STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155137	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brickyard Healthcare - Valparaiso Care Center	251 Sturdy Rd Valparaiso, IN 46383

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record review and interview, the facility failed to ensure an indication or reason for use was documented prior to administering a PRN (as needed) anti-anxiety medication for 1 of 5 residents reviewed for unnecessary medications. (Resident 42)Finding includes:The record for Resident 42 was reviewed on 7/24/25 at 10:59 a.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance, psychotic disorder with delusions, and anxiety disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 6/5/25, indicated the resident was cognitively impaired and received anti-anxiety medications. A Physician's Order, dated 7/14/25, indicated lorazepam (Ativan, an anti-anxiety medication) 2 mg/ml (milligrams/milliliter), give 0.5 ml by mouth every 2 hours as needed for anxiety, insomnia or shortness of breath. A Care Plan, updated on 7/24/25, indicated the resident used anti-anxiety medication. The Medication Administration Record (MAR), dated 7/2025, indicated the lorazepam was administered without any indication or reason for use documented on the following dates and times:-7/19/25 at 3:00 p.m.-7/20/25 at 3:00 p.m.-7/22/25 at 7:20 a.m., 1:00 p.m., and 3:32 p.m.-7/23/25 at 8:25 a.m. and 10:42 a.m. During an interview on 7/25/25 at 10:22 a.m., the Administrator indicated she was unable to provide any further documentation as to why the medication had been administered. A policy, titled PRN Medications, received from the Administrator as current, indicated .1. Documentation will be provided in the resident's medical record to show adequate indications for a medication's use and diagnosed condition for which it was prescribed.3. When administering a PRN medication.b. Document the reason voiced by the resident and/or assessment findings that show why the resident needs the medication. Verify the reason is for the prescribed indication for the medication. 3.1-48(a)(4)

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on observation, record review, and interview, the facility failed to ensure the Minimum Data Set (MDS) assessment was accurately completed related to wandering behaviors for 1 of 18 MDS assessments reviewed. (Resident 78) Finding includes: On 7/21/25 at 1:08 p.m., Resident 78 was observed wandering in a hallway unaccompanied by any staff. He was headed towards a side entrance door. He was unable to open the door and then continued to enter another resident's room. Resident 78's record was reviewed on 7/23/25 at 3:24 p.m. Diagnoses included, but were not limited to, Alzheimer's Disease with late onset, dementia, and generalized anxiety disorder. The Discharge Minimum Data Set (MDS) assessment, dated 6/25/25, indicated the resident was moderately cognitively impaired and had inattention and disorganized thinking that fluctuated. Over the 7-day look-back period, the resident displayed physical behavioral symptoms for 1-3 days and other behavioral symptoms that were not directed towards others for 4-6 days. The Wandering - Presence and Frequency section indicated the resident had no wandering behaviors. The current care plans indicated the resident had Alzheimer's disease and was an elopement risk and was to wear a Wander Guard (bracelet sensor that alarms when too close to an exit or set perimeter). He had a behavior problem of making sexually inappropriate comments and wandering into other residents' rooms attempting to take personal items. The Progress Notes from the 7-day look-back period indicated the resident was wandering in the hallways on 6/17/25 at 9:33 a.m., 6/18/25 at 1:02 a.m., 6/21/25 at 8:54 a.m., 6/21/25 at 10:52 a.m., and 6/25/25 at 10:49 a.m. During an interview on 7/24/25 at 1:09 p.m., the MDS Coordinator and Administrator indicated the wandering behavior should have been marked on the MDS assessment. 3.1-31(c)(7)

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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 record review and interview, the facility failed to ensure care plans were implemented for 1 of 18 resident care plans reviewed. (Resident 13) Finding includes: Resident 13's record was reviewed on 7/24/25 at 11:35 a.m. Diagnoses included, but were not limited to, paranoid schizophrenia, bipolar disorder, sleep disorder, and generalized anxiety disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 6/28/25, indicated the resident was moderately cognitively impaired. He had no behavioral symptoms. He received a scheduled pain medication regimen, antipsychotic, antianxiety, antidepressant, diuretic, antiplatelet, and anticonvulsant medications. A Physician's Order, dated 4/14/25, indicated Depakote (anticonvulsant) sprinkles oral capsule 125 mg, 4 capsules (500 mg) in the morning and 8 capsules (1000 mg) at bedtime. A Physician's Order, dated 6/24/25, indicated risperidone (antipsychotic) 1 milligram (mg) twice daily. The resident's current care plans indicated he was at risk for falls, risk for pain, received antianxiety medications, antidepressant medications, antiplatelet therapy, and had a mood problem related to his diagnosis of paranoid schizophrenia and bipolar disorder. There were no care plans implemented related to the resident receiving antipsychotic or anticonvulsant medications. During an interview on 7/25/25 at 9:25 a.m., the Administrator and Nurse Consultant indicated the care plans should have been in place for the anticonvulsant and antipsychotic medication use. A policy titled, Comprehensive Care Plans, indicated .3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished wto attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . 3.1-35(c)(1)

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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 physician's orders were followed for a respiratory assessment with administration of an as needed (PRN) nebulizer treatment for 1 of 5 resident's reviewed for unnecessary medications. (Resident 13) Finding includes: Resident 13's record was reviewed on 7/24/25 at 11:35 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease and heart failure. The Quarterly Minimum Data Set (MDS) assessment, dated 6/28/25, indicated the resident was moderately cognitively impaired. He had no behavioral symptoms. He received a scheduled pain medication regimen, antipsychotic, antianxiety, antidepressant, diuretic, antiplatelet, and anticonvulsant medications. The current July 2025 Physician's Order Summary indicated ipratropium-albuterol solution (nebulizer treatment to help open airways) 0.5-2.5, 3 milligrams/3 milliliters, inhale orally every 6 hours as needed, documentation to be completed after nebulizer treatment: record minutes, document vital signs and lung sounds before the nebulizer treatment. The ipratropium-albuterol nebulizer treatment was administered on 6/14/25 at 1:40 p.m. and 6/15/25 at 9:14 a.m. There was no documentation of the vital signs and lung sounds before the nebulizer treatment was administered. During an interview on 7/25/25 at 9:25 a.m., the Administrator and Nurse Consultant indicated they were unable to find any documentation of an assessment prior to the administration of the treatments. The orders were put in separately, so the nurses were not prompted to do the assessment and fill it out upon administration. A policy titled, Nebulizer Therapy, indicated .6. Obtain resident's vital signs and perform respiratory assessment to establish a baseline .Documentation .record the following information in the resident's medical record .1. Date, time, and duration of therapy 2. Type and amount of medication 3. Oxygen flow if administered 4. Resident vital signs and respiratory assessment 5. Resident's response to treatment 6. Any resident teaching provided and the resident's understanding of the treatment . 3.1-37(a)

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F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results. Based on record review and interview, the facility failed to obtain prompt diagnostic testing related to a doppler scan (ultrasound) for 1 of 1 resident reviewed for diagnostic testing. (Resident B) Finding includes: Resident B's record was reviewed on 7/22/25 at 1:30 p.m. Diagnoses included, but were not limited to, hemiplegia and hemiparesis (weakness and paralysis) following stroke affecting the left non-dominant side, breast and bone cancer, and heart failure. The Discharge Minimum Data Set (MDS) assessment, dated 6/13/25, indicated the resident was moderately cognitively impaired. A Care Plan, initiated 5/12/25, indicated the resident had fluid overload or potential fluid volume overload related to heart failure. A Physiatry Progress Note, dated 5/28/25, indicated the resident was observed to have bilateral lower extremity edema. A Physician's Order, dated 6/6/25, indicated venous doppler to the left lower extremity for diagnosis of edema. A Physician's Note, dated 6/10/25 at 11:39 a.m., indicated the resident had edema to the left lower extremity and the doppler study was negative. The edema was likely positional related. The record lacked documentation of a completed doppler study. During an interview on 7/24/25 at 1:09 p.m., the Administrator indicated the resident did not receive the doppler scan as ordered by the physician and the note on 6/10/25 was charted in error. A policy titled, Diagnostic Testing Services, indicated .The facility will provide the appropriate diagnostic services required to maintain the overall health of its residents and in accordance with State and Federal guidelines .1. Facility will maintain a schedule of diagnostic tests in accordance with the physician's orders. No diagnostic tests will be performed without specific physician orders in accordance with State law to include scope of practice laws. 2. Qualified nursing personnel will receive and review the diagnostic test reports and communicate the results to the ordering Physician within 72 hours of receipt unless the report results fall outside of clinical reference ranges and require immediate attention at which time the Physician will be notified . This citation relates to Complaint 1321080. 3.1-49(g)

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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 inaccurate documentation of doppler scan test results for 1 of 1 resident reviewed for diagnostic testing. (Resident B) Finding includes: Resident B's record was reviewed on 7/22/25 at 1:30 p.m. Diagnoses included, but were not limited to, hemiplegia and hemiparesis (weakness and paralysis) following stroke affecting the left non-dominant side, breast and bone cancer, and heart failure. The Discharge Minimum Data Set (MDS) assessment, dated 6/13/25, indicated the resident was moderately cognitively impaired. A Care Plan, initiated 5/12/25, indicated the resident had fluid overload or potential fluid volume overload related to heart failure. A Physiatry Progress Note, dated 5/28/25, indicated the resident was observed to have bilateral lower extremity edema. A Physician's Order, dated 6/6/25, indicated venous doppler to the left lower extremity for diagnosis of edema. A Physician's Note, dated 6/10/25 at 11:39 a.m., indicated the resident had edema to the left lower extremity and the doppler study was negative. The edema was likely positional related. A Physician's Note, dated 6/12/25 at 7:50 a.m., indicated the resident said she had not received a doppler scan, however the nurse practitioner indicated the results were negative in the last note she had documented. The resident's legs looked equivalent bilaterally in regard to edema. During an interview on 7/24/25 at 1:09 p.m., the Administrator indicated the resident did not receive the doppler scan as ordered by the physician and the note on 6/10/25 was charted in error. This citation relates to Complaint 1321080. 3.1-50(a)(2)