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	01/12/2026

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

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure a sanitary kitchen related to the dishwasher not reaching the required temperature for a high temperature dish machine. This had the potential to affect 149 residents who received meals from the Main Kitchen. Finding includes: The initial kitchen tour was completed on 1/5/26 at 9:09 a.m. with the Dietary Manager (DM). The DM indicated the dishwasher was a high temperature dish machine. Dietary Server 1 was observed putting trays of dishes through the dishwasher. A wash cycle was observed with Dietary Server 1. There were three gauges on top of the dishwasher. During the wash cycle, the wash temperature gauge and the rinse temperature gauge did not move from 150 degrees F (Fahrenheit). The final rinse sanitation gauge did not move from 130 degrees F. The DM asked the Dietary Server to run a few more cycles. Each time the gauges did not move. The DM then put a digital thermometer on a tray and ran it through a cycle. The reading on the thermometer was 153.6 F.During an interview at the time of the observation, Dietary Server 1 indicated she had not checked the dishwasher temperatures before she started using the dishwasher that day. She indicated she was unaware to check the gauges for the temperatures and what the appropriate temperatures should have been.During an interview at the time of the observation, the DM indicated the Dietary Staff should have checked the dishwasher temperature prior to using it. The final rinse cycle should have been 180 degrees; she was unsure why the gauges were not working and she would have to get it serviced. A policy titled, Dishwasher Temperature and received as current from the facility on 1/12/26, indicated, .3. For high temperature dishwashers (heat sanitization).b. The final rinse temperature shall be 180 F or above but not to exceed 194 F.6. Water temperatures shall be measured and recorded prior to each meal and/or after the dishwasher has been emptied or re-filled for cleaning purposes.3.1-21(i)(3)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, record review, and interview, the facility failed to ensure blood pressure medications and insulin were held according to parameters for 3 of 7 residents reviewed for unnecessary medications. The facility also failed to ensure TED hose (compression stockings) were applied as ordered for 1 of 1 resident reviewed for TED hose and areas of bruising were assessed and monitored for 3 of 4 residents reviewed for non-pressure related skin conditions. (Residents 10, 64, 75, 126, 17, 4, and 114)Findings include: 1. The record for Resident 10 was reviewed on 1/8/26 at 11:32 a.m. Diagnoses included, but were not limited to, hypertension and congestive heart failure The Quarterly Minimum Date Set (MDS) assessment, dated 12/2/25, indicated the resident was moderately impaired for daily decision making. A Physician's Order, dated 11/26/25, indicated the resident was to receive Norvasc (a blood pressure medication) 5 milligrams (mg) in the morning. Hold if the resident's systolic (top number) blood pressure was less than 120 or pulse less than 60. The November 2025 Medication Administration Record (MAR) indicated the resident's blood pressure on 11/29/25 was 116/64 and on 11/30/25 was 116/63. The resident received the medication on both dates. The December 2025 MAR indicated the resident's blood pressure was 108/44 on 12/1/25 and 117/81 on 12/25/25. Again, the resident received the Norvasc on both dates. The January 2026 MAR indicated the resident's blood pressure was 119/60 on 1/1/26. The resident received her Norvasc on that date. A Physician's Order, dated 12/4/25, indicated the resident was to receive Lisinopril (a blood pressure medication) 10 milligrams (mg) daily. Hold the medication if the resident's systolic (top number) was less than 110. The December 2025 Medication Administration Record (MAR) indicated the resident's blood pressure was 119/55. The resident's Lisinopril was held rather than being administered. During an interview on 1/9/26 at 2:30 p.m., the Director of Nursing indicated the Norvasc should have been held based on the parameters and the Lisinopril should have been given. 2. On 1/7/28 at 2:48 p.m., Resident 64 was seated in her room in her wheelchair. An area of reddish/purple discoloration was observed on her right forearm. On 1/9/26 at 9:30 a.m., the reddish/purple discoloration remained to the resident's right forearm. The record for Resident 64 was reviewed on 1/9/26 at 9:31 a.m. Diagnoses included, but were not limited to, atrial fibrillation (irregular heartbeat), atherosclerotic heart disease, and neurocognitive disorder with Lewy bodies. The 11/20/25 admission Minimum Data Set (MDS) assessment indicated the resident was cognitively (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 - Some	intact and had received an anticoagulant (blood thinner) during the assessment reference period. A Care Plan, dated 11/26/25, indicated the resident was on anticoagulant therapy related to atrial fibrillation. Interventions included, but were not limited to, administer anticoagulant medications as ordered by the physician and observe for side effects and effectiveness every shift. Monitor, document, and report PRN (as needed) adverse reactions of anticoagulant therapy such as bruising. A Physician's Order, dated 11/15/25, indicated the resident received Eliquis (a blood thinner) 5 milligrams (mg) twice a day. A Skilled Evaluation note, dated 1/8/26 at 8:30 p.m., indicated no skin issues had been identified. There was no documentation indicating when the bruising appeared and an assessment of the area. During an interview on 1/9/26 at 2:30 p.m., the Director of Nursing indicated the bruise should have been assessed and monitored. 3. On 1/7/26 at 1:40 p.m., Resident 75 was observed in her room in bed. The resident was not wearing any TED hose (compression stockings) at that time. On 1/8/26 at 10:42 a.m. and 1:55 p.m., the resident was again observed in her room sleeping with no TED hose in use. On 1/9/26 at 9:22 a.m., the resident was observed in bed with no TED hose in use. The record for Resident 75 was reviewed on 1/7/25 at 10:35 a.m. Diagnoses included, but were not limited to, stroke, dementia without behavior disturbance, and heart failure. The Annual Minimum Data Set (MDS) assessment, dated 11/26/25, indicated the resident had short and long term memory problems and was severely impaired for daily decision making. The resident was also dependent on staff for upper and lower body dressing. A Care Plan, reviewed on 12/9/25, indicated the resident had an ADL (activities of daily living) self-care performance deficit related to the diagnoses of stroke with left hemiplegia (muscle weakness), dementia, and chronic obstructive pulmonary disease (COPD). Interventions included, but were not limited to, apply TED hose as ordered. A Physician's Order, dated 10/13/25 and listed as current on the January 2026 Physician's Order Summary (POS), indicated the resident was to wear knee high TED hose daily for edema and remove per schedule. The January 2026 Medication Administration Record (MAR) indicated the TED hose were to be applied at 9:00 a.m. and removed at 9:00 p.m. The TED hose were signed out as being applied at 9:00 a.m. on 1/7/26. A Physician's Order, dated 10/14/25 and listed as current on the January 2026 POS, indicated the resident was to receive Coreg (a medication to treat heart failure and high blood pressure) 6.25 milligrams (mg) twice a day. The medication was to be held if the resident's systolic blood pressure (top number) was less than 110 and her heart rate was less than 60. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The October 2025 MAR indicated the resident's morning blood pressure on 10/28/25 was 108/64 and the medication was administered. The November 2025 MAR indicated the resident's evening blood pressure on 11/23/25 was 92/61 and her morning blood pressure on 11/25/25 was 104/66. The resident received the Coreg on both dates. The January 2026 MAR indicated the resident's morning blood pressure on 1/2/26 was 106/62 and the medication was administered. During an interview on 1/9/26 at 2:30 p.m., the Director of Nursing indicated the resident's TED hose should have been applied as ordered and the Coreg should have been held as ordered. 4. During random observations on 1/5/26 at 10:15 a.m., on 1/6/25 at 10:40 a.m. and 2:50 p.m., and 1/7/25 at 9:15 a.m. and 1:30 p.m., Resident 126 was observed in bed. At those times, a large red and purple bruise was observed to his left forearm and the back of his left hand. During a random observation on 1/9/26 at 9:00 a.m., the resident was observed in bed. There was a bruise to his left forearm and a bandage over his left hand. At 9:15 a.m., the B-Wing Unit Manager was asked to perform a skin assessment. She indicated she was unaware of the bruise to his left forearm, but thought it was from a recent fall on 1/3/25 and he had just sustained a skin tear to his left hand from a fall on 1/9/26. The record for Resident 126 was reviewed on 1/7/26 at 9:38 a.m. Diagnoses included, but were not limited to, osteoarthritis, dizziness, repeated falls, dementia with behaviors, major depressive disorder, and, late onset Alzheimer's disease. The 12/8/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making and had a history of falls. The Care Plan, revised on 11/13/25, indicated the resident had potential impairment to skin integrity related to fragile skin and incontinence. The approaches were to monitor/document location, size and treatment of any skin injury and report abnormalities, failure to heal, signs and symptoms of infection, and maceration to the physician. A Change of Condition form, dated 1/3/26 at 10:10 p.m., indicated the resident was sitting on the side of his roommate's bed. He could not explain how he got there and sustained a skin tear to his left elbow area. There was no documentation regarding any bruises to the left arm. A Weekly Skin Review, dated 1/1/26, indicated there were no pre-existing conditions and the resident's skin was intact. A Weekly Skin Review, dated 1/8/26, indicated the resident had no new skin issues and had pre-existing skin tears. There was no documentation regarding any bruising. During an interview on 1/9/26 at 9:15 a.m., the B-wing Unit Manager indicated the bruise should have been assessed, the wound nurse and NP notified, and the findings documented in the clinical record. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The current and undated Skin Assessment policy, provided by the Nurse Consultant on 1/9/26 at 11:20 a.m., indicated a full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/readmission, daily for three days, and weekly thereafter. The assessment may also be performed after a change of condition or after any newly identified pressure injury. Document observations, type and description of wound. 5. The record for Resident 17 was reviewed on 1/7/26 at 1:53 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus. The 12/22/25 Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making and received insulin and an oral hypoglycemic medication. The Care Plan, revised on 11/12/25, indicated the resident had diabetes mellitus. The approaches were to check the blood sugar as ordered by the physician. A Physician's Order, dated 10/16/25, indicated Humalog Insulin (a short acting insulin) inject 5 units subcutaneously (sq) with meals and hold if the blood sugar level was less than 110. The 10/2025 Medication Administration Record (MAR) indicated the Humalog Insulin was administered on the following days when the resident's blood sugar level was less than 110: breakfast: 10/12 and 10/13/25 lunch: 10/8/25 dinner: 10/1 and 10/11/25 A Physician's Order, dated 9/16/25, indicated Nateglinide (oral prescription medication used to manage blood sugar levels in adults with type 2 diabetes) 120 milligrams (mg), give 1 tablet by mouth two times a day and hold if the blood sugar level was less than 110. The 10/2025 MAR indicated the Nateglinide was signed out as being administered on the following days and the resident's blood sugar level was less than 110: 8:00 a.m.: 10/7, 10/8, 10/12, 10/13, 10/20, 10/26, 10/28. and 10/30/25 5:00 p.m.: 10/1, 10/2, 10/7, 10/8, 10/9, 10/11, 10/15, 10/16, and 10/30/25 The 11/2025 MAR indicated the Nateglinide was signed out as being administered on the following days and the resident's blood sugar level was less than 110: 8:00 a.m.: 11/3, 11/6, 11/8, 11/11, 11/14, 11/19, 11/23, 11/24, and, 11/26/25 5:00 p.m.: 11/8, 11/15, 11/17, 11/19, 11/22, 11/23, 11/25, 11/26/25 The 12/2025 MAR indicated the Nateglinide was signed out as being administered on the following days and the resident's blood sugar level was less than 110: 8:00 a.m.: 12/2/25 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5:00 p.m.: 12/19/25 During an interview on 1/12/26 at 9:40 a.m., the Nurse Consultant indicated the medication should have been administered according to the physician's orders. 6. The record for Resident 4 was reviewed on 1/8/26 at 11:02 a.m. Diagnoses included, but were not limited to type 2 diabetes. The 11/12/25 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was not cognitively intact for daily decision making and received insulin. The Care Plan, revised on 11/3/25, indicated the resident had diabetes mellitus. The approaches were to check the resident's blood sugar level as ordered by the physician. A Physician's Order, dated 10/16/25, indicated Insulin Lispro (a short acting insulin) inject 10 units subcutaneously (sq) before meal and hold if blood sugar level was less than 100. The Medication Administration Record (MAR) for the months of 11/2025 and 12/2025, indicated the Lispro Insulin was administered on the following days and blood sugar level was less than 100: breakfast: 11/24/25 the blood sugar was 90, 11/27/25 the blood sugar was 99, 12/1/25 the blood sugar was 82, and on 12/13/25 the blood sugar was 90. Lunch: 12/13/25 the blood sugar was 90. Dinner: 11/2/25 the blood sugar was 99, 11/13/25 the blood sugar was 92, 11/16/25 the blood sugar was 86, 11/20/25 the blood sugar was 67, 11/30/25 the blood sugar was 78, 12/3/25 the blood sugar was 78, 12/7/25 the blood sugar was 98, and on 12/10/25 the blood sugar was 92. During an interview on 1/12/26 at 9:40 a.m., the Nurse Consultant indicated the insulin should have been administered as ordered by the physician. 7. On 1/6/26 at 1:37 p.m., Resident 114 was observed lying in bed with his eyes closed. The resident had a large dark purple discoloration observed to the outer side of his left hand. On 1/9/26 at 10:52 a.m., Resident 114 was observed sitting in a wheelchair in the hallway. The dark purple discoloration was still observed to his left hand. Record review for Resident 114 was completed on 1/9/26 at 10:53 a.m. Diagnoses included, but were not limited to, anemia, atrial fibrillation, hypertension, end stage renal disease, diabetes mellitus, and dementia. The Annual Minimum Data Set (MDS) assessment, dated 11/10/25, indicated the resident was cognitively impaired. The resident required substantial maximal assistance with dressing. The resident received an anticoagulant (blood thinning) medication. A Care Plan, dated 12/8/24 and revised 6/16/25, indicated the resident was on anticoagulant therapy related to atrial fibrillation. An intervention included to monitor, document, and report adverse reactions which included bruising. The January 2026 Physician's Order Summary (POS) indicated an order for Eliquis (blood thinner) 2.5 mg (milligrams) two times a day. The Weekly Skin Assessments, dated 12/31/25 and 1/7/26, indicated no issues. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The record lacked any documentation the resident's discoloration had been assessed or was being monitored. During an interview on 1/9/26 at 11:02 a.m., RN 1 indicated she was unaware the resident had the discoloration to his hand. Staff should have observed the discoloration and assessed it. 3.1-37(a)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, record review, and interview, the facility failed to maintain clinical records that were complete and accurately documented related to clarification of oxygen orders and incorrect documentation of obtaining blood pressure readings on a restricted arm for 4 of 34 records reviewed. (Residents 112, 161, 92, and 2)Findings include:1. On 1/6/26 at 11:00 a.m., Resident 112 was seated in her wheelchair in her room. She had no oxygen in use. On 1/7/26 at 9:33 a.m. and 2:00 p.m., the resident was observed in her room. She was not wearing oxygen per a nasal cannula at the time. On 1/8/26 at 2:05 p.m., the resident was seated in her wheelchair and being transported back to her room. A portable oxygen tank was hanging from the back of the wheelchair. The resident was not wearing oxygen at the time. The record for Resident 112 was reviewed on 1/7/26 at 2:38 p.m. Diagnoses included, but were not limited to, congestive heart failure and chronic obstructive pulmonary disease (COPD). The admission Minimum Data Set (MDS) assessment, dated 12/13/25, indicated the resident was cognitively intact for daily decision making. A Physician's Order, dated 12/7/25, indicated the resident was to receive continuous oxygen at 2 liters per minute via nasal cannula. The physician was to be notified if the resident's oxygen saturation was below 90% every shift. The January 2026 Treatment Administration Record (TAR) indicated the resident's oxygen had been signed out as being applied for all three shifts 1/6/2026 through 1/8/2026. During an interview on 1/9/26 at 2:30 p.m., the Director of Nursing indicated a clarification order would be obtained since the resident wasn't wearing her oxygen as ordered. 2. During a random observation on 1/5/26 at 11:00 a.m., a PICC line (long-term use IV line) was observed in resident 161's left arm. The resident's record was reviewed on 1/7/26 at 10:47 a.m. Diagnoses included, but were not limited to, unspecified severe protein-calorie malnutrition, colostomy, and intestinal obstruction. The admission Skilled Evaluation, dated 12/22/25, indicated the resident was alert and oriented and had a PICC line in his left arm. A review of the Vital Signs Record indicated the resident's blood pressure was checked on his left arm on 12/22/25 at 6:23 p.m., 12/24/25 at 7:09 a.m., 12/24/25 at 8:45 a.m., 12/30/25 at 2:57 p.m., 12/31/25 at 4:12 p.m., 1/4/26 at 12:41 p.m., 1/5/26 at 1:12 p.m., and 1/6/26 at 11:47 a.m. A Care Plan, dated 12/23/25, indicated the resident was at risk for infection related to the PICC Line. Interventions included to not take blood pressure in the arm with the access site (PICC line). During an interview on 1/9/26 at 9:08 a.m., the resident indicated the staff did not check his blood (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pressure on his left arm. During an interview on 1/12/26 at 10:16 a.m., the Nurse Consultant indicated staff must have documented the arm used for the blood pressure incorrectly, and they needed to work with staff on documentation. 3. During a random observation on 1/5/26 at 2:16 p.m., a PICC line (long-term use IV inserted through the arm) was observed in Resident 92's right arm. At that time, the resident indicated the staff did not use his right arm to check his blood pressure. The resident's record was reviewed on 1/8/26 at 2:03 p.m Diagnoses included, but were not limited to, chronic osteomyelitis (bone infection)of the left thigh, and paraplegia. The admission Minimum Data Set (MDS) assessment, dated 12/19/25, indicated the resident was cognitively intact for daily decision making, and required maximal assist in ADLs. and transfers. A Physician's Order, dated 12/13/25, indicated no blood pressure checks in the right arm. A review of the Vital Signs Record indicated the resident's blood pressure was checked on his right arm on 12/13/25 at 11:50 p.m., 12/14/25 at 10:13 p.m., 12/17/25 at 2:37 p.m., and 12/21/25 at 3:44 p.m. A Care Plan, dated 12/15/25, indicated the resident was at risk for infection related to the PICC Line. Interventions included to not take blood pressure in the arm with the access site (PICC line). During an interview on 1/12/26 at 10:16 a.m., the Nurse Consultant indicated staff must have documented the arm used for the blood pressure incorrectly, and they needed to work with staff on documentation. 4. During a random observation on 1/6/26 at 10:54 a.m., Resident 2 had two bandages intact to his right forearm. At that time, he indicated that was where he had a graft (access device) for hemodialysis. The resident's record was reviewed on 1/8/26 at 8:01 a.m Diagnoses included, but were not limited to, end stage renal disease. The Quarterly Minimum Data Set (MDS) assessment, dated 12/23/25, indicated the resident was cognitively intact for daily decision making, and was on dialysis. A Physician's Order, dated 1/3/26, indicated no blood pressures were to be taken on the resident's right arm. A review of the Vital Signs Record indicated the resident's blood pressure was checked on his right arm at the following times: 11/20/25 at 8:25 p.m., 11/25/25 at 8:02 p.m., 11/25/25 at 8:12 p.m., 11/28/25 at 4:46 p.m., 11/28/25 at 4:36 p.m., 12/11/25 at 10:05a.m., 12/21/25 at 3:17 p.m., 12/21 at 10:28 a.m., 1/3/26 at 10:46 p.m. 1/4/26 at 5:11 a.m., and 1/6/26 at 10:44 a.m. A Care Plan, dated 10/4/24, indicated the resident needed dialysis due to end stage renal disease. Interventions included to not draw blood or take blood pressure in the arm with the graft. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/9/26 at 9:16 a.m., the resident indicated the staff did not check his blood pressure on his right arm. During an interview on 1/12/26 at 10:16 a.m., the Nurse Consultant indicated staff must have documented the arm used for the blood pressure incorrectly, and they needed to work with staff on documentation. 3.1-50(a)(1)3.1-50(a)(2)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, record review, and interview, the facility failed to ensure each resident's dignity was maintained related to wearing a hospital gown while in bed during the day for 1 of 1 resident reviewed for dignity. (Resident 75)Finding includes:On 1/5/26 at 11:21 a.m., Resident 75 was observed in her room in bed. The resident was wearing a hospital gown. On 1/6/26 at 9:35 a.m. and 11:38 a.m., the resident was observed in her room in bed and wearing a hospital gown. On 1/7/26 at 9:15 a.m., 11:37 a.m., and 1:40 p.m., the resident was observed in her room in bed wearing a hospital gown. On 1/8/26 at 10:42 a.m. and 1:55 p.m., the resident was observed in her room in bed wearing a hospital gown. The record for Resident 75 was reviewed on 1/7/25 at 10:35 a.m. Diagnoses included, but were not limited to, stroke and dementia without behavior disturbance. The Annual Minimum Data Set (MDS) assessment, dated 11/26/25, indicated the resident had short and long term memory problems and was severely impaired for daily decision making. It was important for the resident to choose what clothes to wear. The resident was dependent on staff for upper and lower body dressing. The resident's last care plan review was on 12/9/25. There was no care plan related to wearing a hospital gown while in bed. During an interview on 1/9/26 at 2:30 p.m., the Director of Nursing (DON) indicated the resident's care plan would be updated. During an interview on 1/12/26 at 11:30 a.m., the DON indicated the resident's family was contacted and they would like the resident to wear a gown when in bed for comfort and her care plan was updated. 3.1-3(t)

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Brickyard Healthcare - Portage Care Center	3175 Lancer St Portage, IN 46368

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on record review and interview, the facility failed to ensure referrals from the optometrist were carried out and appointments were made for 1 of 1 resident reviewed for hearing and vision. (Resident 9)Finding includes:During an interview on 1/5/26 at 2:28 p.m., Resident 9 indicated he had seen the eye doctor a couple of times this year and was still waiting for his glasses and possibly eye surgery. The record for Resident 9 was reviewed on 1/9/26 at 10:32 a.m. Diagnoses included, but not limited to, end stage renal disease, heart failure, stroke, major depressive disorder, vascular dementia, anxiety, and renal dialysis. The 11/4/25 Annual Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and his vision was adequate with no corrective lens. There was no care plan for vision. An Eye Exam Visit Note by the optometrist, dated 7/12/25, indicated the resident had a mild cataract in his left eye and it was recommended to have YAG laser posterior capsulotomy (an outpatient procedure to address scar tissue that forms behind an artificial lens after cataract surgery). The patient wanted to proceed with the surgery and a referral was written and given to social service. An Eye Exam Visit Note by the optometrist, dated 11/11/25, indicated the resident had a opacification of posterior capsule (a clouding of the lens capsule after cataract surgery, causing blurry vision, glare, and halos) of the left eye and a moderate cataract in the right eye. The plan was to recommend YAG laser posterior capsulotomy and cataract surgery. Both referrals were written and given to social service as the patient wanted to proceed with the surgery. During an interview on 1/9/26 at 11:15 a.m., the Social Service Director (SSD) indicated the Medical Records Supervisor (MRS) was helping with ancillary appointments now, so Social Service was not receiving the referrals, as the MRS was getting them. The SSD was unaware of both referrals. During an interview on 1/9/26 at 11:50 a.m., the B-Wing Unit Manager indicated she tried calling the facility where they had sent Medicaid residents before and that facility was closed indefinitely. She then googled other eye surgeons in the area and called them and none of them took the resident's insurance. During an interview on 1/9/26 at 11:50 a.m., the SS Assistant indicated she had not tried calling the ombudsman to get any kind of resources for local eye surgeons who could take care of the laser surgery and the cataract surgery, nor had she reached out to the Corporate Social Service Director. 3.1-39(a)(1)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure a resident was transferred properly in a mechanical lift and a floor mat was in place for a resident with a history of falls for 2 of 8 residents reviewed for accidents. (Residents B and C)Findings include:1. The record for Resident B was reviewed on 1/7/26 at 10:12 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, dementia without behaviors, high blood pressure, major depressive disorder, anxiety, and osteoarthritis. The 12/18/25 Minimum Data Set (MDS) assessment indicated the resident was severely impaired for daily decision making and was dependent on staff for transfers from the bed to the chair. A Care Plan, revised on 6/16/25, indicated the resident had an activities of daily living (ADL) deficit. The approaches were to provide assistance with transfers and the resident required a mechanical lift. The 12/2025 Physician Order Summary indicated the resident received Hospice Services. A Change of Condition form, dated 12/8/25 at 6:57 a.m., indicated while staff was passing morning medications, a scream was heard and then one of the CNA's came out of the room yelling for help. The CNA indicated the resident slipped out of the Hoyer (mechanical lift) pad when she was getting him up. The resident was observed lying on his right side. The CNA indicated the resident did not hit his head. The resident was put back to bed using the Hoyer lift and three staff members. The resident had tenderness on the right side near the rib area. The hospice nurse was called and informed of the fall and indicated they would be out later in the morning to visit the resident. The IDT Fall Review Note, dated 12/8/25 at 9:28 a.m., indicated date and time of fall was 12/8/25 at 5:45 a.m. Writer was passing morning medications when she heard a scream and then one of the CNA's came out the room yelling for help. CNA said resident slipped out of the Hoyer pad when she was getting him up. Writer then rushed to the room and observed resident laying on his right side rib area on the right Hoyer leg. When asked the CNA, she said he did not hit his head. Resident was put back to bed using Hoyer lift with 3 attendees . Interventions were to re-evaluate the size of the Hoyer pad. During a phone interview on 1/6/26 at 1:41 p.m., CNA 2 indicated she was working on 12/8/25 during the midnight shift. At 5:40 a.m., she and another CNA were in Resident B's room and were transferring him to the chair using the Hoyer lift. At that time, the other CNA got called away from the resident across the hall, and she left the room to attend to her. CNA 2 indicated within 30 seconds the resident slipped out of the Hoyer pad and fell to the floor. She screamed for help and the nurse, QMA, and another CNA came into the room and assisted the resident back into bed. The resident had some pain to his rib area. The nurse asked her to write a statement and indicate exactly what happened but not to include the other CNA's name. CNA 2 was terminated after the incident. CNA 2 indicated there were three CNA's working that night and sometimes there was no staff to help transfer the residents with the Hoyer lift and she had to do it by herself. On 1/7/26 at 3:00 p.m., the Director of Nursing (DON) provided a typed statement regarding the fall and indicated it was from the Assistant Director of Nursing (ADON). The statement read, On 12/8/25, I was in the building doing my rounds and the CNA asked me to help with a lift. [resident name] was moving about and began to slide form the Hoyer pad. We lowered [resident name] to the floor. After assessing the resident, he was transferred with 3 staff members back into bed. During an interview on 1/7/26 at 3:10 p.m., the DON indicated she was not sure if there was a statement from CNA 2 during the time of the fall, but would check. On 1/7/26 at 3:30 p.m., the DON provided a typed statement regarding the fall, indicating it was from CNA 2. The statement read, On 12/8/25, I was transferring Resident B with another staff member, when he began to slide out of the hoyer pad and we lowered him to the floor. I let the nurse know and she came and assessed the resident. We put him back into bed with the hoyer. During an interview on 1/7/26 at 3:30 p.m., the DON indicated CNA 2 was terminated after the incident for taking long breaks and wearing her air pods during work. The DON indicated the ADON does come in early at times and had helped (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA 2 lower the resident to the floor. She was not sure if there were any other statements from other staff working that shift and verified this was exactly what happened during the fall. On 1/7/26 at 3:45 p.m., the Human Resource (HR) Director was asked to see CNA 2's employee file. She opened the cabinet drawer and there were 2 visible folders in the cabinet with CNA 2's name on them. The HR Director only removed a purple folder, and left another manilla folder with CNA 2's name in the cabinet. When queried as to what was in the manilla folder, her response was Personal file. She did not remove that file, and was informed the personal file also needed to be reviewed. CNA 2's personal employee file was reviewed on 1/7/26 at 3:50 p.m. in the HR office. An Employee Memorandum, dated 12/8/25, indicated, On 12/7/25, CNA transferred a resident improperly leading to a fall. CNA was educated during orientation on proper transfer techniques and operated a hoyer improperly. The CNA was terminated. The form was signed by the DON and ADON. A typed statement from the DON and ADON indicated, I spoke with CNA 2 on 12/9/25 with the ADON present, and CNA 2 did admit to improperly using the hoyer when transferring a resident resulting in a fall. A hand written statement from CNA 1, who was also working on 12/8/25, was in the employee's file. The hand written statement indicated, On 12/8/25 around 6:00 a.m., I was in room [ROOM NUMBER] doing patient care. While I was doing patient care I heard a loud noise. Once I heard the noise I looked in the hallway and saw the aid [name] asking for help. Me, [nurse's name] and [QMA name], ran to room [ROOM NUMBER] and saw [Resident B] on the floor and the hoyer pad still in the air. The nurse began to assess the patient then we hoyered him into the bed. Once he was in the bed I left and continued to do my work. (sic) During an interview on 1/7/26 at 4:00 p.m., the Administrator and the Nurse Consultant indicated they were unaware of information that was in CNA 2's employee file. During an interview on 1/8/26 at 10:00 a.m., the Administrator indicated she was unaware there was a written statement from CNA 1, she was also unaware CNA 2 had transferred the resident by herself. During an interview on 1/8/26 at 2:50 p.m., the Nurse Consultant indicated she was unaware of the written statement from the CNA 1 and that CNA 2 was terminated due to the improper transfer. She indicated two nursing staff members were to transfer residents while using the Hoyer lift. During an interview on 1/9/26 at 9:20 a.m., CNA 1 indicated she was working that night with CNA 2. She was in a resident's room right across the hall from Resident B's room providing patient care. The CNA indicated she heard a large thump and a scream, and CNA 2 opened the door and yelled for help. She indicated she was not in Resident B's room prior to the fall. There were times when they have to transfer a resident by themselves using the Hoyer lift because it all depended on who was working that night and if they were willing to help. Some CNA's and nurses would not help. The current and undated Safe Resident Handling/Transfers policy, provided by the Nurse Consultant on 1/9/26 at 8:20 a.m., indicated two staff members must be utilized when transferring residents with a mechanical lift. Staff will be educated on the use of safe handling/transfer practices to include use of mechanical lift devices upon hire, annually, and as the need arises or changes in equipment occurred. 2. During random observations on 1/6/26 at 10:20 a.m., on 1/7/26 at 9:17 a.m., 11:00 a.m. and 1:32 p.m., and on 1/8/26 at 7:55 a.m. and 11:00 a.m., Resident C was observed in bed. The bed was in a very high position and at those times and there was no floor mat beside the bed. On 1/8/26 at 11:09 a.m., QMA 1 was asked if she was aware if the resident was supposed to have a floor mat beside the bed. She observed the resident in bed. There was no floor mat beside the bed and she indicated she did not recall if the resident was to have a floor mat beside the bed. The record for Resident C was reviewed on 1/7/26 at 11:35 a.m. Diagnoses included, but were not limited to, fracture of right femur, dementia, anxiety, repeated falls, major depressive disorder, Alzheimer's disease, and osteoarthritis. The 1/1/26 Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making and has had no falls since the previous assessment. The resident had a fracture that required surgery and needed substantial to max assist for bed mobility and was dependent on staff for transfers from the bed to the chair. The Care Plan, revised on 11/10/25, indicated the resident was at risk for falls. The approaches were to place a mat on the floor beside the bed. A Care Plan, revised on (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/10/25, indicated the resident preferred to keep her bed in a high position. A Change of Condition Note, dated 11/14/25 at 2:35 a.m., indicated the resident was found on the floor sitting next to the bed. The resident was complaining of hip and shoulder pain. The NP was notified and ordered X-rays of both hips and shoulders and something for the pain. A Change of Condition Note, dated 11/14/25 at 5:15 p.m., indicated the resident had difficulty waking up and was unresponsive. The physician was notified and orders were obtained to send the resident to the hospital. An IDT Fall Note, dated 11/14/25 at 9:12 a.m., indicated the resident was found on the floor next to the bed. Additional fall interventions put in place included to provide a floor mat beside the bed. Hospital notes, dated 11/14/25, indicated the resident had right neck femur fracture. During an interview on 1/8/26 at 11:12 a.m., the B-Wing Unit Manager indicated the resident was care-planned for having her bed in a high position. She was unaware the resident was to have a floor mat beside her bed. She reviewed the chart and indicated the care plan did indicate for a floor mat to be beside the bed. This citation relates to Intake 2688435. 3.1-45(a)(2)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, record review, and interview, the facility failed to ensure bolus tube feeding administration as well as gastrostomy tube (a tube inserted directly into the stomach for nutrition) site care was completed as ordered for 2 of 2 residents reviewed for tube feeding. (Residents 75 and 13)Findings include:1. The record for Resident 75 was reviewed on 1/7/25 at 10:35 a.m. Diagnoses included, but were not limited to, stroke, dysphagia (difficulty swallowing) and dementia without behavior disturbance. The Annual Minimum Data Set (MDS) assessment, dated 11/26/25, indicated the resident had short and long term memory problems and was severely impaired for daily decision making. The resident was also receiving a tube feeding (a tube inserted directly into the stomach for nutrition). A Care Plan, reviewed on 12/9/25, indicated the resident required a tube feeding related to the diagnosis of dysphagia. The resident was NPO (nothing by mouth) status. A Physician's Order, dated 7/31/25, indicated bolus feedings (a method of delivering liquid nutrition through a feeding tube as a single meal) were permissible per the physician if [brand name] feeding bags were unavailable. A Nurse's Note, dated 12/31/25 at 3:36 p.m., indicted bolus feed continued related to peg (percutaneous endoscopic gastrostomy tube) tube issues. A Nurse's Note, dated 1/2/26 at 3:22 a.m., indicated the resident was recently receiving bolus tube feeding and flushes due to peg port issues. The December 2025 and January 2026 Medication and Treatment Administration Records indicated there was no documentation of the bolus tube feeding administration being completed. During an interview on 1/9/26 at 2:30 p.m., the Director of Nursing indicated documentation of the resident's bolus feeding and how much was instilled should have been completed. 2. On 1/6/26 at 1:53 p.m., Resident 13's PEG tube (a feeding tube inserted through the abdomen) was observed. There was a soiled, undated dressing around the tube insertion site. The skin around the tube was red with tan/yellow drainage and there was thicker, brown drainage noted on the dressing and on the resident's abdomen. At that time, the resident indicated the nurse last changed the dressing on 1/5/26. On 1/7/26 at 9:58 a.m., the resident was observed resting in bed. She indicated she had just gotten cleaned up and changed, but the nurse still had not changed the PEG tube dressing or cleaned the site since 1/5/26. The dressing / site were observed, and appeared the same as when observed on 1/6/26 at 1:53 p.m. On 1/7/26 at 3:19 p.m., the PEG tube dressing was observed to have thick brown drainage. The site was unchanged from the prior aobservation. At that time, the resident's family member was at the bedside. Both the family member and resident indicated the dressing had not been changed on the PEG site and it had not been cleaned. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/8/26 at 7:44 a.m., there was no dressing on the PEG tube site. Scant dried drainage was observed around the tube and there was no visible ointment on the surrounding skin. At that time, the resident indicated the dressing came off around 4:00 a.m. and the nurse threw it away. The nurse did not clean the site or apply topical medication or a dressing. On 1/8/26 at 9:28 a.m., the resident indicated LPN 1 already brought in her morning medications but did not look at, clean, or apply ointment to the PEG tube site. There was no dressing in place. The resident's record was reviewed on 1/7/26 at 2:18 p.m Diagnoses included, but were not limited to having a feeding tube, diabetes, and lupus. The admission Minimum Data Set (MDS) assessment, dated 12/12/25, indicated the resident was cognitively intact for daily decision making, and required maximal assist with ADLs, A Physician's Order, dated 1/5/26, indicated mupirocin-lidocaine external ointment (a topical antibiotic and numbing agent), apply to G-tube site topically three times a day for G-tube site infection. Cleanse site and apply three times a day for 14 days. The order was signed out as completed three times a day on the Medication Administration Record (MAR) on 1/6/26 and 1/7/26 and for the morning of 1/8/26. During an interview on 1/8/26 at 9:38 a.m., LPN 1 indicated he did not perform PEG tube care for the resident that morning, even though he signed it off on the MAR. He indicated he planned to go back and do the care later, but he should not have signed it out. During an interview on 1/8/26 at 10:30 a.m., the Director of Nursing (DON) was informed of the findings and indicated she would follow up with LPN 1. A policy, titled, Care and Treatment of Feeding Tubes was received as current from the Nurse Consultant on 1/9/26 at 11:42 a.m. and indicated, It is a policy of this facility to utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible . Direction for the staff on how to provide the following care will be provided: . Examination and cleaning of the insertion site in order to identify, lessen, or resolve possible skin irritation and local infection. 3.1-44(a)(2)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on record review and interview, the facility failed to document PICC line (a long-term use IV line) measurements as ordered for 1 of 2 residents reviewed with a PICC line. (Resident 161)Finding includes:The record for Resident 161 was reviewed on 1/7/26 at 10:47 a.m Diagnoses included, but were not limited to, unspecified severe protein-calorie malnutrition, colostomy, and intestinal obstruction.The admission Skilled Evaluation, dated 12/22/25, indicated the resident was alert and oriented and had a PICC line (a long-term use IV line).A Physician's Order, dated 12/23/25, indicated to measure the PICC catheter length on admission and with each dressing change thereafter, every Sunday night. The Medication Administration Record (MAR) indicated the PICC line dressing was changed on 12/24/25, 12/28/24, 12/31/24, and 1/4/26. The record lacked measurements of the PICC catheter length.A Care Plan, dated 12/23/25, indicated the resident was at risk for infection related to having a PICC line. Interventions included dressing change as ordered with measurements of the length of the external catheter and the circumference of the arm 10cm (centimeters) above the insertion site.During an interview on 1/12/26 at 8:16 a.m., the Nurse Consultant indicated she reviewed the record, and did not find any documentation of PICC length measurements. 3.1-47(a)(2)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, record review, and interview, the facility failed to ensure oxygen was flowing at the correct rate per minute for 1 of 1 resident reviewed for oxygen. (Resident 14)Finding includes:During random observations on 1/5 at 10:46 a.m., 11:36 a.m., and 2:13 p.m., on 1/6 at 9:50 a.m., on 1/7 at 9:14 a.m. and 11:00 a.m., and on 1/8/26 at 7:56 a.m., Resident 14 was observed in bed. At those times he was wearing oxygen at 1.5 liters per nasal cannula on the room concentrator. On 1/8/26 at 2:25 p.m. RN 1 entered the resident's room and observed the oxygen at 1.5 liters. The RN indicated, she was unaware what his oxygen was to be set at. The record for Resident 14 was reviewed on 1/6/26 at 4:03 p.m. Diagnoses included, but were not limited to, COPD, paranoid schizophrenia, intellectual disabilities, asthma, psychotic disorder, and high blood pressure. The 12/5/26 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact for daily decision making and wore oxygen while at the facility. The Care Plan, revised on 10/23/25, indicated the resident had oxygen therapy related to COPD. The approaches included to set the oxygen per physician's order. A Physician's Order, dated 10/16/25, indicated oxygen at one liter per nasal cannula and keep oxygen saturation about 90%. During an interview on 1/8/26 at 2:27 p.m., the B-Wing Unit Manager indicated the oxygen should be on the current liters per minute as ordered. 3.1-47(a)(6)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents were provided with medically related social services, related to the lack of documentation and follow up of an abuse allegation, missing cell phone, and a referral sent to another facility for 2 of 2 residents reviewed for Social Services. (Residents E and D)Findings include: 1. Closed record review for Resident E was completed on [DATE] at 9:38 a.m. Diagnoses included, but were not limited to, cancer, heart failure, hypertension, end stage renal disease, diabetes mellitus, thyroid disorder, anxiety, depression, chronic obstructive pulmonary disease, and metabolic encephalopathy. The admission Minimum Data Set (MDS) assessment, dated [DATE], indicated the resident was cognitively intact.A Behavior Charting Progress Note, dated [DATE] at 8:42 p.m., indicated the resident contacted 911 multiple times stating, we are breaking into her house. Prior to the behavior the resident was lying in bed. Interventions attempted were redirection and offered a beverage or snack. The resident was placed in a wheelchair and taken to the nurse's station after the second call to 911. The interventions were ineffective until taken to the nurse's station. The record lacked any documentation Social Services followed up on the behavior charting related to the resident calling 911.An Indiana Department Of Health Facility Reported Incident, dated [DATE], indicated the following:Description added - [DATE]-While Resident E was at a doctor's appointment, the resident reported to their staff that she was hit by a staff member at the facility, and her cell phone was stolen.Action Taken added - [DATE]-Investigation initiated. Staff and resident interviews initiated. Physician and family were notified.Type of injury added - [DATE]-Resident was still out of the facility for the appointment and an assessment would be completed immediately upon return to the facility.Type of preventative measures added - [DATE]-Investigation initiated. Staff and resident interviews initiated. Staff education ongoing. Physician and family were notified.-Follow up added - [DATE] -Upon investigation and interviews with staff and residents, the allegation was unsubstantiated. Upon skin assessment the resident showed no evidence of bruising or harm indicating abuse. The resident's inventory did not indicate a cell phone, and family could not confirm having a cell phone. The record lacked any documentation related to the facility reported incident. There was no documentation Social Services had interviewed the resident or completed any follow up with the resident related to the abuse allegation and the missing cell phone. A Change of Condition Progress Note, dated [DATE] at 11:56 p.m., indicated the resident had died. The resident's emergency contact indicated she would pick up the resident's belongings.The Personal Belongings Inventory had a handwritten note on it that indicated, all items were to be donated except the cell phone, charger, and glasses. The inventory was signed by the emergency contact on [DATE].During an interview on [DATE] at 3:06 p.m., the Administrator indicated the resident was confused. Social Services should have documented her interview with the resident and follow up information related to the resident calling 911, the abuse allegation, and the missing cell phone since the resident was showing confusion. During an interview on [DATE] at 11:01 a.m., the Social Services Director (SSD) indicated the resident was confused. She was made aware the resident had called 911. She did not complete any follow up with the resident after the incident as to why she had called 911. She was unsure how the resident called 911. She interviewed the resident after the abuse allegation and the resident indicated it did not happen, and the resident did not know what she was talking about related to a cell phone. She looked at the resident's inventory sheet, and a cell phone was not marked on the sheet, so she did not think the resident had a cell phone. She did not document the interview she completed with the resident related to the abuse allegation or the missing cell phone. She did not do any follow up with the resident since the resident said the abuse did not happen and she did not believe the resident had a cell phone. 2. Record review for Resident D was completed on [DATE] at 9:16 a.m. Diagnoses included, but were (continued on next page)

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	01/12/2026

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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not limited to, dementia, anemia, hypertension, neurogenic bladder, hyperlipidemia, and adult failure to thrive.The Quarterly MDS assessment, dated [DATE], indicated the resident was cognitively impaired. A Progress Note, dated [DATE] at 12:05 p.m., indicated a referral was faxed to another nursing home after a family request to do so.A Progress Note, dated [DATE] at 2:06 p.m., indicated the referred nursing home was called and they indicated the referral was passed on to management and they would return a call with an update.There was a lack of documentation of any more correspondence with the referred nursing home. There was no documentation related to the resident being accepted at the referred nursing home or not or if any more documentation was needed from the referred nursing home.During an interview on [DATE] at 11:10 a.m., the SSD indicated the above notes were written by a Social Services employee who no longer worked at the facility. She was unaware a referral had been sent to another facility for the resident, and the referral should have been followed up on and documented.The facility did not provide any Social Service policies.This citation relates to Intake 2578531.3.1-34(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on record review and interview, the facility failed to ensure insulin was administered as ordered and blood sugars were monitored for 1 of 5 residents reviewed for unnecessary medications. (Resident 4)Finding incudes:The record for Resident 4 was reviewed on 1/8/26 at 11:02 a.m. Diagnoses included, but were not limited to type 2 diabetes. The 11/12/25 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was not cognitively intact for daily decision making and received insulin. The Care Plan, revised on 11/3/25, indicated the resident had diabetes mellitus. The approaches were to check the resident's blood sugar as ordered by the physician. A Physician's Order, dated 11/5/25, indicated Insulin Glargine (a long acting insulin) inject 15 units subcutaneously (sq) every morning and at bedtime and to hold if the blood sugar was less than 100. The Medication Administration Record (MAR) for the months of 11/2025 and 12/2025, indicated the Glargine Insulin was administered at bedtime and there was no documentation the resident's blood sugar was checked on the following days: -11/13/25-11/15/25-11/17/25-12/4/25 During an interview on 1/12/26 at 9:40 a.m., the Nurse Consultant indicated there were no blood sugars available for review for the above mentioned dates. 3.1-48(a)(3)