inspection of the oral cavity for sings of disease, minor partial or full denture adjustments, taking impressions for dentures and fitting dentures. 3.1-24(a)(1)