STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155109	A. Building B. Wing	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brickyard Healthcare - Twelfth Street Care Center	811 E 12th Street Mishawaka, IN 46544

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 34966 Based on interview and record review, the facility failed to ensure the physician was notified in a timely manner when a resident was given a medication in the incorrect form, refused all medications for six consecutive medication passes and experienced a decline in level of consciousness, for 1 of 3 residents review for medication administration. (Resident B). Finding includes: On 3/17/25 at 11:28 A.M., Resident B's medical record was reviewed. Diagnoses included, but were not limited to: history of stroke, seizures, heart failure, hypertension, diabetes, hyperlipidemia, dementia, chronic obstructive pulmonary disease, other symptoms involving emotional state. A Quarterly Minimum Data Set (MDS) assessment, dated 2/5/25, indicated Resident B was severely cognitively impaired, was sometimes able to make his his needs and ideas known and had rejected care 1 to 3 days in the 7 day look back period of the assessment. Physician orders for medications and supplements included- Glyburide 5 mg tablet 2 times daily for type 2 diabetes Ploglitazone HCL 15 mg tablet 1 time daily for type 2 diabetes Sitaglipin Phosphate 100 mg tablet every evening for type 2 diabetes Steglatro 15 mg tablet every evening for type 2 diabetes Fluvoxamine Maleate 100 mg tablet at bedtime for Obsessive-compulsive disorder Geodon 40 mg capsule at bedtime for psychiatric condition Seroquel 25 mg tablet at bedtime for vascular dementia Aricept 10 mg tablet 1 time daily for dementia Doxepin HCL 10 mg capsule at bedtime for memory (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Furosemide 40 mg tablet every 24 hours as needed for extremity swelling Trelegy Ellipta inhalation Aerosol Powder Breath Activated, 1 puff inhale every afternoon for chronic obstructive pulmonary disease Hydralazine HCL 100 mg tablet 2 times daily for hypertension Lorsartan Potassium 100 mg tablet daily for hypertension Metoprolol Tartrate 50 mg tablet 2 times daily for hypertension Nifedipene extended release 90 mg tablet every morning for hypertension Spironolactone 25 mg tablet daily for hypertension Depakote ER (extended release) 500 mg tablet, 2 tablets 2 times daily Aspirin 81 mg tablet every evening for pain related to stroke and hypertension Atorvastatin Calcium 80 mg tablet daily for hyperlipidemia Flonase nasal suspension 1 spray in each nostril daily for allergic rhinitis Gabapentin 300 mg capsule 3 capsules 3 times daily for neuropathy Megestrol Acetate Suspension 20 milliliter in the morning for anorexia 2 cal supplement 60 ml 4 times daily with medications Methotrexate Sodium 6 -2.5 mg tablets every Monday for Rheumatoid Arthritis. A review of Resident B's Medication Administration Record (MAR) from 3/1/25 to 3/3/25, indicated the resident did not receive any of the prescribed medication as follows: On 3/2/25 charted as not given due to nausea and vomiting- 8:00 P.M., Doxepin, Fluvoxamine, Geodon, 9:00 P.M., Seroquel, Depakote ER, Glyburide, Hydralazine, Metoprolol Tartrate, Gabapentin, 2 cal supplement. On 3/3/25 charted as resident refusals- 9:00 A.M., Aricept, Flonase, Depakote ER, 2 cal supplement, 11:00 A.M., Atorvastin, Losartan, Megestrol, Methotrexate, Nifedipine, Pioglitazone, Spironolactone, Glyburide, Hydralazine, Metoprolol Tartrate, (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1:00 P.M., Trelegy Ellipta, 2 cal supplement, 2:00 P.M., Gabapentin. Review of the resident's nursing progress notes included no notes of any kind on 3/2/25. There were no progress notes regarding the resident's condition until 3/3/25 at 3:00 P.M. that indicated the Nurse Practitioner was called at the request of the resident's representative and orders given for a STAT (immediate) Valproic acid (Depakote) blood level because the resident was unresponsive and not eating. On 3/3/25 at 3:05 P.M., a nursing progress note indicated the lab company did not have available staff for a STAT blood collection so the resident's representative requested the resident be sent to the hospital and RN 6 notified the Nurse Practitioner and received an order to send the resident to the hospital. A Nursing progress note, on 3/3/25 at 3:52 P.M., indicated Resident B was transported via a local ambulance service to a local hospital for an evaluation and treatment. Review of the Prehospital Care Report Summary from the ambulance service, dated 3/3/25 from 2:47 P.M. to 3:23 P.M., indicated the onset of Resident B's condition began on 3/2/25 at 11:00 P.M. and the resident had been reported as semi-responsive for 3 days. The Narrative History Text indicated, .Nurse relays that the pt [patient, Resident B] started to become less responsive on the 28th and the nurse relays that they were administering his Depakote wrong. Nurse further relays that pt has not been given any of his medications today due to his responsiveness. Nurse relays that she believed that the pts Depakote levels are too high. Review of Resident B's Emergency Department Note dated 3/3/25 at 10:13 P.M., indicated, .apparently on the past Friday he was receiving doses of Depakote and there is a possibility that he was receiving the wrong dose . Physical examination at 4:36 P.M. indicated an elevated blood pressure of 190/82. and his blood glucose level was 18 mg/DL (milligrams/deciliter) which was corrected after treatment. The Valproic acid level (blood test to determine Depakote level) was within normal range. The Clinical Impression from the Emergency Department assessment indicated Resident B was hypoglycemic (low blood sugar), and had unspecified altered mental status. During an interview on 3/18/25 at 11:00 A.M., LPN 4 indicated Resident B was very difficult to arouse on 3/3/24 and did not take his medications that day because he was not alert enough to take them. LPN 4 indicated the resident had been sleeping more and had been declining for the past few days. LPN 4 indicated she did not notify the physician or the Nurse Practitioner of the residents lack of responsiveness or that he had not been taking his medication, but did report the issues to the Unit Manager, RN 6. LPN 4 indicated she had been checking his vital signs and they had remained within normal limits. There was no documentation LPN 4 had assessed Resident B ' s blood sugar level, even though the resident had a diagnosis of diabetes and had not been eating. (continued on next page)

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/18/25 at 11:03 A.M., RN 6 indicated on 3/3/25, sometime in the afternoon, LPN 4 requested that she see Resident B. RN 6 indicated the resident's responsible party was upset and concerned that the resident was difficult to arouse. RN 6 indicated she had worked the day shift on 3/3/25 and it had been reported to her that Resident B was very sleepy and had not gotten up for breakfast or lunch and had not taken his medications. RN 6 indicated she notified the Nurse Practitioner of the responsible party's concern and had received an order for Depakote levels per the responsible party's request. and the NP had informed her that if the family was adamant about sending him to the ER, they could send him out. During an interview on 3/18/24 at 11:14 A.M., QMA 2 indicated she was Resident B's QMA on 3/3/25 from 7:00 A.M. to 3:00 P.M. QMA 2 indicated the resident refused his meals and medications on 3/3/25 and she had notified LPN 4 of the refusals. During an interview on 3/19/25 at 10:00 A.M., Registered Nurse (RN) 5, indicated Resident B had been having trouble swallowing his medications and so she had crushed his DepakoteER on the evening of 2/28/25. RN 5 indicated she was not aware that Depakote ER was not supposed to be crushed and had reported to RN 6, who was the Unit Manager, that she had crushed the Depakote ER. RN 5 indicated on 3/2/25 she worked 7:00 P.M. to 7:00 A.M. with Qualified Medication Aide (QMA) 1. RN 5 indicated QMA 1 reported to her that Resident B did not receive his night medications because after she gave them to him, he spit them out refusing to take them. She indicated the resident did not have nausea or vomiting and QMA 1 incorrectly charted nausea and vomiting. RN 5 indicated she should have documented the incident in the progress notes but did not. On 3/18/25 at 10:30 A.M., the Director of Nursing provided an undated policy titled, Notification of Changes, and indicated it was the current facility policy. The policy indicated, .The purpose of this policy is to ensure the facility promptly informs .the resident's physician .when there is a change requiring notification . Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health . This citation relates to Complaint IN00455136 3.1-5(a)(2)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34966 Based on interview and record review, the facility failed to ensure a comprehensive care plans related to type 2 diabetes, seizures, bipolar disorder, congestive heart failure and anxiety were in place for 1 of 3 residents reviewed for care plans, (Resident B) Finding includes: On 3/17/25 at 11:28 A.M., Resident B's medical record was reviewed. Upon admission in September 2024, Resident B had diagnoses which included type 2 diabetes, cerebral infarction (stroke) with other symptoms and signs involving emotional state, vascular dementia, congestive heart failure, chronic obstructive pulmonary disease, hypertension, and seizures. A Quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated Resident B had diagnoses that included stroke, heart failure, hypertension, diabetes, hyperlipidemia, dementia, chronic obstructive pulmonary disease, other symptoms involving emotional state. The assessment indicated the resident received the following High risk medications: antipsychotics, antidepressants, and a diuretic. Review of the resident's MDS dated [DATE] for A Discharge MDS assessment dated [DATE], indicated Resident B was also taking hypoglycemic medications. Physician's orders for medications, included the following: -Glyburide 5 mg tablet 2 times daily for type 2 diabetes, with a start date of 9/26/24. -Ploglitazone HCL 15 mg tablet 1 time daily for type 2 diabetes, with a start date of 9/26/24. -Sitaglipin Phosphate 100 mg tablet every evening for type 2 diabetes, with a start date of 9/26/24. -Steglatro 15 mg tablet every evening for type 2 diabetes, with a start date of 9/26/24. -Fluvoxamine Maleate 100 mg tablet at bedtime for Obsessive-compulsive disorder, with astart date of 11/1/24. -Geodon 40 mg capsule at bedtime for psychiatric condition, with a start date of 10/25/24. -Seroquel 25 mg tablet at bedtime for vascular dementia, with a start date of 11/6/24. -Aricept 10 mg tablet 1 time daily for dementia, with a start date of 1/20/25. -Doxepin HCL 10 mg capsule at bedtime for memory, with a start date of 9/30/24. -Furosemide 40 mg tablet every 24 hours as needed for extremity swelling, with a start date of 9/27/24. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Trelegy Ellipta inhalation Aerosol Powder Breath Activated, 1 puff inhale every afternoon for chronic obstructive pulmonary disease, with a start date of 11/29/24. -Ventolin HFA inhalation aerosol solution 2 puffs inhale every 3 hours as needed for shortness of breath related to obstructive pulmonary disease, with a start date of 9/26/24. -Hydralazine HCL 100 mg tablet 2 times daily for hypertension, with a start date of 9/27/24. -Lorsartan Potassium 100 mg tablet daily for hypertension, with a start date of 9/27/24. -Metoprolol Tartrate 50 mg tablet 2 times daily for hypertension, with a start date of 10/3/24. -Nifedipene extended release 90 mg tablet every morning for hypertension, with a start date of 9/26/24. -Spironolactone 25 mg tablet daily for hypertension, with a start date of 9/26/24. -Depakote extended release 500 mg tablet, 2 tablets 2 times daily, with a start date of 12/3/24. Resident B had no care plans in place to address these conditions nor the medications listed above. During an interview on 3/18/24 at 2:10 P.M., the Minimum Data Set (MDS) nurse, indicated Resident B did not have care plans for diagnoses of type 2 diabetes, cerebral infarction with other symptoms and signs involving emotional state, vascular dementia, congestive heart failure, chronic obstructive pulmonary disease, hypertension, and seizures. The MDS nurse indicated the care plans should have been in place for all diagnoses on admission and for the associated medications when the medications were prescribed. On 3/18/25 at 10:30 A.M., the Director of Nursing provided an undated policy titled, Comprehensive Care Plans, and indicated it was the current facility policy. The policy indicated, .It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident .that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial need and ALL services that are identified in the resident's comprehensive assessment .the comprehensive care plan will describe, at a minimum, .The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . This citation relates to Complaint IN00455136. 3.1-35(a)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34966 Based on interview and record review the facility failed to ensure Physician Orders were in place for the treatment of low blood glucose and failed to ensure hypoglycemia was assessed timely for 1 of 3 residents reviewed for diabetic treatment, (Resident B). Finding includes: On 3/17/25 at 11:28 A.M., Resident B's medical record was reviewed. Diagnoses included history of stroke, seizures, heart failure, hypertension, diabetes, hyperlipidemia, dementia, chronic obstructive pulmonary disease, other symptoms involving emotional state. A Quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated Resident B was severely cognitively impaired and was sometimes able to make his his needs and ideas known. Physician's orders included the following medications: -Glyburide 5 mg tablet 2 times daily for type 2 diabetes, ordered 9/26/24. -Ploglitazone HCL 15 mg tablet 1 time daily for type 2 diabetes, ordered 9/26/24. -Sitaglipin Phosphate 100 mg tablet every evening for type 2 diabetes, ordered 9/26/24. -Steglatro 15 mg tablet every evening for type 2 diabetes, ordered 9/26/24. There were no orders for hypoglycemia management and no plan of care to address Resident B 's diabetes diagnosis. Review of the resident's nursing progress notes indicated on 3/3/25 at 3:00 P.M., the Nurse Practitioner was notified by Registered Nurse (RN) 6, that Resident B's family wanted the resident sent to the hospital because he was not very responsive. On 3/3/25 at 3:52 P.M., Resident B was transported via local ambulance service to a local hospital for an evaluation and treatment. Review of Resident B's Emergency Department Note, dated 3/3/25 at 10:13 P.M., indicated the resident had a blood glucose of 18 mm/dl. The Clinical Impression indicated the Resident B was hypoglycemic (had low blood sugar) and had unspecified altered mental status. During an interview on 3/18/25 at 11:00 A.M., LPN 4 indicated Resident B was very difficult to arouse on 3/3/24 and did not take his medications that day because he was not alert enough to take them. LPN 4 indicated the resident had been sleeping more and had been declining for the past few days. LPN 4 indicated she had not notified the physician or the Nurse Practitioner of the resident 's lack of responsiveness or that he had not been taking his medication, but she had reported Resident B 's condition to the Unit Manager, RN 6. LPN 4 indicated she was checking his vital signs routinely and they had remained within normal limits, but she had not checked the resident ' s blood sugar. (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/18/25 at 11:03 A.M., RN 6 indicated on 3/3/25, sometime in the afternoon, LPN 4 had requested that she go see Resident B. RN 6 indicated the resident's responsible party was present and they were upset and concerned that the resident was difficult to arouse. RN 6 indicated she had worked the day shift on 3/3/25 and it had been reported to her that Resident B was very sleepy, and had not gotten up for breakfast or lunch and had not taken his medications. RN 6 indicated she notified the Nurse Practitioner of the responsible party's concern, on 3/3/35 at 3:00 P.M. and had received an order to send the resident to the emergency room (ER), per the family's request. During an interview on 3/18/24 at 11:14 A.M., QMA 2 indicated she was Resident B's QMA on 3/3/25 from 7:00 A.M. to 3:00 P.M. QMA 2 indicated the resident had refused his meals and medications on 3/3/25 and she had notified LPN 4 of the refusals. On 3/18/25 at 3:30 P.M., the Director of Nursing provided an undated policy titled, Hypoglycemia Management, and indicated it was the current facility policy. The policy indicated, .The facility will identify residents that are at risk for hypoglycemia and observe them for signs and symptoms of low blood sugar . Residents that have a diagnosis of diabetes or on medications that could lower the blood sugar should have orders for glucose monitoring and treatment of hypoglycemia .a bedside blood glucose test should be administered for any resident reporting or experiencing symptoms of hypoglycemia such as .Confusion . Feeling sleepy, Weakness or having no energy . This citation relates to Complaint IN00455136 3.1-37(a)