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	01/16/2026

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

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record review and interview, the facility failed to notify a personal representative at the request of the resident of new orders and a change of condition for 1 of 3 residents reviewed for notification of changes. (Resident B)Finding includes:A record review for Resident B was completed on 1/12/2026 at 9:30 A.M. Diagnoses included, but were not limited to: congestive heart failure, chronic kidney disease stage 3, diabetes mellitus type 2 and acute metabolic acidosis.An admission Minimum Data Set (MDS) assessment, dated 11/6/2025, indicated Resident B was cognitively intact. The 11/7/2025 3:28 P.M. Resident preferences evaluation indicated it was very important for the Resident to have their family or a close friend involved in their care.A Social Services note, dated 11/11/2025 at 4:39 P.M. indicated the resident had stated she wanted her granddaughter to be her emergency contact. Although the admission MDS assessment indicated the resident was cognitively intact, nursing progress notes on the following dates and times indicated the resident was exhibiting confusion and her confusion was chronic: 11/13/2025 at 4:09 P.M., 11/15/2025 at 4:11 P.M., 11/18/2025 at 3:37 P.M., 11/22/2025 at 7:18 P.M., 11/23/2025 at 12:41 A.M., 11/30/2025 AT 11:40 P.M. , 12/6/2025 at 7:37 P.M., 12/7/2025 at 6:17 P.M. and 12/21/2025 at 5:00 A.M.A General Nursing Progress Note, on 11/6/2025 at 8:56 A.M., indicated new orders had been obtained from the facility nurse practitioner for labs, melatonin 5 milligrams daily at bedtime and acetaminophen 325 milligrams two tablets daily at bedtime. Resident B's personal representative had not been notified of the new orders.An Alert Nursing Progress Note, on 11/13/2025 at 9:05 A.M., indicated new orders had been received for acetaminophen 325mg two tablets every six hours as needed for pain, metformin 1000 milligrams twice daily, lispro insulin four units before meals, prednisone 10 milligrams daily for COPD (chronic obstructive pulmonary disease) and Robitussin DM 10 milliliters every six hours for cough. Resident B's personal representative had not been notified of the new orders.A Physician's Note, on 11/25/2025 at 1:26 A.M., indicated Resident B had been seen for an acute visit for dehydration related to an increased laboratory result of a bun urea nitrogen (BUN). The physician ordered two liters of normal saline.An Alert Nursing Progress Note, on 11/25/2025 at 8:46 A.M., indicated new orders had been received for normal saline intravenously for two liters at 157 milliliters per hour related to high Bun results. Resident B's personal representative had not been notified of the new orders.An Alert Nursing Progress Note, on 11/26/2025 at 6:03 P.M., indicated urinalysis results had been received and new order for Macrobid 100 milligrams twice daily for five days related to a urinary tract infection. Resident B's personal representative had not been notified of the new orders.An Alert Nursing Progress Note, on 12/4/2025 at 8:26 A.M., indicated Keflex 500 milligrams every six hours for seven days related to cellulitis of the right leg. Resident B's personal representative had not been notified of the new orders.An Alert Nursing Progress Note, on 12/4/2025 at 6:59 P.M., indicated normal saline per hypodermoclysis 50 milliliters per hour for two liters due to a high BUN laboratory result. Resident B's personal representative had not been notified of the new (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	orders.A General Nursing Progress Note, on 12/15/2025 at 4:39 P.M., indicated a new order for furosemide 40 milligrams daily due to excessive fluid seeping from bilateral lower extremities. Resident B's personal representative had not been notified of the new orders.A General Nursing Progress Note, on 12/16/2025 at 4:54 P.M., indicated new orders had been received for an increase in Lantus insulin to 15 units twice daily. Resident B's personal representative had not been notified of the new orders.A General Nursing Progress Note, on 12/17/2025 at 3:10 P.M., indicated Resident B had complained of chest pain. A new ordered had been obtained for nitroglycerin 0.4 milligrams every two hours as needed for chest pain. An initial dose had been given. Resident B's personal representative had not been notified of the change in condition or the new orders.A General Nursing Progress Note, on 12/17/2025 at 3:37 P.M., indicated a new order for a two-view chest x-ray. Resident B's personal representative had not been notified of the new orders.During an interview, on 1/12/2026 at 2:31 P.M., Resident B's emergency contact indicated she had not been informed of her grandmother's changes of condition nor updated on new orders received by the facility. She indicated her grandmother had periods of confusion and would not understand the orders that had been ordered for her conditions.During an interview, on 1/14/2026 at 9:46 A.M., the Assistant Director of Nursing indicated the family of Resident B should have been updated on any change of condition.A policy was provided, on 1/16/2026 at 11:44 A.M., by the Executive Director. The policy titled, Notification of Change, indicated, .The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician and notifies, consistent with his or her authority, the resident's representative when there I a change requiring notification.Compliance Guidelines: The facility must inform the resident, consult with the resident's physician and /or notify the resident's family member or legal representative when there is a change requiring such notification.3. Circumstances that require a need to alter treatment. That may include: a. New treatment.Additional considerations: 1. Competent individuals a. The facility must still contact the resident's physician and notify resident representative, if known. B, A family member that wishes to be informed would designate a member to receive calls. C. When a resident is medically competent, such a designated family member should be notified of significant changes in the resident's health status because the resident may not be able to notify them personally, especially in the case of sudden illness or accident.This citation relates to Intake 27044933.1-4(l)(4)(A)(i)

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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. Based on record review and interview, the facility failed to ensure physician's orders regarding blood pressure medications were followed for 1 of 3 residents reviewed for quality of care. (Resident B)Finding includes:A record review for Resident B was completed on 1/12/2026 at 9:30 A.M. Diagnoses included, but were not limited to: congestive heart failure, chronic kidney disease stage 3, diabetes mellitus type 2 and acute metabolic acidosis.An admission Minimum Data Set (MDS) assessment, dated 11/6/2025, indicated Resident B was cognitively intact.A Physician's order, dated 11/5/2025, indicated the resident was to receive metoprolol 25 milligrams twice daily for hypertension. The order indicated the medication was to be held for a systolic blood pressure reading of less than 110 mm/Hg (millimeters of Mercury) or a pulse less than 60 beats per minute.A Medication Administration Record (MAR), for the month of November 2025 indicated the metoprolol medication had been administered on 11/22/2025 even though the resident's blood pressure was 102/42 mm/Hg.A MAR for the month of December 2025 indicated metoprolol had been administered on 12/20/2025 even though the resident's blood pressure was 102/80 mm/Hg. The medication was also administered on 12/21/2025 even though the resident's blood pressure was 104/73 mm/Hg.During an interview, on 1/16/2026 at 11:26 A.M., the Assistant Director of Nursing indicated nursing staff should have followed the physician's orders.A policy, titled, Provisions of Physician Ordered Services, was provided on 1/16/2026 at 11:41 A.M. The policy indicated, .The purpose of this policy is to provide a reliable process for the proper and constituent provision of physician ordered services according to professional standards of quality .This citation relates to Intake 27044933,1-37