STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. Building B. Wing	02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brickyard Healthcare - Merrillville Care Center	8800 Virginia Place Merrillville, IN 46410

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 1 of 3 residents observed during medication pass. Two errors were observed during 25 opportunities for errors during medication administration. This resulted in a medication error rate of 8%. (Resident G)Finding includes:During a morning Medication Pass Observation on 2/24/26 at 9:21 a.m., RN 1 indicated Resident G's glucometer reading was 285 and Lantus insulin 46 units and Novolog insulin six units were to be administered. She removed two insulin pens from the cart and dialed in 46 units on the Lantus pen and six units on the Novolog pen without priming the insulin pens. She then entered the resident's room and was stopped. She indicated she was unsure about priming the insulin pens and was unsure of the correct way to prime the insulin pens. The Clinical Education Nurse, at the time of the observation, instructed RN 1 to prime both pens with two units of insulin, then to dial in the correct dosage. The insulin was then administered to the resident.Resident G's record was reviewed on 2/24/26 at 2:24 P.M. The diagnoses included, but were not limited to, diabetes mellitus.A Physician's Order, dated 12/3/26, indicate Lispro (Novolog) insulin was to be administered per the results of the blood sugar level (sliding scale) four times a day. The dose for the blood sugar level of 285 was six units.A Physician's Order, dated 2/13/26, indicated 46 units of Glargine (Lantus) insulin was to be administered daily.During an interview on 2/24/26 at 2:20 p.m., the Director of Nursing indicated RN 1 was new to the facility and had been orientated to the medication pass policy and procedures.The facility's insulin pen administration policy, dated 2025 and received per e-mail from the Administrator in Training as current, indicated the insulin pen was to be primed with two units of insulin prior to the administration of the ordered amount of insulin.This citation relates to Intake 2740908.3.1-48(c)(1)

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