STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155178	A. BUILDING 00 B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - FOUNTAINVIEW CARE CENTER	609 W TANGLEWOOD LN MISHAWAKA, IN 46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00460076, IN00457226 and IN00450950. Complaint: IN00460076 - No deficiencies related to the allegations are cited. Complaint: IN00457226 - No deficiencies related to the allegations are cited. Complaint: IN00450950 - No deficiencies related to the allegations are cited. Survey dates: May 19, 20, 21, 22, 23 and 27, 2025. Facility number: 000094 Provider number: 155178 AIM number: 100290310 Census Bed Type: SNF/NF: 78 Total: 78 Census Payor Type: Medicare: 2 Medicaid: 46 Other: 30 Total: 78 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on 6/10/2025	F 0000	This response is not to be construed as an admission of fault by the facility, its employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. The facility respectfully requests paper compliance.	
F 0580 SS=D	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.)			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Anne Morgan	Executive Director	06/20/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155178	A. BUILDING 00 B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - FOUNTAINVIEW CARE CENTER	609 W TANGLEWOOD LN MISHAWAKA, IN 46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Bldg. 00	Based on interview, observation and record review, the facility failed to notify the Physician of a resident's new pain for 1 of 1 residents reviewed for pain. (Resident 49) Finding includes: During an interview on 5/19/2025 at 9:30 A.M., Resident 49 indicated his Foley catheter (indwelling urinary catheter) was causing him pain and he rated the pain as a 7 out of 10, with 0 being no pain and 10 being the worst pain. He pulled his brief down and exposed his catheter. The leg strap of the catheter was stuck to the tip of Resident 49's penis with a dime size amount of blood noted on the catheter strap. During an observation and interview,on 5/19/2025 at 9:34 A.M., the Unit Manager (UM) put on gloves and assessed Resident 49's Foley catheter. Resident 49 again reported his pain as a 7 out of 10. The UM put the leg strap onto the resident's leg and repositioned the Foley catheter tubing. The UM indicated Resident 49 had scheduled pain medications ordered, but did not have any pain medication ordered for breakthrough pain. The UM indicated she had requested an as needed (PRN) pain medication to be added to Resident 49's orders, but the Hospice provider had not yet ordered a PRN medication. During an interview on 5/19/2025 at 11:05 A.M., Resident 49 indicated his Foley catheter was still hurting and rated his pain as an 8 out 10. Resident 49 indicated he had not received any pain medication since his morning medication pass. Resident 49's record review was completed on 5/21/2025 at 9:26 A.M. Diagnoses included, but	F 0580	**F580 Notify of changes (injury/decline/room, etc)** • what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 49 pain management plan of care updated and MD notified and received new orders for breakthrough pain medications as needed. • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by the alleged deficient practice. All residents reviewed for the last 7 days to identify any new pain onset, and NP/MD notified for appropriate orders to manage pain. • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Licensed staff educated on pain management and change of condition policy. Resident nurses notes will be reviewed by DNS and/or nurse management team 5x/wk x 4 weeks, then 3x/wk x 2 months, then weekly x 3 months to ensure management of pain is provided routinely per policy and MD/NP notification per policy of	06/25/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155178	A. BUILDING 00 B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - FOUNTAINVIEW CARE CENTER	609 W TANGLEWOOD LN MISHAWAKA, IN 46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	were not limited to: neurogenic bladder, schizophrenia, anxiety disorder, dysphagia, and major depressive disorder. A Quarterly Minimum Data Set (MDS) assessment indicated Resident 49 had moderate cognitive impairment and was able to understand others and make himself understood. A current Physician's order indicated Resident 49 received Hospice services. Resident 49's record lacked the documentation that the Physician had been contacted on 5/19/2025 regarding the new pain Resident 49 was having related to his Foley catheter. A review of Resident 49's Hospice binder was completed on 5/21/2025 at 9:40 A.M. Resident 49 had been seen by the Hospice Nurse (HN) on 5/20/2025, but the HN had not addressed the penile pain caused by the indwelling catheter. During an observation of catheter care on 5/21/2025 at 10:00 A.M., Resident 49 indicated his Foley catheter was still causing him pain. CNA 3 indicated the nurse was aware of the resident's pain and continued with the Foley catheter care without asking Resident 49 if she could continue the catheter care. During an interview with the Clinical Educator (CE) on 5/21/2025 at 10:05 A.M., the CE indicated Resident 49's pain had been reported to a nurse, but not the nurse that was taking care of Resident 49. She indicated Resident 49's pain had not been assessed and the Foley catheter care should not have been continued until he had been assessed by his nurse.		new onset of pain. • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; DNS/Designee will present the summaries of the audits to the Quality assurance committee monthly for 6 months. Thereafter, if determined by the quality assurance committee that further monitoring is needed, audits will continue.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155178	A. BUILDING 00 B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - FOUNTAINVIEW CARE CENTER	609 W TANGLEWOOD LN MISHAWAKA, IN 46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview with the UM on 5/21/2025 at 11:03 A.M., the UM indicated Resident 49 had not complained of Foley catheter pain in the past and she had called Hospice after Resident 49's catheter care had been completed on, 5/21/2025, to report his pain and requested a nurse visit for that day. The UM indicated Resident 49's pain had not been assessed on 5/21/2025, after the resident had reported his pain to the nursing staff. The UM indicated she had called Hospice on 5/19/2025 but had forgotten to add a note to the record. The UM indicated she had added a late entry note for 5/19/2025 on 5/22/2025. The note indicated Hospice had been notified of the new pain. The UM was unable to provide the name of Hospice employee she had spoken with at the Hospice provider's office on 5/19/2025. The UM indicated the Hospice provider had not given any new orders and had not been to the facility to see Resident 49 since the new pain (pain with the Foley catheter) had started and was reported to them on 5/19/2025. The UM indicated she had had conversations with the Hospice nurses about adding a PRN pain medication in the past, but no PRN pain medication order had been provided by Hospice. During an interview with a Business Office Associate (BOA) of the Hospice company on 5/21/2025 at 12:50 P.M., the BOA indicated she had reviewed the notes and call logs related to Resident 49 and could not find an entry or a call logged from the facility on 5/19/2025. The BOA indicated Resident 49 had been seen by the Hospice Nurse on 5/22/2025 in the facility. During an interview with a Hospice Nurse (HN), on 5/21/2025 at 2:00 P.M., she indicated Resident 49 had been seen by Hospice on 5/20/2024 and the facility had not reported any new or			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155178	A. BUILDING 00 B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - FOUNTAINVIEW CARE CENTER	609 W TANGLEWOOD LN MISHAWAKA, IN 46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	worsening pain related to Resident 49's Foley catheter or requested any PRN pain medication. The HN indicated Resident 49 had not complained of pain with the Foley catheter in the past to her. The HN reported the new pain to the Hospice Physician and obtained an order for a PRN pain medication for Resident 49. During an interview with the Hospice Director of Operations (HDO) on 5/21/2025 at 2:04 P.M., the HDO indicated she had reviewed the call logs to the Hospice office and there was no logged calls from the facility on 5/19/2025 nor did she locate any notes that the facility had called about Resident 49's complaint of penile pain due to his catheter prior to 5/21/2025. A HN had visited Resident 49 on 5/20/2025 and staff had not reported any pain related to the Foley catheter to the HN. The HDO indicated Hospice had not received any requests from staff to include a PRN pain medication. The HDO indicated the facility should have reported the new pain on 5/19/2025 and before they provided catheter care on 5/21/2025 so Resident 49 did not have any unnecessary pain. On 5/21/2025 at 1:03 P.M., the DON provided an undated policy titled, "Pain Management", and identified it as the policy currently used by the facility. The policy indicated, "...The facility must ensure that pain management is provided to residents who require such services... Recognition: 1. In order to help a resident attain or maintain his/her highest practicable level of physical, mental and psychosocial well-being and to prevent or manage pain, the facility will:... b. Evaluate the resident for pain and the cause upon admission, during ongoing scheduled assessments, and when a significant change in condition or status occurs (e.g. after a fall, change			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155178	A. BUILDING 00 B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - FOUNTAINVIEW CARE CENTER	609 W TANGLEWOOD LN MISHAWAKA, IN 46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	in behavior or mental status, new pain or an exacerbation of pain.)...2... j. Facility staff will notify the practitioner, if the resident's pain is not controlled by the treatment regimen...." 3.1-5 (a)(2)			
F 0582 SS=D Bldg. 00	483.10(g)(17)(18)(i)-(v) Medicaid/Medicare Coverage/Liability Notice Based on interview and record review, the facility failed to ensure a Skilled Nursing Facility-Advanced Beneficiary Notice Form (SNF-ABN) was provided timely following the end of Medicare skilled services for 2 of 3 residents who were discharged from Medicare services. (Resident 64 & 178) Finding includes: 1. During a review of Resident 64's SNF-ABN form, on 5/22/2025 at 2:05 P.M., the SNF-ABN document indicated Resident 64's Medicare coverage had ended on 4/1/2025. An undated Notice of Medicare Non-Coverage (NOMNC) form had been provided to Resident 64 and she had signed the document, but there was no date indicating when the resident had been informed. During an interview on 5/22/2025 at 1:34 P.M., the Business Office Manager (BOM) indicated she was unaware Resident 64 needed to have been given the SNF-ABN and NOMNC documents to sign and Resident 64 had not been given the SNF-ABN or NOMNC documents 48 hours before her had therapy ended. 2. During a review of SNF-ABN form, on 5/22/2025 at 2:07 P.M., the SNF-ABN document indicated Resident 178's Medicare coverage had ended on	F 0582	**F582 Medicaid/Medicare Coverage/Liability Notice** • what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Residents 64 and 178 have received their ABN with explanation that Medicare is no longer covering their stay at the facility** • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **Any resident that was receiving Medicare benefits at the facility and remained in the facility after Medicare was cut has the potential to be affected. Business Office Manager will complete an audit of all Medicare residents from the past 3 months that were cut from Medicare and remained in the facility to ensure they received a timely NOMNC and SNF-ABN prior to the cut of Medicare.**	06/25/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155178	A. BUILDING 00 B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - FOUNTAINVIEW CARE CENTER	609 W TANGLEWOOD LN MISHAWAKA, IN 46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	1/28/2025. An undated NOMNC form had been provided to Resident 178 and he had signed the document, but there was not a date to indicate when the resident had been informed. During an interview on 5/22/2025 at 1:35 P.M., the Business Office Manager indicated she was unaware Resident 178 needed to have been given the SNF-ABN and NOMNC documents to sign and Resident 178 had not been given the SNF-ABN or NOMNC document 48 hours before his therapy ended. On 5/22/2025 at 2:54 P.M., the Director of Nursing provided an undated policy title, "Advance Beneficiary Notices", and identified it as the policy currently used by the facility. The policy indicated, "...7. To ensure that the resident, or representative, has enough time to make a decision whether or not to receive the services in question and assume financial responsibility, the notice shall be provided at least two days before the end of a Medicare covered Part A stay... 3.1-4(f)(2)		• what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Business Office Manager has been re-educated on the Advance Beneficiary Notices Policy. Daily in morning meeting the management team will discuss any residents that will be cut from a skilled payor, will be receiving a NOMNC, and whether or not a SNF-ABN is needed. This will be noted on the Daily Morning Meeting Sheets.** • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and **Business Office Manager to perform audits of residents remaining in the facility after being cut from Medicare to ensure timely completion of SNF-ABNs. Audits to be done 3 times per week x 4 weeks, then weekly x 2 months, then monthly x 3 months.** **The results of these audits will be brought to QAPI monthly x 6 months or until 100% compliance is achieved x 3 consecutive months. Results of the audits will be adapted or adjusted as needed to maintain compliance.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155178	A. BUILDING 00 B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - FOUNTAINVIEW CARE CENTER	609 W TANGLEWOOD LN MISHAWAKA, IN 46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0628 SS=E Bldg. 00	483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 48 Discharge Process Based on interview and record review, the facility failed to notify the Long Term Care (LTC) Ombudsman in a timely manner of resident discharges for 3 of 5 residents reviewed for discharges. (Residents 32, 75 and 76) Findings include: 1. On 4/17/2025 Resident 75 was discharged to home after completing therapy and meeting goals. On 5/23/2025 at 1:42 P.M. a list of LTC Ombudsman discharge notifications for February, March and April 2025 were requested from the ED. During an interview on 5/27/2025 at 9:11 A.M. the ED indicated she received an email from the LTC Ombudsman with the discharges for February and March 2025 but not April. The email indicated the LTC Ombudsman had not received any documentation of discharges for April 2025. The ED indicated April 2025 discharges should have been sent on May 1, 2025 but had not been sent.2. During an interview on 5/19/2025 at 10:35 A.M., Resident 32 indicated he had been sent to the hospital in March. Resident 32's record review was completed on 5/23/2025 at 1:25 P.M. Diagnoses included, but were not limited to: chronic obstructive pulmonary disease, emphysema, major depressive disorder and generalized anxiety disorder. A Nursing Note dated, 3/8/2025 at 2:32 P.M., indicated Resident 32 had been admitted to the hospital for pneumonia.	F 0628	**F628 Discharge Process** • what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Ombudsman has been notified of the discharges for Residents 32, 75, 76** • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All residents discharging or being transferred to a hospital have the potential to be affected. Social Services to complete an audit of all transfers or discharges from the last 3 months to ensure Ombudsman notification was completed.** • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Social Service staff to be re-educated on the Transfer and Discharge policy and the process for notifying the Ombudsman. All transfers and discharges will be discussed daily in morning meetings and will be tracked on the Ongoing Audit Tool.** • how the corrective	06/25/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155178	A. BUILDING 00 B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - FOUNTAINVIEW CARE CENTER	609 W TANGLEWOOD LN MISHAWAKA, IN 46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A review of the March 2025 Ombudsmen notification list was completed on 5/27/2025 at 9:45 A.M. Resident 32's name was not on the list. During an interview with Executive Director (ED) on 5/27/2025 at 8:45 A.M., the ED indicated Resident 32's name was not on the Ombudsmen notification list for March 2025. 3. Resident 76's record review was completed on 5/23/2025 at 12:57 P.M. Diagnoses included, but were not limited to: dementia, dysphagia, fracture of right femur, cellulitius and rhabdomyolysis. A Change in Condition note, dated, 2/21/2025 at 2:41 A.M., indicated Resident 76 had been sent to the hospital. Resident 76 was discharged from the facility on 2/22/2025 and was not readmitted. A review of the February 2025 Ombudsmen notification list was completed on 5/27/2025 at 9:46 A.M. Resident 76's name was not on the list. During an interview with Executive Director (ED) on 5/27/2025 at 8:46 A.M., the ED indicated Resident 76's name was not on the Ombudsmen notification list for February 2025. On 5/27/2025 at 9:00 A.M., the ED provided an undated policy title, "Transfer and Discharge" and identified it as the policy currently used by the facility. The policy indicated, "... 5. The facility will maintain evidence that the notice was sent to the Ombudsman...." 3.1-12 (a)(6)(iv)		action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and **Social Services staff to perform audits of Ombudsman notifications for residents being transferred to a hospital or discharging from the facility voluntarily. Audits to be done monthly for the next 6 months. The results of these audits will be brought to QAPI monthly x 6 months or until 100% compliance is achieved x 3 consecutive months. Results of the audits will be adapted or adjusted as needed to maintain compliance.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155178	A. BUILDING 00 B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - FOUNTAINVIEW CARE CENTER	609 W TANGLEWOOD LN MISHAWAKA, IN 46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan Based on record review and interview, the facility failed to ensure an individualized plan of care was created for a resident with an Activity of Daily Living (ADL) self-care performance deficit for 1 of 21 residents reviewed for care plans. (Resident 65) Finding includes: The clinical record of Resident 65 was reviewed on 5/20/2025 at 2:50 P.M. The residents' diagnoses included but were not limited to: local infection of skin and subcutaneous tissue, falls, anxiety, depression, hypertension, bipolar disorder, sepsis and dysphagia. An Admission Minimum Data Set (MDS) assessment, dated 4/9/2025, indicated the resident was severely cognitively impaired and required substantial assistance with upper and lower body dressing, putting on footwear, personal hygiene, toileting, showering and bathing. A current Care Plan, initiated 4/23/2025, indicated Resident 65 had an ADL self-care performance deficit and required assistance by one staff but failed to document the type and frequency of bathing preferred by the resident. During an interview, on 5/22/2025 at 2:08 P.M., the Director of Nursing (DON) indicated resident care plans were completed with an interdisciplinary approach. Social Services completed their portion of the care plan and other disciplines completed their care plans. The DON indicated an aide would have known Resident 65 was an assist of one for bathing or showering but the resident preference on the type or frequency of bathing	F 0656	**F656 Develop/Implement comprehensive care plan** • what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 65 plan of care updated for resident preference of showers • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by the alleged deficient practice. All residents preferences for showers reviewed and care planed accordingly. • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Licensed staff educated on comprehensive care plan policy. Resident preference assessment will be reviewed by DNS and/or nurse management team 5x/wk x 4 weeks, then 3x/wk x 2 months, then weekly x 3 months to ensure plan of care is updated with preferences per policy. • how the corrective action(s) will be monitored to ensure the deficient practice will	06/25/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155178	A. BUILDING 00 B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - FOUNTAINVIEW CARE CENTER	609 W TANGLEWOOD LN MISHAWAKA, IN 46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and the care plan should have been included in the care plan. On 5/22/2025 at 2:30 P.M., the DON provided a policy titled, "Comprehensive Care Plans," dated 2025 and indicated the policy was the one currently used by the facility. The policy indicated " ...develop and implement a comprehensive person-centered care plan for each resident ...that includes measurable objectives and timeframes to meet a resident's medical, nursing, and ...ALL services that are identified in the resident's comprehensive assessment..." 3.1-35(a)		not recur, i.e., what quality assurance program will be put into place; DNS/Designee will present the summaries of the audits to the Quality assurance committee monthly for 6 months. Thereafter, if determined by the quality assurance committee that further monitoring is needed, audits will continue.	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision Based on interview, observation and record review, the facility failed to update a care plan with interventions put into place after a fall for 1 of 1 resident reviewed for falls. (Resident 2) Finding includes: A record review was completed on 5/22/2025 at 11:24 A.M. for Resident 2. Diagnoses included, but were not limited to: acute and chronic respiratory failure with hypoxia and depression. A Quarterly Minimum Data Set (MDS) assessment, dated 4/29/2025, indicated Resident 2's cognition was severely impaired, was dependent for toileting, bed mobility and transfer needs and had had no falls since admission. On 5/22/2025 at 1:52 P.M. a current Care Plan, initiated on 1/8/2025, indicated Resident 2 was at	F 0657	**F657 Care Plan Timing and Revision** • what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 2 plan of care updated with all current fall interventions • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by the alleged deficient practice. All fall incidents within last 30 days reviewed to ensure all interventions are up to date on residents plan of care. • what measures will be	06/25/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155178	A. BUILDING 00 B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - FOUNTAINVIEW CARE CENTER	609 W TANGLEWOOD LN MISHAWAKA, IN 46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	risk for falls. Interventions included: call light within reach and anticipate and meet the resident's needs. A Nursing Progress Noted indicated on 4/14/2025 at 8:20 A.M., Resident 2 fell out of bed and sustained an injury to her head. The post-fall evaluation, completed on 4/14/2025, indicated a fall mat was placed by the bed, the resident was placed in a low bed and the interventions would be placed on the Care Plan. However, the Care Plan was not updated to reflect the interventions until 5/20/2025 when the fall mat was added. The low bed was not added to the Care Plan. During an interview on 5/22/2025 at 2:29 P.M., the DON indicated the care plan should have been updated at the time of the fall with the new interventions. On 5/22/2025 at 2:29 P.M. a current policy, dated August 2024 and titled, "Care Plan Revisions Upon Status Change" was provided by the DON. The policy indicated, "...The care plan will be updated with the new or modified intervention...." 3.1-35(e)		put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Licensed staff educated on revisions of status change plan policy. Resident fall incidents will be reviewed by DNS and/or nurse management team 5x/wk x 4 weeks, then 3x/wk x 2 months, then weekly x 3 months to ensure plan of care is being updated with interventions routinely per policy. • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; DNS/Designee will present the summaries of the audits to the Quality assurance committee monthly for 6 months. Thereafter, if determined by the quality assurance committee that further monitoring is needed, audits will continue.	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance Based on observation, record review and interview, the facility failed to follow a Physician's order related to providing nutritional supplements for 1 of 1 resident who was reviewed for nutrition. (Resident 53) Finding includes:	F 0692	**F692 Nutrition/Hydration Status Maintenance** • what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;	06/25/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155178	A. BUILDING 00 B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - FOUNTAINVIEW CARE CENTER	609 W TANGLEWOOD LN MISHAWAKA, IN 46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During meal observations, Resident 53 did not have a health shake on his lunch meal tray on the following dates: -5/20/2025 -5/21/2025 -5/22/2025 Resident 53's record review was completed 5/22/2025 at 2:15 P.M. Diagnoses included, but were not limited to: dysphagia, rhabdomyolysis, protein-calorie malnutrition, starvation and sacral pressure ulcer. A current Physician's order, dated, 2/28/2025, indicated Resident 53 was to receive a health shake at lunch and dinner. However, a review of the May 2025 Medication Administration Record (MAR) indicated Resident 53 was documented as having received his lunch health shake on 5/20, 5/21 and 5/22/2025 even though there was no health shake served to Resident 53. During an interview on 5/23/2025 at 1:30 P.M., LPN 4 indicated Resident 53 had drank all of his lunch health shake on 5/23/2025. LPN 4 indicated the kitchen was responsible for providing the health shake and the nurse was responsible for documenting the intake. During an interview on 5/23/2025 at 1:37 P.M., Dietary Aide (DA) 5 indicated Resident 53's meal tickets showed a standing order for him to receive a health shake on his lunch tray. DA 5 indicated it was the kitchen's responsibility to provide the health shake, but if the health shake was missing, the nurse should should have contacted the kitchen.		Resident 53 was provided with health shakes per order • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by the alleged deficient practice. All residents identified with a supplement health shake order were reviewed for the last 30 days to ensure compliance with order/documentation per policy. • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All staff educated on Nutritional and Dietary Supplements policy. Residents with a nutritional supplement order will be reviewed/observed by DNS and/or nurse management team 5x/wk x 4 weeks, then 3x/wk x 2 months, then weekly x 3 months to ensure compliance with supplement health shake order per policy. • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; DNS/Designee will present the summaries of the audits to the Quality assurance committee monthly for 6 months. Thereafter,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155178	A. BUILDING 00 B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - FOUNTAINVIEW CARE CENTER	609 W TANGLEWOOD LN MISHAWAKA, IN 46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 4/23/2025 at 2:24 P.M., the Director of Nursing (DON) provided an undated policy titled, "Nutritional and Dietary Supplements" and identified it as the policy currently used by the facility. The policy indicated, "... 2. The facility will provide nutritional and dietary supplements to each resident, consistent with the resident's assessed needs...." 3.1-46 (a)(2)		if determined by the quality assurance committee that further monitoring is needed, audits will continue.	
F 0697 SS=D Bldg. 00	483.25(k) Pain Management Based on interview, observation and record review, the facility failed to notify the address a resident's pain timely and effectively for 1 of 1 residents reviewed for pain. (Resident 49) Finding includes: During an interview on 5/19/2025 at 9:30 A.M., Resident 49 indicated his Foley catheter (indwelling urinary catheter) was causing him pain and he rated the pain as a 7 out of 10, with 0 being no pain and 10 being the worst pain. He pulled his brief down and exposed his catheter. The leg strap of the catheter was stuck to the tip of Resident 49's penis with a dime size amount of blood noted on the catheter strap. During an observation and interview,on 5/19/2025 at 9:34 A.M., the Unit Manager (UM) put on gloves and assessed Resident 49's Foley catheter. Resident 49 again reported his pain as a 7 out of 10. The UM put the leg strap onto the resident's leg and repositioned the Foley catheter tubing. The UM indicated Resident 49 had scheduled pain medications ordered, but did not have any	F 0697	**F697 Pain Management** • what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 49 pain management plan of care updated and provided with breakthrough pain medications as needed. • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by the alleged deficient practice. All residents reviewed for the last 7 days to identify any new pain onset, and NP/MD notified for appropriate orders to manage pain. • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not	06/25/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155178	A. BUILDING 00 B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - FOUNTAINVIEW CARE CENTER	609 W TANGLEWOOD LN MISHAWAKA, IN 46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	pain medication ordered for breakthrough pain. The UM indicated she had requested an as needed (PRN) pain medication to be added to Resident 49's orders, but the Hospice provider had not yet ordered a PRN medication. During an interview on 5/19/2025 at 11:05 A.M., Resident 49 indicated his Foley catheter was still hurting and rated his pain as an 8 out 10. Resident 49 indicated he had not received any pain medication since his morning medication pass. Resident 49's record review was completed on 5/21/2025 at 9:26 A.M. Diagnoses included, but were not limited to: neurogenic bladder, schizophrenia, anxiety disorder, dysphagia, and major depressive disorder. A Quarterly Minimum Data Set (MDS) assessment indicated Resident 49 had moderate cognitive impairment and was able to understand others and make himself understood. A current Physician's order indicated Resident 49 received Hospice services. Resident 49's record lacked the documentation that the Physician had been contacted on 5/19/2025 regarding the new pain Resident 49 was having related to his Foley catheter. A review of Resident 49's Hospice binder was completed on 5/21/2025 at 9:40 A.M. Resident 49 had been seen by the Hospice Nurse (HN) on 5/20/2025, but the HN had not addressed the penile pain caused by the indwelling catheter. During an observation of catheter care on 5/21/2025 at 10:00 A.M., Resident 49 indicated his Foley catheter was still causing him pain. CNA 3		recur; Licensed staff educated on pain management policy. Resident pain documentation/assessments will be reviewed by DNS and/or nurse management team 5x/wk x 4 weeks, then 3x/wk x 2 months, then weekly x 3 months to ensure management of pain is provided routinely per policy. • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; DNS/Designee will present the summaries of the audits to the Quality assurance committee monthly for 6 months. Thereafter, if determined by the quality assurance committee that further monitoring is needed, audits will continue.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155178	A. BUILDING 00 B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - FOUNTAINVIEW CARE CENTER	609 W TANGLEWOOD LN MISHAWAKA, IN 46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated the nurse was aware of the resident's pain and continued with the Foley catheter care without asking Resident 49 if she could continue the catheter care. During an interview with the Clinical Educator (CE) on 5/21/2025 at 10:05 A.M., the CE indicated Resident 49's pain had been reported to a nurse, but not the nurse that was taking care of Resident 49. She indicated Resident 49's pain had not been assessed and the Foley catheter care should not have been continued until he had been assessed by his nurse. During an interview with the UM on 5/21/2025 at 11:03 A.M., the UM indicated Resident 49 had not complained of Foley catheter pain in the past and she had called Hospice after Resident 49's catheter care had been completed on, 5/21/2025, to report his pain and requested a nurse visit for that day. The UM indicated Resident 49's pain had not been assessed on 5/21/2025, after the resident had reported his pain to the nursing staff. The UM indicated she had called Hospice on 5/19/2025 but had forgotten to add a note to the record. The UM indicated she had added a late entry note for 5/19/2025 on 5/22/2025. The note indicated Hospice had been notified of the new pain. The UM was unable to provide the name of Hospice employee she had spoken with at the Hospice provider's office on 5/19/2025. The UM indicated the Hospice provider had not given any new orders and had not been to the facility to see Resident 49 since the new pain (pain with the Foley catheter) had started and was reported to them on 5/19/2025. The UM indicated she had had conversations with the Hospice nurses about adding a PRN pain medication in the past, but no PRN pain medication order had been provided by Hospice.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155178	A. BUILDING 00 B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - FOUNTAINVIEW CARE CENTER	609 W TANGLEWOOD LN MISHAWAKA, IN 46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview with a Business Office Associate (BOA) of the Hospice company on 5/21/2025 at 12:50 P.M., the BOA indicated she had reviewed the notes and call logs related to Resident 49 and could not find an entry or a call logged from the facility on 5/19/2025. The BOA indicated Resident 49 had been seen by the Hospice Nurse on 5/22/2025 in the facility. During an interview with a Hospice Nurse (HN), on 5/21/2025 at 2:00 P.M., she indicated Resident 49 had been seen by Hospice on 5/20/2024 and the facility had not reported any new or worsening pain related to Resident 49's Foley catheter or requested any PRN pain medication. The HN indicated Resident 49 had not complained of pain with the Foley catheter in the past to her. The HN reported the new pain to the Hospice Physician and obtained an order for a PRN pain medication for Resident 49. During an interview with the Hospice Director of Operations (HDO) on 5/21/2025 at 2:04 P.M., the HDO indicated she had reviewed the call logs to the Hospice office and there was no logged calls from the facility on 5/19/2025 nor did she locate any notes that the facility had called about Resident 49's complaint of penile pain due to his catheter prior to 5/21/2025. A HN had visited Resident 49 on 5/20/2025 and staff had not reported any pain related to the Foley catheter to the HN. The HDO indicated Hospice had not received any requests from staff to include a PRN pain medication. The HDO indicated the facility should have reported the new pain on 5/19/2025 and before they provided catheter care on 5/21/2025 so Resident 49 did not have any unnecessary pain.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155178	A. BUILDING 00 B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - FOUNTAINVIEW CARE CENTER	609 W TANGLEWOOD LN MISHAWAKA, IN 46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 5/21/2025 at 1:03 P.M., the DON provided an undated policy titled, "Pain Management", and identified it as the policy currently used by the facility. The policy indicated, "...The facility must ensure that pain management is provided to residents who require such services... Recognition: 1. In order to help a resident attain or maintain his/her highest practicable level of physical, mental and psychosocial well-being and to prevent or manage pain, the facility will:... b. Evaluate the resident for pain and the cause upon admission, during ongoing scheduled assessments, and when a significant change in condition or status occurs (e.g. after a fall, change in behavior or mental status, new pain or an exacerbation of pain.)...2... j. Facility staff will notify the practitioner, if the resident's pain is not controlled by the treatment regimen...." 3.1-37(a)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, record review and interview, the facility failed to wear personal protective equipment (PPE) while providing Foley catheter (indwelling urinary catheter) care for 1 of 4 residents reviewed for Enhanced Barrier Precautions (EBP). (Resident 49) Finding includes: During an observation on 5/19/2025 at 9:34 A.M., the Unit Manager (UM) put on gloves, but did not put on a gown and assessed Resident 49's urinary catheter. The UM put the leg strap onto the resident's leg and repositioned the catheter. There was an Enhanced Barrier Precaution sign hanging on Resident 49's door and a three drawer cart with	F 0880	**F880 Infection Prevention and Control** • what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 49 was provided with enhanced barrier precautions, UM involved provided with on-spot education • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;	06/25/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155178	A. BUILDING 00 B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - FOUNTAINVIEW CARE CENTER	609 W TANGLEWOOD LN MISHAWAKA, IN 46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	PPE supplies noted outside of the resident's room. Resident 49's record review was completed on 5/21/2025 at 9:26 A.M. Diagnoses included, but were not limited to: neurogenic bladder, schizophrenia, anxiety disorder, dysphagia, and major depressive disorder. A current Physician's order, dated, 5/23/2025, indicated Resident 49 was in EBP related to an indwelling catheter and gown and gloves should be worn for high contact resident care. During an interview with the UM on 5/21/2025 at 11:03 A.M., the UM indicated she had only worn gloves while repositioning the resident's Foley catheter and should have worn a gown as well. On 5/27/2025 at 10:30 A.M., the Director of Nursing (DON) provided an undated policy, titled, "Enhanced Barrier Precautions" and identified it as the policy currently used by the facility. The policy indicated, "...b. an order for EBP will be obtained for residents with any of the following: Wounds and/or indwelling medical devices (central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a MDRO... 4. High-contact resident care activities include:... g. Device care or use: central lines, urinary catheters...." 3.1-18 (a)		All residents have the potential to be affected by the alleged deficient practice. All residents assessed/reviewed to ensure enhance barrier compliance per policy. • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All staff educated on enhanced barrier policy. Residents with enhanced barrier orders will be reviewed/observed by IP and/or nurse management team 5x/wk x 4 weeks, then 3x/wk x 2 months, then weekly x 3 months to ensure compliance per policy • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; DNS/Designee will present the summaries of the audits to the Quality assurance committee monthly for 6 months. Thereafter, if determined by the quality assurance committee that further monitoring is needed, audits will continue.	
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ Based on observation, record review and interview, the facility failed to provide a safe and sanitary environment for 7 of 19 rooms reviewed	F 0921	**F921 Safe/Functional/Sanitary/Comfortable Environment**	06/25/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155178	A. BUILDING 00 B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - FOUNTAINVIEW CARE CENTER	609 W TANGLEWOOD LN MISHAWAKA, IN 46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	for the environment. (Room 105, 112, 114, 115, 117, 118 and 119) Findings include: On 5/22/2025, beginning at 10:30 A.M., the following was observed on the 100 Unit: - Room105 had multiple gouges in the wall near the baseboard behind the bed of the resident nearest to the window. - Room 112 had 4 to 5 gouges on the north wall, basketball sized. The window blinds had 3 horizontal slats that were broken and partially missing. - Room 114 had a broken closet door. - Room 115 had a broken closet door. - Room 117 had a broken closet door and the window blinds were non-functional. - Room 118 had a broken closet door. - Room 119 had a broken closet door. During an interview, on 5/22/2025 at 2:28 P.M., the Area Maintenance Director indicated 24 rooms a month were toured to identify problems. The Area Maintenance Director indicated the facility utilized a "TELS" (technilogial system to streamline building maintence) system to submit work orders and all staff should have been submitting requests (regarding the broken and damaged items above). The Area Maintenance Director indicated the damaged and disrepaired items needed to be repaired and remedied. On 5/23/2025 at 10:08 A.M., the Director of Nursing (DON) provided a policy titled, "Facility Maintenance Guidelines and Procedure," undated and indicated the policy was the one currently used by the facility. The policy indicated " ...provide a clean, comfortable environment...Maintenance will attempt to repair		• what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **100 Unit:** **1.Gouges in walls repaired in rooms 105, 112,** **2.Blinds have been repaired or replaced in rooms 112, 117** **3.Closet doors have been repaired in rooms 114, 115, 117, 118, 119** • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All residents have the potential to be affected by the alleged deficient practice. ED and Maintenance Director will complete a facility walk through to inspect and determine if any other residents have gauges in walls, broken blinds, or broken closet doors.** • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **ED/designee educated Maintenance Staff regarding the Resident Environmental Quality policy prior to the date of compliance. All staff have been re-educated about the**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155178	A. BUILDING 00 B. WING	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - FOUNTAINVIEW CARE CENTER	609 W TANGLEWOOD LN MISHAWAKA, IN 46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	items as soon as possible ..." 3.1-19 (e)		**use of the TELS system for creating new work orders.** • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place **Resident Advocates to perform observations and audits of the resident rooms 3 times per week x 4 weeks, then weekly x 2 months, then monthly x 3 months.** **The results of these audits will be brought to QAPI monthly x 6 months or until 100% compliance is achieved x 3 consecutive months. Results of the audits will be adapted or adjusted as needed to maintain compliance.**	