STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155685	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brickyard Healthcare - Elkhart Care Center	1001 W Hively Ave Elkhart, IN 46517

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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 - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to dispose of expired foods in a timely manner within the main kitchen's walk-in cooler. This deficient practice had the potential to affect 112 of 114 residents who consumed food from the kitchen.Finding includes:During an initial tour of the kitchen, on 8/4/2025 at 9:44 A.M., the following was observed in the walk-in cooler:-A container of corn dated 7/29/2025 with a use by of 7/31/2025-A container of chicken dated 7/3/2025-7 individualized cartons of yogurt in a cardboard box with use by date of 8/1/2025 -A serving bin with ice had 2 outdated yogurts -6 one-half gallon jugs of lime juice with a use by date of 7/14/2025 During an observation and interview on 8/4/2025 at 9:54 A.M. with the Regional Certified Dietary Manager of the walk- in cooler, she indicated the foods should have been disposed within the expiration dates. A policy was provided, on 8/4/2025 at 11:27 A.M., by the Regional Certified Dietary Manager. The policy, titled, Date Marking for Food Safety, indicated, .The facility adheres to a date marking system to ensure the safety of ready-to-eat, time/temperature control for safety of food .1. Refrigerated, ready-to-eat, time/temperature control for safety food [i.e. perishable food] shall be held at a temperature of 41 [degrees Fahrenheit] or less for a maximum of 7 days. 2. The food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded .5. The discard day or date may not exceed the manufacturer's use-by-date, or four days, which ever is earliest. The date of opening or preparation counts as day 1. [For example, food prepared on Tuesday shall be discarded on or by Friday]. 6. The Head Cook, or designee, shall be responsible for checking the refrigerator daily for food items that are expiring, and shall discard accordingly. 7. The Dietary Manager, or designee, shall spot check refrigerators weekly for compliance, and document accordingly. Corrective action shall be taken as needed 3.1-21(i)(2)

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure a clean, sanitary and comfortable environment was maintained on 2 of 4 units. (400 hall and 500 hall).Findings include: 1. During an interview and observation, on 8/4/2025 at 10:18 A.M., Resident 56 complained of gnats and flies in her room. The resident indicated it had been going on for the past 2-3 weeks. The wall by the resident's bed had dark colored liquid speck marks and the privacy curtains were stained with dark colored specks. 2. During an observation, on 8/4/2025 at 10:41 A.M., several live flies were observed in room [ROOM NUMBER]. 3. During an interview, on 8/4/2025 at 11:07 A.M., Resident 95 indicated she still had flies in her room. She stated, We have them (flies) bad. 4. During an observation, on 8/4/2025 at 11:52 A.M., the wall behind Resident 87's bed was gouged and had black scuff marks. 5. During an observation of the memory care unit on 8/5/2025 at 8:38 A.M., there were several fruit flies seen throughout the unit. Resident 77 indicated, they (flies) were in his room and everyone else's. 6. During an observation, on 8/5/2025 at 10:10 A.M. in room [ROOM NUMBER], a foam fall mat on the floor next to Resident 3's bed had dark circular stained areas, the window blind was broken in numerous places and the trim around the window was cracked in two places.7. During an observation, on 8/5/2025 at 11:24 A.M., several flies were noted on Resident 17's bed linens. During a tour of the facility with the Administrator, on 8/12/2025 at 3:01 P.M., the following was observed:-flies were observed flying in the hallway leading to the 400 hall.-the floor in room [ROOM NUMBER]smelled of urine and floor was sticky -the 500 hall shower room had dead bugs in the sink and gnats flying around the sink, there was equipment stored in the tub and the tub had a dried brown substance in the bottom, there was also a bucket from a bed side commode that had a dark brown substance dried to the bottom surface. -the 400 hall lounge area had an accumulation of food crumbs on the rug, cob webs behind a love seat, a dried dark substance, bed linens and an empty snack bag on the floor. During an interview, on 8/12/2025 at 3:29 P.M., the Administrator indicated the dirty items, walls and broken items should be fixed and cleaned. He indicated the shower room was not being used as a shower room at this time. He indicated there should be a lock on the door to keep any resident out of the shower room. He indicated the facility followed the state guidelines on cleaning. On 8/12/2025 at 3:45 P.M., the Administrator provided the policy titled, Preventative Maintenance Program, undated, and indicated the policy was the one currently used by the facility. The policy indicated . A Preventative Maintenance Program shall be developed and implemented to ensure the provision of a safe, functional, sanitary, and comfortable environment for residents, staff and the public . 2. The Maintenance Director shall assess all aspects of the physical plant to determine if Preventative Maintenance (PM) is required . 3. If preventative maintenance is required, the Maintenance director shall decide what tasks need to be completed and how often to complete them This citation relates to complaints IN00462615 and IN00461580. 3.1-19(f)

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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 ensure 2 of 6 residents reviewed for medications were free from unnecessary medications related to having an appropriate diagnosis for the use of an antipsychotic medication and a PRN (as needed) antianxiety medication used for greater than 14 days without adequate documentation. (Resident 125 and 72).1. The closed record for Resident C was completed on 8/10/2025 at 2:45 P.M. Diagnoses included but were not limited to: fracture to the left femur, diabetes, end stage renal disease, depression and anxiety. Resident C's medication orders included Olanzapine (an antipsychotic medication) Oral Tablet 5 MG, 1 tablet by mouth at bedtime for Depression. During an interview, on 8/11/2025 at 12:10 P.M., the Director of Nursing indicated depression was not an appropriate diagnoses for the medication. There was no other diagnosis or medical symptom to support the use of Olanzapine for Resident C. 2. A record review was completed for Resident 72 on 8/7/2025 at 10:49 A.M. Diagnoses included ,but were not limited to: anxiety disorder and dementia. A Physician's Order, initiated on 12/18/2025 and discontinued on 1/18/2025 indicated Resident 72 had been prescribed lorazepam 0.5 mg (milligrams) one tablet by mouth as needed for anxiety and agitation. Resident 72's electronic medical record lacked documentation from the physician for the use of an antianxiety medication for greater than 14 days. During an interview, on 8/11/2025 at 2:36 P.M., the DON indicated Resident 72 should not have been on the lorazepam for greater than 14 days. On 8/8/2025 at 1:09 P.M., the ED provided the policy titled Use of Psychotropic Medications, no date and indicated it was the policy currently being used by the facility. The policy indicated, 2. Psychotropic medications are to be used only when a practitioner determines that the medication is appropriate to treat a resident's specific, diagnosed and documented condition and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication. 16a. PRN orders for psychotropic medications, excluding antipsychotics, shall be limited to no more than 14 days, unless the attending physician or prescribing practitioner believes it is appropriate to extend the order beyond the 14 days. The medical record should include documentation from the physician or prescriber for the rationale for the extended time period and indicate a specific duration This citation relates to Complaint 1547766 3.1-26

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review and interview, the facility failed to ensure a care plan related to pressure ulcers was initiated timely for 1 of 3 residents reviewed for pressure ulcers. (Resident 7) In addition, the facility failed to ensure a comprehensive plan of care initiated for post traumatic stress disorder had personalized interventions for 1 of 1 residents reviewed .for post traumatic stress disorder (Resident 46) 1.A record review for Resident 7 was completed, on 8/6/2025 at 11:11 A.M. Diagnoses included, but not limited to, cardiac arrest, ischemia of lower extremity resulting in left leg gangrene and amputation, right leg extensive debridement and resulting foot drop, cardiomyopathy, sarcoidosis of the heart, type 2 diabetes, atrial fibrillation and sleep apnea. A weekly skin check, dated 4/23/25, indicated the resident had developed a new, unstageable deep tissue injury, on the right lateral forefoot near the 5th digit. The wound measured 0.4 centimeters wide by 1.6 centimeters deep. On 4/25/2025, the facility physician examined the resident's right foot wound and recommended to continue Betadine treatment. On 4/29/2025, an order was received for ProT Gold twice daily. On 5/7/2025, weekly skin check records indicated the wound measured 0.4 cm wide by 0.7 deep. On 5/19/2025, nursing progress notes indicated the resident had returned from a doctor appointment with new orders to cleanse the right lateral foot wound, stop the Betadine and apply Medihoney and cover with gauze daily. On 5/28/2025, weekly skin check forms indicated the right foot wound measured 1 cm wide by 1.2 cm deep. An order was received, on 5/30/2025, to refer the resident to a wound center. On 6/4/2025, nursing progress notes indicated the referral had been faxed to a local wound clinic, and the facility was waiting on the wound clinic to call back with a scheduled appointment for the resident. On 6/4/2025 an order for fortified foods for nutritional support was entered in the medical record. On 6/11/2025, per the weekly skin check record, the right foot wound measured 0.8 cm wide by 0.9 cm deep. On 6/12/2025, a care plan was created for the right foot wound which included the following interventions: following facility protocols for treatment of injury, monitor and document location, size and treatment of skin injury and providing a pressure relieving/reducing mattress to protect skin while in bed. During an iinterview, on 08/11/2025 8:52 AM, the Director of Nursing indicated a care plan for the right foot wound should have been created when the wound was identified in April. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. A record review was completed for Resident 46 on 8/8/2025 at 8:55 A.M. Diagnoses included, but were not limited to: post-traumatic stress disorder and behavioral disturbance. A Care Plan, initiated on 5/10/2017 indicated Resident 46 had a diagnosis of personal history of adult physical and sexual abuse, personal history of physical and sexual abuse in childhood, and post traumatic stress disorder that may contribute to behaviors. Interventions included and were limited to: encourage participation from resident who depends on others to make own decisions, if I'm upset, please re-direct the conversation or task as able, offer me step-by-step instructions and give me visual and verbal cues throughout care. Resident 46's care plan lacked person centered interventions. During an interview, on 8/8/2025 at 9:37 A.M., LPN 5 indicated loud noises and overstimulation were triggers for Resident 46's post traumatic stress disorder. She indicated doing one on one time, offering the resident drinks or snacks and taking the resident to a new area were interventions that worked for the resident. She indicated Resident 46's care plan was not person centered and the interventions that helped the resident should have been added to her care plan. On 8/11/2025 at 12:02 P.M., the DON provided the policy titled Comprehensive Care Plans, no date and indicated it was the policy currently being used by the facility. The policy indicated, Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality. 2. The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment. All care areas triggered by the MDS will be considered in the developing the plan of care. 3. The comprehensive care plan with describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. 3G. Individualized interventions for trauma survivors that recognizes the interrelation between trauma and symptoms of trauma, as indicated . Trigger-specific interventions will be used to identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the triggers on the resident. 3.1-35 3.1-35(b)(1) 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure medication orders were followed correctly regarding administering blood pressure medications and insulin and blood glucose assessments for 5 of 7 residents whose medications were reviewed. (Residents 87, 122, 2, 53 and 13) 1. The record for Resident 87 was completed on 8/4/2025 at 11:48 A.M. Diagnoses included, but were not limited to end stage renal disease, orthostatic hypotension, hypertension and aortic valve stenosis. Resident 87's Physician's Order, dated 7/21/2025, indicated to administer Midodrine (medication to treat low blood pressure) 10 milligrams (mg), 1 tablet three times a day for hypotension. The order indicated the following parameter: Do not give if SBP (systolic blood pressure) is greater than 100. The Medication Administration Record (MAR) from July 22- 29, 2025, indicated the following: -on 7/23 at 8:00 A.M., the blood pressure (B/P) was documented as 126/45 mmHg and the medication had been administered. -on 7/23 at 2:00 P.M., the B/P was documented as 126/45 mmHg and the medication had been administered. -on 7/24 at 2:00 P.M., the B/P was documented as 104/61 mmHg and the medication had been administered. -on 7/26 at 8:00 A.M., the B/P was documented as 121/73 mmHg and the medication had been administered -on 7/26 at 10:00 P.M., the B/P was documented as 107/75 mmHg and the medication had been administered. -on 7/27 at 10:00 P.M., the B/P was documented as 133/59 mmHg and the medication had been administered. -on 7/28 at 10:00 P.M., the B/P was documented as 134/63 mmHg and the medication had been administered. A Physician's Order, dated 7/29/2025, indicated Midodrine 5 mg, 1 tablet three times a day for hypotension. The order included the following parameter: Do not give if SBP is greater than 110. The Medication Administration Record (MAR) for July 30 - 31, 2025, indicated the following: -on 7/30 at 2:00 P.M., the B/P was documented as 126/47 mmHg and the medication had been administered. -on 7/30 at 10:00 P.M., the B/P was documented as 102/64 mmHg and the medication had been administered. The MAR for August 2025 indicated the following: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-on 8/1 at 10:00 P.M., the B/P was documented as 111/58 mmHg and the medication had been administered. -on 8/2 at 2:00 P.M., the B/P was documented as 108/58 mmHg and the medication had been administered. -on 8/4 at 8:00 A.M., the B/P was documented as 117/55 mmHg and the medication had been administered. -on 8/4 at 2:00 P.M., the B/P was documented as 104/43mmHg and the medication had been administered. -on 8/4 at 10:00 P.M., the B/P was documented as 114/50 mmHg and the medication had been administered. -on 8/5 at 2:00 P.M., the B/P was documented as 124/50 mmHg and the medication had been administered. -on 8/6 at 8:00 A.M., the B/P was documented as 120/51 mmHg and the medication had been administered. During an interview, on 8/8/2025 at 11:54 A.M., the Director of Nursing indicated the medication should have been held on the days the blood pressure was out of the parameters. 2 A record review for Resident 122 was completed on 08/11/2025 at 9:29 A.M . Diagnoses included, but were not limited to: Chronic Obstructive Pulmonary Disease, Type 2 Diabetes , Chronic Kidney Disease stage 3, muscle weakness, history of Pulmonary embolism, Congestive Heart Failure, heart valve disease, and atrial fibrillation. A Physician's order, dated 6/11/2025, indicated Midodrine 2.5 milligrams, 1 tablet by mouth three times a day for low BP (blood pressure) for 2 weeks was to be administered. In addition, the following parameter was ordered: Hold for a systolic BP < (sic) 110* A review of the June Medication Administration Record (MAR) indicated the following: 6/11/25 PM Blood Pressure 104/52 mmHg , Midodrine 2.5 mg administered. 6/12/25 AM Blood Pressure 121/56 mmHg , Midodrine 2.5 mg administered 6/12/25 Noon Blood Pressure 108/60 mmHg , Midodrine 2.5 mg administered 6/13/25 Noon Blood Pressure 102/64 mmHg , Midodrine 2.5 mg administered 6/14/25 AM Blood Pressure 96/53 mmHg , Midodrine 2.5 mg administered 6/14/2025 Noon Blood Pressure 90/51mmHg , Midodrine 2.5 mg administered, 6/14/2026 PM Blood Pressure 89/56 mmHg , Midodrine 2.5 administered (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/15/25 AM Blood Pressure 90/50 mmHg , Midodrine 2.5 administered 6/15/25 Noon Blood Pressure 90/51 mmHg , Midodrine 2.5 administered 6/15/25, PM Blood Pressure 93/58 mmHg , Midodrine 2.5 administered 6/16/25 AM Blood Pressure 109/75 mmHg, Midodrine 2.5 administered 6/16/25 Noon Blood Pressure 98/54 mmHg , Midodrine 2.5 administered 6/16/25 PM Blood Pressure 97/58 mmHg , Midodrine 2.5 administered 6/17/25 AM Blood Pressure 98/60 mmHg , Midodrine 2.5 mg administered 6/17/25 Noon Blood Pressure 96/66 mmHg , Midodrine 2.5 administered 6/18/25 AM Blood Pressure 95/66 mmHg , Midodrine 2.5 mg administered. Resident122 was then discharged to an acute hospital for gastrointestinal bleeding. During an interview, on 08/12/2025 at 9:55 AM, the DON reviewed the June MAR and July MAR for the inconsistency of the midodrine administration due to the incorrect use of the < symbol. The DON agreed that the < sign was wrong and should have been >. The DON indicated the facility did not have a policy regarding the use of symbols in charting. 3. A record review for Resident 2 was completed on 8/7/2025 at 10:33 A.M. Diagnoses included, but were not limited to: diabetes mellitus type 2, borderline intellectual functioning and schizophrenia. A Quarterly Minimum Data Set (MDS) assessment, dated 5/29/2025, indicated Resident 2 had moderate cognitive impairment and received insulin injections. A current Care Plan, initiated on 3/21/2025, indicated Resident 2 had diabetes mellitus and was at risk for complications. Interventions included, but were not limited to: to give diabetes medications as ordered by the physician and monitor/document/report PRN (as needed) any signs/symptoms of hyperglycemia: increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, abdominal pain, Kussmaul breathing (a deep, labored and sometimes gasping type of breathing associated with metabolic acidosis), acetone breath (smells fruity), stupor or coma A Physician's Order, dated 5/14/2025, indicated the resident was to receive Lispro Injection Solution (short acting insulin) 100 units per milliliters (unit/ml) inject 10 units subcutaneously before meals for hyperglycemia. A Physician's Order, dated 7/13/2025, indicated the resident was to receive Glargine Subcutaneous Solution (long acting insulin) 100 unit/ml inject 20 units one time a day for diabetes mellitus type 2. A blood glucose assessment, obtained, on 7/14/2025 at 5:20 P.M. had a result of 563 mg/dL (milligrams per deciliter) and was reported to the on-call Physician's Assistant. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Physician's Assistant Triage Note, dated 7/14/2025 at 5:42 P.M., indicated the facility was to give 16 units of Lispro Injection Solution, ensure the Resident 2 ate dinner, push oral fluids and recheck the resident's blood sugar in 1 hour and if the blood sugar was greater than 450 mg/dL , they were to call for additional instructions. However, review of the clinical record for Resident 2 indicated there was no documentation that the newly ordered amount of Lispro Injection Solution had been given, on 7/14/2025 or that the blood sugar had been rechecked an hour after the insulin was given. During an interview, on 8/12/2025 at 11:35 A.M., the Director of Nursing (DON) indicated there was no documentation the orders given by the Physician Assistant, on 7/14/2025 in regards to a one time dose of Lispro insulin, pushing fluids or rechecking the resident's blood sugar after an hour had been followed. The DON indicated, on 8/12/2025 at 11:53 A.M., that the nurse on duty on 7/14/2025 indicated she had not documented the orders as having been completed. A policy for following physician orders was requested on 8/12/2025 at 12:42 P.M. The DON indicated, on 8/12/2025 at 2:44 P.M., a policy was not available for following physician orders. 4. A record review was completed for Resident 53 on 8/6/2025 at 11:16 A.M. Diagnoses included, but were not limited to: hypertension and hypotension. An admission Minimum Data Set (MDS), dated [DATE] indicated Resident 53's cognition was severely impaired. A Physician's Order, dated 6/6/2025 indicated to give Propranolol hydrochloride 10mg (milligrams) one tablet by mouth three times a day for hypertension. Additional instructions included were to Hold Propranolol hydrochloride if systolic blood pressure was less than 110 mmHg (millimeters of mercury) or if heart rate was less than 60 bpm (beats per minute). A Physician's Order, dated 5/15/2025 indicated to give Midodrine hydrochloride 5mg tablet by mouth three times a day for hypotension. Additional instructions were to: Hold Midodrine hydrochloride if systolic blood pressure was greater than 120 mmHg. A review of Resident 53's Medication Administration Record (MAR) indicated Propranolol hydrochloride 10mg one tablet by mouth was administered to the resident on the following dates with the corresponding blood pressures readings: -On 6/11/2025 Resident 53's blood pressure result was 109/73 mmHg. -On 6/21/2025 Resident 53's blood pressure result was 98/52 mmHg. -On 7/5/2025 Resident 53's blood pressure result was 98/74 mmHg. -On 7/10/2025 Resident 53's heart rate was 56 bpm. -On 7/20/2025 Resident 53's blood pressure result was 102/68 mmHg. -On 7/30/2025 Resident 53's blood pressure results were 109/72 mmHg and 101/68 mmHg. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 53's MAR indicated Midodrine hydrochloride 5mg tablet by mouth was administered to the resident on the following dates with the corresponding blood pressures: -On 5/17/2025 Resident 53's blood pressure result was 128/74 mmHg. -On 5/19/2025 Resident 53's blood pressure results were 126/76 mmHg and 122/70 mmHg. -On 5/23/2025 Resident 53's blood pressure results were 132/82 mmHg and 136/78 mmHg. -On 5/27/2025 Resident 53's blood pressure results were 150/82 mmHg and 132/82 mmHg. -On 5/28/2025 Resident 53's blood pressure results were 142/72 mmHg and 126/74 mmHg. -On 5/30/2025 Resident 53's blood pressure result was 128/72 mmHg. -On 5/31/2025 Resident 53's blood pressure result was 130/78 mmHg. -On 6/1/2025 Resident 53's blood pressure results were 146/88 mmHg and 134/82 mmHg. -On 6/2/2025 Resident 53's blood pressure results were 146/74 mmHg and 130/70 mmHg. -On 6/6/2025 Resident 53's blood pressure results were 128/64 mmHg and 124/82 mmHg. -On 6/9/2025 Resident 53's blood pressure result was 124/78 mmHg. -On 6/10/2025 Resident 53's blood pressure results were 132/68 mmHg and 124/62 mmHg. -On 6/12/2025 Resident 53's blood pressure result was 128/72 mmHg. -On 6/14/2025 Resident 53's blood pressure results were 138/60 mmHg and 122/60 mmHg. -On 6/15/2025 Resident 53's blood pressure results was 142/82 mmHg. -On 6/18/2025 Resident 53's blood pressure result was 124/62 mmHg. -On 6/19/2025 Resident 53's blood pressure result was 124/70 mmHg. -On 6/20/2205 Resident 53's blood pressure results were 128/66 mmHg and 130/74 mmHg. -On 6/22/2025 Resident 53's blood pressure result was 131/66 mmHg. -On 6/23/2025 Resident 53's blood pressure results were 124/80 mmHg and 132/84 mmHg. -On 6/24/2025 Resident 53's blood pressure results were 153/88 mmHg and 142/72 mmHg. -On 6/25/2025 Resident 53's blood pressure results were 138/74 mmHg and 148/88 mmHg.-On 6/26/2025 Resident 53's blood pressure results were 130/62 mmHg and 160/93 mmHg. -on 6/28/2025 Resident 53's blood pressure results were 130/76 mmHg and 136/80 mmHg. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155685	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brickyard Healthcare - Elkhart Care Center	1001 W Hively Ave Elkhart, IN 46517

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 6/29/2025 Resident 53's blood pressure results were 130/76 mmHg and 128/60 mmHg. -On 6/30/2025 Resident 53's blood pressure result was 126/78 mmHg. -On 7/1/2025 Resident 53's blood pressure result was 128/72 mmHg.-On 7/2/2025 Resident 53's blood pressure result was 128/72 mmHg. -On 7/4/2025 Resident 53's blood pressure results were 130/76 mmHg and 144/62 mmHg. -On 7/8/2025 Resident 53's blood pressure result was 128/82 mmHg. -On 7/10/2025 Resident 53's blood pressure result was 140/76 mmHg. -On 7/12/2025 Resident 53's blood pressure results were 132/74 mmHg, 124/66 mmHg and 128/68 mmHg. -On 7/13/2025 Resident 53's blood pressure results were 138/96 mmHg and 134/92 mmHg. -On 7/16/2025 Resident 53's blood pressure result was 128/72 mmHg. -On 7/18/2025 Resident 53's blood pressure results were 122/74 mmHg and 128/64 mmHg. -On 7/23/2025 Resident 53's blood pressure results were 154/90 mmHg and 122/65 mmHg. -On 7/26/2025 Resident 53's blood pressure result was 126/68 mmHg. -On 7/27/2025 Resident 53's blood pressure results were 122/86 mmHg, 124/72 mmHg and 125/75 mmHg. -On 8/1/2025 Resident 53's blood pressure results were 130/94 mmHg, 124/88 mmHg and 130/82 mmHg. -On 8/5/2025 Resident 53's blood pressure result was 152/90 mmHg. -On 8/7/2025 Resident 53's blood pressure result was 129/83 mmHg. 5. A record review was completed for Resident 13 on 8/7/2025 at 2:27 P.M. Diagnoses included, but were not limited to: hypotension. A Physician's Order, dated 7/14/2025 indicated Midodrine hydrochloride 5mg give one tablet by mouth three times a day for hypotension. Additional instructions included to hold Midodrine hydrochloride 5mg tablet when the systolic blood pressure was greater than 125 mmHg. A review of Resident 13's MAR indicated Midodrine hydrochloride was administered to the resident on the following dates with the corresponding blood pressures: -On 7/16/2025 Resident 13's blood pressure result was 128/72 mmHg. -On 7/17/2025 Resident 13's blood pressure result was 126/78 mmHg. (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 - Few	-On 7/18/2025 Resident 13's blood pressure results were 130/68 mmHg and 128/76 mmHg. -On 7/21/2025 Resident 13's blood pressure result was 127/76 mmHg. -On 7/22/2025 Resident 13's blood pressure results were 150/96 mmHg and 134/82 mmHg. -On 7/23/2025 Resident 13's blood pressure results were 142/76 mmHg and 132/74 mmHg. -On 7/24/2025 Resident 13's blood pressure result was 128/68 mmHg. -On 7/26/2025 Resident 13's blood pressure result was 126/72 mmHg. -On 7/27/2027 Resident 13's blood pressure results was 128/92 mmHg. -On 7/28/2025 Resident 13's blood pressure result was 128/72 mmHg. -On 7/30/2025 Resident 13's blood pressure result was 128/74 mmHg. -On 7/31/2025 Resident 13's blood pressure results were 134/82 mmHg and 130/70 mmHg. -On 8/1/2025 Resident 13's blood pressure results were 150/98 mmHg, 136/82 mmHg and 133/78 mmHg. -On 8/5/2025 Resident 13's blood pressure results were 126/70 mmHg and 140/88 mmHg. -On 8/9/2025 Resident 13's blood pressure results were 126/70 mmHg, 130/72 mmHg and 132/68 mmHg. -On 8/10/2025 Resident 13's blood pressure result was 140/86 mmHg. During an interview, on 8/11/2025 at 8:50 A.M. the DON indicated Residents 53 and 13 should not have been receiving the Midodrine or the Propranolol if their vital signs were outside the ordered parameters. On 8/11/2025 at 12:02 P.M., the DON provided the policy titled, Medication Administration, no date and indicated it was the policy currently being used by the facility. The policy indicated, 8. Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters This citation relates to Complaints 1547766 and 1547767 3.1-37

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure interventions were implemented to prevent contractures for 1 of 3 residents reviewed for range of motion. (Resident 95)Finding includes:During an observation and interview on 8/5/2025 at 11:04 A.M., Resident 95 indicated she had an orthosis for her left hand, but did not know were the orthosis was located in her room. The resident was not wearing any orthosis on her left hand. During observations, on 8/6/2025 at 9:22 A.M., 8/6/2025 at 11:53 A.M., 8/7/2025 at 9:55 A.M., 8/7/2025 at 2:04 P.M., 8/8/2025 at 1:20 P.M. and 8/12/2025 at 9:45 A.M., Resident 95 was lying in bed with her left hand in a fisted position. She did not have an orthosis in place. A record review for Resident 95 was on 8/6/2025 at 11:16 A.M. Diagnoses included, but were not limited to: hemiplegia, lymphedema, diabetes mellitus type 2 and neuromuscular dysfunction of the bladder. A Quarterly Minimum Data Set (MDS) assessment, dated 7/20/2025, indicated Resident 95 was cognitively intact, was dependent for bed mobility and transfers, had range of motion impairment on one side of the body and had received occupational therapy from February 18, 2025 through March 17, 2025. A Physician's Order, dated 3/12/2025, indicated, .Place hand orthosis on in the morning and remove at bedtime An Occupational Therapy Discharge summary, dated [DATE] at 4:11 P.M., included a long term goal of: .Patient will tolerate opponens (opponent muscle])inflate hand orthosis [NAME] (inflatable splint) on discharge from occupational therapy, The notes indicated Resident 95 had been tolerating the [NAME] placements throughout the day with device removed at nighttime. A Nursing Progress Note, on 7/18/2025 at 2:23 P.M., indicated Resident 95 had upper and lower extremity impairment due to hemiplegia and staff assisted her with dressing, grooming, bathing, skin care, toileting/hygiene, transfers, bed mobility, and nutrition/fluid needs. There was no Care Plan addressing the resident's hemiplegia or the use of the orthosis. During an interview, on 8/12/2025 9:48 A.M., CNA 3 indicated Resident 95 had had an orthosis the prior year, but had not worn the orthosis recently. During an interview, on 8/12/2025 at 9:52 A.M., RN 4 indicated Resident 95 wore the orthosis when she was out of bed and in her wheelchair. However, during morning and afternoon observations, Resident 95 was always in her bed. A policy for orthosis use and range of motion was requested on 8/12/2025 at 12:42 P.M. The DON indicated, on 8/12/2025 at 2:44 P.M., a policy was not available for orthosis use or range of motion. 3.1-42(a)(2)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure medications were available and administered as ordered (Resident B) and failed to ensure a residents reviewed for medications was assessed for potential adverse side effects. (Resident 13) This deficient practice affected 2 of 7 residents reviewed for medications. (Resident B and 13) Findings include: 1.The closed record for resident B was reviewed on 8/8/2025 at 7:52 A.M. Diagnoses included: diabetes, kidney transplant, epilepsy, atrial fibrillation, gastro esophageal reflux disease and depression. The resident was re-admitted to the facility on [DATE] and was discharged on 6/24/2025. Resident B's May and June medications included the following: Apixaban 5 mg (milligram) 1 tablet twice a day; Glipizide 10 mg 1 tablet every day; Pantoprazole 40 mg 1 tablet twice a day and Pregabalin 50 mg 1 tablet once a day. A Nurse's Progress Note, dated 5/10/2025 at 9:07 P.M. indicated the Apixaban medication was unavailable and was not administered. A Nurse's Progress Note, dated 5/10/2025 at 9:08 P.M., indicated the Pantoprazole medications was unavailable and was not administered. A Nurse's Progress Note, dated 5/10/2025 at 10:02 P.M., indicated the Pregabalin medication was unavailable and was not administered. A Nurse's Progress Note, dated 5/11/2025 at 5:35 A.M , indicated awaiting from pharmacy of the Pregabalin medication and was not administered. A Nurse's Progress Note, dated 5/11/2025 at 1:27 P.M., indicated awaiting from pharmacy of the Pregabalin medication. A Nurse's Progress Note, dated 5/11/2025 at 9:01 P.M., indicated the Pregabalin medication was unavailable and was not administered. A Nurse's Progress Note, dated 5/11/2025 at 9:13 P.M., indicated awaiting from pharmacy of the Pregabalin medication. A Nurse's Progress Note, dated 5/11/2025 at 10:02 P.M., indicated the Pregabalin medication was on order and the nurse was notified. A Nurse's Progress Note, dated 5/16/2025 at 10:20 A.M., indicated the Glipizide medication was not in the cart and was not administered. On 8/11/2025 at 10:24 A.M., the Director of Nursing provided the list of emergency medications that would have been available in the emergency drug storage. The following medications were listed: Eliquis (Apixaban) 5mg tablets; Pantoprazole 40 mg tablets; Pregabalin 50 mg tablets and Glipizide 5 mg tablets. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 8/12/2025 at 2:45 PM., the Director of Nursing indicated the medications should have been pulled from the emergency drug supply and administered as ordered. During an interview, on 8/12/2025 at 3:30 P.M., the Director of Nursing indicated she could not provide a policy regarding utilizing the facility's emergency drug supply. 2. A record review was completed for Resident 13 on 8/7/2025 at 2:27 P.M. Diagnoses included, but were not limited to: dementia with agitation, delirium due to known physiological condition and generalized anxiety disorder. A Physician's Order, initiated on 12/12/2024 and discontinued on 12/23/2024 indicated Seroquel (an antipsychotic medication) 100 mg (milligrams), 1.5 tablets by mouth at bedtime was to be administered. A Physician's Order, initiated on 5/13/2025 and discontinued on 6/10/2025 indicated quetiapine fumarate (an antipsychotic medication) 100 mg, one tablet by mouth at bedtime was to be administered. A Physician's Order, initiated on 6/10/2025 and discontinued on 7/6/2025 indicated Seroquel 75 mg give one tablet by mouth at bedtime was to be administered. A Physician's Order, initiated on 7/7/2025 indicated quetiapine fumarate 100 mg give one tablet by mouth at bedtime was to be administered. There was only one Abnormal Involuntary Movement Scale (AIMS) assessment, dated 6/23/2025, completed for Resident 13 in the past 12 months. During an interview, on 8/11/2025 at 8:50 A.M., the DON indicated Resident 13 should have had more than one AIMS assessment in the last 12 months and there was no other documentation Resident 13 had been assessed for adverse side effects related to the use of antipsychotic medications. On 8/8/2025 at 1:09 P.M., the ED provided the policy titled, Use of Psychotropic Medications no date and indicated it was the policy currently being used by the facility. The policy indicated, .13. Residents who receive and antipsychotic medication will have an Abnormal Involuntary Movement Scale (AIMS) test performed on admission, quarterly, or PRN This citation relates to Complaint 1547766 3.1-25(a) 3.1-25(b)(2)