STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155686	A. Building B. Wing	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brickyard Healthcare - Knox Care Center	300 E Culver Rd Knox, IN 46534

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, record review, and interview, the facility failed to ensure care plans were implemented and/or updated for 1 of 15 resident care plans reviewed. (Resident 43) Finding includes: On 3/30/25 at 10:38 a.m., Resident 43 was observed lying in bed. There was a dime-sized scabbed area to his left upper cheek/temple area. The resident indicated he was unsure what happened or how long the scabbed area had been there. On 3/31/25 at 3:05 p.m., Resident 43 was observed lying in bed. The scabbed area remained to his left upper cheek/temple area. On 4/1/25 at 8:58 a.m., Resident 43 was observed lying in bed. The scabbed area remained to his left upper cheek/temple area. The record for Resident 43 was reviewed on 4/1/25 at 2:57 p.m. Diagnoses included, but were not limited to, dementia, type 2 diabetes mellitus, and hypertension. The Annual Minimum Data Set (MDS) assessment, dated 1/3/25, indicated the resident was cognitively impaired and required staff assistance with activities of daily living (ADLs). A Care Plan, dated 11/7/24, indicated the resident had a scab to the left temporal area. The interventions included to monitor the area and document weekly. There was a lack of documentation of any skin-picking behaviors by the resident or why the scabbed area remained unhealed. A Skin Check Note, dated 3/27/25, indicated the resident had a scab to the left temporal area measuring 2 cm (centimeters) by 1 cm. The wound was acquired in house and was greater than 3 months old. It was previously improving but progress had stalled. There was a lack of documentation of any skin-picking behaviors by the resident or why the scabbed area remained unhealed. During an interview on 4/2/25 at 1:47 p.m., the Director of Nursing (DON) indicated the resident had the scabbed area for a while now and would pick at the area frequently. She thought the skin-picking behaviors had been documented and care planned but was unable to provide any documentation. A treatment had been attempted to the area but was discontinued due to the resident continually picking at the area. 3.1-35(c)(1)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on record review and interview, the facility failed to ensure residents received necessary care and services, related to lack of monitoring of sleep patterns per the care plan for 1 of 1 resident reviewed for care planning. (Resident 22) Finding includes: On 3/30/25 at 10:48 a.m., Resident 22 indicated she had been having difficulty sleeping at night and it had been ongoing since she had her trazodone (antidepressant) discontinued. Resident 22's record was reviewed on 4/1/25 at 1:12 p.m. Diagnoses included, but were not limited to, major depressive disorder, insomnia, and seizures. The Quarterly Minimum Data Set (MDS) assessment, dated 1/6/25, indicated the resident was cognitively intact. She had received antidepressant, opioid, and anticonvulsant medications during the 7-day look back period. The Physician Order Summaries indicated the resident had an order for trazodone 150 milligram (mg) one tablet in the evening which was started on 12/4/24 and discontinued on 5/20/24. On 5/20/24, a new order was started for trazodone 100 mg one tablet in the evening, which was discontinued on 6/3/24. On 6/3/24, a new order was started for trazodone 50 mg one tablet in the evening, which was discontinued on 6/17/24. A Care Plan, updated on 12/10/24, indicated the resident was at risk for sleep pattern disturbance related to insomnia or not being able to sleep. Interventions included, but were not limited to, administer sleep medications as ordered by the physician, assess for side effects, and assess usual pattern of sleep. A Care Plan, updated on 12/10/24, indicated the resident had depression related to a major depressive disorder diagnosis. Interventions included, but were not limited to, administer medications as ordered and provide psychiatry consult if indicated. A Psychiatry Progress Note, dated 3/17/25, indicated the resident continued to report ongoing concerns with sleep and depression. The diagnoses and plan indicated the resident had sleep disorder and staff were monitoring sleep patterns due to reports of poor sleep. The record lacked documentation of any monitoring of sleep patterns. During an interview on 4/1/25 at 4:00 p.m., the Director of Nursing indicated she was not aware the resident was having complaints of trouble sleeping. There was no documentation in the record for monitoring of the resident's sleep patterns. 3.1-37(a)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review, the facility failed to ensure indwelling Foley (urinary) catheter tubing was kept off of the floor for a resident with a history of urinary tract infections (UTIs) for 1 of 1 resident reviewed for urinary catheters. (Resident 46) Finding includes: Resident 46 was observed on 3/31/25 at 3:35 p.m., 3:44 p.m., and 4:14 p.m. sitting in a manual wheelchair in the East Hall near the nurses' station. The catheter collection bag was hanging in a dignity bag under the chair. The tubing was touching the floor. During observations of the resident, a nursing staff member was sitting at the nurses' station across from the resident and a medication pass administration observation was ongoing from 3:35 p.m. to 3:55 p.m. with QMA 1 in the same hall. Resident 46's record was reviewed on 4/1/25 at 9:14 a.m. Diagnoses included, but were not limited to, chronic kidney disease, history of urinary tract infections, and retention of urine. The admission 5-day Minimum Data Assessment, dated 3/9/25, indicated the resident was severely cognitively impaired and had an indwelling catheter. The April 2025 Physician Order Summary indicated the resident had a urinary catheter and was currently taking macrobid (antibiotic) 100 mg, one capsule twice a day for a urinary tract infection (UTI) for 7 days. A Care Plan, dated 3/4/25, indicated the resident had an indwelling urinary catheter. Interventions included, but were not limited to, provide catheter care per orders, monitor for signs and symptoms of UTI, and monitor intake and output. On 3/31/25 at 4:25 p.m., the Director of Nursing was notified of the catheter on the floor. She indicated the catheter dignity bag needed to be adjusted so that it hung higher under the chair, she immediately took the resident to her room so that she could adjust the bag and get the tubing off of the floor. A policy related to catheters was received and was not applicable to the concern. 3.1-41(a)(2)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure timely follow up on dietary recommendations was completed for a resident with a history of weight loss for 1 of 3 residents reviewed for nutrition. (Resident 38) Finding includes: Resident 38's record was reviewed on 3/31/25 at 1:37 p.m. Diagnoses included, but were not limited to, chronic kidney disease and heart failure. The resident admitted to the facility on [DATE], discharged on 2/25/25, and was re-admitted on [DATE]. The admission Minimum Data Set (MDS) assessment, dated 3/5/25, indicated the resident was severely cognitively impaired and had weight loss while not on a prescribed weight-loss regimen. A Care Plan, updated on 3/5/25, indicated the resident had a potential nutritional problem related to a diet restrictions, weight loss over the last 30 days, and the resident having a large weight loss between discharge home and readmission. Interventions included, but were not limited to, administer medications as ordered, monitor intake and record every meal, and the Registered Dietician was to evaluate and make diet change recommendations as needed. The resident weighed 244.6 pounds (lbs) on 2/7/25, 205.8 lbs on 2/28/25, and 218 lbs on 3/28/25. A Physician Order, dated 2/28/25, indicated no salt packet diet, regular texture and regular consistency. A Nutrition Assessment, dated 3/4/25, indicated a recommendation for 30 milliliters ProT gold daily (a protein supplement) due to skin impairments and ice cream at lunch to aid with weight maintenance. There were no updated dietary or physician's orders related to ProT gold daily or ice cream at lunch. During an interview on 4/1/25 at 1:35 p.m., the Director of Nursing (DON) indicated the Registered Dietician sent email updates regarding any new recommendations. The DON did not recall receiving any update around that time for the resident so the recommendations were not implemented. A policy titled, Nutritional Management, revised on 1/1/25, indicated .4. Monitoring/revision .e. Nutritional recommendations may be made by the dietitian based on the resident's preferences, goals, clinical condition or other factors and followed up with the physician/practitioner for orders as per facility policy, if indicated. Best practice to address RDN recommendations is within ~72 hours . 3.1-46(a)(1) 3.1-46(a)(2)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and interview, the facility failed to maintain clinical records that were complete and accurately documented related to the lack of documentation prior to a urinalysis being completed on a resident for 1 of 1 resident reviewed for UTIs (urinary tract infections). (Resident 9) Finding includes: Record review for Resident 9 was completed on 4/1/25 at 2:20 p.m. Diagnoses included, but were not limited to, hypertension, diabetes mellitus, and dementia. The Quarterly Minimum Data Set assessment, dated 1/9/25, indicated the resident was moderately cognitively impaired. The resident had an indwelling urinary catheter. A Care Plan, dated 11/20/24, indicated the resident had an indwelling urinary catheter related to obstructive and reflux uropathy. An intervention included to monitor/record/report to physician any signs or symptoms of UTI which included: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse,increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, or change in eating patterns. A Progress Note, dated 3/19/25 at 2:13 p.m., indicated the urinalysis was reviewed by the physician. A new order for an antibiotic was received. There was a lack of documentation in the Progress Notes or Assessments prior to 3/19/25 to indicate why the urinalysis was completed. During an interview on 4/1/25 at 4:00 p.m., the Director of Nursing indicated the urinalysis was completed on the resident because he was not acting like himself. The urine in his catheter tube and bag was cloudy and discolored, he was pale, and he complained of back pain. They completed the urinalysis and the resident had met the criteria for an antibiotic. There was no documentation she could provide that was completed before the note about the urinalysis results on 3/19/25. 3.1-50(a)(2)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented related to not changing gloves and performing hand hygiene during a wound treatment for 1 of 2 residents reviewed for pressure ulcers. (Resident 14) Finding includes: On 4/1/25 at 8:57 a.m., LPN 1 was observed completing Resident 14's wound care. She donned a gown and gloves, removed the resident's left heel protector boot and sock, removed her gloves and washed her hands. She donned new gloves and cleaned the resident's left heel wound. She then applied the treatment to the wound. After completing the treatment, she removed her gloves and washed her hands. LPN 1 had not changed her gloves or performed hand hygiene after cleaning the wound and before applying the treatment to the wound. During an interview on 4/1/25 at 9:40 a.m., the Director of Nursing (DON) indicated LPN 1 told her she thought she had changed her gloves after cleaning the wound. A facility policy, titled Clean Dressing Change, provided by the DON as current, indicated, .12. Cleanse the wound as ordered, taking care to not contaminate other skin surfaces or other surfaces of the wound .Pat dry with gauze .14. Perform hand hygiene and put on clean gloves. 15. Apply topical ointments or creams and dress the wound as ordered. Protect surrounding skin as indicated with skin protectant .17. Discard disposable items and gloves into appropriate trash receptacle and perform hand hygiene . 3.1-18(b)