| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 155264 | A. Building<br>B. Wing | 09/09/2025 |

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| Brickyard Healthcare - Golden Rule Care Center | 2330 Straight Line Pike<br>Richmond, IN 47374 |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>Based on observation, interview, and record review, the facility failed to ensure insulin pens were current and not outdated or expired, labelled for date when opened or put into use, with the directions for use and the prescribing physician's name during observations of 2 of 2 medication carts for medication storage. (Residents 23, 24 and 53). The facility failed to ensure the Change of Shift Control Substances Count Sheet, was routinely completed with signatures of the arriving nurse for duty and the departing nurse for duty present to signify that all controlled substances were accounted for during the time period of 8-15-25 at 6:00 p.m. through 9-4-25 at 6:30 a.m. for a total of 49 entries with concerns related to missing or illegible dates, times and/or missing signatures. This missing or incomplete information had the potential to adversely affect all 29 residents of the affected South Unit. Findings include:A. During an observation on 9/4/25 at 2:21 p.m., with Licensed Practical Nurse (LPN) 8, the Hall 5 medication cart contained an Ozempic medication pen for Resident 23 marked with an opened date of 6/24/25 and an expiration date of 8/20/25, and an undated albuterol 90 mcg inhaler for Resident 24. At the same time, LPN 8 indicated the nurses on the hall were supposed to remove expired medications from the medication carts. The nurses were supposed to put opened dates on the inhalers and insulin pens. She indicated the Ozempic had been discontinued within the past few days.<br><br>A review of Resident 23's physician orders, on 9/4/25 at 3:33 p.m., indicated the resident's order for Ozempic was discontinued on 8/29/25.<br><br>A review of Resident 24's physician orders, on 9/4/25 at 3:36 p.m., indicated the resident had an order for albuterol sulfate aerosol solution 108 (90) base – inhale two puffs orally one time a day for a diagnosis of allergic rhinitis.<br><br>During an interview on 9/4/25 at 3:50 p.m., LPN 7 indicated whatever nurse noticed a medication was expired or discarded should discard the medication. Opened dates were supposed to be marked on medications like inhalers, medication pens, and eye drops when they were opened.<br><br>During an interview on 9/4/25 at 3:53 p.m., the Director of Nursing (DON) indicated the floor nurses should remove medications that were expired or discontinued. The medications, such as medication pens, eye drops, and inhalers, should have opened dates once opened. The Ozempic should have been removed from the cart.<br><br>On 9/5/25 at 10:01 a.m., the Executive Director provided an undated facility policy, titled Insulin Pens. This policy indicated, .Insulin pens should be disposed of after 28 days or according to manufacturer's recommendation.<br><br>On 9/5/25 at 10:01 a.m., the Executive Director provided an undated facility policy, titled Medication<br>(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 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Storage. This policy indicated, .The pharmacy and all medications are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn, illegible or missing labels. These medications are destroyed.<br><br>B. During 1 of 2 observations of 1 of 5 medication carts on 9-5-25 at 11:25 a.m., with LPN 5, one insulin pen of Lantus/Basaglar KwikPen, Lot 0755924A, with an expiration date of 2-23-2026, was found without directions for use or the physician's name present. The insulin pen was labelled with Resident 53's handwritten name and an opened (or begin use) date of 9-5-25. LPN 5 indicated the KwikPen had been obtained from the facility's emergency supply this morning. She indicated when insulin pens were obtained from the emergency supply kit, they do not come with any labels for directions for use.<br><br>On 9-5-25 at 12:30 p.m., the Executive Director provided a copy of the emergency kit transaction record for Resident 53's insulin pen. It indicated, on 9-5-25 at 11:55:31 a.m., one Lantus/Basaglar KwikPen was dispensed to LPN 5. The transaction date and time were not explained regarding a clarification of the transaction date and time and the date and time of the observation.<br><br>A review of Resident 53's medication order summary, for 9-5-25, indicated he was to receive 34 units of Lantus (also known as insulin glargine or Basaglar KwikPen) subcutaneously (under the skin) daily at bedtime for a diagnosis of diabetes.<br><br>C. During 1 of 2 observations of 1 of 5 medication carts on 9-4-25 at 2:21 p.m., with LPN 8, on the South Unit, LPN 8 provided a copy of the Change of Shift Control Substances Count Sheet, for the time period of 8-15-25 at 6:00 p.m. through 9-4-25 at 6:30 a.m. for a total of 49 entries. This document indicated, Signature of the nurse arriving on duty and nurse departing from duty indicates that all items (including refrigerated items) are accounted for and that visual verification of placement of Fentanyl patches has been confirmed by both responsible parties. The document had columns to identify the date, time, nurse departing from duty and nurse arriving on duty to complete. Additional columns that were not being utilized included, Count (i.e., Number of Cards With Corresponding Blue Count Sheets), Additions (Medication Cards and/or Blue Sheets Added During Shift and Reason for Addition), and Subtractions (Medication Cards and/or Blue Sheets Removed During Shift and Reason for Removal).<br><br>Concerns for this document are listed below:<br><br>-An undated and untimed entry, listed between entries for 8-19-25 at 10:00 p.m., and 8-20-25 for 2:00 p.m. to 7:00 p.m., had the signature of the departing nurse and the initials of the arriving nurse.<br><br>-An entry for 8-22-25 at 6:00 a.m. to 2:30 p.m. did not have a signature or initials for the departing nurse.<br><br>-Three (3) sequential entries, dated 8-23-25 at 6:30 a.m. to 4:00 p.m., followed by an entry for 8-24-25 at 6:30 a.m. to 2:30 p.m. and the third for 8-25-25 at 6:30 a.m. to 6:30 p.m. These entries reflected a lack of reconciliation for the time periods of 8-23-25 at 4:00 p.m., until 8-24-25 at 6:30 a.m.; from 8-24-25 at 2:30 p.m., until 8-25-25 at 6:30 a.m. Additionally, the initials of the person for the entries on 8-23-25 at 6:30 a.m. to 4:00 p.m., and for 8-24-25 at 6:30 a.m. to 2:30 p.m., appeared to be the same initials of the departing and arriving nurse.<br><br>-Entries for 8-28-25 and 8-29-25, were present, but were not recorded in sequential order.<br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -Entry for 8-29-25, timed for 6:00 p.m. and until 8-30-25 at 7:00 a.m., did not have a signature for the arriving nurse, but did have Registered Nurse (RN) 14's signature as the departing nurse.<br><br>-Four (4) sequential entries, dated for 8-30-25 through 8-31-25, had an initial entry with the date only listed on that entry. The second entry, dated 8-30-25, entry had no time listed, but the arriving nurse was identified as RN 14, with no signature or initials listed for the departing nurse. The third entry, had the date of 8-30-25, listed with the time of 6p-7a, documented with only the departing nurse of RN 14 listed and no arriving nurse's signature present. The fourth entry, was undated and untimed, but assumed to be for 8-31-25 for the day shift, had only the arriving nurse's signature of RN 14 present.<br><br>-Entries dated for 9-1-25, reflected a lack of arriving nurse's signature for the time period of 6:30 a.m. through 2:30 p.m. There were no entries or signatures to indicate any nurses had reviewed or reconciled the controlled substances for the time period of 9-1-25 from 2:30 p.m. until 6:30 p.m. However, at 6:30 p.m., the document indicated 2 nurses had signed, one as the arriving nurse on duty and one as the departing nurse on duty.<br><br>-Entries dated for 9-2-25, reflected the presence of nurse signatures for arriving and departing duty for the time period of 6:30 a.m. through 2:30 p.m. There were no entries or signatures to indicate any nurses had reviewed or reconciled the controlled substances for the time period of 9-1-25 from 2:30 p.m. until 6:30 p.m. However, at 6:30 p.m., the document indicated 2 nurses had signed, one as the arriving nurse on duty and one as the departing nurse on duty.<br><br>-Entries dated for 9-3-25 at 6:00 p.m. through 9-4-25 at 7:00 a.m., reflected the nurse signatures for the departing and arriving nurse on duty. An entry dated 9-4-25 at 0630 – (blank) was present with the initials of the departing nurse present.<br><br>In an interview with LPN 8 on 9-4-25 at 2:21 p.m., she indicated she had already signed her departure signature for 9-4-25 at 6:30 p.m. She indicated she sometimes does this ahead of time, not necessarily at the time she was leaving.<br><br>On 9-5-25 at 11:16 a.m., the Executive Director provided a copy of policy entitled Controlled Substance Administration and Accountability. This policy indicated, It is the policy of this facility to promote safe, high-quality patient care compliant with state and federal regulations regarding monitoring the use of controlled substances. The facility will have safeguards in place to prevent the loss, diversion or accidental exposure.Inventory Verification.For areas without automated dispensing systems, two licensed nurses account for all controlled substances and access keys at the end of each shift.<br><br>On 9-5-25 at 12:30 p.m., the Executive Director provided a copy of a policy entitled, Labeling of Medications and Biologicals. This policy indicated, All medications and biologicals used in the facility will be labeled in accordance with current state and federal regulations to facilitate consideration of precautions and safe administration.All medications and biologicals will be labeled in accordance with applicable federal and state requirements and current accepted pharmaceutical principles and practices.Labels for individual drug containers must include the resident's name; the prescribing physician's name.The prescribed dose, strength, and quantity of the medication; the prescription date (if applicable); the date the drug was prescribed; appropriate instructions and precautions (such as shake well, take with meals, do not crush, special storage instructions).the route of administration.Only the issuing pharmacy may place a drug label on a medication container.<br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 3.1-25(e)(2)<br><br>3.1-25(e)(3)<br><br>3.1-25(j)<br><br>3.1-25(k)(2)<br><br>3.1-25(k)(3)<br><br>3.1-25(k)(5)<br><br>3.1-25(k)(6)<br><br>3.1-25(k)(7)<br><br>3.1-25(o)<br><br>3.1-25(r) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>Based on observation, interview, and record review, the facility failed to treat a resident with respect and dignity by engaging in inappropriate conversation with 1 of 4 residents reviewed for dignity. (Resident 61)Findings include:The clinical record for Resident 61 was reviewed on 9/2/25 at 1:15 p.m. Her diagnoses included, but were not limited to, bipolar disorder, insomnia, and anxiety disorder. The bipolar disorder care plan, revised 6/24/25, indicated she had behavioral symptoms as exhibited by attempts at inappropriate conversations with staff. An interview was conducted with Resident 61 on 9/2/25 at 1:26 p.m. She indicated one day last week Housekeeper 11 informed her (Resident 61) that CNA (Certified Nurse Aide) 12 told Housekeeper 11 that CNA 12 did not like Resident 61. Resident 61 did not hear or see CNA 12 say this. An interview and observation was conducted with Housekeeper 11, on 9/8/25 at 12:01 p.m., in the presence of the Housekeeping Manager. Housekeeper 11 indicated other staff don't typically talk to her about residents. I heard a couple say they didn't like one person or another, but I don't feed into that. A couple of weeks ago, CNA 12 informed her she did not like Resident 61. This occurred in the hallway, outside of Resident 61's door to her room. The door was open at the time. Housekeeper 11 never told anyone about it, and she didn't think any other staff were around. CNA 12 said she couldn't stand her and raised her middle fingers on both hands, but it was where Resident 61 was unable to see her. Housekeeper 11 put both hands in the air and raised her middle finger on each hand at this time. When Housekeeper 11 went into Resident 61's room afterwards, Resident 61 asked Housekeeper 11 what CNA 12 said, but she didn't respond to her or tell her what CNA 12 said. Housekeeper 11 wasn't sure if Resident 61 heard CNA 12 say this. Housekeeper 11 was just trying to ignore it, but she probably should have told the ED (Executive Director) about it. An interview was conducted with the Housekeeping Manager on 9/8/25 at 12:01 p.m. She indicated this was her first time hearing about the incident. She tried to encourage her staff to not speak about residents or get involved in drama between them. She told her staff to stay out of stuff like that, but she knew Housekeeper 11 and Resident 61 were close. An interview was conducted with CNA 12 on 9/8/25 at 12:26 p.m. She indicated when she worked, on 9/4/25, she assisted Resident 61 with care. While providing care that day, Resident 61 questioned why CNA 12 didn't come into her room anymore. CNA 12 informed her she didn't work her hallway anymore. Resident 61 informed CNA 12 she thought CNA 12 [expletive] hated her guts, because that's what [name of Housekeeper 11] told me. CNA 12 informed Resident 61 she never said that and didn't talk to Housekeeper 11. Prior to 9/4/25, CNA 12 hadn't provided care for Resident 61 in approximately two months. An interview was conducted with the ED on 9/9/25 at 10:53 a.m. He indicated he spoke with Resident 61 about the conversation with Housekeeper 11. Resident 61 did not feel the situation was abusive, but she was put out by it. When he interviewed Housekeeper 11 about it, she would not maintain eye contact, and her story kept changing. He couldn't explain why Housekeeper 11 would involve a resident in something like this. He thought Housekeeper 11 was lying or embellishing about CNA 12. He did not know what Housekeeper 11's motivation was in all of this.The Promoting/Maintaining Resident Dignity policy was provided by the ED on 9/9/25 at 12:07 p.m. It indicated, It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. Compliance Guidelines: 1. All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights 5. When interacting with a resident, pay attention to the resident as an individual.3.1-3(t) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>Based on observation, interview, and record review, the facility failed to ensure 1 of 7 residents were directly observed to receive and consume the medications which were administered to them during 1 of 4 medication pass observations with 7 residents and 5 staff members. (Resident 19, Registered Nurse 4) Findings include: During a medication pass observation on 9-3-25 at 12:06 p.m., with Registered Nurse (RN) 4, she was observed to prepare two tablets of buspirone hydrochloride 5 milligrams (mg) for a total of 10 mg to administer to Resident 19. She then crushed the medication and added it to a container of yogurt and placed it on her lunch tray. RN 4 indicated the resident does not like to have staff remain in her room while she eats lunch, including the yogurt which contained the medication. So we just leave the yogurt on her tray and check back. Normally, we leave the door cracked so we can check in on her to make sure she takes the med. At 12:12 p.m., RN 4 left Resident 19 unattended with the cup of yogurt with the medication in it. At that time, Resident 19 requested that her door be closed. RN 4 indicated this was Resident 19's normal routine and staff honored her preferences. RN 4 indicated the typical manner to administer medications was for the person giving the medication to remain with the resident while they take their medications to ensure medications were consumed. We just check on her throughout her meal and she normally eats all of her yogurt. At 12:18 p.m., RN 4 checked on Resident 19 again and indicated she was eating the yogurt. At 12:37 p.m., RN 4 had not been observed to return to check on resident's intake of yogurt w/medication in it. At 1:18 p.m., RN 4 indicated she did verify Resident 19 had eaten the yogurt with the crushed medication in it. RN 4 indicated she was unsure if Resident 19 was care planned to be able to receive her medications without staff direct observation.The clinical record for Resident 19 was reviewed on 9-3-25 at 1:35 p.m. It indicated her diagnoses included, but were not limited to, anxiety. Her physician orders indicated she was to receive buspirone 5 mg, two tablets for a total of 10 mg, three times daily for anxiety. A care plan, initiated on 2-7-20, and revised on 3-2-25, indicated she received some of her medications crushed and mixed in a drink or food. One of the listed approaches for this care plans included, but was not limited to, Nurse to observe and see that I take my medication in drink or food.On 9-4-25 at 8:47 a.m., the Executive Director provided a copy of a policy entitled, Medication Administration. It indicated, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in the state, as ordered by the physician and in accordance with professional standards of practice.Observe resident consumption of medication.3.1-35(g)(1)3.1-35(g)(2) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>Based on observation, interview, and record review, the facility failed to assist a resident to the restroom in a timely manner for 1 of 2 residents reviewed for activities of daily living (ADLs). (Resident 2)Findings include: The clinical record for Resident 2 was reviewed on 9/4/25 at 11:45 a.m. The diagnoses included, but were not limited to, retention of urine, hypertensive heart disease with heart failure, and emphysema. The Quarterly Minimum Data Set (MDS) assessment, dated 8/5/25, indicated Resident 2 was cognitively intact and utilized a manual wheelchair. Resident 2 indicated he had a Foley catheter (a thin tube inserted into the urethra to drain urine from the bladder) removed the day before, on 9/3/25. During an observation on 9/4/25 at 12:42 p.m., Resident 2 had his call light on. The Registered Dietician (RD) walked into Resident 2's room, and the resident indicated he needed help going to the restroom. The RD then went down the hallway to inform Certified Nurse Aide (CNA) 5 that Resident 2 needed assistance to the restroom. CNA 5 was passing meal trays with CNA 6. CNA 5 indicated to the RD that it was, going to be a little while. CNA 5 and CNA 6 continued to pass lunch trays down the main hallway and then proceeded to go down the opposite hallway from Resident 2's room and pass lunch trays. While passing lunch trays, Licensed Practical Nurse (LPN) 7 and LPN 8 were sitting at the nurses' station while the call light was going off. The RD turned Resident 2's call light off at that time. During an observation on 9/4/25 at 12:53 p.m., the RD went back into Resident 2's room and turned his call light back on. The RD informed the Unit Manager at that time that Resident 2 was waiting for assistance to go to the restroom, and she turned his call light back on so staff would be reminded that he still needed to go to the restroom. The UM did not get up at that time to assist the resident and replied ok to the RD. CNA 5 was observed on 9/4/25 at 12:55 p.m. answering Resident 2's call light and assisting him to the restroom. Resident 2 had a physician's order, dated 9/4/25 at 10:48 a.m., that indicated a urinalysis to be obtained due to difficulty urinating with burning upon urination. During an interview with CNA 5 on 9/4/25 at 1:09 p.m., they indicated if a resident needed assistance to the restroom while meal trays were being passed, residents were told they just have to wait. CNA 5 indicated they do not ask the nurse for help because they tell us (aides) to go do it. During an interview with the Director of Nursing (DON) on 9/4/25 at 3:25 p.m., she indicated it was expected of staff to provide the care when a resident asked to go to the restroom during meal pass times. The plan of care for Resident 2, dated 7/31/25, indicated the resident had an ADL performance deficit related to activity intolerance. The interventions included, but were not limited to, assisting with toileting as needed. A Call Lights: Accessibility and Timely Response Policy was provided by the Nurse Consultant on 9/9/25 at 10:26 a.m. It indicated, .10. All staff members who see or hear an activated call light are responsible for responding . The Activities of Daily Living (ADLs) Policy was provided by the Nurse Consultant on 9/9/25 at 10:26 a.m. It indicated, .Care and services will be provided for the following activities of daily living .3. Toileting .A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good personal hygiene . 3.1-38(a)(2)(C)3.1-38(a)(3)(A) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>Based on observation, interview and record review the facility failed to implement individualized pressure ulcer prevention and treatment of rotating the resident from the bed to the recliner every two hours as ordered by the physician for a stage 4 pressure ulcer (full thickness skin loss with extensive destruction; tissue necrosis or damage to muscle, bone, or supporting structure), failed to investigate the root cause of the stage 4 pressure ulcer and failed to date a pressure ulcer dressing for a stage 3 (full thickness tissue loss) pressure ulcer for 1 of 1 resident's reviewed for pressure ulcers (Resident 11). Finding include: During an observation on 9/5/25 at 11:39 a.m., Resident 11 was sitting in a wheelchair with a pressure reducing cushion. The resident had an air mattress on the bed. Resident 11 had a recliner with a pressure-relieving cushion in place in the room. During an observation on 9/5/25 at 1:25 p.m., Resident 11 was eating lunch independently and remained in the wheelchair with the cushion. The resident was in the same position. Resident 11 had a recliner with a pressure-relieving cushion in place in the room. During an observation on 9/5/25 1:43 p.m., Resident 11 was sitting in her wheelchair in the same position. During an observation on 9/8/25 at 11:05 a.m., Resident 11 was sitting in a wheelchair with a cushion. During an observation and interview on 9/8/25 at 11:54 a.m., Resident 11 remained in the wheelchair. Resident 11 indicated she only laid in bed when staff permitted her to, but they did not always let her. The resident indicated it was more comfortable laying in her bed. During an observation on 9/8/25 at 12:53 p.m., Resident 11 was sitting in the wheelchair in the same position. During an observation on 9/8/25 at 1:43 p.m., Resident 11 was in the same position in the wheelchair, the resident indicated she needed to go to the restroom. The call light was activated. Resident 11 had a recliner with a pressure relieving cushion in it. During an observation on 9/8/25 1:53 p.m., Certified Nurse Aide (CNA) 6 and CNA 10 were assisting Resident 11 to the bathroom utilizing a gait belt from the wheelchair to the toilet. There was no date on the pressure ulcer dressing on the left buttocks. Both CNAs indicated there was not a date on the dressing. Resident 11 requested to lay down in bed. CNA 6 and CNA 10 assisted the resident from the wheelchair to the bed. This indicated the resident had been sitting in the wheelchair for 2 hours and 48 minutes. During an interview with the Nurse Consultant on 9/8/25 at 10:09 a.m., they indicated Resident 11 acquired a stage 4 pressure ulcer on the left hip in the facility, on 3/19/25, that measured 2.5 centimeters (cm) by 3.0 cm by 0.1 cm and acquired a stage three pressure ulcer on the left buttock in the facility, on 8/20/25, that measured 2 cm by 2 cm by 0.1 cm. During an interview with the Director of Nursing (DON) on 9/8/25 at 10:35 a.m., they indicated the facility should have investigated the root cause of the stage 4 pressure ulcer on the left hip of Resident 11. During an interview with the DON on 9/8/25 at 12:02 p.m., they indicated there was no root cause analysis completed for Resident 11's stage 4 pressure ulcer on her hip. During an interview with the DON on 9/8/25 at 2:40 p.m., they indicated CNAs were responsible to ensure Resident 11 was repositioned and the CNAs were the first line of defense for residents with pressure ulcers. The DON indicated pressure ulcer dressings were supposed to be dated. The clinical record for Resident 11 was reviewed on 9/8/25 at 12:05 p.m. The diagnoses included, but were not limited to, osteoarthritis, congestive heart failure, chronic kidney disease, muscle weakness, hypertension, and stage 4 pressure ulcer of the left hip and stage 3 pressure ulcer to the left buttocks. The physician recapitulation for Resident 11, dated September 2025, indicated the resident was to alternate from the bed to the recliner every two hours (initiated on 4/3/25). The predicting pressure ulcer risk evaluation for Resident 11, dated 6/29/25, indicated the resident was at high risk of developing pressure ulcers. The Quarterly Minimum Data Set (MDS) assessment for Resident 11, dated 8/26/25, indicated the resident was severely impaired for daily decision making. The resident was dependent on staff to stand, roll left and right, transfer and did not ambulate. The resident was at risk of acquiring pressure ulcers and currently had a stage 3 and a stage 4 pressure ulcer. The resident had no behavior of refusal of care. The wound assessment for Resident 11, dated 9/3/25, indicated the resident had a<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155264 | A. Building<br>B. Wing | 09/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Brickyard Healthcare - Golden Rule Care Center | 2330 Straight Line Pike<br>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.

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | stage 4 pressure ulcer on the left hip measuring 1.5 cm by 1.5 cm by 1.7 cm and acquired in the facility. There was a heavy amount of serosanguineous drainage. The wound status was stalled. The wound assessment for Resident 11, dated 9/3/25, indicated the resident had a stage 3 pressure ulcer on the right buttock measuring 1.5 cm by 1.6 cm by 0.1 cm that was not was acquired in the facility. The wound status was improving without complications. The wound assessment for Resident 11, dated 9/3/25, indicated the resident had a stage 3 pressure ulcer to left buttock measuring 1.6 cm by 1.4 cm by 0.1 cm acquired in the facility. The wound status was stable. The pressure injury prevention and management policy was provided by the Nurse Consultant on 9/9/25 at 10:25 a.m. The policy indicated the resident would commit to the prevention of avoidable pressure injuries and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers. The facility would establish and utilize a systematic approach for pressure ulcer 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 interventions as appropriate. After completing a thorough assessment/evaluation, the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management of pressure ulcers with appropriate interventions. 3.1-40(a)(2) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>Based on observation, interview, and record review, the facility failed to provide a nutritional supplement as ordered by the physician for a resident who had significant weight loss for 1 of 3 residents reviewed for weight loss (Resident 7). Findings include:The clinical record of Resident 7 was reviewed on 9/5/25 at 10:20 a.m. The diagnoses included, but were not limited to, hemiplegia, pain, hypertensive heart disease, and weakness. The care plan for Resident 7, dated 5/5/25, indicated the resident had a nutritional problem related to cerebral infarction with hemiplegia affecting resident's right dominant side requiring adaptive equipment with meals. The resident triggered for malnourishment related to history of significant weight changes. The interventions included, but were not limited to, provide nutrition interventions as ordered. A physician's order for Resident 7, dated 6/13/25, indicated the resident was ordered yogurt or equivalent with meals. Resident 7's weight, on 7/1/25, was 153.8 pounds and the resident's weight, on 8/31/25, was 134. This indicated the resident lost 12.87% of their body weight in two months. During an observation on 9/8/25 at 12:44 p.m., Resident 7 had tuna casserole, mashed potatoes, peas, and peach cobbler. The resident did not have yogurt. The resident's meal ticket indicated he was supposed to have yogurt. During an interview with the Unit Manager on 9/8/25 at 12:47 p.m., they indicated the dietary department was responsible to ensure Resident 7 received yogurt on his lunch tray. During an interview with Licensed Practical Nurse (LPN) 7 on 9/8/25 at 12:50 p.m., they indicated the dietary department was out of yogurt, but they should have sent something equivalent to the yogurt. LPN 7 indicated she would see if she had a mighty shake in her medication cart to give to the resident. During an interview with the Director of Nursing (DON) on 9/8/25 at 2:41 p.m., they indicated dietary was responsible to ensure Resident 7 had yogurt on the tray. The nutritional management policy was provided by the Nurse Consultant on 9/9/25 at 10:10 a.m. The policy indicated the facility would provide care and services to each resident to ensure the resident maintains acceptable parameters of nutritional status in the context of his or her overall condition. The facility would evaluate the care plan to determine if the current interventions were being implemented and effective. 3.1-46(a)(2) |

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| | 155264 | A. Building<br>B. Wing | 09/09/2025 |

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| Brickyard Healthcare - Golden Rule Care Center | 2330 Straight Line Pike<br>Richmond, IN 47374 |

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| F 0770<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide timely, quality laboratory services/tests to meet the needs of residents.<br><br>Based on interview and record review, the facility failed to obtain a Hemoglobin A1C lab, as ordered, for 1 of 5 residents reviewed for unnecessary medications. (Resident 75)Findings include:The clinical record for Resident 75 was reviewed on 9/9/25 at 12:19 p.m. Her diagnoses included, but were not limited to, type 2 diabetes mellitus. The 8/17/25 diabetes mellitus care plan indicated an intervention was to administer diabetes medication as ordered by the doctor, and to monitor/document for side effects and effectiveness. The Medications section of Physician 13's, 7/30/25, progress note indicated to give one 750 mg tablet of Metformin Extended Release one time a day related to type 2 diabetes mellitus. The Assessments and Plans section of the note indicated, Type 2 diabetes mellitus with other specified complication: Recheck hemoglobin A1c and consider changing metforminto [sic] glargine insulin. The 7/30/25 physician order indicated to obtain a Hemoglobin A1c level. There were no Hemoglobin A1c level results in the clinical record after the above 7/30/25 order. An interview was conducted with the Director of Nursing on 9/9/25 at 1:00 p.m. She indicated she did not find the Hemoglobin A1c lab was completed. They needed to inform Physician 13 of this to see what he wanted to do now. An interview was conducted with Physician 13 on 9/9/25 at 1:12 p.m. He indicated he still wanted the lab to be completed. It was a missed order. The Laboratory Services and Reporting policy was provided by the Nurse Consultant on 9/9/25 at 1:32 p.m. It indicated, The facility must provide or obtain laboratory services when ordered by a physician, physician assistant, nurse practitioner, or clinical nurse specialist in accordance with state law. Policy Explanation and Compliance Guidelines: 1. The facility must provide or obtain laboratory services to meet the needs of its residents. 2. The facility is responsible for the timeliness of the services. 3.1-49(a) |