STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included Investigation of Complaints IN00436200 and IN00429831. This visit resulted in an Extended Survey - Substandard Quality of Care - Immediate Jeopardy. Complaint IN00436200 - No deficiencies related to the allegations are cited. Complaint IN00429831 - No deficiencies related to the allegations are cited. Survey dates: June 13, 14, 17, 18, 19, and 20, 2024. Facility number: 000165 Provider number: 155264 AIM number: 100288220 Census Bed Type: SNF/NF: 75 Total: 75 Census Payor Type: Medicare: 5 Medicaid: 44 Other: 26 Total: 75 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 28, 2024.	F 0000	Preparation, submission and implementation of this Plan of Correction does not constitute an admission or agreement with the facts and conclusions set forth on the survey report. Our plan of correction was prepared and executed as a means of to continuously improve the quality of care and comply with all applicable state and federal requirements. The facility respectfully requests a desk review of our responses to this survey.	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights.			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on observation, interview, and record review, the facility failed to ensure services were provided to preserve the dignity of a dependent resident who required the assistance of staff for activities of eating and dressing by removing food debris from the resident's clothing after a meal and provide incontinent care in a timely manner for a resident dependent on staff assistance with toileting for 2 of 5 residents reviewed for dignity. (Resident 2 and confidential resident) Findings include: 1. The clinical record for Resident 2 was reviewed on 6/18/2024 at 11:10 a.m. The medical diagnosis included heart failure. A baseline activities of daily living care plan, dated 5/28/2024, indicated to assist Resident 2 with eating as needed. This care plan did not indicate the amount of assistance, or the number of staff needed. An Admission Minimum Data Set Assessment, dated 5/30/2024, indicated that Resident 2 was cognitively impaired, independent with eating, and needed substantial to maximum assistance with dressing. An observation and interview, on 6/14/2024 at 11:30 a.m., with Family Member 12 indicated that Resident 2 had an overall decline in their condition since they were admitted to the facility at the end of May. Family Member 12 tried to come every day to spend time with her mother. She usually arrived between 11:00 and 11:30 a.m. Resident 2 needed assistance with eating and there had been multiple times that Resident 2 would be found covered in food on her clothing,	F 0550	-what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Staff ensured resident 2s clothing was free of debris. Confidential resident states on 2567 that the call light was addressed, and care was completed at that time. -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 residents have the potential to be affected. Advocates completed rounds on all residents to ensure resident cleanliness and completed interviews on call light timeliness. All concerns were addressed, and proper follow-up completed. Attachment #1A and #1B -what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur DNS or designee completed education with all staff on promoting and maintaining resident dignity which includes incontinence care and assisting with removing debris from resident clothing following meals, and call light timeliness. Attachment #2 and #3A, #3B, #3C, #3DAdvocate education completed which includes monitoring resident for	07/11/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	have food spilled in her room on the floor, and still have her breakfast tray in her room when Family Member 12 came to visit around 11:00 a.m. to 11:30 a.m. Family Member 12 recalled an event that had happened less than a week ago, on what she believed was 6/9/2024, resulted in Family Member 12 making a formal grievance that she had not received any follow through on. She stated she came in that morning of 6/9/2024, "around 11:00 or 11:30 a.m.", and her mother (Resident 2) was sitting in her chair. Family Member 12 recalled that when she pulled down Resident 2's blanket some, she found her mother with dried oatmeal all down the front of her clothing and had a gripper sock missing. Family Member 12 indicated that this was very upsetting to her, coupled with other events of 6/9/2024. So, Family Member 12 talked to the Director of Nursing about everything. Family Member 12 indicated that she had not heard anything about any of her concerns. She felt if her mother was more cognitively aware, she would have been "embarrassed" by the state she was found in. During this observation, it was noted there was tan debris built up on the brown recliner. Family Member 12 indicated it was oatmeal dried on the recliner and has been there since the aforementioned event. An activities of daily living care plan, dated 5/28/2024, indicated to assist Resident 2 with eating as needed. A grievance form, dated 6/9/2024, indicated that staff did not "know/realize" Resident 2 had oatmeal on her clothing that day. A confidential staff interview completed during the survey indicated that they assisted with Resident 2's care, on 6/9/2024, and it was a "bad day". They did not realize Resident 2 had oatmeal		cleanliness, monitoring assistive devices for cleanliness, and interviewing resident about call light response times. Advocate rounds to be completed 5 X weekly. Attachment #4A and #4BDNS or will conduct random audits and resident interviews to ensure staff are maintaining resident dignity. Audits and interviews will be completed on random shifts to include all shifts. Audits will be completed 5X weekly X4 weeks, 3X weekly X 4 weeks, weekly X 4 weeks, and monthly thereafter to complete 6 months. Attachment #5-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 The results of these audits to be reviewed at QAPI x 6 months to track for any trends. If any identified, will continue audits based on QAPI recommendations, otherwise will review on PRN basis. -by what date the systemic changes for each deficiency will be completed 7/11/2024 7/11/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	on her clothing, but "so much was happening" that day and they were unusually busy. 2. A confidential resident record was reviewed on 6/19/2024 at 2:25 p.m. The medical diagnosis for the resident indicated muscle wasting. The most recent Minimum Data Set Assessment indicated the confidential resident was cognitively intact and dependent on staff for assistant with toileting. The most recently revised care plans, last revised in April of 2024, indicated that the resident had incontinence of bladder and was at risk for skin break down related to incontinence. An intervention to provide the resident with incontinence care was listed During a confidential resident interview conducted during the survey, the resident indicated that they were made to wait a long time for their call light to be answered. They indicated recently, over the weekend, they had to wait almost 45 minutes to have their call light answered. Due to the long wait time to receive assistance, they had lost their urine and soiled themselves with bowel movement. They indicated they had looked at their cellphone when they hit the call light, at 10:45 a.m., and the staff did not respond until 11:30 a.m. The resident stated they were sitting in their "mess" the majority of that time and it made them feel "disgusted and humiliated". An interview with the Director of Nursing, on 6/19/2024 at 2:00 p.m., indicated that residents should be treated with dignity and respect, that direct care staff should be assisting with cleaning of the resident and their clothing after meals if			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated, and all staff are responsible for answering call lights and delegating needs based on residents' need. A copy of the resident rights was provided by the Area Vice President on 6/18/2024 at 12:45 p.m. The resident rights indicated that, "The resident has the right to a dignified existence...." 3.1-3(t)			
F 0584 SS=D Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition;			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. Based on observation, interview, and record review, the facility failed to promote a clean environment for Resident 2 by having dried debris built up on her recliner, thick dust built up on a box fan utilized by Resident 17, and by having dust built up on an open ledge under the seat and food debris on the footboard of Resident 46's motorized scooter for 3 of 3 residents reviewed for a clean environment. Findings include: 1. The clinical record for Resident 2 was reviewed on 6/18/2024 at 11:10 a.m. The medical diagnosis included heart failure. An Admission Minimum Data Set Assessment, dated 5/30/2024, indicated that Resident 2 was cognitively impaired. An observation and interview, on 6/14/2024 at 11:30 a.m., with Family Member 12 indicated that Resident 2 had declined since she was admitted to the facility at the end of May. Family Member 12 tried to come every day and spend time with her	F 0584	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Resident 2 recliner cleaned and debris removed. Resident 17 box fan and wheelchair cleaned and dust removed from ledge under seat. Resident 46 motorized scooted cleaned and debris removed from footboard. -how other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken Advocate rounds completed on all residents and room cleanliness and adaptive equipment cleanliness ensured. Attachment #6A and #6B-what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur DNS or designee completed	07/11/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	mother usually between 11:00 and 11:30 a.m. Resident 2 needed assistance with eating and there had been multiple times that Resident 2 would be found covered in food on her clothing, have food spilled in her room on the floor, and still have her breakfast tray in her room. An event that had happened less than a week ago resulted in Family Member 12 making a formal grievance that she did not receive any follow through on. During this observation, it was noted there was tan debris built up on the brown recliner that Family Member 12 indicated it was oatmeal and has been there since the event. An observation conducted, on 6/17/2024 at 1:00 p.m., indicated that the tan debris build up on the brown recliner in Resident 2's room remained unchanged. An observation conducted, on 6/18/2024 at 11:20 a.m., indicated that the tan debris built up on the brown recliner in Resident 2's room remained unchanged. An interview and observation with Housekeeper 13, on 6/18/2024 at 11:25 a.m., indicated that the food built up on the brown recliner remained, he indicated he would clean it with a "machine" they have for upholstery, and that cleaning of the rooms should be done on their schedule and as needed. 2. The clinical record for Resident 17 was reviewed on 6/18/2024 at 1:22 p.m. The medical diagnosis included respiratory failure. An Annual Minimum Data Set Assessment, dated 3/28/2024, indicated Resident 17 was cognitively impaired and needed assistance with activities of daily living.		education with all staff on safe and homelike environment which includes room cleanliness and wheelchair cleanliness. Attachment #7A and #7B and #3A, 3B, 3C, 3DAdvocate education completed which includes monitoring resident for cleanliness, monitoring assistive devices for cleanliness, and ensuring room and personal items are clean and free of debris. Advocate rounds to be completed 5 X weekly. Attachment #4A #4BDNS or will conduct random audits and resident interviews to ensure staff are maintaining a clean environment. Audits and interviews will be completed on random shifts to include all shifts. Audits will be completed 5X weekly X4 weeks, 3X weekly X 4 weeks, weekly X 4 weeks, and monthly thereafter to complete 6 months. Attachment #5 -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 The results of these audits to be reviewed at QAPI x 6 months to track for any trends. If any identified, will continue audits based on QAPI recommendations, otherwise will review on PRN basis. -by what date the systemic changes for each deficiency will be completed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	An observation, on 6/13/2024 at 1:20 p.m., indicated that Resident 17 utilized a box fan on his bedside table. The front of the box fan had heavy dust build up and Resident 17 was utilizing oxygen at that time. An observation, on 6/17/2024 at 1:07 p.m., indicated that the heavy dust built up remained to the box fan on the bedside table in Resident 17's room. An interview and observation with Housekeeper 13, on 6/18/2024 at 11:20 a.m., indicated that the box fan had heavy dust built up on the front of the fan and that he could "wipe it down with a rag". 3. The clinical record for Resident 54 was reviewed on 6/17/2024 at 11:05 a.m. The medical diagnosis included diabetes with neuropathy. A Significant Change Minimum Data Set Assessment, dated 6/5/2024, indicated that Resident 54 was cognitively intact. An interview and observation with Resident 54, on 6/13/2024 at 11:20 a.m., indicated he primarily utilized is motorized scooter to move about the facility. He indicated he drops food sometimes and it lands on the footboard. The footboard was noted to have a black grit non-skid top with tan and brown food debris. An open ledge under the seat of the motorized scooter was noted to have a light layer of dust build up with a handprint on the right front side in the dust. Resident 54 stated he needed to "get it cleaned", but he was not able to do it himself. An observation, on 6/17/2024 at 3:00 p.m.,		7/11/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated that the footboard was noted to have a black grit non-skid top remaining with tan and brown food debris. The open ledge under the seat of the motorized scooter was noted to have a light layer of dust build up with a handprint on the right front side in the dust. An interview with the Director of Nursing, on 6/18/2024 at 12:00 p.m., indicated that the staff should be cleaning Resident 54's wheelchair and scooter on his regular shower days and as needed. A policy entitled, "Safe and Homelike Environment", was provided by the Area Vice President on 6/18/2024 at 12:45 p.m. The policy indicated, " ...the facility will provide a safe, clean, comfortable, and homelike environment ..." 3.1-19(f)			
F 0600 SS=G Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;	F 0600	-what corrective action(s) will be	07/11/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on observation, interview and record review, the facility failed to ensure residents were free from sexual abuse on the Alzheimer's Care Unit of the facility for 3 of 5 residents reviewed for abuse. (Residents 50, 56, and 74) Findings include: 1. The clinical record for Resident 50 was reviewed on 6/17/24 at 1:10 p.m. The diagnoses included, but were not limited to, Alzheimer's disease, dementia, anxiety, and insomnia. The 5/15/24 Quarterly MDS (Minimum Data Set) assessment indicated the BIMS (brief interview for mental status) was not conducted, as she was rarely/never understood. The staff assessment for mental status indicated she had short and long-term memory problems. She did not know the current season or that she was in a nursing home. Her cognitive skills for daily decision making were severely impaired, in that she rarely/never made decisions. It indicated she had physical behavioral symptoms directed towards others, such as hitting, kicking, pushing, scratching, grabbing, and/or abusing others sexually during one to three days of the past seven days. She had verbal behavioral symptoms directed towards others such as threatening, screaming at, and/or cursing at others during one to three days of the past seven days. The 10/5/23 behavior care plan, last revised 12/19/23, indicated she demonstrated sexually inappropriate behaviors by entering male resident rooms, laying in male resident's bed, and making sex-related comments. The goal, with a target date of 8/13/24, was for her to interact with others appropriately during social and care situations. Interventions were to quietly attempt to redirect,		accomplished for those residents found to have been affected by the deficient practice Resident 56 was placed on one-on-one supervision until transfer to geriatric psych facility. -how other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken Progress notes for all residents for reviewed with no concerns identified. Attachment #8-what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur Education completed with ED/ DNS on daily review of progress notes to include SBARs and Behavior Documentation as well as reporting guidelines for in-appropriate touching Attachment #9Education completed with all staff on abuse and behavior management including PRN pool staff. Attachement #10A, #10B, #10C, #10D, #10E, #11A #11B, #11C, #11D, #11E, #3A, #3B, #3C, #3DDNS or designee to complete on-going monitoring to review documentation. Audit to be completed during daily clinical stat up 5X weekly X 4 weeks, 3X weekly X 4 weeks, then weekly to complete 6 months. Attachment #12 The results of these audits to be reviewed at QAPI x 6 months to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	reminding her that the behavior was not appropriate; to let her physician know if her behaviors were interfering with her daily care/living; and to please refer her to mental health services as needed. There was no assessment/evaluation in the clinical record indicating Resident 50 had the capacity to consent to sexual activity in the facility. 2. The clinical record for Resident 74 was reviewed on 6/13/24 at 1:17 p.m. Her diagnoses included, but were not limited to: dementia, anxiety, and insomnia. The 5/25/24 Significant Change MDS assessment indicated she was severely cognitively impaired. She had a behavior of wandering during one to three of the previous seven days. The wandering behavior significantly intruded on the privacy of activities of others. An observation of Resident 74 was made on 6/13/24 at 1:17 p.m. She was continuously wandering about the unit from the dining room into the hallway and into the sunroom. The 4/8/24 behavior care plan indicated she demonstrated sexually inappropriate behaviors by entering a male resident's room, laying in male resident's bed, and inappropriate touching. The goal was for her behaviors to lessen. Interventions, effective 4/8/24, were to offer her something else she liked as a diversion; let her physician know if her behaviors were interfering with her daily care/living; and to refer her to mental health services as needed. The 4/9/24 behavior care plan indicated she		track for any trends. If any identified, will continue audits based on QAPI recommendations, otherwise will review on PRN basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	wandered in others' rooms; may crawl in bed with others; believed other male resident was her husband and became agitated and aggressive when attempting to redirect. The goal was for her to not harm herself or others due to her behaviors. Interventions, effective 4/9/24, were to attempt interventions before her behaviors began; make family aware of behaviors; let her physician know if her behaviors were interfering with her daily living and offer here something she liked as a diversion. There was no assessment/evaluation in the clinical record indicating Resident 74 had the capacity to consent to sexual activity in the facility. A behavior note, dated 6/6/24 at 8:35 a.m., written by LPN (Licensed Practical Nurse) 5, read, "Resident was standing in the dining room next to a male resident allowing him to grope her butt in front of the other residents. Interventions attempted: Residents were separated and redirected. Effectiveness of the interventions: Somewhat effective, though resident is pacing the unit trying to figure out how to get back to this male resident. She is also becoming very irritated with anyone whom [sic] is standing in her way or attempting to keep them apart." The note did not include documentation to show all the identified interventions to address behaviors were implemented, the facility initiated new interventions to address behaviors when the identified interventions were ineffective, or adequate supervision was provided to prevent further resident-to-resident abuse. The next consecutive behavior progress note, dated 6/6/24 at 9:35 a.m., written by LPN 5 indicated, "Resident was standing next to the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	couch in the dayroom while a male resident was sitting on the couch with his hand up her shirt and rubbing on her breast. Interventions attempted: Residents were separated and a CNA (Certified Nursing Assistant) was asked to monitor that they remain apart. Effectiveness of the interventions: Ineffective as the two residents continue to seek one another out." The next subsequent progress note related to Resident 74's behaviors, dated 6/6/24 at 2:49 p.m., written by LPN 5, read, "Resident has roamed the unit seeking out a certain male resident all shift. Whenever staff attempted to separate the two residents, both residents would become aggressive and begin to lash out at staff verbally and physically." The note did not include documentation to show all the identified interventions to address behaviors were implemented, the facility initiated new interventions to address behaviors when the identified interventions were ineffective, or adequate supervision was provided to prevent further resident-to-resident abuse. 3. The clinical record for Resident 56 was reviewed on 6/14/24 at 11:37 a.m. The diagnoses included, but were not limited to: Alzheimer's disease, dementia, anxiety, and insomnia. The 5/10/24 Quarterly MDS assessment indicated the BIMS was not conducted, as he was rarely/never understood. The staff assessment for mental status indicated he had short and long-term memory problems. He did not know the current season or that he was in a nursing home. His cognitive skills for daily decision making were moderately impaired, in that decisions were poor, requiring cues/supervision.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	An observation of Resident 56 was made on 6/14/24 at 2:05 p.m. He was lying awake in bed. He began speaking but was unable to understand what he was attempting to say. The 3/23/23 behavior care plan, last revised 4/16/24, indicated he demonstrated sexually inappropriate behaviors, believing others were his significant other. He would hug and sometimes attempt to kiss others. He displayed inappropriate touching and made sexually explicit comments to others. The goal was for him to interact with others appropriately during social and care situations. Interventions, effective 3/23/23, were to let his physician know if his behaviors were interfering with his daily care/living; quietly attempt to re-direct, reminding him that the behavior was not appropriate; let him know that his behavior was affecting others; and to refer him to mental health services as needed. The care plan did not include an intervention to provide adequate supervision to prevent resident to resident abuse. The 10/5/23 behavior care plan, last revised 4/16/24, indicated he sometimes demonstrated sexually inappropriate behaviors by entering female residents' rooms, having female resident come into his room, and lay in bed with others. The goal was for him to interact with others appropriately during social and care situations. Interventions, initiated 10/5/23, were to let his physician know if his behaviors were interfering with his daily care/living; offer him something else he liked; quietly attempt to re-direct, reminding him that the behavior was not appropriate; and to refer him to mental health services as needed. The care plan did not include an intervention to provide adequate supervision to prevent resident to resident abuse.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

The 8/31/23 behavior care plan, last revised 4/16/24, indicated he sometimes became frustrated or agitated, pushing, grabbing, being physically aggressive, and threatening when staff tried to redirect other residents from his room. He may resist care by hitting and kicking. The goal was for him to have fewer episodes of becoming frustrated and for his behavior to stop with staff intervention. Interventions were to attempt interventions before his behaviors began; give medications as doctor ordered; and to offer him something he liked as a diversion. The care plan did not include an intervention to provide adequate supervision to prevent resident to resident abuse.

There was no assessment/evaluation in the clinical record indicating Resident 56 had the capacity to consent to sexual activity in the facility.

The 5/29/24 psychiatry progress note indicated, "Patient was seen today per facility request for psychiatric evaluation, medication management, and GDR [gradual dose reduction] review. Patient was seen in the common area, pacing up and down the hallway. Patient presents anxious, restless and he continues to follow another female resident. Patient is confused at times during the interview. Staff reports that he has good appetite and sleeps well at night. Per facility, patient can get anxious, irritable, agitation, verbally and physically aggressive toward staff and some resident and hard to redirect at times. Starts Lorazepam 0.5mg po [by mouth] bid [twice daily] ..." Follow up in two weeks and as needed.

A progress note, dated 6/5/24 at 9:31 a.m., for Resident 56, written by the DON (Director of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Nursing) read, "resident continues to have episodes of becoming agitated at staff when staff is attempting to assist female residents on the unit. resident believes that some of the female residents are "his girls" and becomes very protective. also continues to wonder [sic] about unit and at times will enter other resident's room uninvited, usually easily to redirect out of unwanted areas. Word salad frequently present, however during periods of agitation speech becomes coherent and resident will begin cursing at staff. staff will continue to attempt to ensure safety, provide interventions and assistance as warranted. Resident is followed by in-house mental health provider and is followed by in-house PCP [primary care physician] provider." A behavior note, dated 6/6/24 at 9:01 a.m., for Resident 56, written by LPN (Licensed Practical Nurse) 5, indicated, "Resident shoved this nurse out of the doorway as staff was attempting to keep he and a female resident separated due to sex behaviors. What was the resident doing prior to or at the time of behavior/mood: Resident was in the dining room and had been noticed rubbing a female resident's butt as she stood next to him. Interventions attempted: separation of resident's [sic.] Effectiveness of the interventions: Intervention was ineffective...." The note did not include documentation to show all the identified interventions to address behaviors were implemented, the facility initiated new interventions to address behaviors when the identified interventions were ineffective, or adequate supervision was provided to prevent further resident-to-resident abuse. During an interview with LPN 5, on 6/17/24 at 3:00 p.m., he indicated the behavior in the above progress note was the first behavior he witnessed			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	on 6/6/24 between Resident 56 and Resident 74. The next consecutive behavior note, dated 6/6/24 at 9:30 a.m., written by LPN 5 indicated, "Resident was noted sitting in the sunroom with his hand up the shirt of the same female resident as earlier. Resident was rubbing the breast of this resident at this time. Interventions attempted: Both resident's [sic] were separated. Effectiveness of the interventions: Intervention was ineffective as these two resident's [sic] continue to seek one another out." The note did not include documentation to show all the identified interventions to address behaviors were implemented, the facility initiated new interventions to address behaviors when the identified interventions were ineffective, or adequate supervision was provided to prevent further resident-to-resident abuse. During an interview with LPN 5, on 6/17/24 at 3:00 p.m., he indicated he just happened to walk in the sunroom and see Resident 56 with his hand up Resident 74's shirt. There were quite a few other residents in the sunroom at the time, who were just sitting there, roughly six residents total including Resident 56 and Resident 74, and no staff. The next consecutive behavior note, dated 6/6/24 at 9:40 a.m., for Resident 56, written by LPN 5 indicated, "Resident walked up to the same female resident and grab [sic] her by the face them [sic] kissed her on the lips. Interventions attempted: Separated resident's [sic.] Effectiveness of the interventions: Ineffective." The note did not include documentation to show all the identified interventions to address behaviors were implemented, the facility initiated new interventions to address behaviors when the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	identified interventions were ineffective, or adequate supervision was provided to prevent further resident-to-resident abuse. During an interview with LPN 5, on 6/17/24 at 3:00 p.m., he indicated the kiss on the lips happened in the hallway and he just happened to see it. He was coming down hallway with the medication cart when Resident 74 walked past him, and Resident 56 came out of the dining room. Resident 56 grabbed Resident 74 on both sides of her face, leaned in, and kissed her. It happened quickly, more like a peck on the lips. The next consecutive behavior note, dated 6/6/24 at 2:33 p.m., for Resident 56, written by LPN 5, read, "Resident was noted sitting on the couch in the sunroom with a female resident on either side of him and the three of them were touching and rubbing on one another. Interventions attempted: Resident's [sic] were asked to stop and then separated. Effectiveness of the interventions: Ineffective." The note did not include documentation to show all the identified interventions to address behaviors were implemented, the facility initiated new interventions to address behaviors when the identified interventions were ineffective, or adequate supervision was provided to prevent further resident-to-resident abuse. During an interview with LPN 5, on 6/17/24 at 3:00 p.m., he indicated there was another female resident, Resident 50, sitting on one side of Resident 56, and Resident 74 sitting on his other side in reference to the 6/6/24, 2:33 p.m. behavior note. The touching and rubbing he observed while the 3 of them were on the couch was outside of the clothing, rubbing legs, and holding hands. The two female residents weren't touching each			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	other. Resident 56 was in the middle, touching both female residents, and both female residents were touching him. He stated, "[Name of Resident 56] was a little too busy for me that day." A progress note, dated 6/6/24 at 2:36 p.m., written by LPN 5, read, "Resident has been aggressive with staff while they were attempting to redirect and separate him from the same female resident whom his [sic] is drawn to." During an interview with LPN 5, on 6/17/24 at 3:00 p.m., he indicated the 6/6/24, 2:36 p.m. progress note just referenced a continuation of separating Resident 56 and Resident 74 throughout the day. The 3 residents on the couch was the last occurrence he witnessed on 6/6/24. "From the time he shoved me, it didn't get any better." He'd only worked at the facility for about 3 weeks through an agency but was off all last week. He normally worked other units and had only worked the Alzheimer's Care Unit maybe twice. It was his understanding, from talking to other employees who'd worked on the unit for a while, that Resident 56 had been showing behaviors, and they were increasing and intensifying. When he spoke with someone about Resident 56's behaviors on 6/6/24, he made sure his behavior progress notes were "documented to the best of my ability." Resident 56 was very sexual in nature, but also aggressive at times, with staff, including LPN 5. At one point, Resident 56 shoved him. He told "full time staff management that day," because he noticed the issues, and he was trying to see how he was supposed to address them. "I was told it was care planned. They could be together, just couldn't have sex, and the family was aware, so I just documented." He believed it was either the Unit Manager/Alzheimer's Care Director, the DON, or the Administrator who told			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	him this, but he wasn't sure exactly who, because he was still "trying to learn people." Resident 56's behaviors had been brought up on several occasions. He told quite a few people, including the CNAs (Certified Nursing Assistants) so they could keep an eye on them and keep them separated. He was just told to document everything he saw. He didn't think of it as sexual abuse, because both residents were seeking each other out, and it was clear they both became agitated due to staff trying to separate them, but with the residents being on the "dementia unit and not having capacity to consent," he saw it as possible sexual abuse. His concern was that families would come in and be upset by it, because it was something that families should be aware of. That's why he went forward with making sure someone knew, and it didn't just stop with him. Prior to 6/6/24, he'd seen Resident 56 be flirtatious, but not touching, more like holding hands, "helping and guiding them like they were lost," at least the way that he took it. On 6/6/24, there was no mistaking what was going on between Resident 56 and Resident 74. They were seeking each other out. He'd been trained on abuse multiple times. He worked full time for the PRN (as needed) Float Pool, and they trained him on abuse, but could not recall the last time. He thought it was less than a year ago. He had not received any abuse training in the facility itself. An interview was conducted with the ACD (Alzheimer's Care Director) on 6/14/24 at 1:50 p.m. She indicated she'd been the ACD for about 2 years and was familiar with Resident 56. She did not consider his behaviors with other female residents as inappropriate. "They will love on each other, kiss and cuddle." It was mostly with Resident 74, but Resident 50 gravitated toward Resident 56 as well, would sit and hold hands,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	nothing inappropriate. She'd spoken to both Resident 56's and Resident 74's families and made them aware. Resident 74's family was religious and understood, as long as nothing got out of hand. She knew others had seen Resident 56 with his hands up Resident 74's shirt, but she had not seen that. A male agency nurse told her Resident 56 put his hands up the back of Resident 74's shirt and he separated them. In the last month, Resident 56 had been generally harder to redirect. The IDT [Interdisciplinary Team] had talked about this; it was care planned; they talked to families and made a note about a month and a half ago. An interview was conducted with CNA 8, on 6/14/24 at 2:00 p.m., who worked the day shift of 6/6/24. She indicated she normally worked the Alzheimer's Care Unit of the facility and had witnessed Resident 56 wrap his arm around female residents and caught him attempting to kiss female residents. She was told by CNA 9 that Resident 56 groped women's breasts, but CNA 8 hadn't witnessed this. His behaviors had been going on "at least a few months. Some days he was hard to redirect and would be loud and aggressive toward staff. Resident 56 pushed a male nurse on 6/6/24, who didn't normally work the unit. Resident 56 tended to try and kiss Resident 74, as she was the main female resident. "They are like glue." CNA 8 was told their families were aware. Once in a while, Resident 56 would try to kiss Resident 50 and a few times tried to kiss Resident 49. CNA 9 was unavailable for interview. An interview was conducted with CNA 25 on 6/17/24 at 2:02 p.m. She indicated she worked on 6/6/24. The only thing she saw was Resident 56 kiss Resident 74 on the forehead in the sunroom,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	just a quick peck. She was coming out a resident's room when LPN 5 informed her in the hallway that Resident 56's hand was up Resident 74's shirt. She didn't report this to anyone, because LPN 5 informed her that he was going to take care of it. She thought LPN 5 had it handled, because he was the nurse in charge. A progress note, dated 6/10/24 at 9:56 p.m., for Resident 56, written by the DON, read, "Resident continues to have episodes of becoming easily irritated and upset with staff when staff provides interventions r/t [related to] behaviors displayed with female residents. Resident has been noted to be holding hands with female residents and occasionally kissing. Resident with severe impaired cognition status and unable to recall behavior as being inappropriate. resident with word salad and when staff intervenes, word salad becomes more severe, tone of voice becoming stern, with an occasional cursing noted. wanders about unit and at times will enter other resident's room without invitations. Resident frequently leaves unwanted areas without incident. family is aware of behaviors and understands [sic] that resident is not able to recognize inappropriateness of behaviors. Resident continues to be followed by in house PCP and in house psych provider. Staff will continue to attempt to ensure safety, offer interventions and assistance as warranted." An interview was conducted with the Administrator, DON, Vice President of Risk and Regulatory Compliance, and Regional Director of Clinical Operations on 6/14/24 at 1:45 p.m. after they read Resident 56's 6/6/24 behavior notes from the electronic health record. The Administrator indicated she did not know about Resident 56's 6/6/24 behaviors. She knew Resident 56 was flirtatious, would hold hands, and thought			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident 74 was his wife. The ACD had spoken to both families in regard to these things. The Administrator did not report, investigate, or take action after the 6/6/24 occurrences, as she was unaware of them. The DON indicated she had never heard about Resident 56's 6/6/24 behaviors prior to just now reading the notes. She was not aware Resident 56 had his hand up Resident 74's shirt, nor was she aware of him rubbing on her buttocks in the dining room and touching on the couch. There was a male nurse on the unit on 6/6/24, so when he was trying to intervene, she thought Resident 56 may have had a problem with him being male and trying to intervene, as Resident 56 would say "Those are my girls," and a protective mode would step in. They tried to intervene, distract, take him outside, and use various interventions to address his behaviors. An interview was conducted with Family Member 6, Resident 74's daughter, on 6/18/24 at 10:33 a.m. She indicated the facility informed her, on 6/14/24, of the 6/6/24 sexual activity involving her mom. Resident 74 would have been very opposed to this behavior, as she was quite religious. "If she didn't have dementia, she would be appalled." To her knowledge, nothing happened prior to 6/6/24. Resident 56 and Resident 74 had been "kind of buddies for a while." They would sit together, but no hand holding or kissing "that I know of," just sitting next to each other. One time she saw Resident 56 try to give Resident 74 a kiss on her forehead, which didn't bother Family Member 6. It was kind of sweet. Family Member 6 would have wanted to know about previous hand holding or kissing and didn't realize it had "gotten into this." An interview was conducted with Family Member 7, Resident 56's son, on 6/18/24 at 12:12 p.m. He indicated he wasn't notified about his father's			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	6/6/24 behaviors until 6/14/24. They called him a year ago and informed him Resident 74 "was in bed with him, kinda messing around, not sure anything was done, kinda fooling around." The staff was responsible for his father and the other residents, so he questioned how this happened and thought the responsibility was on the facility. An interview was conducted with the DON on 6/17/24 at 10:53 a.m. She indicated the home office was responsible for training PRN (as needed) Float Pool staff on abuse, identification, and reporting, as it was not provided to them in the facility. Her understanding was they were already trained when they came into the facility to work. The Dementia Care policy was provided by the DON on 6/19/24 at 3:00 p.m. It read, "It is the policy of this facility to provide the appropriate treatment and services to every resident who displays signs of, or is diagnosed with dementia, to meet his or her highest practicable physical, mental, and psychosocial well-being....1. The facility will assess, develop, and implement care plans through an interdisciplinary team (IDT) approach that includes the resident, their family, and/or resident representative, the extent possible....6. If needed, the environment will be modified to accommodate individual resident care needs. 7. The care plan goals and interventions will be monitored on an ongoing basis for effectiveness, and will be reviewed/revised as necessary. 8. Appropriate referrals will be made if current interventions are ineffective or resident shows a decline in psychosocial, mood, or behavioral status (i.e. physician, mental health provider, licensed counselor, pharmacist, social worker)." The Abuse, Neglect, and Exploitation policy was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	provided by the DON on 6/17/24 at 11:08 a.m. It read, "Sexual Abuse is non-consensual sexual contact of any type with a resident.... Employee Training A. New employees will be educated on abuse, neglect, exploitation and misappropriation of resident property during initial orientation. B. Existing staff will receive annual education through planned in-services and as needed. C. Training topics will include: 1. Prohibiting and preventing all forms of abuse, neglect, misappropriation of resident property, and exploitation; 2 Identifying what constitutes abuse, neglect, exploitation, and misappropriation of resident property; 3. Recognizing signs of abuse, neglect, exploitation and misappropriation of resident property, such as physical or psychosocial indicators;4. Reporting process for abuse, neglect exploitation, and misappropriation of resident property, including injuries of unknown sources; 5. Understanding behavioral symptoms of residents that may increase the risk of abuse and neglect such as; a. Aggressive and/or catastrophic reactions of residents; b. Wandering or elopement-type behaviors; c. Resistance to care; d. Outbursts or yelling out; and e. Difficulty in adjusting to new routines or staff. Prevention of Abuse, Neglect and Exploitation. The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves: A. Establishing a safe environment that supports, to the extent possible, a resident's consensual sexual relationship and by establishing policies and protocols for preventing sexual abuse. This may include identifying when, how, and by whom determinations of capacity to consent to a sexual contact will be made and where this documentation will be recorded; and the resident's right to establish a relationship with another			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	individual, which may include the development of or the presence of an ongoing sexually intimate relationship; B. Identifying, correcting and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur with the deployment of trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms." 3.1-27(a)(1)			
F 0609 SS=E Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on observation, interview and record review, the facility failed to notify the Administrator immediately of allegations of sexual abuse on the Alzheimer's Care Unit of the facility for 3 of 18 residents on the Alzheimer's Care Unit. (Residents 50, 56, and 74) Findings include: 1. The clinical record for Resident 50 was reviewed on 6/17/24 at 1:10 p.m. The diagnoses included, but were not limited to, Alzheimer's disease, dementia, anxiety, and insomnia. The 5/15/24 Quarterly MDS (Minimum Data Set) assessment indicated the BIMS (brief interview for mental status) was not conducted, as she was rarely/never understood. The staff assessment for mental status indicated she had short and long-term memory problems. She did not know the current season or that she was in a nursing home. Her cognitive skills for daily decision making were severely impaired, in that she rarely/never made decisions. It indicated she had physical behavioral symptoms directed towards others, such as hitting, kicking, pushing, scratching, grabbing, and/or abusing others sexually during one to three days of the past seven days. She had verbal behavioral symptoms directed towards others such as threatening, screaming at, and/or cursing at others during one to three days of the	F 0609	-what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice -what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Resident 56 was placed on one-on-one supervision until transferred to geriatric psych facility. -how other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken Progress notes for all residents for reviewed with no concerns identified. Attachment #8 -what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur Education completed with ED and DNS on daily review of progress notes to include SBAR and Behavior documentation as well as reporting guidelines for inappropriate touching. Attachment #9 Education completed with all staff	07/11/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	past seven days. The 10/5/23 behavior care plan, last revised 12/19/23, indicated she demonstrated sexually inappropriate behaviors by entering male resident rooms, laying in male resident's bed, and making sex-related comments. The goal, with a target date of 8/13/24, was for her to interact with others appropriately during social and care situations. Interventions were to quietly attempt to redirect, reminding her that the behavior was not appropriate; to let her physician know if her behaviors were interfering with her daily care/living; and to please refer her to mental health services as needed. There was no assessment/evaluation in the clinical record indicating Resident 50 had the capacity to consent to sexual activity in the facility. 2. The clinical record for Resident 74 was reviewed on 6/13/24 at 1:17 p.m. Her diagnoses included, but were not limited to: dementia, anxiety, and insomnia. The 5/25/24 Significant Change MDS assessment indicated she was severely cognitively impaired. She had a behavior of wandering during one to three of the previous seven days. The wandering behavior significantly intruded on the privacy of activities of others. An observation of Resident 74 was made on 6/13/24 at 1:17 p.m. She was continuously wandering about the unit from the dining room into the hallway and into the sunroom. The 4/8/24 behavior care plan indicated she demonstrated sexually inappropriate behaviors by		on abuse and behavior management including all PRN pool staff. Attachment #10A, #10B, #10C, #10D, #10E, #11A #11B, #11C, #11D, #11E, #3A, #3B, #3C, #3D DNS or designee to complete on-going monitoring to review documentation. Audit to be completed during daily clinical stat up 5X weekly X 4 weeks, 3X weekly X 4 weeks, then weekly to complete 6 months. Attachment #12 -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 div="">\ div="">The results of these audits to be reviewed at QAPI x 6 months to track for any trends. If any identified, will continue audits based on QAPI recommendations, otherwise will review on PRN basis. -by what date the systemic changes for each deficiency will be completed 7/11/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	entering a male resident's room, laying in male resident's bed, and inappropriate touching. The goal was for her behaviors to lessen. Interventions, effective 4/8/24, were to offer her something else she liked as a diversion; let her physician know if her behaviors were interfering with her daily care/living; and to refer her to mental health services as needed. The 4/9/24 behavior care plan indicated she wandered in others' rooms; may crawl in bed with others; believed other male resident was her husband and became agitated and aggressive when attempting to redirect. The goal was for her to not harm herself or others due to her behaviors. Interventions, effective 4/9/24, were to attempt interventions before her behaviors began; make family aware of behaviors; let her physician know if her behaviors were interfering with her daily living and offer here something she liked as a diversion. There was no assessment/evaluation in the clinical record indicating Resident 74 had the capacity to consent to sexual activity in the facility. The 6/6/24, 8:35 a.m. behavior note, written by LPN (Licensed Practical Nurse) 5, read, "Resident was standing in the dining room next to a male resident allowing him to grope her butt in front of the other residents. Interventions attempted: Residents were separated and redirected. Effectiveness of the interventions: Somewhat effective, though resident is pacing the unit trying to figure out how to get back to this male resident. She is also becoming very irritated with anyone whom is standing in her way or attempting to keep them apart."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The 6/6/24, 9:35 a.m. behavior note, written by LPN 5 read, "Resident was standing next to the couch in the dayroom while a male resident was sitting on the couch with his hand up her shirt and rubbing on her breast. Interventions attempted: Residents were separated and a CNA (Certified Nursing Assistant) was asked to monitor that they remain apart. Effectiveness of the interventions: Ineffective as the two residents continue to seek one another out." The 6/6/24, 2:49 p.m. progress note, written by LPN 5, read, "Resident has roamed the unit seeking out a certain male resident all shift. Whenever staff attempted to separate the two residents, both residents would become aggressive and begin to lash out at staff verbally and physically." 3. The clinical record for Resident 56 was reviewed on 6/14/24 at 11:37 a.m. The diagnoses included, but were not limited to: Alzheimer's disease, dementia, anxiety, and insomnia. The 5/10/24 Quarterly MDS assessment indicated the BIMS was not conducted, as he was rarely/never understood. The staff assessment for mental status indicated he had short and long-term memory problems. He did not know the current season or that he was in a nursing home. His cognitive skills for daily decision making were moderately impaired, in that decisions were poor, requiring cues/supervision. The 3/23/23 behavior care plan, last revised 4/16/24, indicated he demonstrated sexually inappropriate behaviors, believing others were his significant other. He would hug and sometimes attempt to kiss others. He displayed inappropriate touching and made sexually explicit comments to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	others. The goal was for him to interact with others appropriately during social and care situations. Interventions, effective 3/23/23, were to let his physician know if his behaviors were interfering with his daily care/living; quietly attempt to re-direct, reminding him that the behavior was not appropriate; let him know that his behavior was affecting others; and to refer him to mental health services as needed. The care plan did not include an intervention to provide adequate supervision to prevent resident to resident abuse. The 10/5/23 behavior care plan, last revised 4/16/24, indicated he sometimes demonstrated sexually inappropriate behaviors by entering female residents' rooms, having female resident come into his room, and lay in bed with others. The goal was for him to interact with others appropriately during social and care situations. Interventions, initiated 10/5/23, were to let his physician know if his behaviors were interfering with his daily care/living; offer him something else he liked; quietly attempt to re-direct, reminding him that the behavior was not appropriate; and to refer him to mental health services as needed. The care plan did not include an intervention to provide adequate supervision to prevent resident to resident abuse. The 8/31/23 behavior care plan, last revised 4/16/24, indicated he sometimes became frustrated or agitated, pushing, grabbing, being physically aggressive, and threatening when staff tried to redirect other residents from his room. He may resist care by hitting and kicking. The goal was for him to have fewer episodes of becoming frustrated and for his behavior to stop with staff intervention. Interventions were to attempt interventions before his behaviors began; give			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	medications as doctor ordered; and to offer him something he liked as a diversion. The care plan did not include an intervention to provide adequate supervision to prevent resident to resident abuse. There was no assessment/evaluation in the clinical record indicating Resident 56 had the capacity to consent to sexual activity in the facility. The 6/5/24, 9:31 a.m. progress note for Resident 56, written by the DON (Director of Nursing) read, "resident continues to have episodes of becoming agitated at staff when staff is attempting to assist female residents on the unit. resident believes that some of the female residents are "his girls" and becomes very protective. also continues to wonder [sic] about unit and at times will enter other resident's room uninvited, usually easily to redirect out of unwanted areas. Word salad frequently present, however during periods of agitation speech becomes coherent and resident will begin cursing at staff. staff will continue to attempt to ensure safety, provide interventions and assistance as warranted. Resident is followed by in-house mental health provider and is followed by in-house PCP [primary care physician] provider." A behavior note, dated 6/6/24 at 9:01 a.m., for Resident 56, written by LPN (Licensed Practical Nurse) 5, indicated, "Resident shoved this nurse out of the doorway as staff was attempting to keep he and a female resident separated due to sex behaviors. What was the resident doing prior to or at the time of behavior/mood: Resident was in the dining room and had been noticed rubbing a female resident's butt as she stood next to him. Interventions attempted: separation of resident's			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	[sic.] Effectiveness of the interventions: Intervention was ineffective...." The note did not include documentation to show all of the identified interventions to address behaviors were implemented, the facility initiated new interventions to address behaviors when the identified interventions were ineffective, or adequate supervision was provided to prevent further resident-to-resident abuse. During an interview with LPN 5, on 6/17/24 at 3:00 p.m., he indicated the behavior in the above progress note was the first behavior he witnessed on 6/6/24 between Resident 56 and Resident 74. The next consecutive behavior note, dated 6/6/24 at 9:30 a.m., written by LPN 5 indicated, "Resident was noted sitting in the sunroom with his hand up the shirt of the same female resident as earlier. Resident was rubbing the breast of this resident at this time. Interventions attempted: Both resident's [sic] were separated. Effectiveness of the interventions: Intervention was ineffective as these two resident's [sic] continue to seek one another out." The note did not include documentation to show all the identified interventions to address behaviors were implemented, the facility initiated new interventions to address behaviors when the identified interventions were ineffective, or adequate supervision was provided to prevent further resident-to-resident abuse. During an interview with LPN 5, on 6/17/24 at 3:00 p.m., he indicated he just happened to walk in the sunroom and see Resident 56 with his hand up Resident 74's shirt. There were quite a few other residents in the sunroom at the time, who were just sitting there, roughly six residents total including Resident 56 and Resident 74, and no			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	staff. The next consecutive behavior note, dated 6/6/24 at 9:40 a.m., for Resident 56, written by LPN 5 indicated, "Resident walked up to the same female resident and grab [sic] her by the face them [sic] kissed her on the lips. Interventions attempted: Separated resident's [sic.] Effectiveness of the interventions: Ineffective." The note did not include documentation to show all the identified interventions to address behaviors were implemented, the facility initiated new interventions to address behaviors when the identified interventions were ineffective, or adequate supervision was provided to prevent further resident-to-resident abuse. During an interview with LPN 5, on 6/17/24 at 3:00 p.m., he indicated the kiss on the lips happened in the hallway and he just happened to see it. He was coming down hallway with the medication cart when Resident 74 walked past him, and Resident 56 came out of the dining room. Resident 56 grabbed Resident 74 on both sides of her face, leaned in, and kissed her. It happened quickly, more like a peck on the lips. The next consecutive behavior note, dated 6/6/24 at 2:33 p.m., for Resident 56, written by LPN 5, read, "Resident was noted sitting on the couch in the sunroom with a female resident on either side of him and the three of them were touching and rubbing on one another. Interventions attempted: Resident's [sic] were asked to stop and then separated. Effectiveness of the interventions: Ineffective." The note did not include documentation to show all the identified interventions to address behaviors were implemented, the facility initiated new interventions to address behaviors when the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	identified interventions were ineffective, or adequate supervision was provided to prevent further resident-to-resident abuse. During an interview with LPN 5, on 6/17/24 at 3:00 p.m., he indicated there was another female resident, Resident 50, sitting on one side of Resident 56, and Resident 74 sitting on his other side in reference to the 6/6/24, 2:33 p.m. behavior note. The touching and rubbing he observed while the 3 of them were on the couch was outside of the clothing, rubbing legs, and holding hands. The two female residents weren't touching each other. Resident 56 was in the middle, touching both female residents, and both female residents were touching him. He stated, "[Name of Resident 56] was a little too busy for me that day." A progress note, dated 6/6/24 at 2:36 p.m., written by LPN 5, read, "Resident has been aggressive with staff while they were attempting to redirect and separate him from the same female resident whom his [sic] is drawn to." During an interview with LPN 5, on 6/17/24 at 3:00 p.m., he indicated the 6/6/24, 2:36 p.m. progress note just referenced a continuation of separating Resident 56 and Resident 74 throughout the day. The 3 residents on the couch was the last occurrence he witnessed on 6/6/24. "From the time he shoved me, it didn't get any better." He'd only worked at the facility for about 3 weeks through an agency but was off all last week. He normally worked other units and had only worked the Alzheimer's Care Unit maybe twice. It was his understanding, from talking to other employees who'd worked on the unit for a while, that Resident 56 had been showing behaviors, and they were increasing and intensifying. When he spoke with someone about Resident 56's			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	behaviors on 6/6/24, he made sure his behavior progress notes were "documented to the best of my ability." Resident 56 was very sexual in nature, but also aggressive at times, with staff, including LPN 5. At one point, Resident 56 shoved him. He told "full time staff management that day," because he noticed the issues, and he was trying to see how he was supposed to address them. "I was told it was care planned. They could be together, just couldn't have sex, and the family was aware, so I just documented." He believed it was either the Unit Manager/Alzheimer's Care Director, the DON, or the Administrator who told him this, but he wasn't sure exactly who, because he was still "trying to learn people." Resident 56's behaviors had been brought up on several occasions. He told quite a few people, including the CNAs (Certified Nursing Assistants) so they could keep an eye on them and keep them separated. He was just told to document everything he saw. He didn't think of it as sexual abuse, because both residents were seeking each other out, and it was clear they both became agitated due to staff trying to separate them, but with the residents being on the "dementia unit and not having capacity to consent," he saw it as possible sexual abuse. His concern was that families would come in and be upset by it, because it was something that families should be aware of. That's why he went forward with making sure someone knew, and it didn't just stop with him. Prior to 6/6/24, he'd seen Resident 56 be flirtatious, but not touching, more like holding hands, "helping and guiding them like they were lost," at least the way that he took it. On 6/6/24, there was no mistaking what was going on between Resident 56 and Resident 74. They were seeking each other out. He'd been trained on abuse multiple times. He worked full time for the PRN (as needed) Float Pool, and they trained him			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	on abuse, but could not recall the last time. He thought it was less than a year ago. He had not received any abuse training in the facility itself. An interview was conducted with the ACD (Alzheimer's Care Director) on 6/14/24 at 1:50 p.m. She indicated she'd been the ACD for about 2 years and was familiar with Resident 56. She did not consider his behaviors with other female residents as inappropriate. "They will love on each other, kiss and cuddle." It was mostly with Resident 74, but Resident 50 gravitated toward Resident 56 as well, would sit and hold hands, nothing inappropriate. She'd spoken to both Resident 56's and Resident 74's families and made them aware. Resident 74's family was religious and understood, as long as nothing got out of hand. She knew others had seen Resident 56 with his hands up Resident 74's shirt, but she had not seen that. A male agency nurse told her Resident 56 put his hands up the back of Resident 74's shirt and he separated them. In the last month, Resident 56 had been generally harder to redirect. The IDT [Interdisciplinary Team] had talked about this; it was care planned; they talked to families and made a note about a month and a half ago. An interview was conducted with CNA 8, on 6/14/24 at 2:00 p.m., who worked the day shift of 6/6/24. She indicated she normally worked the Alzheimer's Care Unit of the facility and had witnessed Resident 56 wrap his arm around female residents and caught him attempting to kiss female residents. She was told by CNA 9 that Resident 56 groped women's breasts, but CNA 8 hadn't witnessed this. His behaviors had been going on "at least a few months. Some days he was hard to redirect and would be loud and aggressive toward staff. Resident 56 pushed a male nurse on 6/6/24, who didn't normally work			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the unit. Resident 56 tended to try and kiss Resident 74, as she was the main female resident. "They are like glue." CNA 8 was told their families were aware. Once in a while, Resident 56 would try to kiss Resident 50 and a few times tried to kiss Resident 49. CNA 9 was unavailable for interview. An interview was conducted with CNA 25 on 6/17/24 at 2:02 p.m. She indicated she worked on 6/6/24. The only thing she saw was Resident 56 kiss Resident 74 on the forehead in the sunroom, just a quick peck. She was coming out a resident's room when LPN 5 informed her in the hallway that Resident 56's hand was up Resident 74's shirt. She didn't report this to anyone, because LPN 5 informed her that he was going to take care of it. She thought LPN 5 had it handled, because he was the nurse in charge. An interview was conducted with the Administrator, DON, Vice President of Risk and Regulatory Compliance, and Regional Director of Clinical Operations on 6/14/24 at 1:45 p.m. after they read Resident 56's 6/6/24 behavior notes from the electronic health record. The Administrator indicated she did not know about Resident 56's 6/6/24 behaviors. She knew Resident 56 was flirtatious, would hold hands, and thought Resident 74 was his wife. The ACD had spoken to both families in regard to these things. The Administrator did not report, investigate, or take action after the 6/6/24 occurrences, as she was unaware of them. The DON indicated she had never heard about Resident 56's 6/6/24 behaviors prior to just now reading the notes. She was not aware Resident 56 had his hand up Resident 74's shirt, nor was she aware of him rubbing on her buttocks in the dining room and touching on the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	couch. There was a male nurse on the unit on 6/6/24, so when he was trying to intervene, she thought Resident 56 may have had a problem with him being male and trying to intervene, as Resident 56 would say "Those are my girls," and a protective mode would step in. They tried to intervene, distract, take him outside, and use various interventions to address his behaviors. An interview was conducted with the DON on 6/17/24 at 10:53 a.m. She indicated home office was responsible for training PRN (as needed) Float Pool staff on abuse, identification, and reporting, as it was not provided to them in the facility. Her understanding was they were already trained when they came into the facility to work. The Abuse, Neglect, and Exploitation policy was provided by the DON on 6/17/24 at 11:08 a.m. It read, "Sexual Abuse is non-consensual sexual contact of any type with a resident....Employee Training. A. New employees will be educated on abuse, neglect, exploitation and misappropriation of resident property during initial orientation. B. Existing staff will receive annual education through planned in-services and as needed. C. Training topics will include: ...2. Identifying what constitutes abuse, neglect, exploitation, and misappropriation of resident property; ...4. Reporting process for abuse, neglect, exploitation, and misappropriation of resident property, including injuries of unknown sources...Prevention of Abuse, Neglect and Exploitation. The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves: A. Establishing a safe environment that supports, to the extent possible, a resident's consensual sexual relationship and by establishing policies and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	protocols for preventing sexual abuse. This may include identifying when, how, and by whom determinations of capacity to consent to a sexual contact will be made and where this documentation will be recorded; and the resident's right to establish a relationship with another individual, which may include the development of or the presence of an ongoing sexually intimate relationship; B. Identifying, correcting and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur with the deployment of trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms....Reporting/Response A. The facility fill have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies...within specified time frames: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury." 3.1-28(c)			
F 0610 SS=J Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on observation, interview and record review, the facility failed to initiate an investigation into an allegation of sexual abuse identified by a nurse and ensure adequate protection was provided to 3 of 18 residents on the unit. (Residents 49, 50, 56, and 74) The immediate jeopardy began on 6/6/24, when 2 residents' clinical records indicated allegations of sexual abuse. The Administrator, Director of Nursing, Area Vice President, Vice President of Risk and Regulatory Compliance, and Regional Director of Clinical Operations were notified of the immediate jeopardy on 6/18/24 at 3:23 p.m. The immediate jeopardy was removed on 6/14/24, but noncompliance remained at the lower scope and severity level of pattern, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. Findings include: 1. The clinical record for Resident 50 was reviewed on 6/17/24 at 1:10 p.m. The diagnoses included, but were not limited to, Alzheimer's disease, dementia, anxiety, and insomnia. The 5/15/24 Quarterly MDS (Minimum Data Set)	F 0610	What corrective ation(s) will be accomplished for those residents found to be affected by the deficient practice Resident 56 was placed on one-on-one supervision until transferred to geriatric psych facility. -how other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken Progress notes for all residents for the last 90 days reviewed with no concerns identified. Attachment #8 -what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur Education with ED and DNS completed on daily review of progress notes to include SBARSs and behavior documentation as well as reporting guidelines for inappropriate touching. Attachment #9	07/11/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	assessment indicated the BIMS (brief interview for mental status) was not conducted, as she was rarely/never understood. The staff assessment for mental status indicated she had short and long-term memory problems. She did not know the current season or that she was in a nursing home. Her cognitive skills for daily decision making were severely impaired, in that she rarely/never made decisions. It indicated she had physical behavioral symptoms directed towards others, such as hitting, kicking, pushing, scratching, grabbing, and/or abusing others sexually during one to three days of the past seven days. She had verbal behavioral symptoms directed towards others such as threatening, screaming at, and/or cursing at others during one to three days of the past seven days. The 10/5/23 behavior care plan, last revised 12/19/23, indicated she demonstrated sexually inappropriate behaviors by entering male resident rooms, laying in male resident's bed, and making sex-related comments. The goal, with a target date of 8/13/24, was for her to interact with others appropriately during social and care situations. Interventions were to quietly attempt to redirect, reminding her that the behavior was not appropriate; to let her physician know if her behaviors were interfering with her daily care/living; and to please refer her to mental health services as needed. There was no assessment/evaluation in the clinical record indicating Resident 50 had the capacity to consent to sexual activity in the facility. 2. The clinical record for Resident 74 was reviewed on 6/13/24 at 1:17 p.m. Her diagnoses included, but were not limited to: dementia,		Education completed with all staff on abuse and behavior management including all PRN pool staff. Attachment #10A, #10B, #10C, #10D, #10E, #11A #11B, #11C, #11D, #11E, #3A, #3B, #3C, #3D DNS or designee to complete on-going monitoring to review documentation. Audit to be completed during daily clinical stat up 5X weekly X 4 weeks, 3X weekly X 4 weeks, then weekly to complete 6 months. Attachment #12 -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 The results of these audits be reviewed at QAPI x 6 months to track for 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 7/11/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	anxiety, and insomnia. The 5/25/24 Significant Change MDS assessment indicated she was severely cognitively impaired. She had a behavior of wandering during one to three of the previous seven days. The wandering behavior significantly intruded on the privacy of activities of others. The 4/8/24 behavior care plan indicated she demonstrated sexually inappropriate behaviors by entering a male resident's room, laying in male resident's bed, and inappropriate touching. The goal was for her behaviors to lessen. Interventions, effective 4/8/24, were to offer her something else she liked as a diversion; let her physician know if her behaviors were interfering with her daily are/living; and to refer her to mental health services as needed. The 4/9/24 behavior care plan indicated she wandered in others' rooms; may crawl in bed with others; believed other male resident was her husband and became agitated and aggressive when attempting to redirect. The goal was for her to not harm herself or others due to her behaviors. Interventions, effective 4/9/24, were to attempt interventions before her behaviors began; make family aware of behaviors; let her physician know if her behaviors were interfering with her daily living, and offer here something she liked as a diversion. There was no assessment/evaluation in the clinical record indicating Resident 74 had the capacity to consent to sexual activity in the facility. The 6/6/24, 8:35 a.m. behavior note, written by LPN (Licensed Practical Nurse) 5, read, "Resident			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was standing in the dining room next to a male resident allowing him to grope her butt in front of the other residents. Interventions attempted: Residents were separated and redirected. Effectiveness of the interventions: Somewhat effective, though resident is pacing the unit trying to figure out how to get back to this male resident. She is also becoming very irritated with anyone whom is standing in her way or attempting to keep them apart." The 6/6/24, 9:35 a.m. behavior note, written by LPN 5 read, "Resident was standing next to the couch in the dayroom while a male resident was sitting on the couch with his hand up her shirt and rubbing on her breast. Interventions attempted: Residents were separated and a CNA (Certified Nursing Assistant) was asked to monitor that they remain apart. Effectiveness of the interventions: Ineffective as the two residents continue to seek one another out." The 6/6/24, 2:49 p.m. progress note, written by LPN 5, read, "Resident has roamed the unit seeking out a certain male resident all shift. Whenever staff attempted to separate the two residents, both residents would become aggressive and begin to lash out at staff verbally and physically." 3. The clinical record for Resident 56 was reviewed on 6/14/24 at 11:37 a.m. The diagnoses included, but were not limited to: Alzheimer's disease, dementia, anxiety, and insomnia. The 5/10/24 Quarterly MDS assessment indicated the BIMS was not conducted, as he was rarely/never understood. The staff assessment for mental status indicated he had short and long-term memory problems. He did not know the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	current season or that he was in a nursing home. His cognitive skills for daily decision making were moderately impaired, in that decisions were poor, requiring cues/supervision. An observation of Resident 56 was made on 6/14/24 at 2:05 p.m. He was lying awake in bed. He began speaking but was unable to understand what he was attempting to say. The 3/23/23 behavior care plan, last revised 4/16/24, indicated he demonstrated sexually inappropriate behaviors, believing others were his significant other. He would hug and sometimes attempt to kiss others. He displayed inappropriate touching and made sexually explicit comments to others. The goal was for him to interact with others appropriately during social and care situations. Interventions, effective 3/23/23, were to let his physician know if his behaviors were interfering with his daily care/living; quietly attempt to re-direct, reminding him that the behavior was not appropriate; let him know that his behavior was affecting others; and to refer him to mental health services as needed. The care plan did not include an intervention to provide adequate supervision to prevent resident to resident abuse. The 10/5/23 behavior care plan, last revised 4/16/24, indicated he sometimes demonstrated sexually inappropriate behaviors by entering female residents' rooms, having female resident come into his room, and lay in bed with others. The goal was for him to interact with others appropriately during social and care situations. Interventions, initiated 10/5/23, were to let his physician know if his behaviors were interfering with his daily care/living; offer him something else he liked; quietly attempt to re-direct, reminding			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	him that the behavior was not appropriate; and to refer him to mental health services as needed. The care plan did not include an intervention to provide adequate supervision to prevent resident to resident abuse. The 8/31/23 behavior care plan, last revised 4/16/24, indicated he sometimes became frustrated or agitated, pushing, grabbing, being physically aggressive, and threatening when staff tried to redirect other residents from his room. He may resist care by hitting and kicking. The goal was for him to have fewer episodes of becoming frustrated and for his behavior to stop with staff intervention. Interventions were to attempt interventions before his behaviors began; give medications as doctor ordered; and to offer him something he liked as a diversion. The care plan did not include an intervention to provide adequate supervision to prevent resident to resident abuse. There was no assessment/evaluation in the clinical record indicating Resident 56 had the capacity to consent to sexual activity in the facility. The 6/5/24, 9:31 a.m. progress note for Resident 56, written by the DON (Director of Nursing) read, "resident continues to have episodes of becoming agitated at staff when staff is attempting to assist female residents on the unit. resident believes that some of the female residents are "his girls" and becomes very protective. also continues to wonder [sic] about unit and at times will enter other resident's room uninvited, usually easily to redirect out of unwanted areas. word salad frequently present, however during periods of agitation speech becomes coherent and resident will begin cursing at staff. staff will continue to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	attempt to ensure safety, provide interventions and assistance as warranted. resident is followed by in-house mental health provider and is followed by in-house PCP [primary care physician] provider." A behavior note, dated 6/6/24 at 9:01 a.m., for Resident 56, written by LPN (Licensed Practical Nurse) 5, indicated, "Resident shoved this nurse out of the doorway as staff was attempting to keep he and a female resident separated due to sex behaviors. What was the resident doing prior to or at the time of behavior/mood: Resident was in the dining room and had been noticed rubbing a female resident's butt as she stood next to him. Interventions attempted: separation of resident's [sic.] Effectiveness of the interventions: Intervention was ineffective...." The note did not include documentation to show all the identified interventions to address behaviors were implemented, the facility initiated new interventions to address behaviors when the identified interventions were ineffective, or adequate supervision was provided to prevent further resident-to-resident abuse. During an interview with LPN 5, on 6/17/24 at 3:00 p.m., he indicated the behavior in the above progress note was the first behavior he witnessed on 6/6/24 between Resident 56 and Resident 74. The next consecutive behavior note, dated 6/6/24 at 9:30 a.m., written by LPN 5 indicated, "Resident was noted sitting in the sunroom with his hand up the shirt of the same female resident as earlier. Resident was rubbing the breast of this resident at this time. Interventions attempted: Both resident's [sic] were separated. Effectiveness of the interventions: Intervention was ineffective as these two resident's [sic] continue to seek one			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	another out." The note did not include documentation to show all the identified interventions to address behaviors were implemented, the facility initiated new interventions to address behaviors when the identified interventions were ineffective, or adequate supervision was provided to prevent further resident-to-resident abuse. During an interview with LPN 5, on 6/17/24 at 3:00 p.m., he indicated he just happened to walk in the sunroom and see Resident 56 with his hand up Resident 74's shirt. There were quite a few other residents in the sunroom at the time, who were just sitting there, roughly six residents total including Resident 56 and Resident 74, and no staff. The next consecutive behavior note, dated 6/6/24 at 9:40 a.m., for Resident 56, written by LPN 5 indicated, "Resident walked up to the same female resident and grab [sic] her by the face them [sic] kissed her on the lips. Interventions attempted: Separated resident's [sic.] Effectiveness of the interventions: Ineffective." The note did not include documentation to show all the identified interventions to address behaviors were implemented, the facility initiated new interventions to address behaviors when the identified interventions were ineffective, or adequate supervision was provided to prevent further resident-to-resident abuse. During an interview with LPN 5, on 6/17/24 at 3:00 p.m., he indicated the kiss on the lips happened in the hallway and he just happened to see it. He was coming down hallway with the medication cart when Resident 74 walked past him, and Resident 56 came out of the dining room. Resident 56 grabbed Resident 74 on both sides of her face,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	leaned in, and kissed her. It happened quickly, more like a peck on the lips. The next consecutive behavior note, dated 6/6/24 at 2:33 p.m., for Resident 56, written by LPN 5, read, "Resident was noted sitting on the couch in the sunroom with a female resident on either side of him and the three of them were touching and rubbing on one another. Interventions attempted: Resident's [sic] were asked to stop and then separated. Effectiveness of the interventions: Ineffective." The note did not include documentation to show all the identified interventions to address behaviors were implemented, the facility initiated new interventions to address behaviors when the identified interventions were ineffective, or adequate supervision was provided to prevent further resident-to-resident abuse. During an interview with LPN 5, on 6/17/24 at 3:00 p.m., he indicated there was another female resident, Resident 50, sitting on one side of Resident 56, and Resident 74 sitting on his other side in reference to the 6/6/24, 2:33 p.m. behavior note. The touching and rubbing he observed while the 3 of them were on the couch was outside of the clothing, rubbing legs, and holding hands. The two female residents weren't touching each other. Resident 56 was in the middle, touching both female residents, and both female residents were touching him. He stated, "[Name of Resident 56] was a little too busy for me that day." A progress note, dated 6/6/24 at 2:36 p.m., written by LPN 5, read, "Resident has been aggressive with staff while they were attempting to redirect and separate him from the same female resident whom his [sic] is drawn to."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview with LPN 5, on 6/17/24 at 3:00 p.m., he indicated the 6/6/24, 2:36 p.m. progress note just referenced a continuation of separating Resident 56 and Resident 74 throughout the day. The 3 residents on the couch was the last occurrence he witnessed on 6/6/24. "From the time he shoved me, it didn't get any better." He'd only worked at the facility for about 3 weeks through an agency but was off all last week. He normally worked other units and had only worked the memory care unit maybe twice. It was his understanding, from talking to other employees who'd worked on the unit for a while, that Resident 56 had been showing behaviors, and they were increasing and intensifying. When he spoke with someone about Resident 56's behaviors on 6/6/24, he made sure his behavior progress notes were "documented to the best of my ability." Resident 56 was very sexual in nature, but also aggressive at times, with staff, including LPN 5. At one point, Resident 56 shoved him. He told "full time staff management that day," because he noticed the issues, and he was trying to see how he was supposed to address them. "I was told it was care planned. They could be together, just couldn't have sex, and the family was aware, so I just documented." He believed it was either the Unit Manager/Alzheimer's Care Director, the DON, or the Administrator who told him this, but he wasn't sure exactly who, because he was still "trying to learn people." Resident 56's behaviors had been brought up on several occasions. He told quite a few people, including the CNAs (Certified Nursing Assistants) so they could keep an eye on them and keep them separated. He was just told to document everything he saw. He didn't think of it as sexual abuse, because both residents were seeking each other out, and it was clear they both became agitated due to staff trying to separate them, but			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	with the residents being on the "dementia unit and not having capacity to consent," he saw it as possible sexual abuse. His concern was that families would come in and be upset by it, because it was something that families should be aware of. That's why he went forward with making sure someone knew, and it didn't just stop with him. Prior to 6/6/24, he'd seen Resident 56 be flirtatious, but not touching, more like holding hands, "helping and guiding them like they were lost," at least the way that he took it. On 6/6/24, there was no mistaking what was going on between Resident 56 and Resident 74. They were seeking each other out. He'd been trained on abuse multiple times. He worked full time for the PRN (as needed) Float Pool, and they trained him on abuse, but could not recall the last time. He thought it was less than a year ago. He had not received any abuse training in the facility itself. An interview was conducted with the ACD (Alzheimer's Care Director) on 6/14/24 at 1:50 p.m. She indicated she'd been the ACD for about 2 years and was familiar with Resident 56. She did not consider his behaviors with other female residents as inappropriate. "They will love on each other, kiss and cuddle." It was mostly with Resident 74, but Resident 50 gravitated toward Resident 56 as well, would sit and hold hands, nothing inappropriate. She'd spoken to both Resident 56's and Resident 74's families and made them aware. Resident 74's family was religious and understood, as long as nothing got out of hand. She knew others had seen Resident 56 with his hands up Resident 74's shirt, but she had not seen that. A male agency nurse told her Resident 56 put his hands up the back of Resident 74's shirt and he separated them. In the last month, Resident 56 had been generally harder to redirect. The IDT [Interdisciplinary Team] had talked about			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	this; it was care planned; they talked to families and made a note about a month and a half ago. An interview was conducted with CNA 8, on 6/14/24 at 2:00 p.m., who worked the day shift of 6/6/24. She indicated she normally worked the memory care unit of the facility and had witnessed Resident 56 wrap his arm around female residents and caught him attempting to kiss female residents. She was told by CNA 9 that Resident 56 groped women's breasts, but CNA 8 hadn't witnessed this. His behaviors had been going on "at least a few months. Some days he was hard to redirect and would be loud and aggressive toward staff. Resident 56 pushed a male nurse on 6/6/24, who didn't normally work the unit. Resident 56 tended to try and kiss Resident 74, as she was the main female resident. "They are like glue." CNA 8 was told their families were aware. Once in a while, Resident 56 would try to kiss Resident 50 and a few times tried to kiss Resident 49. CNA 9 was unavailable for interview. An interview was conducted with CNA 25 on 6/17/24 at 2:02 p.m. She indicated she worked on 6/6/24. The only thing she saw was Resident 56 kiss Resident 74 on the forehead in the sunroom, just a quick peck. She was coming out a resident's room when LPN 5 informed her in the hallway that Resident 56's hand was up Resident 74's shirt. She didn't report this to anyone, because LPN 5 informed her that he was going to take care of it. She thought LPN 5 had it handled, because he was the nurse in charge. A progress note, dated 6/10/24 at 9:56 p.m., for Resident 56, written by the DON, read, "Resident continues to have episodes of becoming easily irritated and upset with staff when staff provides			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	interventions r/t [related to] behaviors displayed with female residents. Resident has been noted to be holding hands with female residents and occasionally kissing. Resident with severe impaired cognition status and unable to recall behavior as being inappropriate. resident with word salad and when staff intervenes, word salad becomes more severe, tone of voice becoming stern, with an occasional cursing noted. wanders about unit and at times will enter other resident's room without invitations. Resident frequently leaves unwanted areas without incident. family is aware of behaviors and understands [sic] that resident is not able to recognize inappropriateness of behaviors. Resident continues to be followed by in house PCP and in house psych provider. Staff will continue to attempt to ensure safety, offer interventions and assistance as warranted." An interview was conducted with the Administrator, DON, Vice President of Risk and Regulatory Compliance, and Regional Director of Clinical Operations on 6/14/24 at 1:45 p.m. after they read Resident 56's 6/6/24 behavior notes from the electronic health record. The Administrator indicated she did not know about Resident 56's 6/6/24 behaviors. She knew Resident 56 was flirtatious, would hold hands, and thought Resident 74 was his wife. The ACD had spoken to both families in regard to these things. The Administrator did not report, investigate, or take action after the 6/6/24 occurrences, as she was unaware of them. The DON indicated she had never heard about Resident 56's 6/6/24 behaviors prior to just now reading the notes. She was not aware Resident 56 had his hand up Resident 74's shirt, nor was she aware of him rubbing on her buttocks in the dining room and touching on the couch. There was a male nurse on the unit on 6/6/24, so when he was trying to intervene, she			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	thought Resident 56 may have had a problem with him being male and trying to intervene, as Resident 56 would say "Those are my girls," and a protective mode would step in. They tried to intervene, distract, take him outside, and use various interventions to address his behaviors. An interview was conducted with Family Member 6, Resident 74's daughter, on 6/18/24 at 10:33 a.m. She indicated the facility informed her, on 6/14/24, of the 6/6/24 sexual activity involving her mom. Resident 74 would have been very opposed to this behavior, as she was quite religious. "If she didn't have dementia, she would be appalled." To her knowledge, nothing happened prior to 6/6/24. Resident 56 and Resident 74 had been "kind of buddies for a while." They would sit together, but no hand holding or kissing "that I know of," just sitting next to each other. One time she saw Resident 56 try to give Resident 74 a kiss on her forehead, which didn't bother Family Member 6. It was kind of sweet. Family Member 6 would have wanted to know about previous hand holding or kissing and didn't realize it had "gotten into this." An interview was conducted with Family Member 7, Resident 56's son, on 6/18/24 at 12:12 p.m. He indicated he wasn't notified about his father's 6/6/24 behaviors until 6/14/24. They called him a year ago and informed him Resident 74 "was in bed with him, kinda messing around, not sure anything was done, kinda fooling around." The staff was responsible for his father and the other residents, so he questioned how this happened and thought the responsibility was on the facility. An interview was conducted with the DON on 6/17/24 at 10:53 a.m. She indicated the home office was responsible for training PRN (as needed) Float Pool staff on abuse, identification, and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	reporting, as it was not provided to them in the facility. Her understanding was they were already trained when they came into the facility to work. The Administrator provided a copy of the 6/12/24 Daily Census for the facility on 6/13/24 at 11:00 a.m. It indicated there were 18 residents on the Alzheimer's Care Unit of the facility including Residents 49, 50, 56, and 74. The Abuse, Neglect, and Exploitation policy was provided by the DON on 6/17/24 at 11:08 a.m. It read, "Sexual Abuse is non-consensual sexual contact of any type with a resident....Prevention of Abuse, Neglect and Exploitation. The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves: A. Establishing a safe environment that supports, to the extent possible, a resident's consensual sexual relationship and by establishing policies and protocols for preventing sexual abuse. This may include identifying when, how, and by whom determinations of capacity to consent to a sexual contact will be made and where this documentation will be recorded; and the resident's right to establish a relationship with another individual, which may include the development of or the presence of an ongoing sexually intimate relationship; B. Identifying, correcting and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur with the deployment of trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms;...Investigation of Alleged Abuse,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Neglect and Exploitation A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur....Protection of Resident. The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to: A. responding immediately to protect he alleged victim and integrity of the investigation; ...C. Increased supervision of the alleged victim and residents; D. Room or staffing changes, if necessary to protect the resident(s) from the alleged perpetrator; E. Protection from retaliation; F. Providing emotional support and counseling to the resident during and after the investigation, as needed; G. Revision of the resident's care plan if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of an incident of abuse. Reporting/Response A. The facility fill have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies...within specified time frames: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury." 3.1-28(d)			
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on interview and record review, the facility	F 0641	-what corrective action(s) will be accomplished for those residents	07/11/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	failed to accurately encode minimum data set assessments for Resident 17's prognosis of six months or less and for Resident 54's utilization of hospice services for 2 of 2 residents reviewed for minimum data set assessment hospice accuracy. Findings include: 1. The clinical record for Resident 17 was reviewed on 6/18/2024 at 1:22 p.m. The medical diagnosis included respiratory failure. An Annual Minimum Data Set Assessment, dated 3/28/2024, indicated Resident 17 was cognitively impaired, did not have a life expectancy of six months or less, but utilized hospice services. A physician order, dated 3/21/2023, indicated for Resident 17 to receive hospice services. A hospice standing order, dated 12/31/2023, located inside of Resident 17's hospice binder at the nurses' station. The order indicated that Resident 17 had a terminal illness with a life expectancy of six months or less. 2. The clinical record for Resident 54 was reviewed on 6/17/2024 at 11:05 a.m. The medical diagnosis included diabetes with neuropathy. A Significant Change Minimum Data Set Assessment, dated 6/5/2024, indicated that Resident 54 was cognitively intact, had a life expectancy of six months or less, but did not receive hospice services. A physician order, dated 6/3/2024, indicated for Resident 54 to receive hospice services. A hospice standing order, dated 5/31/2024,		found to have been affected by the deficient practice MDS for resident 17 and 54 corrected. -how other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken MDS for all residents on hospice services reviewed to ensure accuracy. Attachment #13-what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur Education completed with RNAC on coding MDS accurately. Attachment #14Administrator or designee to complete ongoing audits of completed MDS for those on hospice to ensure accurate coding. Audits to be completed weekly X 4 weeks and monthly thereafter to complete 6 months. Attachment #15-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 The results of these audits to be reviewed at QAPI x 6 months to track for any trends. If any identified, will continue audits based on QAPI recommendations, otherwise will review on PRN basis. br="">-by what date the systemic	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	located inside of Resident 54's hospice binder at the nurses' station. The order indicated that Resident 54 had a terminal illness with a life expectancy of six months or less. An interview with the Registered Nurse Assessment Coordinator (RNAC), on 6/19/2024 at 11:40 a.m., indicated the aforementioned assessment were encoded in error and she would initiate modifications of their records. A policy entitled, "Conducting an Accurate Resident Assessment", was provided by the Area Vice President on 6/18/2024 at 12:45 p.m. The policy indicated the purpose of the policy was for all residents to receive an accurate assessment.		changes for each deficiency will be completed 7/11/2024	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview, and record review, the facility failed to assist a resident with eating (Resident 2) and a dependent resident with shaving to their preference (Resident 54) for 2 of 4 residents reviewed for activities of daily living. Findings include: 1. The clinical record for Resident 2 was reviewed on 6/18/2024 at 11:10 a.m. The medical diagnosis included heart failure. A baseline activities of daily living care plan, dated 5/28/2024, indicated to assist Resident 2 with eating as needed. This care plan did not	F 0677	-what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Resident 2 no longer resides in the facility. Resident 54 was assisted with shaving. -how other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken Audit completed of all residents to ensure shaving completed per resident preference. Audit completed of all residents that require assistance	07/11/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicate the amount of assistance, or the number of staff needed. An Admission Minimum Data Set Assessment, dated 5/30/2024, indicated that Resident 2 was cognitively impaired, independent with eating, and needed substantial to maximum assistance with dressing. An observation and interview, on 6/14/2024 at 11:30 a.m., with Family Member 12 indicated that Resident 2 had an overall decline in their condition since they were admitted to the facility at the end of May. Family Member 12 tried to come every day to spend time with her mother. She usually arrived between 11:00 and 11:30 a.m. Resident 2 needed assistance with eating and there had been multiple times that Resident 2 would be found covered in food on her clothing, have food spilled in her room on the floor, and still have her breakfast tray in her room when Family Member 12 came to visit around 11:00 a.m. to 11:30 a.m. Family Member 12 recalled an event that had happened less than a week ago, on what she believed was 6/9/2024, and during that time, staff came in to pass Resident 2's lunch tray. Family Member 12 indicated while she was visiting with her mother, Resident 2's lunch tray was passed, and no staff came back to assist Resident 2 with her meal. Resident 2 had not attempted to feed herself during this time. Family Member 12 began to assist her mother with eating about 45 minutes after the meal was passed because her food was getting cold, and her ice cream was melting. Family Member 12 indicated that staff had already picked up the rest of the trays on the unit when she started helping her mother eat, reiterating that no one ever came in to check on them or offer to assist her mother with eating.		with eating to ensure plan of care reflects need for assistance. Attachment #16a and #16B-what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur Education completed with all nursing staff on Activities of Daily Living which includes assisting residents with meals if needed and shaving residents. Attachment #17 and #3A, #3B, #3C, #3DEducation completed with advocates and monitoring resident facial hair during advocate rounds 5 X weekly. Attachment #4A and #4BDNS or will complete on-going audits to ensure residents are assisted with shaving being completed. Audits will be completed 5X weekly X4 weeks, 3X weekly X 4 weeks, weekly X 4 weeks, and monthly thereafter to complete 6 months. Meal audits to be completed at random meals to include all 3 meals to ensure assistance is provided to those residents that require assistance with meals. Audit to be completed 5X weekly X4 weeks, 3X weekly X 4 weeks, weekly X 4 weeks, and monthly thereafter to complete 6 months. Attachment #18-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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A grievance form, dated 6/9/2024, indicated that staff believed that Family Member 12 was going to help Resident 2 with eating. A confidential staff interview completed during the survey indicated that they assisted with Resident 2's care that day and it was a "bad day". They did not offer to assist Resident 2 with eating because "her daughter usually is here for lunch" and "so much was happening" that day. 2. The clinical record of Resident 54 was reviewed on 6/18/24 at 11:30 a.m. The diagnoses included, but was not limited to, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, other sequelae of cerebral infarction, and muscle weakness (generalized). The Annual Minimum Data Set (MDS) assessment for Resident 54, dated 5/1/24, indicated the resident was cognitively intact for daily decision making. A care plan, initiated on 7/19/22, indicated Resident 54 had a physical functioning deficit related to mobility and selfcare impairment. An observation and interview of Resident 54, on 6/13/24 at 12:45 p.m., noted the resident was lying in bed with a moderate amount of facial hair. Resident 54 indicated he did not want a beard and preferred to be shaven. Resident 54 stated he was unable to shave his own face and he had a contracture (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) to the left hand. An observation, on 6/14/24 at 11:25 a.m., noted Resident 54 in bed with a long beard.		The results of these audits to be reviewed at QAPI x 6 months to track for any trends. If any identified, will continue audits based on QAPI recommendations, otherwise will review on PRN basis. br="">-by what date the systemic changes for each deficiency will be completed 7/11/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	An observation, on 6/17/24 at 12:04 p.m., noted Resident 54 sitting in a wheelchair with a shaved face. He indicated that he was shaved that morning. An interview with the DNS (Director of Nursing Services), on 6/19/24 at 12:32 p.m., indicated that direct nursing staff were responsible for residents being shaved. DNS indicated that shaving should be offered with every shower and/or bath. A policy entitled, "Activities of Daily Living (ADLs)", was provided by the Area Vice President, on 6/18/24 at 12:45 p.m. The policy indicated the following, " ...Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming, and oral care; 4. Eating to include meals and snacks". A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene...." 3.1-38(a)(2)(D) 3.1-38(a)(3)(D) 3.1-38(b)(4)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on observation, interview, and record review, the facility failed to change the humidification for Resident 2's oxygen concentrator for 1 of 2 residents reviewed for respiratory care needs. Findings include: The clinical record for Resident 2 was reviewed on 6/18/2024 at 11:10 a.m. The medical diagnosis included heart failure. An Admission Minimum Data Set Assessment, dated 5/30/2024, indicated that Resident 2 was cognitively impaired. A physician order for Resident 2, dated 5/24/2024, indicated to change prefilled bottles on her oxygen concentrator and humifaction weekly and as needed. An observation conducted, on 6/13/2024 at 11:45 a.m., noted Resident 2 sitting in her BRODA chair with her daughter sitting next to her. Resident 12 was utilizing oxygen via nasal cannula with the humidification bottle empty and labelled "6/6/2024". An observation conducted, on 6/14/2024 at 11:30 a.m., noted Resident 2 sitting in her BRODA chair with her daughter sitting next to her. Resident 12 was utilizing oxygen via nasal cannula with the humidification bottle empty and labelled "6/6/2024". An observation conducted, on 6/17/2024 at 12:50 p.m., noted Resident 2 lying in bed utilizing oxygen via nasal cannula with a humidification bottle empty and labelled "6/6/2024".	F 0695	-what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Resident 2 no longer resides in the facility. -how other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken Audit completed of all residents with oxygen to ensure humidification changed per policy. Attachment #19-what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur Education completed with all nursing staff on oxygen administration which includes changing humidification. Attachment #20 A, #20B and #3A, #3B, #3C, #3D Education completed with advocates on monitoring for timely changing of 02 supplies during rounds. Advocate rounds 5 times weekly. Attachment #4B #4BDNS or designee will complete on- going monitoring to ensure o2 supplies are changed weekly per policy. Random resident with o2 will be checked 5X weekly X4 weeks, 3X weekly X 4 weeks, weekly X 4 weeks, and monthly thereafter to complete 6 months. Attachment #21-how the corrective action will be monitored to ensure that deficient practice will not recur; I.e., what quality	07/11/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	An observation and interview conducted, on 6/17/2024 at 12:55 p.m., with Licensed Practical Nurse (LPN) 11 indicated that the humidification bottle was empty, dated 6/6/2024, and that they should be changed weekly. LPN 11 indicated they would change the "whole setup" in regard to the nasal cannula and humidification. A policy entitled, "Oxygen Administration", was provided by the Area Vice President on 6/18/2024 at 12:45 p.m. The policy indicated the following, " ...Change humidified bottle when empty, every 72 hours or per facility policy, or as recommended by the manufacturer..." 3.1-47(a)(6)		assurance program will be put into place The results of these audits to be reviewed at QAPI x 6 months to track for any trends. If any identified, will continue audits based on QAPI recommendations, otherwise will review on PRN basis. br="">-by what date the systemic changes for each deficiency will be completed 7/11/2024	
F 0744 SS=E Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on observation, interview, and record review, the facility failed to implement residents' behavior care plans and provide adequate monitoring and supervision to timely address residents' behaviors for 6 of 18 residents on the Alzheimer's Care Unit. (Residents 11, 14, 50, 51, 56, 57, 67, and 74) Findings include: 1. The clinical record for Resident 50 was reviewed on 6/17/24 at 1:10 p.m. Her diagnoses included, but were not limited to: Alzheimer's disease, anxiety, and insomnia.	F 0744	-what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Resident 11, 14, 50, 51, 56, 57, 67, and 74 behavior care plans were reviewed and updated. -how other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken Audit completed of all resident behavior care plans completed to identify	07/11/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The 5/15/24 Quarterly MDS (Minimum Data Set) assessment indicated the BIMS (brief interview for mental status) was not conducted, as she was rarely/never understood. The staff assessment for mental status indicated she had short term and long-term memory problems. She did not know the current season or that she was in a nursing home. Her cognitive skills for daily decision making were severely impaired, in that she rarely/never made decisions. It indicated she had physical behavioral symptoms directed towards others, such as hitting, kicking, pushing, scratching, grabbing, and/or abusing others sexually during one to three days of the past seven days. She had verbal behavioral symptoms directed towards others such as threatening, screaming at, and/or cursing at others during one to three days of the past seven days. The 10/5/23 behavior care plan, last revised 12/19/23, indicated she demonstrated sexually inappropriate behaviors by entering male resident rooms, laying in male resident's bed, and making sex-related comments. The goal, with a target date of 8/13/24, was for her to interact with others appropriately during social and care situations. Interventions were to quietly attempt to redirect, reminding her that the behavior was not appropriate; to let her physician know if her behaviors were interfering with her daily care/living; and to please refer her to mental health services as needed. There was no assessment/evaluation in the clinical record indicating Resident 50 had the capacity to consent to sexual activity in the facility. The 6/6/24, 2:33 p.m. behavior note for Resident		proper behavior monitoring interventions are in place. Attachment #22 -what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur All staff educated on proper rounding and behavior monitoring policies and procedures. Attachment #23 and #3A, #3B, #3C, #3D The Executive Director or her designee to assess the unit for potential adaptations throughout unit to allow for increased supervision. Executive Director or designee will complete on-going monitoring of resident behaviors and care plans during morning meeting 5X weekly X4 weeks, 3X weekly X 4 weeks, weekly X 4 weeks, and monthly thereafter to complete 6 months. Attachment #24 -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 The results of these audits to be reviewed at QAPI x 6 months to track for any trends. If any identified, will continue audits based on QAPI recommendations, otherwise will review on PRN basis. br="">-by what date the systemic changes for each deficiency will be completed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	56, written by LPN 5, indicated, "Resident was noted sitting on the couch in the sunroom with a female resident on either side of him and the three of them were touching and rubbing on one another. Interventions attempted: Resident's [sic] were asked to stop and then separated. Effectiveness of the interventions: Ineffective." The note did not include documentation to show all the identified interventions to address behaviors were implemented, the facility initiated new interventions to address behaviors when the identified interventions were ineffective, or adequate supervision was provided to prevent further resident-to-resident abuse. During an interview with LPN 5 on 6/17/24 at 3:00 p.m., he indicated on 6/624 at 2:33 p.m., he observed Resident 50 sitting on a couch in between Resident 56 and Resident 74. LPN 5 indicated he observed Resident 56 touching and rubbing Resident 50 and Resident 74. The touching and rubbing he observed while the three of them were on the couch was outside of the clothing, rubbing legs, and holding hands. Resident 74 and Resident 50 weren't touching each other, but both Resident 74 and Resident 50 were touching Resident 56. Resident 50's progress notes did not reference the behaviors indicated in Resident 56's 6/6/24, 2:33 p.m. behavior note. There was no information in Resident 50's clinical record, including the progress notes, to indicate Resident 50's physician was informed of her behaviors referenced in Resident 56's above 6/6/24, 2:33 p.m. behavior note or that her mental health provider was made aware, as care planned. An interview was conducted with LPN 5 on		7/11/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	6/17/24 at 3:00 p.m. He indicated he did not inform Resident 50's "family or doctor or anything." He just documented the behaviors to the best of his ability. 2. The clinical record for Resident 74 was reviewed on 6/13/24 at 1:17 p.m. Her diagnoses included, but were not limited to: dementia, anxiety, and insomnia. The 5/25/24 Significant Change MDS assessment indicated she was severely cognitively impaired. She had a behavior of wandering during one to three of the previous seven days. The wandering behavior significantly intruded on the privacy of activities of others. An observation of Resident 74 was made on 6/13/24 at 1:17 p.m. She was continuously wandering about the unit from the dining room into the hallway and into the sunroom. The 4/8/24 behavior care plan indicated she demonstrated sexually inappropriate behaviors by entering a male resident's room, laying in male resident's bed, and inappropriate touching. The goal was for her behaviors to lessen. Interventions, effective 4/8/24, were to offer her something else she liked as a diversion; let her physician know if her behaviors were interfering with her daily care/living; and to refer her to mental health services as needed. The 4/9/24 behavior care plan indicated she wandered in others' rooms; may crawl in bed with others; believed other male resident was her husband and became agitated and aggressive when attempting to redirect. The goal was for her to not harm herself or others due to her behaviors. Interventions, effective 4/9/24, were to attempt			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	interventions before her behaviors began; make family aware of behaviors; let her physician know if her behaviors were interfering with her daily living and offer here something she liked as a diversion. There was no assessment/evaluation in the clinical record indicating Resident 74 had the capacity to consent to sexual activity in the facility. A behavior note, dated 6/6/24 at 8:35 a.m., written by LPN (Licensed Practical Nurse) 5, read, "Resident was standing in the dining room next to a male resident allowing him to grope her butt in front of the other residents. Interventions attempted: Residents were separated and redirected. Effectiveness of the interventions: Somewhat effective, though resident is pacing the unit trying to figure out how to get back to this male resident. She is also becoming very irritated with anyone whom [sic] is standing in her way or attempting to keep them apart." The note did not include documentation to show all the identified interventions to address behaviors were implemented, the facility initiated new interventions to address behaviors when the identified interventions were ineffective, or adequate supervision was provided to prevent further resident-to-resident abuse. The next consecutive behavior progress note, dated 6/6/24 at 9:35 a.m., written by LPN 5 indicated, "Resident was standing next to the couch in the dayroom while a male resident was sitting on the couch with his hand up her shirt and rubbing on her breast. Interventions attempted: Residents were separated and a CNA (Certified Nursing Assistant) was asked to monitor that they remain apart. Effectiveness of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the interventions: Ineffective as the two residents continue to seek one another out." The next subsequent progress note related to Resident 74's behaviors, dated 6/6/24 at 2:49 p.m., written by LPN 5, read, "Resident has roamed the unit seeking out a certain male resident all shift. Whenever staff attempted to separate the two residents, both residents would become aggressive and begin to lash out at staff verbally and physically." The note did not include documentation to show all the identified interventions to address behaviors were implemented, the facility initiated new interventions to address behaviors when the identified interventions were ineffective, or adequate supervision was provided to prevent further resident-to-resident abuse. There was no information in the clinical record, including the progress notes, to indicate Resident 74's physician was informed of her behaviors referenced in the above 6/6/24, 8:35 a.m. behavior note, 6/6/24, 9:35 a.m. behavior note, or 6/6/24, 2:49 p.m. progress note or that her mental health provider was made aware, as care planned. An interview was conducted with LPN 5 on 6/17/24 at 3:00 p.m. He indicated he did not inform Resident 74's "family or doctor or anything." He just documented the behaviors to the best of his ability. An interview was conducted with Family Member 6 on 6/18/24 at 10:33 a.m. She indicated Resident 74, and Resident 56 had been kind of "buddies for a while." They would sit together, but no hand holding or kissing that she knew of, just sitting next to each other. Family Member 6 would have wanted to know about prior kissing and hand			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	holding. One time, she saw Resident 56 try to give Resident 74 a kiss on her forehead, which didn't bother her. There were a couple times Resident 74 was in Resident 56's bed, while he was in his recliner. The staff knew and kept having to move her. She'd walked into Resident 74's room before, and another resident was in her bed. No one informed her about Resident 56 rubbing Resident 74's buttocks in the dining room on 6/6/24. Resident 74 would have been very opposed to this behavior, as she was quite religious. "If she didn't have dementia, she would be appalled." 3. The clinical record for Resident 56 was reviewed on 6/14/24 at 11:37 a.m. The diagnoses included, but were not limited to: Alzheimer's disease, dementia, anxiety, and insomnia. The 5/10/24 Quarterly MDS assessment indicated the BIMS was not conducted, as he was rarely/never understood. The staff assessment for mental status indicated he had short and long-term memory problems. He did not know the current season or that he was in a nursing home. His cognitive skills for daily decision making were moderately impaired, in that decisions were poor, requiring cues/supervision. An observation of Resident 56 was made on 6/14/24 at 2:05 p.m. He was lying awake in bed. He began speaking but was unable to understand what he was attempting to say. The 3/23/23 behavior care plan, last revised 4/16/24, indicated he demonstrated sexually inappropriate behaviors, believing others were his significant other. He would hug and sometimes attempt to kiss others. He displayed inappropriate touching and made sexually explicit comments to others. The goal was for him to interact with			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	others appropriately during social and care situations. Interventions, effective 3/23/23, were to let his physician know if his behaviors were interfering with his daily care/living; quietly attempt to re-direct, reminding him that the behavior was not appropriate; let him know that his behavior was affecting others; and to refer him to mental health services as needed. The care plan did not include an intervention to provide adequate supervision to prevent resident to resident abuse. The 10/5/23 behavior care plan, last revised 4/16/24, indicated he sometimes demonstrated sexually inappropriate behaviors by entering female residents' rooms, having female resident come into his room, and lay in bed with others. The goal was for him to interact with others appropriately during social and care situations. Interventions, initiated 10/5/23, were to let his physician know if his behaviors were interfering with his daily care/living; offer him something else he liked; quietly attempt to re-direct, reminding him that the behavior was not appropriate; and to refer him to mental health services as needed. The care plan did not include an intervention to provide adequate supervision to prevent resident to resident abuse. The 8/31/23 behavior care plan, last revised 4/16/24, indicated he sometimes became frustrated or agitated, pushing, grabbing, being physically aggressive, and threatening when staff tried to redirect other residents from his room. He may resist care by hitting and kicking. The goal was for him to have fewer episodes of becoming frustrated and for his behavior to stop with staff intervention. Interventions were to attempt interventions before his behaviors began; give medications as doctor ordered; and to offer him			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	something he liked as a diversion. The care plan did not include an intervention to provide adequate supervision to prevent resident to resident abuse. There was no assessment/evaluation in the clinical record indicating Resident 56 had the capacity to consent to sexual activity in the facility. The 5/29/24 psychiatry progress note indicated, "Patient was seen today per facility request for psychiatric evaluation, medication management, and GDR [gradual dose reduction] review. Patient was seen in the common area, pacing up and down the hallway. Patient presents anxious, restless and he continues to follow another female resident. Patient is confused at times during the interview. Staff reports that he has good appetite and sleeps well at night. Per facility, patient can get anxious, irritable, agitation, verbally and physically aggressive toward staff and some resident and hard to redirect at times. Starts Lorazepam 0.5mg po [by mouth] bid [twice daily ...]" Follow up in two weeks and as needed. The 6/5/24, 9:31 a.m. progress note for Resident 56, written by the DON (Director of Nursing) indicated, "resident continues to have episodes of becoming agitated at staff when staff is attempting to assist female residents on the unit. resident believes that some of the female residents are "his girls" and becomes very protective. also continues to wonder [sic] about unit and at times will enter other resident's room uninvited, usually easily to redirect out of unwanted areas. Word salad frequently present, however during periods of agitation speech becomes coherent and resident will begin cursing at staff. staff will continue to attempt to ensure safety, provide			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	interventions and assistance as warranted. Resident is followed by in-house mental health provider and is followed by in-house PCP [primary care physician] provider." A behavior note, dated 6/6/24 at 9:01 a.m., for Resident 56, written by LPN (Licensed Practical Nurse) 5, indicated, "Resident shoved this nurse out of the doorway as staff was attempting to keep he and a female resident separated due to sex behaviors. What was the resident doing prior to or at the time of behavior/mood: Resident was in the dining room and had been noticed rubbing a female resident's butt as she stood next to him. Interventions attempted: separation of resident's [sic.] Effectiveness of the interventions: Intervention was ineffective...." The note did not include documentation to show all the identified interventions to address behaviors were implemented, the facility initiated new interventions to address behaviors when the identified interventions were ineffective, or adequate supervision was provided to prevent further resident-to-resident abuse. During an interview with LPN 5, on 6/17/24 at 3:00 p.m., he indicated the behavior in the above progress note was the first behavior he witnessed on 6/6/24 between Resident 56 and Resident 74. The next consecutive behavior note, dated 6/6/24 at 9:30 a.m., written by LPN 5 indicated, "Resident was noted sitting in the sunroom with his hand up the shirt of the same female resident as earlier. Resident was rubbing the breast of this resident at this time. Interventions attempted: Both resident's [sic] were separated. Effectiveness of the interventions: Intervention was ineffective as these two resident's [sic] continue to seek one another out." The note did not include			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	documentation to show all the identified interventions to address behaviors were implemented, the facility initiated new interventions to address behaviors when the identified interventions were ineffective, or adequate supervision was provided to prevent further resident-to-resident abuse. During an interview with LPN 5, on 6/17/24 at 3:00 p.m., he indicated he just happened to walk in the sunroom and see Resident 56 with his hand up Resident 74's shirt. There were quite a few other residents in the sunroom at the time, who were just sitting there, roughly six residents total including Resident 56 and Resident 74, and no staff. The next consecutive behavior note, dated 6/6/24 at 9:40 a.m., for Resident 56, written by LPN 5 indicated, "Resident walked up to the same female resident and grab [sic] her by the face them [sic] kissed her on the lips. Interventions attempted: Separated resident's [sic.] Effectiveness of the interventions: Ineffective." The note did not include documentation to show all the identified interventions to address behaviors were implemented, the facility initiated new interventions to address behaviors when the identified interventions were ineffective, or adequate supervision was provided to prevent further resident-to-resident abuse. During an interview with LPN 5, on 6/17/24 at 3:00 p.m., he indicated the kiss on the lips happened in the hallway and he just happened to see it. He was coming down hallway with the medication cart when Resident 74 walked past him, and Resident 56 came out of the dining room. Resident 56 grabbed Resident 74 on both sides of her face, leaned in, and kissed her. It happened quickly,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	more like a peck on the lips. The next consecutive behavior note, dated 6/6/24 at 2:33 p.m., for Resident 56, written by LPN 5, read, "Resident was noted sitting on the couch in the sunroom with a female resident on either side of him and the three of them were touching and rubbing on one another. Interventions attempted: Resident's [sic] were asked to stop and then separated. Effectiveness of the interventions: Ineffective." The note did not include documentation to show all the identified interventions to address behaviors were implemented, the facility initiated new interventions to address behaviors when the identified interventions were ineffective, or adequate supervision was provided to prevent further resident-to-resident abuse. During an interview with LPN 5, on 6/17/24 at 3:00 p.m., he indicated there was another female resident, Resident 50, sitting on one side of Resident 56, and Resident 74 sitting on his other side in reference to the 6/6/24, 2:33 p.m. behavior note. The touching and rubbing he observed while the 3 of them were on the couch was outside of the clothing, rubbing legs, and holding hands. The two female residents weren't touching each other. Resident 56 was in the middle, touching both female residents, and both female residents were touching him. He stated, "[Name of Resident 56] was a little too busy for me that day." The 6/6/24, 2:36 p.m. progress note, written by LPN 5, read, "Resident has been aggressive with staff while they were attempting to redirect and separate him from the same female resident whom his [sic] is drawn to." There was no information in Resident 56's clinical			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	record, including the progress notes, to indicate Resident 56's physician was informed of his behaviors referenced in the above 6/6/24, 9:01 a.m. behavior note, 6/6/24, 9:40 a.m. behavior note, 6/6/24, 2:33 p.m. behavior note, or 6/6/24, 2:36 p.m. progress note or that his mental health provider was made aware, as care planned. An interview was conducted with LPN 5 on 6/17/24 at 3:00 p.m. He indicated he did not inform Resident 56's "family or doctor or anything." He just documented the behaviors to the best of his ability. An interview was conducted with the Medical Director on 6/20/24 at 10:35 a.m. He indicated he did not really like the physical set up of the Alzheimer's Care Unit, as it was hard to have eyes on everyone, and there was not a lot of space for the residents to move about. A learning point for the facility was that when they see residents with certain types of behaviors, they needed to have a better plan to manage them. They needed to realize sooner that the relationship between Resident 56 and Resident 74 could be a track to a more intimate connection, so they needed to have more of a plan in place to address it, without adding medications. They needed to be able to identify Resident 56's issues earlier to get him the help he needed sooner. Their psychiatric provider used in the facility was good and could probably help them with this. He was not aware Resident 56 was having physical closeness with other residents, other than sitting next to each other. He was not made aware of Resident 56 and Resident 74 lying in bed together or him trying to be alone in the room together. The breakdown was the nursing staff not bringing these things forward to work on.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	4. During an observation, on 6/17/24 at 1:51 p.m., Resident 11 was sitting on a couch in the sunroom. Resident 57 was observed to enter the sunroom with her walker and walk toward Resident 1. There were no other residents or staff in the sunroom at this time. Resident 11 was observed to loudly ask Resident 57 why Resident 57 was looking at Resident 11. Resident 57 stopped walking towards Resident 11 approximately 6 feet in front of her and swung her arm in the air. Resident 11 yelled at Resident 57 for doing so. Resident 57 then turned around and walked out of the sunroom. Resident 57 began saying how mean Resident 57 was and that Resident 11 didn't bother or talk to Resident 57. There were no staff present to address the interaction between these 2 residents. On 6/17/24 at 1:57 p.m., CNA (Certified Nursing Assistant) 25 was observed in the dining room of the unit, across the hall from the sunroom. There were no staff present in the sunroom at this time. Commotion/yelling was heard coming from the sunroom, so CNA 25 went into the sunroom to address it. An interview was conducted with CNA 25 on 6/17/24 at 1:59 p.m. She indicated when she went into the sunroom, Resident 11 informed her that Resident 57 was reaching for her walker. She stated, "[Name of Resident 11] does yell at people a lot." An observation and interview were conducted with CNA 25 on 6/17/24 at 2:00 p.m. in the hallway near the nurse's station. Resident 57 was standing in the hallway near Resident 51. CNA 25 indicated Resident 57 just smacked Resident 51 on the shoulder. Resident 57 was redirected down the hallway by staff.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	An interview was conducted with CNA 25 on 6/17/24 at 2:02 p.m. She indicated she'd worked at the facility since March 2023. Resident 57's attitude and anger had increased lately, but never physically saw her hit anyone prior to her hitting Resident 51 in the hallway on 6/17/24 at 2:00 p.m. As far as the unit's physical set-up was concerned, she thought she was able to monitor the residents efficiently, as she was always on guard, and her head was going "in a million directions." Usually, they tried to have three CNAs and one nurse working on the unit during the day. There were some days when they didn't run that way, due to staffing issues. There were only two CNAs working on 6/6/24. The nurses needed to do "activities and stuff" after they finished passing medications to assist with monitoring the residents. Two of the regular nurses would do that, but two of them wouldn't, so it just depended on who was working. Their ACD (Alzheimer's Care Director) was "not normally" on the floor and helping out. She was usually in her office, which was on another unit, or running around the facility. On 6/17/24 at 2:21 p.m., a commotion was heard coming from the dining room. Upon entrance to the dining room, it was determined Resident 57 just hit Resident 14. CNA 27 was present in the dining room for a baking activity. An interview was conducted with CNA 27 on 6/17/24 at 2:22 p.m. She indicated Resident 57 just punched Resident 14 in the shoulder. She heard Resident 14's wheelchair hit the wall first, and when she looked around the corner from the stove, she saw Resident 57 punch him. Resident 57 was "getting ready to do it again," but she was able to intervene in time. She indicated she			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	thought the unit needed to "be more open back here," as "I don't care to chase everyone around." When the residents are out and about the unit, the staff go "back and forth" between the sunroom, the dining room, the back dining room, and down the hallway. It was more difficult to monitor with the set up. The clinical record for Resident 11 was reviewed on 6/18/24 at 11:00 a.m. The diagnoses included, but were not limited to, vascular dementia and anxiety. The 5/18/24 Quarterly MDS assessment indicated she was severely cognitively impaired. The 8/23/23 behavior care plan indicated she had a history of being confrontational and yelling at others. The goal was for her aggression to not cause harm to herself or others. Interventions were to not allow a lot of people to approach her at one time; during episodes of behaviors, to please redirect her by approaching slowly and speaking to her in a calm and steady voice, trying to redirect her to an alternative activity or topic of discussion; encourage activity and/or exercise that would allow her to release some energy; encourage her to get involved in activities related to her interests; remove any residents in the immediate area that may be in danger if she did become aggressive; if she and those around her were safe, to not bother her until she calmed down; medicate per physician orders and observe for possible side effects; refer her to mental health services as needed; provide a quiet, nonthreatening environment with decreased stimulation; slowly assess her needs such as toileting, hunger, thirst, and/or pain; and for staff to stay pleasant and in a non-defensive nature while being firm but not loud.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	5. The clinical record for Resident 57 was reviewed on 6/13/24 at 1:35 p.m. Her diagnosis included, but were not limited to, Alzheimer's disease. The 3/12/24 Quarterly MDS assessment indicated she was short tempered, easily annoyed for 12-14 days, nearly every day over the last 2 weeks. 6. The clinical record for Resident 67 was reviewed on 6/13/24 at 1:30 p.m. Her diagnosis included, but were not limited to, Alzheimer's disease. The 10/28/22 behavior care plan, last revised 3/19/24, indicated she had little, or no awareness of safety or boundaries related to other's personal space, going into other resident's rooms, wandering about my living space. The goal was for her to continue to wander freely as she desired within the safety parameters of a secured, specialized unit. An intervention for when she wandered into other people's rooms was to gently redirect her with the suggestion of visiting at another time; offer her another place to visit. During an observation, on 6/17/24 at 2:26 p.m., Resident 67 was observed wandering around in another resident's room, while the other resident was asleep in her recliner. There were no staff present to observe this, so CNA 25 was informed of Resident 67's presence in the room. During an interview with LPN 5, on 6/17/24 at 3:00 p.m., he indicated the layout of the unit was "definitely a challenge for me," the way the nurse's desk was located and the layout of the unit. It was kind of "hard to keep track of the residents and see everything that's going on."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155264	A. BUILDING 00 B. WING	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - GOLDEN RULE CARE CENTER	2330 STRAIGHT LINE PIKE RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The Behavioral Health Services policy was provided by the DON on 6/17/24 at 11:08 a.m. It indicated, "The resident, and as appropriate the resident's family, are included in the comprehensive assessment process along with the interdisciplinary team and outside sources, as indicated. The care plan shall: ...Be reviewed and revised as needed, such as when interventions are not effective or when the resident experiences a change in condition." The Dementia Care policy was provided by the DON on 6/19/24 at 3:00 p.m. It read, "It is the policy of this facility to provide the appropriate treatment and services to every resident who displays signs of, or is diagnosed with dementia, to meet his or her highest practicable physical, mental, and psychosocial well-being....1. The facility will assess, develop, and implement care plans through an interdisciplinary team (IDT) approach that includes the resident, their family, and/or resident representative, to the extent possible....6. If needed, the environment will be modified to accommodate individual resident care needs. 7. The care plan goals and interventions will be monitored on an ongoing basis for effectiveness, and will be reviewed/revised as necessary. 8. Appropriate referrals will be made if current interventions are ineffective or resident shows a decline in psychosocial, mood, or behavioral status (i.e. physician, mental health provider, licensed counselor, pharmacist, social worker)." 3.1-37(a)			