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	08/08/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record review and interview, the facility failed to ensure interventions were attempted prior to administering a PRN (as needed) anti-anxiety medication for 1 of 3 residents reviewed for mood/behavior. (Resident 114)Finding includes:The record for Resident 114 was reviewed on 8/6/25 at 3:03 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, psychotic disorder with delusions, and anxiety disorder. The Significant Change Minimum Data Set (MDS) assessment, dated 7/16/25, indicated the resident was severely cognitively impaired. A Care Plan, updated on 11/8/24, indicated the resident used psychotropic medications related to psychotic disorder, depression, and anxiety.A Physician's Order, dated 7/10/25, indicated lorazepam (Ativan, an anti-anxiety medication) 1 mg (milligram), every 8 hours as needed for anxiety. A Physician's Order, dated 7/7/25, indicated hydroxyzine pamoate (an antihistamine medication also used to treat anxiety) 25 mg every 8 hours as needed for anxiety.The Medication Administration Record (MAR), dated 7/2025, indicated the lorazepam was administered without any prior interventions documented on the following dates and times:-7/11/25 at 10:15 a.m.-7/16/25 at 2:00 a.m., 10:07 a.m., and 6:12 p.m. The Medication Administration Record (MAR), dated 7/2025, indicated the hydroxyzine was administered without any prior interventions documented on the following dates and times:-7/7/25 at 2:27 p.m.-7/11/25 at 6:22 a.m. During an interview on 8/7/25 at 3:29 p.m., the Director of Nursing (DON) indicated she was unable to provide any further documentation. A policy on PRN medication administration was requested.A policy, titled PRN Medications, received from the DON as current, indicated .1. Documentation will be provided in the resident's medical record to show adequate indications for a medication's use and diagnosed condition for which it was prescribed.3. When administering a PRN medication.b. Document the reason voiced by the resident and/or assessment findings that show why the resident needs the medication. Verify the reason is for the prescribed indication for the medication. 3.1-48(a)(4)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 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 was developed and in place for a resident receiving an anti-anxiety medication for 1 of 33 residents reviewed for care plan development. (Resident 11)Finding includes:Resident 11's record was reviewed on 8/6/25 at 10:17 a.m. Diagnoses included, but were not limited to, fracture of the right femur, rheumatoid arthritis and generalized anxiety disorder. The admission Minimum Data Set (MDS) assessment, dated 6/27/25, indicated the resident was cognitively intact and was dependent for toileting, bed mobility and transfer assistance. The resident received anti-anxiety medications. A Nurse Practitioner Note, dated 7/30/25, indicated the resident's medications included chlordiazepoxide 5 milligram (mg) capsules, every 8 hours as needed for anxiety for 14 days. The current Physician Order Summary indicated clonazepam 5 mg every 12 hours for anxiety. There was no care plan related to anti-anxiety medication use. On 8/7/25, the Director of Nursing provided care plans related to a mood problem, psychotropic medication use and discharge planning. The care plans did not include any indication the resident was using anti-anxiety medications or interventions related to anxiety. During an interview on 8/7/25 at 3:37 p.m., the MDS Nurse indicated if a resident was taking an anti-anxiety medication, there should be an Anti-anxiety Medication Care Plan. 3.1-35(a)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, record review and interview, the facility failed to ensure a dependent resident received the activities of daily living (ADL) assistance required related to dirty, uncut fingernails for 1 of 5 residents reviewed for ADL care. (Resident 144)Finding includes: On 8/4/25 at 10:21 a.m., Resident 144 was observed lying in his bed. He indicated he wasn't getting his scheduled showers and they hadn't cleaned his fingernails. He held up his hands and there was dark debris observed under his fingernails. On 8/8/25 at 1:32 p.m., the resident was again observed in his bed. He indicated he had received a bath, but they sill had not cleaned or cut his fingernails. His fingernails were slightly long and there was dark debris under his fingernails. The resident's record was reviewed on 8/8/25 at 1:08 p.m. Diagnoses included, but were not limited to, diabetes mellitus, congestive heart failure and osteoarthritis. The admission Minimum Data Set (MDS) assessment, dated 6/15/25, indicated the resident had moderate cognitive impairment and required substantial assistance for bed mobility and was dependent for transfers and toileting. The current ADL Care Plan indicated the resident had a self-care deficit and needed 1-2 person assistance with bathing and 1 person assistance with personal hygiene and oral care as needed, During an interview on 8/8/25 at 1:34 p.m. , the MDS Nurse indicated that she would take care of his fingernails. 3.1-38(a)(3)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, record review, and interview, the facility failed to ensure an indwelling urinary catheter collection bag and tubing for a resident with a history of infection was kept off the floor for 1 of 2 residents reviewed for urinary catheters. (Resident 91)Finding includes:On 8/4/25 at 11:40 a.m., Resident 91 was observed lying in bed. The resident's urinary catheter bag was resting on the floor next to the bed.On 8/6/25 at 3:06 p.m., Resident 91 was observed lying in bed. The resident's urinary catheter bag and tubing were resting on the floor next to the bed.Record review for Resident 91 was completed on 8/6/25 at 3:02 p.m. Diagnoses included, but were not limited to, end stage renal disease, neurogenic bladder, and hypertension. The Annual Minimum Data Set (MDS) assessment, dated 5/23/25, indicated the resident was dependent on staff with bed mobility and transfers. The resident had an indwelling urinary catheter. A Care Plan, dated 5/17/24, indicated the resident was incontinent of bowel and had an indwelling catheter present. An intervention included to keep the drainage bag of the catheter below the level of the bladder at all times and off the floor.A Physician's Note, dated 6/6/25 at 4:16 p.m., indicated a wound culture of the resident's suprapubic catheter site had MRSA (methicillin-resistant staphylococcus aureus) infection. The resident was to be started on the antibiotic Bactrim for the infection.During an interview on 8/6/25 at 3:08 p.m., RN 2 indicated the resident's catheter bag and tubing should not have been on the floor and she would fix it.A policy for catheter care was requested but was not provided by the facility.3.1-41(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 a resident received the necessary care and treatment related to oxygen administration for 1 of 2 residents reviewed for respiratory care. (Resident 2)Finding includes: On 8/4/25 at 2:26 p.m., Resident 2 was observed sitting in a wheelchair in his room. He had a portable oxygen tank attached to the back of the wheelchair. The oxygen was on via a nasal cannula and set at 4 liters.On 8/6/25 at 10:43 a.m., Resident 2 was observed propelling himself down the hallway. He had a portable oxygen tank attached to the back of his wheelchair. The oxygen was on via a nasal cannula and set at 2 liters. Record review for Resident 2 was completed on 8/6/25 at 10:53 a.m. Diagnoses included, but were not limited to, atrial fibrillation, hypertension, chronic obstructive pulmonary disease and respiratory failure.The Annual Minimum Data Set (MDS) assessment, dated 6/18/25, indicated the resident was cognitively intact. The resident had impairment on both sides of his upper and lower extremities for a functional limitation in range of motion. The resident was dependent on staff for upper body dressing, personal hygiene, bed mobility, and transfers. The resident received oxygen therapy.A Care Plan, dated 11/6/24, indicated the resident had emphysema, chronic obstructive pulmonary disease, and respiratory failure. An intervention included for oxygen via nasal prongs as ordered. A Physician's Order, dated 5/8/25, indicated, may provide oxygen at 3 liters via nasal cannula if oxygen saturations are below 90% every shift.The August 2025 Medication Administration Record (MAR) indicated the oxygen order for 3 liters was checked off as administered for every shift. The residents' oxygen saturation for every shift was documented with percentages above 90%.The record lacked any documentation about how much oxygen the resident was supposed to receive if the oxygen saturation was above 90%.During an interview on 8/6/25 at 11:02 a.m., RN 1 indicated the resident was supposed to be on 3 liters of oxygen. The resident had continuous oxygen therapy, and the order would have to be clarified. During an interview on 8/6/25 at 11:11 a.m., the [NAME] President of Regulatory Compliance (VPRC) indicated the order would have to be clarified with the Physician of how much oxygen the resident was supposed to be on.A Policy titled, Oxygen Administration and received as current from the VPRC, indicated, .1. Oxygen is administered under orders of physician. 3.1-47(a)(6)

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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 a narcotic pain medication was obtained and administered as ordered and PRN (as needed) medications were accurately recorded as dispensed on the Medication Administration Record for 1 of 5 closed records reviewed. (Resident 152)Finding includes: During an interview on 8/5/25 at 3:12 p.m., a family member indicated the resident had stage 4 lung cancer and had pain issues. She indicated all the medications the resident had received were prn (as needed), and the resident had difficulty asking for them. She was concerned he was having pain during his stay. The closed record for Resident 152 was reviewed on 8/8/25 at 1:50 p.m. Diagnoses included, but were not limited to, malignant neoplasm of the left bronchus and Hodgkin's lymphoma. The resident was on hospice services. A General Note dated 7/31/25, indicated the resident had arrived at the facility. He was alert and oriented with some confusion noted. The resident was admitted to the facility on [DATE] for a respite stay. He was discharged back to home on 8/5/25. A Physician's Order, dated 7/31/25, indicated to apply a Fentanyl patch (opioid pain medication), 50 micrograms (mcg) every 72 hours for pain. The August 2025 Medication Administration Record (MAR) indicated the Fentanyl patch was due on 8/2. The patch was not given. A Medication Note indicated the patch was on order. The patch was due again on 8/5 and not given. A Medication Note indicated it was not available. There were no progress notes that indicated the family or the pharmacy had been contacted regarding the missing medication. During an interview on 8/8/25 at 2:40 p.m., the Administrator indicated their pharmacy was located in Indianapolis. If a medication was not available in the facility supply, they could order it stat from the pharmacy and it would be delivered within 4 hours. During an interview on 8/8/25 at 4:15 p.m., the Director of Nursing indicated the family was supposed to bring the medication from home. There was no additional information provided why the family or pharmacy had not been contacted when the medication was unavailable. A Physician's Order, dated 7/31/25, indicated to give morphine sulfate 20 milligrams (mg)/ 1 milliliter (ml), 0.25 ml every 2 hours as needed for pain. A Physician's Order, dated 8/1/25, indicated to give lorazepam (an anti-anxiety medication) 2 mg/1 ml, 0.25 ml every 4 hours as needed. The July 2025 MAR indicated the resident had not received any PRN morphine sulfate. The August 2025 MAR indicated the resident was given morphine sulfate once a day on 8/2, 8/3, 8/4 and 8/5. The Narcotic Reconciliation sheet indicated morphine sulfate had been given on 8/1, 8/2 x 3, 8/3 x 3, 8/4 x 3 and 8/5 x 5. The July 2025 MAR indicated the resident had not received any PRN lorazepam. The August 2025 MAR indicated the resident was given lorazepam 0.25 ml once a day on 8/2, 8/3, 8/4 and 8/5. There was no documentation lorazepam tablets had been ordered or given. The Narcotic Reconciliation sheet indicated nine lorazepam tablets had been delivered on 7/31/25. There were no instructions on the Narcotic Reconciliation sheet related to the medication. They were administered on 8/1, 8/2 x 3, date unreadable x 1 and 8/4 x 2. The Narcotic Reconciliation sheet indicated lorazepam 0.25 ml had been given on 8/4 x 2 and 8/5 x 4. During an interview on 8/8/25 at 3:49 p.m., the Director of Nursing indicated the nurses were only documenting medication use on the reconciliation sheets and should have documented on the MAR. Policies were provided but did not pertain. 3.1-25(a)3.1-25(a)(3)

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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 8 residents observed during medication administration. Two medication errors were observed during 27 opportunities for error in medication administration. This resulted in a medication error rate of 7.41%. (Resident 41) Finding includes: On 8/6/25 at 9:15 a.m., RN 1 was observed preparing Resident 41's medications. She placed aspirin 81 milligram (mg) enteric coated tablet, Certavite/multivitamin tablet, clopidogrel 75 mg tablet, escitalopram 5 mg tablet, levetiracetam 500 mg tablet, lisinopril 20 mg tablet, and metoprolol succinate extended-release 25 mg tablet into medication bags and crushed the medications. She then administered the crushed medications mixed with applesauce. Resident 41's record was reviewed at 9:20 a.m. The current August 2025 Physician's Order Summary indicated aspirin 81 mg chewable tablet once daily and metoprolol succinate extended release 25 mg once daily. During an interview on 8/6/25 at 10:58 a.m., RN 1 indicated that the aspirin and metoprolol medications should not have been crushed since they were enteric coated and extended-release medications. She indicated the medications were sent from pharmacy and the pharmacy did not take into account what form the resident required the medications to be in, such as crushed, for safe administration. The [NAME] President of Regulatory Compliance was notified of the concern on 8/6/25 at 11:31 a.m. and had no further information to provide. A policy titled, Medication Administration, indicated, .17. Administer medication as ordered in accordance with manufacturer specifications . c. Crush medications as ordered. Do not crush medications with do not crush instructions . 3. 1-48(c)(1)

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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, record review and interview, the facility failed to ensure a sanitary kitchen was maintained related to testing of the chemical dishwasher. This had the potential to affect all residents who received meals prepared in the Main Kitchen. Finding includes:On 8/4/25 at 9:00 a.m., the Initial Kitchen tour was completed with the Dietary Service Manager (DSM). The DSM indicated the dishwasher was a chemical system. He indicated the dishwashing solution was tested every shift. He obtained a test strip from a bottle on top of the dishwasher. The test strip was weaved into the tines of a fork and placed on a tray that was put through the dishwasher. When completed, the DSM removed the test strip and indicated it read 50 parts per million (ppm), he indicated it should be 150 ppm. He then indicated they were the incorrect strips. He retrieved the correct strips and again wove the strip into the tines of a fork and ran it through the dishwasher. When the cycle was complete, the strip had washed away. He attempted again and the strip again washed away. He then took a strip and dipped it into the dishwashing solution. The strip did not register any ppm reading. Dietary Aides 1, 2 and 3 were present washing dishes and indicated they had not tested the solution that day. The August 2025 Dish Machine Temperature Log indicated on 8/1, 8/2, 8/3 and 8/4 the wash temperature was 160 degrees Fahrenheit, and the rinse temperature was 150 degrees. The ppm column was blank. The current policy, Dishwasher Temperature, indicated, .4. For low temperature dishwashers (chemical sanitation): .b. The sanitizing solution shall be 50 ppm hypochlorite (chlorine) on dish surface in final rinse . and, .5. Chemical solutions shall be maintained at the correct concentration, based on periodic testing, at least once per shift, and for the effective contact time according to manufacturer's guidelines. Results of concentration checks shall be recorded 3.1-21(i)(3)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure infection control guidelines were in place and implemented, related to incorrect use of alcohol wipes during insulin administration for 1 of 1 resident observed for insulin administration and lack of physician's orders for contact isolation for 2 of 3 residents reviewed for transmission based precautions. (Residents 42, 39, and 14) Findings include: 1. During a medication pass observation on 8/5/25 at 11:06 a.m., RN 3 was observed preparing to administer an insulin injection for Resident 42. She performed hand hygiene and donned clean gloves. She opened the container holding the insulin lispro 100 unit/milliliter vial and wiped the top with an alcohol wipe. She used the same alcohol wipe and cleaned an area on the resident's abdomen to prepare the area for a subcutaneous injection. She then removed 24 units from the insulin lispro vial with a syringe and injected the medication into the resident's abdomen. During an interview on 8/5/25 at 11:36 a.m., RN 3 indicated she used the same alcohol swab for the insulin vial and to wipe the abdominal site because she had only brought one alcohol wipe with her. She usually used two separate wipes, but she didn't bring enough with her at the time so she just used one side for the vial and the other to wipe the resident's abdomen. The [NAME] President of Regulatory Compliance was made aware of the concern on 8/5/25 at 11:51 a.m. She had no further information to provide. A facility policy was requested and an applicable policy was not available. 2. On 8/6/25 at 1:30 p.m., Resident 39's room was observed to have a contact isolation sign posted at the entrance. Resident 39's record was reviewed on 8/7/25 at 2:00 p.m. The August 2025 Physician's Order Summary indicated the resident was on enhanced barrier precautions. A Physician Note, dated 7/23/25 at 4:24 p.m., indicated the resident was being seen for a follow-up of antibiotics as he continued to take vancomycin every Monday, Wednesday, and Friday with dialysis for 6 weeks total. The antibiotic course was ordered by a prior provider for left shoulder surgery with methicillin-resistant staphylococcus aureus (MRSA) bacterial infection. There were no physician's orders for contact isolation. There was no care plan related to contact isolation. During an interview on 8/7/25 at 2:30 p.m., the Infection Preventionist and Assistant Director of Nursing indicated the resident was on contact isolation for MRSA. There should have been an order for contact isolation. 3. Resident 14's record was reviewed on 8/7/25 at 2:04 p.m. A Progress Note, dated 7/14/25 at 3:51 p.m., indicated the resident arrived to the facility on a stretcher. He had a colostomy and suprapubic catheter. He was positive for Clostridioides difficile (C. difficile) infection (bacterial infection that causes diarrhea). A Physician Note, dated 7/17/25 at 4:03 p.m., indicated the resident was being treated with vancomycin until 7/25/25 for C. difficile. The resident was to be on isolation per the facility protocol. Per patient's report, he was still having diarrhea. The July 2025 Physician's Order Summary indicated the resident was on enhanced barrier precautions beginning on 7/15/25. There were no orders for contact isolation. During an interview on 8/7/25 at 2:39 p.m., the Infection Preventionist and Assistant Director of Nursing indicated there should have been an order for contact isolation due to the resident testing positive for Clostridioides difficile infection. The CDC Guideline for Isolation Precautions: Appendix A, indicated, . Infection: Clostridium difficile .Type of precaution: Contact + Standard .Duration of Precaution: Duration of illness . A facility policy titled, Transmission-Based (Isolation) Precautions indicated, .9. Initiation of Transmission-Based Precautions .b. An order for transmission-based precautions/isolation will be obtained for residents who are known or suspected to be infected or colonized with infectious agents that require additional controls to prevent transmission effectively. c. The order for transmission-based precautions/isolation will specify the type of precaution and reason for the transmission-based precautions. The duration will depend upon the infectious agent or organism involved . 3.1-18(b)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure the residents' environment was clean and in good repair related to discolored ceiling tiles, dirty ceiling vents, broken window curtains, peeling wallpaper around window sill, gouges in walls, and marred floors for 3 of 3 units. (Reflections, C-wing, and D-wing) Findings include:During the Environmental Tour on 8/7/25 at 3:21 p.m., with the Regional Maintenance Director and the Housekeeping Manager, the following was observed: 1. C-wing a. There were several ceiling tiles that were discolored and stained. b. The ceiling vents were dirty throughout the unit. c. The window curtain fasteners were broken in room [ROOM NUMBER]. There were two resident's residing in the room. d. In the lounge/common area, the window sills had peeling wallpaper underneath them. e. There were two large gouges in the wall across from the nurses' station. 2. D-wing a. The flooring in room [ROOM NUMBER] was marred and had black scuff marks throughout the room. There were two resident's residing in the room. 3. Reflections a. There were several ceiling tiles that were discolored and stained. b. The ceiling vents were dirty throughout the unit. During an interview with the Regional Maintenance Director and the Housekeeping Manager at the time, they both indicated the above were in need of cleaning and/or repair. 3.1-19(f)