STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. Building B. Wing	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brickyard Healthcare - Golden Rule Care Center	2330 Straight Line Pike Richmond, IN 47374

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to promote residents' dignity by not answering call lights in a timely manner resulting in incontinence (Resident M, Resident Q, and Resident U), not assisting with activities of daily living (ADLs) as preferred with showers and after toileting care (Resident J), and refusing to assist Resident M to get into their recliner from the bed at night, and refusing to heat up a resident's food when the resident reported the food was cold (Resident M) for 4 of 4 residents reviewed for dignity.Findings include: 1. The clinical record for Resident J was reviewed on 7/14/25 at 1:45 p.m. The diagnoses included, but were not limited to, fracture of right lower leg and muscle weakness. The Quarterly Minimum Data Set (MDS) assessment, dated 5/20/25, indicated Resident J was cognitively intact, used a wheelchair for mobility, frequently incontinent of bladder and always incontinent of bowel, and required supervision or touching assistance with mobility. During an interview with Resident J’s family member on 7/15/25 at 9:50 a.m., they indicated Resident J had been placed on a bedpan and put her call light on once she was done to let staff know she needed help. Resident J’s family member indicated she had waited thirty minutes with the call light on, and no staff ever came to take her off it. Resident J’s family member then walked to the nurses’ station herself to see if she could get help taking Resident J off of the bedpan. Resident J’s family indicated there was one nurse sitting at the nurses station and when she told her Resident J had her call light on and had been on the bedpan for over thirty minutes, and needed to be taken off, the nurse indicated, the aides were busy passing meal trays and someone would get to her once that was all done. Resident J’s family member indicated this type of incident happened several times. Resident J’s family member felt this behavior was very disrespectful to their family member and could have been detrimental by having the risk of skin breakdown. The plan of care for Resident J, dated 2/13/25, indicated the resident required assistance with activities of daily living (ADLs) related to impaired balance and limited mobility. The interventions included, but were not limited to, the resident requires assistance of one to two staff to turn and reposition in bed. The plan of care for Resident J, dated 2/14/25, indicated the resident was at risk for falls related to gait and balance problems. The interventions included, but were not limited to, the resident requiring prompt response to all requests for assistance. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During another interview with Resident J’s family member on 7/17/25 at 10:00 a.m., they indicated Resident J was in her room sitting in her wheelchair after receiving physical therapy that day. The family member indicated a certified nurse aide (CNA) had come into the room ready to assist Resident J with a bath. The family member indicated Resident J had reported being tired from just getting therapy and wanted to lay down for a little bit. The CNA then handed her a paper to sign. The family member asked what she was signing and the CNA indicated she needed to initial it; that she was refusing her bath and then she would help her back to bed. Resident J’s family member told the CNA, no she was not refusing, she just wanted to wait a little bit until she took one. During an interview with the Director of Nursing (DON) on 7/17/25 at 11:57 a.m., she indicated if a resident was too tired at the time a bath was being offered, staff should offer to do it later or do a bed bath. 2. The clinical record for Resident Q was reviewed on 7/17/2025 at 11:20 a.m. The diagnoses included, but were not limited to, stroke and respiratory failure. The last Quarterly Minimum Data Set Assessment indicated Resident Q was cognitively aware, did not reject care, and was always continent with bowel and bladder. The resident needed standby assistance for transferring and toileting needs. A care plan, revised on 3/2/2025, indicated Resident Q was at risk for bowel and bladder incontinence related to the need for assistance with toileting, transfers, and stroke. Interventions included having a call bell within reach and providing one staff as needed for assistance with toileting. During an interview on 7/15/2025 at 2:10 p.m., Resident Q indicated she needed assistance for transfers for safety. In the last month, there have been times she had to wait up to an hour to get assistance to the bathroom, resulting in her becoming incontinent of urine. She indicated she used the clock to tell time and was able to accurately discern the time displayed during the interview. Becoming incontinent of urine made Resident Q feel “humiliated”. 3. During an interview with Resident M on 7/15/25 at 11:57 a.m., they indicated they ate their meals in their room and the food was sometimes cold. The resident reported to the nursing staff that the food was cold, and they did not warm it up. It was not a certain meal; it happened with all three meals. The resident indicated their call light was not answered timely, and it mainly happened on third shift. The resident indicated they had to wait up to two and 1/2 hours for the call light to be answered. This caused the resident to become soiled with urine. The resident's pajamas, sheets and blankets would be soaked with urine. The resident indicated third shift refused to assist the resident to the recliner. Also, the resident had a bad back and could only lay for so long in the bed. The resident did not know the staffs’ names and had not reported it to anyone. The resident indicated they were afraid of retaliation and were dependent on staff for care. The resident had a cell phone and that was how they timed how long it was for the call light to be answered. The clinical record for Resident M was reviewed on 7/15/25 at 2:20 p.m. The diagnoses included, but were limited to, weakness, age related physical debility and hypertensive heart disease. The admission MDS assessment for Resident M, dated 6/10/25, indicated the resident was cognitively intact for daily decision making. The resident was reasonable and consistent. The resident had no behaviors, and the resident was dependent on staff for toileting needs. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During an interview and observation with Resident U on 7/16/25 at 2:08 p.m., she indicated sometimes she had to wait forever for the call light to be answered. Resident U indicated she messed my pants with bowel movement (BM) this morning. She had waited 45 minutes for the staff to come. The resident indicated this happened before where she had become incontinent with urine and BM because she had to wait so long for the call light to be answered. The resident had a clock in the room with the correct time and also had a cell phone to time how long it took for the call light to be answered. The resident indicated she had not reported it to anyone because she felt sorry for the staff because the facility did not have enough staff. The resident indicated she knew when she needed to use the restroom but was unable to hold her bowels and bladder for long periods of time. The clinical record for Resident U was reviewed on 7/17/25 at 1:25 p.m. The diagnoses included, but were not limited to, spinal stenosis, hypertensive heart failure, syncope, repeated falls, muscle weakness, age related debility and chronic kidney disease. The Quarterly MDS assessment, dated 6/24/25, indicated the resident was cognitively intact for daily decision making. The resident was reasonable and consistent. The resident required substantial to maximum assistance with toileting needs. During an interview with the Director of Nursing (DON) on 7/16/25 at 2:50 p.m., she indicated the facility’s expectations were call lights to be answered within five minutes. The resident rights policy provided by the Executive Director (E.D.), on 7/16/25 at 2:05 p.m., indicated the resident had the right to be treated with respect and dignity. The call light policy provided by the E.D., on 7/17/25 at 10:25 a.m., indicated all staff members who see or hear an activated call light were responsible for responding. This citation relates to Complaint IN00458694 and Complaint IN00462315. 3.1-3(t)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Based on interview and record review, the facility failed to administer insulin as ordered by the physician for Resident C and Resident V, failed to complete a weekly skin assessment timely for Resident C, and failed to complete neurological checks after a fall for 2 of 4 residents reviewed for falls and for 2 of 3 residents reviewed for quality of care (Resident C, Resident V, Resident T, and Resident O).Findings include:1. During an interview with Confidential Staff 5 on 7/15/25 at 12:23 p.m., they indicated the facility was not conducting weekly skin assessments for residents and was not administering insulin as ordered by the physician. The clinical record for Resident C was reviewed on 7/15/25 at 11:00 a.m. The diagnoses included, but were not limited to, diabetes, Parkinson disease, chronic kidney disease, dementia, Alzheimer's disease, anxiety, muscle weakness, difficulty walking and morbid (severe) obesity. A physician’s order, dated July 2025, indicated the resident was ordered insulin glargine (long-acting insulin) 24 units at bedtime for diabetes. The instructions were to hold the insulin if the blood sugar was below 120. A physician’s order, dated July 2025, indicated the resident was ordered weekly skin assessments. The pressure ulcer risk assessment for Resident C, dated 5/4/25, indicated the resident was at moderate risk for skin breakdown. The clinical record for Resident C indicated the last skin assessment was completed on 7/3/25. The resident did not have a skin assessment completed for 13 days. The July 2025 medication administration record (MAR) for Resident C indicated the resident did not receive her blood sugar check or insulin at bedtime, as ordered, on 7/12/25 and 7/13/25. During an interview with the Director of Nursing (DON) on 7/16/25 at 2:50 p.m., she indicated the nurse was responsible to ensure Resident C's weekly skin assessments were completed and administer her insulin as ordered by the physician. The skin assessment policy provided by the DON, on 7/17/25 at 2:10 p.m., indicated it was the policy to perform a full body skin assessment as a part of the facility’s systematic approach to pressure ulcer injury prevention and management. 2. The clinical record for Resident V was reviewed on 7/16/25 at 2:15 p.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus, anxiety, and pain. The Quarterly Minimum Data Set (MDS) assessment, dated 7/9/25, indicated Resident V was cognitively intact and received insulin. A physician’s order, dated 3/25/25, indicated Resident V was to receive Lantus Subcutaneous (under the skin) Solution (insulin glargine): inject 18 units subcutaneously at bedtime. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The July 2025 MAR for Resident V indicated there were omissions of the medication on 7/12/25 and 7/13/25. During an interview with Resident V on 7/16/25 at 2:25 p.m., he indicated he was not sure if he received insulin or not on those days. During an interview with the DON on 7/16/25 at 2:40 p.m., she indicated she did not know why the bedtime dose of Lantus was not given on 7/12/25 or 7/13/25. A “Timely Administration of Insulin” policy was provided by the Executive Director (ED) on 7/17/25 at 10:24 a.m. It indicated,”…1. All insulin will be administered in accordance with physician’s orders…” 3. The clinical record for Resident T was reviewed on 7/16/25 at 1:42 p.m. The diagnoses included, but were not limited to, dementia, cognitive communication deficit, and weakness. The Quarterly Minimum Data Set (MDS) assessment, dated 4/28/25, indicated Resident T was severely cognitively impaired, used a walker, and was dependent on staff for activities of daily living (ADLs). A facility reported incident, dated 7/10/25, indicated Resident T had fallen on the floor beside her roommate’s bed. The resident was sent to the ER (Emergency Room) for evaluation and treatment. An investigation was initiated at that time. A change in condition nursing note, dated 7/10/25 at 3:06 a.m., indicated the nurse was called to the unit because Resident T had fallen on the floor by her roommate’s bed. The note indicated Resident T had a small amount of blood on the floor by her head. The resident did not talk much and refused to open her eyes. During a review of neurological checks on 7/16/25 at 1:45 p.m., the neurological checks were to be done every 15 minutes four times, every 30 minutes four times, every hour four times, every four hours four times, then every 12 hours four times. The neurological check sheet had omission times for neurological checks completed once resident returned to the facility from the hospital and for 19 hours post check, 23 hours post check, 48 hours post check, and 72 hours post check. A fall risk evaluation, dated 7/10/25, indicated Resident T had balance problems with standing and walking, decreased muscular coordination, and had changes in gait pattern when walking through the doorway. The plan of care for Resident T, dated 7/2/23, indicated the resident was at risk for falls related to poor safety awareness, dementia, and history of falls. Interventions included, but were not limited to, following facility fall protocol. During an interview with Confidential Staff Member 4 on 7/15/25 at 12:23 p.m., they indicated residents were not getting neurological checks completed after falls. 4. The clinical record for Resident O was reviewed on 7/17/2025 at 2:05 p.m. The diagnoses included, but were not limited to, stroke and muscle weakness. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Quarterly MDS assessment, dated 6/21/2025, indicated Resident O was cognitively intact, did not reject care, required substantial assistance with transferring, but did not have impairments to upper and/or lower extremities. A fall care plan, initiated on 12/19/2024 and revised on 6/30/2025, indicated Resident O was at risk for falls related to balance problems and being unaware of safety needs. Interventions included, but were not limited to, follow facility fall protocol. A nursing assessment, dated 5/19/2025, indicated Resident O was at risk for falls. A post fall assessment, dated 5/29/2025, indicated Resident O had an unwitnessed fall. Review of the clinical record did not disclose any neurological checks completed for Resident O after her fall on 5/29/2025. During an interview on 7/17/2025 at 2:30 p.m., the DON indicated she could not find neurological checks for Resident O related to the fall on 5/29/2025. The facility’s expectation was that neurological checks were initiated and completed after an unwitnessed fall, and she was unsure why they were not completed. This citation relates to Complaint IN00458299. 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. A. Based on observation, interview, and record review, the facility failed to notify the physician of urinalysis results (Resident C), failed to implement contact isolation or enhanced barrier precautions (EBP) for a resident with multidrug-resistant organism (MDRO) (Resident C), failed to move a resident to a private room after a resident was revealed to have a MDRO (bacteria or other microorganisms that have become resistant to multiple antibiotics) (Resident C), and failed to implement EBP for Resident K for 2 of 3 residents reviewed for infection control (Resident C and Resident K).B. Based on observation and interview, the facility failed to properly store an ice scoop to ensure infection control measures for 1 of 1 random observation.Findings include: 1. During an interview with Confidential Staff 4 on 7/15/25 at 12:23 p.m., they indicated Resident C had a urinalysis completed, in December 2024, with the diagnoses of providencia stuartii (bacteria that was considered a MDRO). The facility did not implement any EBP or move the resident to a private room until April 2025. The clinical record of Resident C was reviewed on 7/15/25 at 11:00 a.m. The diagnoses included, but were not limited to, cellulitis of left lower limb and diabetes. The urinalysis for Resident C, dated 12/10/24, indicated the resident had a diagnosis of providencia stuartii. The lab was flagged by the laboratory as an organism known to possess inducible beta-lactamase. Suggest clinical observation for the development of resistance. The physician recapitulation of orders for Resident C, dated July 2025, indicated the resident was ordered on 4/3/25, to be on enhanced barrier precautions. That included a sign outside the resident's room and utilization of gown and gloves for high contact resident care activities. This was used for residents with a known MDRO or have an increased risk of MDRO acquisition (residents with wounds or indwelling medical devices). A face shield should be used for any task that has a high potential of splash or spray. Resident C’s record indicated the resident was in a semi-private room with another resident, from 1/1/25 until 4/7/25, until she was moved to a private room. The plan of care for Resident C, dated 4/3/25, indicated the resident required EBP related to a chronic wound to the left lower leg. The interventions included but were not limited to, following EBP precaution guidelines, inform my visitors of necessary precautions, and personal protective equipment (PPE) used for high contact resident care activities include dressing, bathing, transferring, providing hygiene, changing linens, changing brief or assisting with toileting and wound care. During an observation on 7/15/25 at 11:30 a.m., Resident C had a sign on the door for EBP. There was no observed PPE (gloves, gowns or face shields) observed in the hallway or in the resident’s room. There was no container observed for PPE disposal in the resident's room. During an observation and interview with the Unit Manager on 7/15/25 at 11:43 a.m., they verified Resident C did not have PPE in the bedroom or outside the room available for staff to utilize. The Unit Manager also verified there was no container available for PPE disposal. The Unit Manager indicated she would find out why the appropriate PPE equipment was not available. The Unit Manager indicated it was the responsibility of the central supply staff person to ensure PPE was available for the care of residents on EBP. The reason Resident C was on EBP had something to do with a urine test, but she was unsure what the organism was. The Unit Manager indicated she would find out. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Unit Manager on 7/15/25 at 1:55 p.m., they indicated the organism was providencia stuartii in Resident C's urinalysis results dated 12/10/24. 2. During an observation on 7/15/25 at 11:51 a.m., Resident K had a sign on his door for EBP and there was no PPE outside the room or visible in the room. There was no container for PPE disposal observed. The clinical record for Resident K was reviewed on 7/17/25 at 11:00 a.m. The diagnoses included, but were not limited to, cellulitis of the lower extremities. The Quarterly Minimum Data Set (MDS) assessment for Resident K, dated 5/29/25, indicated the resident was cognitively intact for daily decision making. The resident was reasonable and consistent. The resident had no behaviors. The physician recapitulation of orders for Resident K, dated July 2025, indicated the resident was ordered, on 6/16/25, to be on enhanced barrier precautions. The plan of care for Resident K, dated 7/15/25, indicated the resident was on antibiotic therapy related to cellulitis. The interventions included, but were not limited to, EBP isolation. During an observation and interview with Resident K on 7/16/25 at 11:30 a.m., there was no PPE or container inside or outside of the room. Resident K indicated the staff do not wear gloves, gowns or face shields when providing care. The resident's bilateral legs were red, swollen, and seeping clear fluid. During an interview with Certified Nurse Aide (CNA) 1 on 7/16/25 at 11:40 a.m., she indicated she was Resident K's CNA and verified Resident K did not have PPE or a container for used PPE. CNA 1 indicated Resident K had never had PPE. CNA 1 did not know who was responsible for ensuring the PPE was in place for residents. During an interview with Licensed Practical Nurse (LPN) 2 on 7/16/25 at 11:43 a.m., they indicated the medical supplies staff person was responsible for ensuring there was PPE available for Resident K. During an interview with the Director of Nursing (DON) on 7/16/25 at 2:50 p.m., she indicated it was the responsibility of all nursing staff to ensure PPE was available for staff to utilize when caring for residents on EBP. The DON indicated she was not sure why Resident C was not moved to a private room until 4/7/25 or precautions were not implemented for Resident C after the urinalysis with providencia stuartii was received by the facility on 12/10/24. The DON indicated she was unable to find any documentation about the urinalysis/culture. The DON was unsure who the nurse was that received the lab for Resident C. During an interview with the DON on 7/17/25 at 11:57 a.m., she indicated she was unable to find any documentation that the physician was notified of Resident C’s urinalysis, on 12/10/24, or that any physician’s orders were implemented for precautions for Resident C until 4/3/25. The infection control map captured the urinalysis, but it was not on the facilities infection control surveillance log. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The MDRO infection policy provided by the Executive Director (E.D.), on 7/14/25 at 1:00 p.m., indicated the facility would implement facility wide strategies for preventing the spread of infections with multidrug-resistant organisms. Infection, as opposed to colonization with MDRO would be determined by a physician in accordance with the Centers for Disease Control (CDC). The facility would report it to the Infection Preventionist for surveillance and other infection prevention and control program activities. Contact precautions would be initiated for a resident with MDRO, contact signage would be placed at the entry of the resident's room and the type of PPE that was required to enter the resident's room. When the physician and Infection Preventionist review the situation and determine the resident was no longer infectious and was colonized, contact precautions would be discontinued and the resident would be placed on EBP. When private rooms were available, assign the room to residents with known MDRO. When a private room was not available, cohort residents with the same MDRO in the same room. The EBP policy provided by the E.D., on 7/17/25 at 10:25 a.m., indicated the facility would implement EBP precautions for the prevention of transmission of multidrug-resistant organisms. Implementation of EBP: make gowns and gloves available immediately near or outside of the resident's room. Note face protection may also be needed if performing activity with a risk of splash or spray. Position a trash can inside the resident room and near the exit for discarding the PPE after removal, prior to exit of the room or before providing care for another resident. 3. During an observation down the center hallway on 7/16/25 at 2:28 p.m., CNA 3 was observed passing ice water out of a portable cooler. CNA 3 opened the cooler, and the ice scoop was laying inside of the cooler. During an interview with CNA 3 at that time, when asked if the ice scoop should be inside of the cooler, CNA 3 indicated “I guess not”. During an interview with the DON on 7/16/25 at 2:40 p.m., she indicated it was the facility’s expectations to put and store the ice scoop in the proper holder and not leave the scoop in the cooler for infection control practices. This citation relates to Complaint IN00462315 and Complaint IN00458299. 3.1-18(b)(1)(A) 3.1-18(b)(2)