STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155157	A. BUILDING 00 B. WING	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - RICHMOND CARE CENTER	1042 OAK DR RICHMOND, IN 47374

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00453938 and IN00454495. Complaint IN00453938 - Federal/State deficiencies related to the allegations are cited at F-689. Complaint IN00454495 - Federal/State deficiencies related to the allegations are cited at F-842. Survey dates: March 3, 4, & 5, 2025 Facility number: 000077 Provider number: 155157 AIM number: 100266490 Census Bed Type: SNF/NF: 64 Total: 64 Census Payor Type: Medicare: 7 Medicaid: 54 Other: 3 Total: 64 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 7, 2025.	F 0000		
F 0689 SS=G Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, interview, and record review, the facility failed to ensure a resident who	F 0689	Facility Received PNC no POC required.	03/06/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Marshall Bowman	Administrator	03/24/2025

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	required more than limited assistance with transfers received adequate assistance and supervision to prevent accidents related to only one staff person assisting during a transfer without the utilization of gait belt and ensure the resident's wheelchair was free from sharp objects resulting in the resident requiring 18 sutures to the left lower leg for 1 of 3 residents reviewed for accidents (Resident C). This deficient practice was corrected on 2/28/25, prior to the start of the survey, and was therefore past noncompliance. The facility implemented a systemic plan that included the following actions: in-service education to nursing staff to ensure residents were transferred safely, conducted an audit of all residents' wheelchairs to ensure they were free from any sharp objects, and conducted audits on safe transfers and wheelchair safety with ongoing review presented to the Quality Assessment and Assurance (QAA) Committee for review. Findings include: The clinical record for Resident C was reviewed on 3/5/25 at 9:45 a.m. The diagnoses included, but were not limited to, metabolic encephalopathy, chronic kidney disease, anxiety disorder, congestive heart failure, vascular dementia, and acute respiratory failure. The resident was admitted to the facility on 1/31/25. The fall risk assessment for Resident C, dated 1/31/25, indicated the resident was at high risk for falls. The plan of care for Resident C, dated 1/31/25, indicated the resident was at high risk for falls due to medication use. The interventions included, but			

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	were not limited to, determine the resident's ability to transfer. The Admission Minimum Data Set (MDS) assessment for Resident C, dated 2/3/25, indicated the resident utilized a wheelchair. The resident required substantial/maximal assistance (helper does more than half the effort) to sit to stand and transfer from chair to bed. The resident did not ambulate. The plan of care for Resident C, dated 2/10/25, indicated the resident had an activity of daily living (ADL) performance deficit related to limited mobility and cognitive loss. The interventions included, but were not limited to, the resident required extensive assistance of 1-2 staff to transfer. At the time of increased weakness, a sit to stand lift may be utilized, initiated on 2/18/25. A progress note for Resident C, dated 2/18/25 at 7:30 p.m., indicated the nurse was called to the resident's room by another nurse who reported the resident needed to go to the hospital. Upon entering the room, a very large skin tear was observed to the resident's left lower leg. Emergency Medical Services (EMS) was called. Pressure was applied to the wound with towels until EMS arrived and applied a pressure dressing. The hospital emergency department note for Resident C, dated 2/18/25 at 9:08 p.m., indicated the resident presented to the emergency room with a left leg laceration from the Extended Care Facility (ECF). The resident was being transferred from the wheelchair to the bed and her leg was injured by the bed frame versus the wheelchair causing a left lower leg laceration. The resident complained of worsening pain to the left leg wound when touched or movement of the left			

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	lower extremity. The resident was given a tetanus shot and lidocaine. The laceration length was 18.5 centimeters (cm) long and was closed with 18 sutures. A statement from Certified Nurse Aide (CNA) 1, dated 2/18/25, indicated she went to get the sit to stand mechanical lift to transfer Resident C. Resident C asked if she (CNA 1) would let her stand with the bar and the CNA explained that she was told the resident was supposed to utilize the sit to stand lift. The resident asked the CNA not to use it because it hurt her. The CNA scooted the wheelchair beside the bed and got in front of the resident and put both arms under the resident's arms and counted to three. When the resident sat down on the bed she started to cry. The resident put her hand down to her leg and the CNA seen the tear to the resident's leg. The CNA ran to the nurse and told the nurse to call 911 and she needed help. A statement from Licensed Practical Nurse (LPN) 2, (no date), indicated she was alerted there was an emergency in Resident C's room. The resident's left outer leg was bleeding profusely. CNA 1 indicated the resident's leg got caught while she was transferring her. The resident was currently on her way to the hospital. A statement from LPN 3, (no date) at 7:25 p.m., indicated staff had alerted her there was an emergency in Resident C's room. The resident had a wound on the left leg with a gaping hole and flapping skin. During an observation and interview with Resident C on 3/5/25 at 10:24 a.m., the resident was sitting in a wheelchair with a bandage around her left lower leg. When queried about what			

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	happened to her left leg the resident indicated "a girl" was trying to help her from the wheelchair to the bed. She lifted the resident up underneath her arms and tried to put Resident C into the bed and when the resident turned around, she lost her balance and fell into the bed and hit her left leg on the leg of the bed. The resident began crying and indicated it hurt "really bad", and she had to go to the hospital. The resident rated her current pain of the left leg at "medium", a 5 on the 1-10 pain scale. During an interview with the Therapy Manager on 3/5/25 at 11:10 a.m., they indicated Resident C had been assessed prior to the incident on 2/18/25. Resident C fluctuated between three different ways of transferring. The resident fluctuated between a two person transfer, a sit to stand mechanical lift, and a sling mechanical lift (Hoyer lift). The therapy manager indicated it was not good practice to transfer a resident by lifting them under their arms and a gait belt should have been utilized unless a resident was independent. The CNA should have been utilizing two staff for the transfer on 2/18/25. During an interview with the Director of Nursing (DON) on 3/5/25 at 11:32 a.m., she indicated the facility investigation into the incident, on 2/18/25, with Resident C indicated it was the resident's wheelchair that caused the skin tear. The wheelchair was missing a rubber/plastic piece and there was a sharp metal edge exposed. The DON indicated CNAs were supposed to utilize gait belts during transfers and only in an emergency situation would it be acceptable to lift a resident under their arms. During an interview with the DON on 3/5/25 at 12:44 p.m., she indicated CNA 1 must have obtained, during shift report, that the resident was			

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	to be utilizing a sit to stand lift. During an interview with the DON on 3/5/25 at 1:00 p.m., she verified Resident C did not have a care plan on how she was supposed to be transferred until the incident on 2/18/25. The safe resident handling/transfer policy provided by the DON, on 3/5/25 at 12:45 p.m., indicated the facility would ensure residents were handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure and comfortable experience for the resident. Handling aides may include gait belt, transfer boards, and other devices. Resident lifting and transferring would be performed according to the resident's individual plan of care. The accidents and supervision policy provided by the DON, on 3/5/25 at 2:15 p.m., indicated the resident environment would remain as free of accident hazards as was possible. Each resident would be provided with adequate supervision and assistive devices to prevent accidents. "Accident" refers to any unexpected or unintentional incident, which resulted in an injury to a resident. This citation relates to Complaint IN00453938. 3.1-45(a)(1) 3.1-45(a)(2)			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information Based on interview and record review, the facility failed to document a resident's death, the notification of a resident's death to the physician,	F 0842	F 842 Resident Records -what corrective action(s) will be accomplished for those residents found to have been affected by the	04/04/2025

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	family, responsible party, disposition of the resident's body, personal possessions, medications, or a complete and accurate notation of the resident's condition preceding the resident's death in the clinical record for 1 of 1 resident reviewed for death (Resident B). Findings include: During an interview with the Director of Nursing (DON) on 3/3/25 at 12:20 p.m., she indicated Resident B died, on 2/26/25, on day shift. The facility did not document anything about the resident's death in the clinical record because the facility's legal department did not want anything documented as a late entry. During an interview with Licensed Practical Nurse (LPN) 5 on 3/3/25 at 1:23 p.m., they indicated, on 2/26/25, a Certified Nurse Aide (CNA) came and got her and said they needed her help on the other unit with Resident B. LPN 5 checked Resident B's code status when she got to the unit and he was a Do Not Resuscitate (DNR) code status. When LPN 5 entered Resident B's room, Registered Nurse (RN) 6 was there checking for the resident's pulse and reported she could not find a pulse. LPN 5 then checked Resident B for a pulse and respirations, and he did not have a pulse or respirations. During an interview with RN 6 on 3/3/25 at 1:45 p.m., she indicated she was not caring for Resident B, on 2/26/25, when he died. Qualified Medication Aide (QMA) 7 came to RN 6's office to get her. When RN 6 got to Resident B's bedroom, he was lying on the bed, he had no pulse, one eye closed and one eye open and fixed, and he had no respirations. RN 6 requested LPN 5 to come to the resident's room and verify that he		deficient practice Documentation completed for the resident's death, proper notification, and the disposition of the resident's body. -how other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken All nursing staff are educated on the Documentation in Medical Records Policy. -what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur Ensure the placement of proper documentation is made in the resident's medical record, within a reasonable time, of the resident's death. -how the corrective action will be monitored to ensure that deficient practice will not recur, I.e., what quality assurance program will be put into place All residents' deaths to be monitored, as they occur, for the 6 months. The results of these audits are to be reviewed at QAPI x 6 months to track any trends. If any identified, will continue audits based on QAPI recommendations, otherwise will review on a prn basis. -by what date the systemic changes for each deficiency will be completed	

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	did not have a pulse or respirations. During an interview with CNA 8 on 3/3/25 at 3:23 p.m., she indicated, on 2/26/25, she was caring for Resident B when he died. CNA 8 indicated she went to check on Resident B and found him lying in his bed with a plastic bag over his head. CNA 8 removed the bag and felt the resident's chest to see if it was moving and it was not. CNA 8 ran and got help. The clinical record for Resident B was reviewed on 3/4/25 at 11:05 a.m. The diagnoses included, but were not limited to, dementia, psychotic disturbance, bipolar disorder, depression, suicidal ideations, and anxiety disorder. The resident's code status was DNR. The last documentation in Resident B's clinical record, dated 2/26/25 at 9:00 a.m., indicated the Social Service Director (S.S.D.) went to the resident's room to complete a psychosocial assessment. The resident was fully dressed and asleep in the recliner. The S.S.D. also noted that the resident's room was clean and orderly. During an interview with the Vice President of the facility, on 3/4/25 at 12:07 p.m., they indicated the facility team made the decision not to document Resident B's death, on 2/26/25, in the clinical record and the legal department agreed. The facility did this to ensure accuracy of documentation due to it was a high stress situation. The documentation in the medical record policy provided by the DON, on 3/5/25 at 2:15 p.m., indicated each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough			

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	information to provide a picture of the resident's progress through complete, accurate, and timely documentation. Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred. Documentation shall be accurate, relevant, and complete. Documentation shall be timely and in chronological order. This citation relates to Complaint IN00454495. 3.1-50(a)(1) 3.1-50(a)(2) 3.1-50(j)(1) 3.1-50(j)(2) 3.1-50(j)(3)			