STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155136	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brickyard Healthcare - Terrace Care Center	1900 Andrew Ave LA Porte, IN 46350

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 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 observation, record review, and interview, the facility failed to administer medications as ordered related to not following pain indicator parameters for 1 of 3 residents reviewed for medication administration. (Resident C) Finding includes: Resident C's record was reviewed on 6/11/26 at 10:00 a.m. The diagnoses included, but were not limited to, dementia, high blood pressure, COPD, depression, and anxiety. The Quarterly Minimum Data Set (MDS) assessment, dated 5/11/26, indicated the resident was severely impaired for daily decision making. Eating and oral hygiene required substantial to maximum assistance. All other Activities of Daily Living (ADLs) required dependent care. A Physician's Order, dated 2/4/25, indicated to administer Morphine Sulfate 0.25 milliliters every four hours as needed for severe pain rated seven to ten, or for shortness of breath (SOB). The Medication Administration Record (MAR) was reviewed from April 2026 through June 2026. The PRN order for Morphine indicated to administer for severe pain rated from seven to ten. The following dates did not have a pain rating of seven or higher and did not indicate SOB before administered. April 8, 12, 19, 20, and 22, 2026May 13, 15, and 19, 2026June 3, 6, and 9, 2026 A Care Plan, revised on 5/20/26, indicated the resident had impaired cognitive function/dementia. Interventions were to administer medications as ordered and observe for side effects and effectiveness. During an interview on 6/11/26 at 2:57 p.m., the Director of Nursing indicated she understood the concern and had no additional information to provide. This citation relates to Intake 3017728. 410 IAC (Indiana Administrative Code) 16.2-3.1-37(a)

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