STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155187	A. Building B. Wing	06/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brickyard Healthcare - Portage Care Center	3175 Lancer St Portage, IN 46368

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 record review and interview, the facility failed to ensure assessments of a resident's vascular wound were timely and accurate for 1 of 3 residents reviewed for wounds. (Resident H) The facility also failed to ensure Physician's Orders were followed related to insulin administration and blood sugar monitoring, for 3 of 3 residents reviewed for insulin administration and blood sugars. (Residents H, F, and J)Findings include:1. Resident H's closed record was reviewed on 6/25/26 at 11:13 a.m. The diagnoses included, but were not limited to, severe peripheral arterial occlusive disease with right common iliac artery and right common femoral artery occlusions (major blood vessels supplying the right leg), diabetes mellitus, and dementia.A Care Plan, dated 5/22/26, indicated a diagnosis of diabetes mellitus. The interventions included, the body would be assessed for breaks in the skin and treated promptly as ordered by a Physician, diabetes medication would be administered and blood sugars would be obtained as ordered by the Physician.A Care Plan, dated 5/22/26, indicated a risk for impairment of the skin. The interventions included, the facility protocols would be followed for the treatment of injuries.An admission Minimum Data Set (MDS) assessment, dated 5/28/26, indicated a moderately impaired cognitive status, required maximum assistance with bathing and hygiene, no venous/arterial ulcers present, and received and anticoagulant and insulin.A Care Plan, dated 6/11/26, indicated a scab was observed on the right foot. The interventions indicated the causative factors would be identified and eliminated/resolved if possible, the location, size and treatment would be monitored and the Physician notified if changes.a) The Nurse's Skin Check Progress Note, dated 5/21/26 at 5:36 p.m., indicated the skin was warm, dry and color was within normal limits. There was dry skin to the bilateral legs and feet and no skin issues were identified.A Change of Condition Progress Note, dated 6/6/26 at 12:00 p.m., indicated an open area was observed on the side of the right foot. The Physician was notified and a monitoring order was received. The Responsible Party was notified.A Skin Assessment Progress Note, dated 6/6/26 at 8:41 p.m., indicated a new skin issue of the right lateral foot had been observed. There was a new open area of the right lateral foot. The measurements were one centimeter (cm) in length by one cm in width. There was no further assessment of the description or the depth of the open area.The Skilled Evaluation Nurses' Progress Notes, dated 6/7/26 at 7:21 p.m., 6/8/26 at 8:33 a.m., 6/10/26 at 1:20 p.m., and 6/11/26 at 11:56 a.m., indicated the skin issue on the right lateral foot had not been evaluated and was an open wound acquired in-house.A Wound Nurse Progress Note/Assessment, dated 6/11/26 (five days after the area was first observed), indicated the wound on the right lateral foot had been resolved (healed) and a new area described as a scab was observed on the right dorsum of the foot (top of the foot), that measured 1 cm by 1.4 cm with no depth. The family had been notified.The Skilled Evaluation Nurses' Progress Notes, dated 6/13/26 at 7:51 p.m., 6/14/26 at 9:47 p.m., 6/15/26 at 8:22 p.m., 6/16/26 at 3:39 p.m., 6/17/26 at 9:00 p.m., 6/18/26 at 11:59 a.m., 6/19/26 at 12:22 a.m., 6/20/26 at 12:36 a.m., and 6/21/26 at 2:26 a.m., indicated there were now two areas on the resident's right foot, .Skin Issue: #001: Skin issue has not been evaluated. Location: Right Dorsum foot. Additional location information: right foot Issue type: Other skin issue. Other skin issue description: scab Wound acquired in-house. #002: Skin issue has not been evaluated. Location: Right Dorsum foot. Issue type: Other skin issue. Other skin issue description: Scab Wound acquired in-house (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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.There was no Weekly Skin Assessment completed by the Wound Nurse. A Change of Condition Nurse's Progress Note, dated 6/22/26 at 10:05 a.m., indicated the right foot was cold to touch and the toes were discolored. There were no complaints of pain. The Physician was notified and the resident was transferred to the Hospital emergency room (ER).The Hospital ER physical exam, Dated 6/22/26, indicated the right foot had ischemic ulcers, extensive with multiple digit discoloration. The resident had severe peripheral artery disease with occlusion of the right leg blood vessels. The Abdominal Angiogram indicated the right iliac artery was 100% occluded with no reconstitution in the right lower extremity seen. Due to the location of the occlusion they were unable to open the artery.During an interview on 6/24/26 at 8:45 a.m., the Wound Nurse indicated the Wound Nurse Practitioner (NP) visited weekly to assess/treat all pressure and vascular open areas. The NP also assessed all new admissions. During an interview on 6/24/26 at 9:40 a.m., the Wound Nurse indicated the nurses complete the weekly skin assessments and if an area is found, they fill out a Risk Management Form, then she looks at the forms every morning and follows up with an assessment of the area.A Wound Nurse Practitioner's Progress Note, dated 6/24/26 at 12:28 p.m. with the date of service on 6/11/26, indicated a dark reddish brown healing crusted area was observed on the the right foot, consistent with a resolved previous injury. The periwound was clean and dry and free from infection and inflammation. No treatment or dressing was necessary. Preventative skin care and injury avoidance were recommended. Risk factors included diabetes mellitus and peripheral vascular disease. There was no open wounds observed.During interviews on 6/25/26 at 1:04 p.m., the Wound Nurse indicated the open area on the lateral right foot was observed on Saturday 6/6/26. The Director of Nursing (DON) indicated the Risk Management Form had been completed by the nurse on 6/6/26. The Wound Nurse indicated she had not seen the Risk Management Form completed on 6/6/26. She and the Wound NP assessed the area on 6/11/26 and there was no open area on the right lateral foot. The area was marked as healed. There was a scab observed on the right dorsum foot and this would have been labeled as wound two. She was unsure if the scab was the same area as the open wound. The nurses had not been questioned on this. She acknowledged the Nurses' Progress Notes indicated there were two wounds and she only assessed the open wounds weekly and the floor nurses complete the assessments on non-opened areas. The DON indicated the resident had diabetes mellitus, peripheral vascular disease, and smoked. The wound should have been assessed by the Wound Nurse.During an interview on 6/25/26 at 2:26 p.m., the DON indicated the protocol at the facility for wounds was the nurse filled out the Risk Management Form, the Wound Nurse read the Risk Management Form the next working day and was to assess the wound as soon as possible. During an interview on 6/29/26 at 8:40 a.m., LPN 1 indicated she was the nurse who transferred the resident to the ER. She indicated there were thick scabs on the side of the foot though unsure how many. She had not taken care of the resident prior to 6/22/26.During an interview on 6/29/26 at 8:45 a.m., LPN 2 indicated there was one area on the foot and was not sure why she had documented there were two areas.During an interview on 6/29/26 at 8:50 a.m., LPN 3 indicated the resident had scabs on his right foot. She was unsure how many areas there were. He would refuse to let them assess the areas frequently.During an interview on 6/29/26 at 9:15 a.m., CNA 4 indicated she gave him a bed bath on 6/18/26 because he refused his shower. There was one small scabbed area in the shape of a circle on the top of the right foot. He would refuse to have his socks removed frequently.A Skin Assessment Policy, dated 2/2023, and received as current from the Corporate Staff Development Coordinator (SDC) as current, indicated a full body skin assessment would be conducted by a licensed or registered nurse upon admission/re-admission and weekly there after. Documentation of the skin assessment was to include the date and time, the observation, the type of wound, and the description of the wound.b) A Physician's Order, dated 5/21/26, indicated Glargine-yfgn insulin 30 units was to be administered every morning after the blood sugar level was checked.The Medication Administration Record (MAR), dated 5/2026, indicated the insulin had not been administered as ordered on 5/26/26. The MAR was coded with a seven (see Nurse's Notes). There was no documentation in the Nurse's (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notes that indicated why the insulin had not been administered.The MAR, dated 6/2026, indicated the insulin had not been administered on the following mornings:On 6/1/26 due to a blood sugar of 106. There were no ordered parameters for the insulin.On 6/3/26 there was no blood sugar result and it was coded with a three/see Nurse's Notes. There was no documentation in the Nurses' Notes that indicated why the insulin had not been given.On 6/7/26 due to blood sugar of 94.On 6/12/26 there was no blood sugar recorded or reason given for not administering the insulin.During an interview on 6/25/26 at 1 p.m., the DON acknowledged there were no parameters to hold the insulin and the insulin administrarion and blood sugar testing were not completed as ordered. 2) Resident F's record was reviewed on 6/25/26 at 6:50 a.m. The diagnoses included, but were not limited to, diabetes mellitus.A Care Plan, dated 12/13/24 and revised 4/16/26, indicated a diagnoses of diabetes mellitus. The interventions included the blood sugars would be checked and medications would be administered as ordered by the physician.a) A Physician's Order, dated 10/23/25, indicated Fiasp insulin, 15 units was to be administered before meals. The MAR, dated 4/2026, indicated the insulin had not been given before dinner on 4/7/26, 4/29/26, and 4/23/26.The MAR, dated 5/2026, indicated the insulin had not been given before dinner on 5/3/26 and before breakfast on 5/8/26.b) A Physician's Order, dated 3/20/26, indicated Lantus insulin, 45 units was to be given twice a day in the morning and evening. The insulin was to be held if the blood sugar was less than 110.The MAR, dated 4/2026, indicated on 4/27/26 the morning blood sugar was 96 and the insulin was administered. The blood sugar in the evening on 4/7/26 was 108, on 4/10/26 was 100, and 4/23/26 was 109 and the insulin had been administered. On 4/8/26 the evening blood sugar was 163 and the insulin was not given.The MAR, dated 5/2026, indicated the morning blood sugar on 5/7/26 was 205 and the insulin had not been given. On 5/30 26, the blood sugar was 81 and the insulin had been administered. The evenings of 5/5/26 the blood sugar was 104, 5/21/26 the blood sugar was 87, and 5/29/26 the blood sugar was 81 and the insulin had been administered.The MAR, dated 6/2026, indicated the morning blood sugar on 6/5/26 was 94 and the insulin had been administered. The evening blood sugar on 6/15/26 was 82 and on 6/18/26 was 84 and the insulin had been administered.c) A Physician's Order, dated 4/5/26, indicated Aspart insulin was to be given on a sliding scale (amount given was based on blood sugar result) in the morning, mid-day and evening. The sliding scale indicated a blood sugar result of 150 -200 was to receive four units of insulin.The MAR, dated 4/2026, indicated the evening blood sugar on 4/8/26 was 163 and no insulin was administered. The MAR, dated 5/2025, indicated the mid-day blood sugar on 5/2/26 was 150 and the insulin had not been administered. The morning blood sugar on 5/8/26 was not checked and no insulin was documented as received.During an interview on 6/25/26 at 10:05 a.m., the DON acknowledged the insulin and blood sugar orders were not followed. 3) Resident J's record was reviewed on 6/25/26 at 1:42 p.m. The diagnoses included, but were not limited to, diabetes mellitus. A Care Plan, dated 10/30/24 and revised on 3/5/26, indicated a diagnosis of diabetes mellitus. The interventions included the medication and blood sugars would be administered as ordered by the physician.A Physician's Order, dated 4/15/26, indicated Glargine insulin, 55 units was to be administered every morning and bedtime. The insulin was not to be administered if the blood sugar was less than 100.The MAR, dated 4/2026, indicated there was no blood sugar checked and insulin had not been administered on the morning of 4/24/26.The MAR, dated 6/2026, indicated on 6/11/26, the morning blood sugar was 94 and the insulin had been administered.The medication administration policy, dated 2026 and received as current from the Corporate EDC, indicated medications were to be administered as ordered by the physician.This citation relates to Intakes 3002892 and 3045641.410 IAC (Indiana Administrative Code) 16.2-3.1-48(a)(6)