PRINTED: 06/25/2025

	TOF HEALTH AND HU! R MEDICARE & MEDIC						RM APPROVED B NO. 0938-039	
	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155178	A. Bl	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/27/2025	
	PROVIDER OR SUPPLIER	E - FOUNTAINVIEW CARE CENT	ER	609 W	ADDRESS, CITY, STATE, ZIP COD TANGLEWOOD LN AWAKA, IN 46545			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE	
F 0000								
Bldg. 00	Licensure Survey.	Recertification and State This visit included the mplaints IN00460076, 100450950.	F 0	000	This response is not to be construed as an admission of by the facility, its employees, agents, or other individuals w draft or may be discussed in t	ho		
	the allegations are o	7226 - No deficiencies related to			response and plan of correction. This plan of correction is submitted as the facility's creat allegation of compliance. The facility respectfully requests prompliance.	dible		
	Complaint: IN0045 the allegations are c	0950 - No deficiencies related to itted.			·			
	Survey dates: May	19, 20, 21, 22, 23 and 27, 2025.						
	Facility number: 00 Provider number: 1 AIM number: 1002	55178						
	Census Bed Type: SNF/NF: 78 Total: 78							
	Census Payor Type Medicare: 2 Medicaid: 46 Other: 30 Total: 78	:						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Notify of Changes (Injury/Decline/Room, etc.)

These deficiencies reflect State Findings cited in

accordance with 410 IAC 16.2-3.1.

483.10(g)(14)(i)-(iv)(15)

F 0580

SS=D

Quality Review completed on 6/10/2025

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.

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES		OMB NO. 0938-039			
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155178	B. W	NG		05/27/2025	
							
NAME OF I	PROVIDER OR SUPPLIEF	t			ADDRESS, CITY, STATE, ZIP COD		
DDIOI0/		E EOUNTAIN (IENA CARE OFNI	TED		TANGLEWOOD LN		
BRICKY	ARD HEALTHCARE	E - FOUNTAINVIEW CARE CEN	IER	MISHA	AWAKA, IN 46545		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
Bldg. 00							
	Based on interview	, observation and record	F 0:	580	F580 Notify of changes	06/25/2025	
	review, the facility	failed to notify the Physician of			(injury/decline/room, etc)		
	a resident's new pai	s new pain for 1 of 1 residents reviewed					
	for pain. (Resident	49)			what corrective action	on(s)	
					will be accomplished for those	, ,	
	Finding includes:				residents found to have been		
					affected by the deficient pract	tice;	
	During an interview	v on 5/19/2025 at 9:30 A.M.,			Resident 49 pain managemer	I	
	Resident 49 indicate	ed his Foley catheter			plan of care updated and MD		
		catheter) was causing him pain			notified and received new ord	I	
		n as a 7 out of 10, with 0 being			for breakthrough pain medica		
		g the worst pain. He pulled his			as needed.		
	_	osed his catheter. The leg strap			how other residents		
	_	stuck to the tip of Resident			having the potential to be affe	ected	
		me size amount of blood noted			by the same deficient practice		
	on the catheter strap				be identified and what correct		
	•				action(s) will be taken;		
	During an observati	ion and interview, on 5/19/2025			All residents have the potential	al to	
	_	nit Manager (UM) put on			be affected by the alleged de		
		Resident 49's Foley catheter.			practice. All residents reviewe	I	
	_	eported his pain as a 7 out of			the last 7 days to identify any		
		e leg strap onto the resident's			pain onset, and NP/MD notified		
	leg and repositioned	d the Foley catheter tubing.			appropriate orders to manage		
	The UM indicated I	Resident 49 had scheduled			pain.		
	pain medications or	dered, but did not have any			what measures will be	ре	
		lered for breakthrough pain.			put into place and what syste	mic	
	The UM indicated s	she had requested an as			changes will be made to ensu		
	needed (PRN) pain	medication to be added to			that the deficient practice doe		
		s, but the Hospice provider			recur;		
	had not yet ordered				Licensed staff educated on pa	ain	
					management and change of		
	During an interview	v on 5/19/2025 at 11:05 A.M.,			condition policy. Resident nur	rses	
		ed his Foley catheter was still			notes will be reviewed by DN		
		s pain as an 8 out 10. Resident			and/or nurse management te		
		not received any pain			5x/wk x 4 weeks, then 3x/wk	I	
		s morning medication pass.			months, then weekly x 3 mon		
		_			to ensure management of pai		

Resident 49's record review was completed on

5/21/2025 at 9:26 A.M. Diagnoses included, but

provided routinely per policy and

MD/NP notification per policy of

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155178	B. WI	ING		05/27/	2025
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
DDIOLOVADD LIEAL TUOADE - FOUNTAINIVIEW CADE CENT				TANGLEWOOD LN			
BRICKY	ARD HEALTHCARE	E - FOUNTAINVIEW CARE CENTE	:K	MISHA	WAKA, IN 46545		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOVIDED'S DI AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	rc	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	were not limited to:	neurogenic bladder,			new onset of pain.		
	schizophrenia, anxi	ety disorder, dysphagia, and			how the corrective		
	major depressive di	sorder.			action(s) will be monitored to		
	3 1				ensure the deficient practice w	rill	
	A Ouarterly Minim	um Data Set (MDS) assessment			not recur, i.e., what quality		
		49 had moderate cognitive			assurance program will be put	into	
		s able to understand others and			place;		
	make himself under				DNS/Designee will present the	•	
					summaries of the audits to the		
	A current Physician	n's order indicated Resident 49			Quality assurance committee		
	received Hospice se				monthly for 6 months. Therea	fter	
					if determined by the quality	1101,	
	Resident 49's record	d lacked the documentation			assurance committee that furth	ner	
		ad been contacted on			monitoring is needed, audits w		
	_	g the new pain Resident 49 was			continue.	111	
	having related to his	-			Continue.		
	naving related to in	s roley cameter.					
	A review of Reside	nt 49's Hospice binder was					
		2025 at 9:40 A.M. Resident 49					
	•	te Hospice Nurse (HN) on					
	-	HN had not addressed the					
		by the indwelling catheter.					
	penne pam causeu i	by the mawering catheter.					
	Duning on absorbed	ion of catheter care on					
	_						
		A.M., Resident 49 indicated his					
	· ·	still causing him pain. CNA 3					
		was aware of the resident's					
	-	with the Foley catheter care					
		ident 49 if she could continue					
	the catheter care.						
	_	w with the Clinical Educator					
	` '	at 10:05 A.M., the CE indicated					
		nad been reported to a nurse,					
		at was taking care of Resident					
		esident 49's pain had not been					
		ley catheter care should not					
		d until he had been assessed					
	by his nurse.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155178			UILDING	nstruction <u>00</u>	(X3) DATE COMPL 05/27 /	ETED		
	F PROVIDER OR SUPPLIEI	RE - FOUNTAINVIEW CARE CENTE	STREET ADDRESS, CITY, STATE, ZIP COD 609 W TANGLEWOOD LN TER MISHAWAKA, IN 46545					
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ΓE	(X5) COMPLETION	
	REGULATORY OF REGULATORY OF During an interview 11:03 A.M., the UN complained of Foles she had called Hospicatheter care had be to report his pain at that day. The UM is had not been assess resident had reported The UM indicated 5/19/2025 but had record. The UM indicated Hospicatheter Care Hospicatheter Care Hospicatheter Care Hospicatheter Care Hospicatheter Care Hospicatheter (Hospicatheter) had them on 5/19/2025 conversations with adding a PRN pain PRN pain medicatheter Hospicatheter).				(EACH CORRECTIVE ACTION SHOULD BE	TE		
	Resident 49 and co logged from the fac indicated Resident	otes and call logs related to uld not find an entry or a call cility on 5/19/2025. The BOA 49 had been seen by the 5/22/2025 in the facility.						
	During an interview on 5/21/2025 at 2:0 49 had been seen b	w with a Hospice Nurse (HN), 00 P.M., she indicated Resident y Hospice on 5/20/2024 and reported any new or						

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Event ID: ZLYD11 Facility ID: 000094

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	` ′		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPL	
		155178	B. W	ING		05/27	/2025
NAME OF T	DROWNED OF CURPUSE			STREET A	DDRESS, CITY, STATE, ZIP COD	_	
NAME OF F	PROVIDER OR SUPPLIER	<u>C</u>		609 W T	TANGLEWOOD LN		
BRICKY	ARD HEALTHCARE	E - FOUNTAINVIEW CARE CENT	ER ——	MISHAV	VAKA, IN 46545		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
		ted to Resident 49's Foley					
	1	d any PRN pain medication.					
		Resident 49 had not complained					
	_	ey catheter in the past to her. e new pain to the Hospice					
	_						
	medication for Resi	ned an order for a PRN pain					
	medication for Resi	dent 49.					
	During an interview	with the Hospice Director of					
	1	on 5/21/2025 at 2:04 P.M., the					
	HDO indicated she	had reviewed the call logs to					
	the Hospice office a	and there was no logged calls					
	from the facility on	5/19/2025 nor did she locate					
	any notes that the fa	acility had called about					
	Resident 49's comp	laint of penile pain due to his					
	catheter prior to 5/2	1/2025. A HN had visited					
	Resident 49 on 5/20	0/2025 and staff had not					
	reported any pain re	elated to the Foley catheter to					
	the HN. The HDO i	ndicated Hospice had not					
	received any reques	sts from staff to include a PRN					
	pain medication. Th	ne HDO indicated the facility					
	should have reporte	ed the new pain on 5/19/2025					
	and before they pro	vided catheter care on					
	5/21/2025 so Reside	ent 49 did not have any					
	unnecessary pain.						
	On 5/21/2025 at 1:0	3 P.M., the DON provided an					
	undated policy title	d, "Pain Management", and					
	identified it as the p	oolicy currently used by the					
	facility. The policy	indicated, "The facility must					
	ensure that pain ma	nagement is provided to					
	residents who requi	re such services					
	Recognition: 1. In o	order to help a resident attain or					
	maintain his/her hig	ghest practicable level of					
		d psychosocial well-being and					
		ge pain, the facility will: b.					
		nt for pain and the cause upon					
	admission, during o	ongoing scheduled					
	assessments, and wi	hen a significant change in					
	condition or status of	occurs (e.g. after a fall, change					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155178		· ′	UILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/27/2025		
	ROVIDER OR SUPPLIER	- FOUNTAINVIEW CARE CENT	ER	609 W	ADDRESS, CITY, STATE, ZIP COD TANGLEWOOD LN WAKA, IN 46545		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
F 0582 SS=D Bldg. 00	in behavior or mentexacerbation of pair notify the practition controlled by the tree 3.1-5 (a)(2) 483.10(g)(17)(18)(Medicaid/Med	al status, new pain or an h.)2 j. Facility staff will er, if the resident's pain is not eatment regimen" (i)-(v) the Coverage/Liability Notice and record review, the facility cilled Nursing Beneficiary Notice Form ovided timely following the end services for 2 of 3 residents d from Medicare services.	FO			n(s) dice; dice; dicted divide dive ding dity he	06/25/2025
	her had therapy end 2. During a review of	NC documents 48 hours before ed. of SNF-ABN form, on 5/22/2025 JF-ABN document indicated			past 3 months that were cut from Medicare and remained in the facility to ensure they received a timely NOMNC an SNF-ABN prior to the cut of		
		icare coverage had ended on			Medicare		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPLET	
		155178	B. W	ING		05/27/2	U 2 5
	PROVIDER OR SUPPLIER	E - FOUNTAINVIEW CARE CENTE	ĒR	609 W	ADDRESS, CITY, STATE, ZIP COD TANGLEWOOD LN WAKA, IN 46545		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROWING DLANLOS CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	,	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	ii E	DATE
	1/28/2025. An unda	nted NOMNC form had been			what measures will b	е	
	*	nt 178 and he had signed the			put into place and what syster	nic	
		e was not a date to indicate			changes will be made to ensu	re	
	when the resident h	ad been informed.			that the deficient practice does	s not	
					recur;		
	_	v on 5/22/2025 at 1:35 P.M., the			Business Office Manager ha	s	
		anager indicated she was			been re-educated on the		
		78 needed to have been given			Advance Beneficiary Notices	•	
		NOMNC documents to sign			Policy. Daily in morning		
		ad not been given the INC document 48 hours before			meeting the management tea		
	his therapy ended.	inc document 48 hours before			will discuss any residents th will be cut from a skilled pay		
	ins therapy ended.				will be receiving a NOMNC,	01,	
	On 5/22/2025 at 2.5	54 P.M., the Director of Nursing			and whether or not a SNF-A	RN	
		d policy title, "Advance			is needed. This will be noted	1	
	1 ^	s", and identified it as the			on the Daily Morning Meeting		
	I -	ed by the facility. The policy			Sheets.	•	
		ensure that the resident, or			how the corrective		
	· ·	enough time to make a			action(s) will be monitored to		
	decision whether or	not to receive the services in			ensure the deficient practice v	vill	
	question and assum	e financial responsibility, the			not recur, i.e., what quality		
	notice shall be prov	ided at least two days before			assurance program will be put	t into	
	the end of a Medica	are covered Part A stay			place; and		
					Business Office Manager to		
					perform audits of residents		
	3.1-4(f)(2)				remaining in the facility after	.	
					being cut from Medicare to		
					ensure timely completion of		
					SNF-ABNs. Audits to be don	I	
					times per week x 4 weeks, the	ien	
					weekly x 2 months, then monthly x 3 months.		
					The results of these audits w	, _{ill}	
					be brought to QAPI monthly	1	
					months or until 100%	^	
					compliance is achieved x 3		
					consecutive months. Results	s of	
					the audits will be adapted or	I	
					adjusted as needed to maint		
					compliance		

CENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES				OMI	B NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL		
		155178	B. WI	NG		05/27/	2025	
	PROVIDER OR SUPPLIEF	R E - FOUNTAINVIEW CARE CEN	TER	609 W	ADDRESS, CITY, STATE, ZIP COD TANGLEWOOD LN WAKA, IN 46545			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
F 0628 SS=E Bldg. 00	483.15(c)(2)(iii)(3) Discharge Proces)-(6)(8)(d)(1)(2); 48 es						
			F 06	528	F628 Discharge Process		06/25/2025	
		and record review, the facility			what corrective actio	n(s)		
	failed to notify the	Long Term Care (LTC)			will be accomplished for those	Э		
	Ombudsman in a ti	mely manner of resident			residents found to have been			
	_	5 residents reviewed for			affected by the deficient pract	ice;		
	discharges. (Reside	ents 32, 75 and 76)			Ombudsman has been notifi	ied		
	Findings include:				of the discharges for Reside 32, 75, 76	nts		
					how other residents			
	1. On 4/17/2025 Re	esident 75 was discharged to			having the potential to be affe	ected		
	home after complet	ing therapy and meeting goals.			by the same deficient practice	e will		
					be identified and what correct	ive		
	On 5/23/2025 at 1:4	42 P.M. a list of LTC			action(s) will be taken;			
	Ombudsman discha	arge notifications for February,			All residents discharging or			
		25 were requested from the ED.			being transferred to a hospi			
	•	•			have the potential to be			
	During an interview	v on 5/27/2025 at 9:11 A.M. the			affected. Social Services to			
	_	eceived an email from the LTC			complete an audit of all			
		he discharges for February and			transfers or discharges from	n the		
		t April. The email indicated the			last 3 months to ensure			
		nad not received any			Ombudsman notification wa	ıs		
		lischarges for April 2025. The			completed.			
		2025 discharges should have			what measures will be	ne e		
	_	, 2025 but had not been sent.2.			put into place and what syste			
		v on 5/19/2025 at 10:35 A.M.,			changes will be made to ensu			
	_	ed he had been sent to the			that the deficient practice doe			
	hospital in March.				recur;	01100		
	nespital in march				Social Service staff to be			
	Resident 32's record	d review was completed on			re-educated on the Transfer			
		P.M. Diagnoses included, but			and Discharge policy and th			
		: chronic obstructive pulmonary			process for notifying the	•		
		a, major depressive disorder			Ombudsman. All transfers a	nd		
	and generalized any	-			discharges will be discussed			
	and generalized all	nery disorder.			daily in morning meetings a			
	A Nursing Note date	ted. 3/8/2025 at 2:32 P.M			will be tracked on the Ongoi			
i e	T A DUISHIE NOR GAL	ieu. 3/0/2023 at 2.32 f.W			I WIII DE ITACKEO ON THE CINANI	a101 - J		

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hospital for pneumonia.

indicated Resident 32 had been admitted to the

Event ID:

ZLYD11

Facility ID: 000094

Audit Tool.

If continuation sheet

how the corrective

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		155178	B. W	ING		05/27/	2025
NAME OF D	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD	_	
					TANGLEWOOD LN		
BRICKYA	ARD HEALTHCARE	- FOUNTAINVIEW CARE CENTE	R	MISHA	WAKA, IN 46545		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	A marriagy of the Ma	rch 2025 Ombudsmen			action(s) will be monitored to	.:11	
		s completed on 5/27/2025 at			ensure the deficient practice w not recur, i.e., what quality	/111	
		t 32's name was not on the list.			assurance program will be put	into	
	7. 13 71 resident	22 5 Hairie Was Hot on the Hist.			place; and	· iiito	
	During an interview	w with Executive Director (ED)			Social Services staff to perfo	rm	
	_	5 A.M., the ED indicated			audits of Ombudsman		
		was not on the Ombudsmen			notifications for residents be	ing	
	notification list for	March 2025.			transferred to a hospital or		
	2 D 11 176				discharging from the facility		
		ord review was completed on			voluntarily. Audits to be don		
		P.M. Diagnoses included, but dementia, dysphagia, fracture			monthly for the next 6 month The results of these audits w		
		ılitius and rhabdomyolysis.			be brought to QAPI monthly		
	or right femal, cent	antitus and maodomyorysis.			months or until 100%	^ 0	
	A Change in Condi	tion note, dated, 2/21/2025 at			compliance is achieved x 3		
	_	d Resident 76 had been sent to			consecutive months. Results	of	
	the hospital.				the audits will be adapted or		
					adjusted as needed to maint	ain	
		scharged from the facility on			compliance.		
	2/22/2025 and was	not readmitted.					
	A review of the Feb	oruary 2025 Ombudsmen					
		s completed on 5/27/2025 at					
		76's name was not on the list.					
	_	with Executive Director (ED)					
		6 A.M., the ED indicated					
		was not on the Ombudsmen					
	notification list for	February 2025.					
	On 5/27/2025 at 0.0	00 A.M., the ED provided an					
		, "Transfer and Discharge"					
		the policy currently used by					
		licy indicated, " 5. The facility					
	will maintain evider	nce that the notice was sent to					
	the Ombudsman"	•					
	21.12/3/22						
	3.1-12 (a)(6)(iv)						
			I				

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CENTERS FOR MEDICARE & MEDICAID SERVICES						ON	IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE C	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		155178	B. W	ING		05/27	/2025
BRICKY	ı	E - FOUNTAINVIEW CARE CEN	ΤER	STREET ADDRESS, CITY, STATE, ZIP COD 609 W TANGLEWOOD LN ER MISHAWAKA, IN 46545			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0656 SS=D Bldg. 00		nt Comprehensive Care Plan					
	Based on record rev	view and interview, the facility	F 00	656	F656 Develop/Implement		06/25/2025
	failed to ensure an i	individualized plan of care was			comprehensive care plan		
	created for a resider	nt with an Activity of Daily					
	Living (ADL) self-	care performance deficit for 1 of			what corrective action	n(s)	
	21 residents review	red for care plans. (Resident 65)			will be accomplished for those	. ,	
		•			residents found to have been		
	Finding includes:				affected by the deficient practi	ce:	
	8				Resident 65 plan of care upda		
	The clinical record	of Resident 65 was reviewed			for resident preference of show		
		0 P.M. The residents' diagnoses			ler resident preference of one	11010	
		not limited to: local infection of			how other residents		
		ous tissue, falls, anxiety,			having the potential to be affe	ctad	
		nsion, bipolar disorder, sepsis			by the same deficient practice		
	and dysphagia.	nsion, orpotar disorder, sepsis			be identified and what correcti		
	and dyspnagia.				action(s) will be taken;	VC	
	An Admission Min	imum Data Set (MDS)			All residents have the potentia	ul to	
		4/9/2025, indicated the resident			be affected by the alleged def		
		tively impaired and required			practice. All residents preferer		
		ce with upper and lower body			for showers reviewed and care		
		n footwear, personal hygiene,				5	
	toileting, showering				planed accordingly.	_	
	tolleting, showering	g and batting.			what measures will b put into place and what system		
	A aurrant Cara Dlar	n, initiated 4/23/2025, indicated			put into place and what syster changes will be made to ensu		
		ADL self-care performance			that the deficient practice does	S HOL	
	_	assistance by one staff but the type and frequency of			recur;		
					Licensed staff educated on		
	bathing preferred by	y the resident.			comprehensive care plan police	•	
	During on interni	u on 5/22/2025 at 2:00 D.M. 41			Resident preference assessm		
		v, on 5/22/2025 at 2:08 P.M., the			will be reviewed by DNS and/o		
		g (DON) indicated resident care			nurse management team 5x/w		
	•	ed with an interdisciplinary			4 weeks, then 3x/wk x 2 mont		
		ervices completed their portion			then weekly x 3 months to ens	sure	
		l other disciplines completed			plan of care is updated with		
	•	ne DON indicated an aide			preferences per policy.		
		Resident 65 was an assist of			how the corrective		
	one for bathing or s	showering but the resident			action(s) will be monitored to		

preference on the type or frequency of bathing

ensure the deficient practice will

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155178 B. WING 05/27/2025 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 609 W TANGLEWOOD LN BRICKYARD HEALTHCARE - FOUNTAINVIEW CARE CENTER MISHAWAKA. IN 46545 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE and the care plan should have been included in not recur, i.e., what quality the care plan. assurance program will be put into On 5/22/2025 at 2:30 P.M., the DON provided a DNS/Designee will present the policy titled, "Comprehensive Care Plans," dated summaries of the audits to the 2025 and indicated the policy was the one Quality assurance committee currently used by the facility. The policy indicated monthly for 6 months. Thereafter, " ...develop and implement a comprehensive if determined by the quality person-centered care plan for each resident ...that assurance committee that further includes measurable objectives and timeframes to monitoring is needed, audits will meet a resident's medical, nursing, and ...ALL continue. services that are identified in the resident's comprehensive assessment..." 3.1-35(a) F 0657 483.21(b)(2)(i)-(iii) SS=D Care Plan Timing and Revision Bldq. 00 F 0657 F657 Care Plan Timing and 06/25/2025 Based on interview, observation and record Revision review, the facility failed to update a care plan with interventions put into place after a fall for 1 what corrective action(s) of 1 resident reviewed for falls. (Resident 2) will be accomplished for those residents found to have been Finding includes: affected by the deficient practice; Resident 2 plan of care updated A record review was completed on 5/22/2025 at with all current fall interventions

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 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

how other residents

what measures will be

interventions are up to date on

residents plan of care.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 05/27/2025 155178 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 609 W TANGLEWOOD LN BRICKYARD HEALTHCARE - FOUNTAINVIEW CARE CENTER MISHAWAKA. IN 46545 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE risk for falls. Interventions included: call light put into place and what systemic within reach and anticipate and meet the resident's changes will be made to ensure needs. that the deficient practice does not A Nursing Progress Noted indicated on 4/14/2025 Licensed staff educated on at 8:20 A.M., Resident 2 fell out of bed and revisions of status change plan sustained an injury to her head. The post-fall policy. Resident fall incidents will evaluation, completed on 4/14/2025, indicated a be reviewed by DNS and/or nurse fall mat was placed by the bed, the resident was management team 5x/wk x 4 placed in a low bed and the interventions would weeks, then 3x/wk x 2 months, be placed on the Care Plan. then weekly x 3 months to ensure plan of care is being updated with However, the Care Plan was not updated to reflect interventions routinely per the interventions until 5/20/2025 when the fall mat policy. was added. The low bed was not added to the how the corrective Care Plan. action(s) will be monitored to ensure the deficient practice will During an interview on 5/22/2025 at 2:29 P.M., the not recur, i.e., what quality DON indicated the care plan should have been assurance program will be put into updated at the time of the fall with the new place; interventions. DNS/Designee will present the summaries of the audits to the On 5/22/2025 at 2:29 P.M. a current policy, dated Quality assurance committee August 2024 and titled, "Care Plan Revisions monthly for 6 months. Thereafter, Upon Status Change" was provided by the DON. if determined by the quality The policy indicated, "...The care plan will be assurance committee that further updated with the new or modified intervention...." monitoring is needed, audits will continue. 3.1-35(e)F 0692 483.25(g)(1)-(3) SS=D Nutrition/Hydration Status Maintenance Bldg. 00 F692 Nutrition/Hydration Status Based on observation, record review and F 0692 06/25/2025 interview, the facility failed to follow a Physician's Maintenance order related to providing nutritional supplements what corrective action(s) for 1 of 1 resident who was reviewed for nutrition. (Resident 53) will be accomplished for those residents found to have been

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Finding includes:

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affected by the deficient practice;

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CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES				OMB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		155178	B. WI	NG		05/27	/2025
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	2			TANGLEWOOD LN		
BRICKY	ARD HEALTHCARE	- FOUNTAINVIEW CARE CEN					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					Resident 53 was provided wit	:h	
	_	rations, Resident 53 did not			health shakes per order		
		on his lunch meal tray on the			how other residents		
	following dates:				having the potential to be affe	ected	
	-5/20/2025				by the same deficient practice	e will	
	-5/21/2025				be identified and what correct	tive	
	-5/22/2025				action(s) will be taken;		
					All residents have the potential	al to	
		d review was completed			be affected by the alleged det	ficient	
		.M. Diagnoses included, but			practice. All residents identifie	ed	
	were not limited to:	dysphagia, rhabdomyolysis,			with a supplement health sha	ke	
	protein-calorie malı	nutrition, starvation and sacral			order were reviewed for the la	ast 30	
	pressure ulcer.				days to ensure compliance w	ith	
					order/documentation per police	cy.	
	A current Physician	's order, dated, 2/28/2025,					
	indicated Resident	53 was to receive a health			what measures will be	ре	
	shake at lunch and	dinner.			put into place and what syste	mic	
					changes will be made to ensu	ıre	
	However, a review	of the May 2025 Medication			that the deficient practice doe	s not	
	Administration Rec	ord (MAR) indicated Resident			recur;		
	53 was documented	as having received his lunch			All staff educated on Nutrition	ıal	
	health shake on 5/2	0, 5/21 and 5/22/2025 even			and Dietary Supplements poli	icy.	
	though there was no	health shake served to			Residents with a nutritional		
	Resident 53.				supplement order will be		
					reviewed/observed by DNS a	nd/or	
	During an interview	on 5/23/2025 at 1:30 P.M.,			nurse management team 5x/v	wk x	
	LPN 4 indicated Re	sident 53 had drank all of his			4 weeks, then 3x/wk x 2 mont	ths,	
	lunch health shake	on 5/23/2025. LPN 4 indicated			then weekly x 3 months to en	sure	
	the kitchen was resp	ponsible for providing the			compliance with supplement		
	health shake and the	e nurse was responsible for			health shake order per policy.		
	documenting the in	take.			how the corrective		
					action(s) will be monitored to		
	During an interview	on 5/23/2025 at 1:37 P.M.,			ensure the deficient practice v	will	
		5 indicated Resident 53's meal			not recur, i.e., what quality		
	tickets showed a sta	anding order for him to receive			assurance program will be pu	ıt into	
		is lunch tray. DA 5 indicated it			place;		1
		sponsibility to provide the			DNS/Designee will present th	e	
	health shake, but if	the health shake was missing,			summaries of the audits to the		

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kitchen.

the nurse should should have contacted the

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Quality assurance committee monthly for 6 months. Thereafter,

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155178	B. WI	NG		05/27/	/2025
				CTDEET.	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	L			TANGLEWOOD LN		
BDICKV	ADD HEVI THOVDE	- FOUNTAINVIEW CARE CENTE	D		WAKA, IN 46545		
DICIOICIA	AND HEALTHOAKE	O ON TAINVIEW GARE GENTE		WIIOTIA	• • • • • • • • • • • • • • • • • • •		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ιΤΕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					if determined by the quality		
		24 P.M., the Director of Nursing			assurance committee that furt		
		undated policy titled,			monitoring is needed, audits w	vill	
		etary Supplements" and			continue.		
	_	olicy currently used by the					
		indicated, " 2. The facility will					
	-	and dietary supplements to					
	· ·	stent with the resident's					
	assessed needs"						
	3.1-46 (a)(2)						
F 0697	483.25(k)						
SS=D	Pain Management	•					
Bldg. 00	l all Management	•					
	Based on interview.	observation and record	F 06	697	F697 Pain Management		06/25/2025
		failed to notify the address a	1 00	,,,,	what corrective action	n(s)	00/23/2023
	-	ly and effectively for 1 of 1			will be accomplished for those		
	-	for pain. (Resident 49)			residents found to have been		
		,			affected by the deficient practi	ice:	
	Finding includes:				Resident 49 pain managemen		
	C				plan of care updated and prov		
	During an interview	on 5/19/2025 at 9:30 A.M.,			with breakthrough pain		
	_	ed his Foley catheter			medications as needed.		
		catheter) was causing him pain			how other residents		
		n as a 7 out of 10, with 0 being			having the potential to be affect	cted	
	_	g the worst pain. He pulled his			by the same deficient practice		
		osed his catheter. The leg strap			be identified and what correcti		
	_	stuck to the tip of Resident			action(s) will be taken;		
		me size amount of blood noted			All residents have the potentia	al to	
	on the catheter strap				be affected by the alleged defi		
	1				practice. All residents reviewe		
	During an observati	on and interview, on 5/19/2025			the last 7 days to identify any		
		nit Manager (UM) put on			pain onset, and NP/MD notifie		
		Resident 49's Foley catheter.			appropriate orders to manage		
		eported his pain as a 7 out of			pain.		
		leg strap onto the resident's			what measures will b	e	
	_	If the Foley catheter tubing.			put into place and what syster		
		Resident 49 had scheduled			changes will be made to ensu		
		dered, but did not have any			that the deficient practice does		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER			, ,	UILDING	instruction 00	(X3) DATE COMPL 05/27 /	LETED	
		ROVIDER OR SUPPLIEF		ER	609 W	ADDRESS, CITY, STATE, ZIP COD FANGLEWOOD LN NAKA, IN 46545		
	BRICKYA (X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 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,	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION Idered for breakthrough pain. Ishe had requested an as medication to be added to s, but the Hospice provider a PRN medication. If you on 5/19/2025 at 11:05 A.M., and his Foley catheter was still s pain as an 8 out 10. Resident not received any pain s morning medication pass. If review was completed on A.M. Diagnoses included, but neurogenic bladder,	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 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		(X5) COMPLETION DATE	
		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				place; DNS/Designee will present the summaries of the audits to the Quality assurance committee monthly for 6 months. Therea if determined by the quality assurance committee that furt monitoring is needed, audits v continue.	e after, :her	
		having related to hi A review of Reside completed on 5/21/had been seen by th 5/20/2025, but the I penile pain caused I During an observat: 5/21/2025 at 10:00	g the new pain Resident 49 was s Foley catheter. Int 49's Hospice binder was 2025 at 9:40 A.M. Resident 49 he Hospice Nurse (HN) on HN had not addressed the by the indwelling catheter. It ion of catheter care on A.M., Resident 49 indicated his still causing him pain CNA 3					

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3)			(X3) DATE	(3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED	
		155178	B. WING			05/27/2025		
			Ь—	STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF P	PROVIDER OR SUPPLIER	₹			TANGLEWOOD LN			
BRICKY	ARD HEALTHCARE	- FOUNTAINVIEW CARE CENTE						
				1,110117	1		1	
(X4) ID	· ·			ID PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE	
	indicated the nurse was aware of the resident's							
	-	with the Foley catheter care						
	_	ident 49 if she could continue						
	the catheter care.							
	Duning on intermi	with the Clinical Educator						
	-	w with the Clinical Educator at 10:05 A.M., the CE indicated						
		at 10:03 A.M., the CE indicated and been reported to a nurse,						
	-	at was taking care of Resident						
		esident 49's pain had not been						
		esident 47 s pain had not been sley catheter care should not						
	have been continued until he had been assessed							
	by his nurse.							
	by his harse.							
	During an interview with the UM on 5/21/2025 at							
	-	// 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 f	forgotten to add a note to the						
		licated she had added a late						
	entry note for 5/19/2	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							
		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							
-		started and was reported to					1	
	them on 5/19/2025. The UM indicated she had had							
		the Hospice nurses about						
		medication in the past, but no						
	-	on order had been provided by						
Hospice.			1		I		1	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION (X3) DA			(X3) DATE	DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED		
		155178	B. WING		·	05/27/2025		
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF P	ROVIDER OR SUPPLIER	8			TANGLEWOOD LN			
BRICKYARD HEALTHCARE - FOUNTAINVIEW CARE CENTER					WAKA, IN 46545			
BRICKTARD HEALTHCARE - POONTAINVIEW CARE CENTER				MISHA			_	
(X4) ID				ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	-	with a Business Office						
	· · ·	f the Hospice company on						
		P.M., the BOA indicated she						
		otes and call logs related to						
		ald not find an entry or a call						
		ility on 5/19/2025. The BOA						
		49 had been seen by the						
	Hospice Nurse on 5	/22/2025 in the facility.						
	Descioner and the state of the	and Hamilan Market						
	_	with a Hospice Nurse (HN),						
		0 P.M., she indicated Resident						
		y Hospice on 5/20/2024 and						
	-	reported any new or						
		ted to Resident 49's Foley						
	_	d any PRN pain medication.						
		Resident 49 had not complained						
	-	ey 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.							
	illedication for Kesi	dent 49.						
	During an interview	with the Hospice Director of						
	-	on 5/21/2025 at 2:04 P.M., the						
		had reviewed the call logs to						
		and there was no logged calls						
	-	5/19/2025 nor did she locate						
		acility had called about						
		laint of penile pain due to his						
	-	1/2025. A HN had visited						
Resident 49 on 5/20/2025 and staff had not								
reported any pain related to the Foley catheter to								
		indicated Hospice had not						
		received any requests from staff to include a PRN						
		ne HDO indicated the facility						
	-	ed the new pain on 5/19/2025						
	_	vided catheter care on						
		ent 49 did not have any						
	unnecessary pain.	,						
	, , , , , , , , , , , , , , , , , , ,							

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06/25/2025 PRINTED: FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY

AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 05/27/2025 155178 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 609 W TANGLEWOOD LN BRICKYARD HEALTHCARE - FOUNTAINVIEW CARE CENTER MISHAWAKA, IN 46545 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG 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 483.80(a)(1)(2)(4)(e)(f) SS=D Infection Prevention & Control Bldg. 00 Based on observation, record review and F 0880 F880 Infection Prevention and 06/25/2025 interview, the facility failed to wear personal Control protective equipment (PPE) while providing Foley catheter (indwelling urinary catheter) care for 1 of what corrective action(s) 4 residents reviewed for Enhanced Barrier will be accomplished for those Precautions (EBP). (Resident 49) residents found to have been affected by the deficient practice; Finding includes: Resident 49 was provided with enhanced barrier precautions, UM During an observation on 5/19/2025 at 9:34 A.M., involved provided with on-spot the Unit Manager (UM) put on gloves, but did not education put on a gown and assessed Resident 49's urinary how other residents catheter. The UM put the leg strap onto the having the potential to be affected resident's leg and repositioned the catheter. There by the same deficient practice will was an Enhanced Barrier Precaution sign hanging be identified and what corrective on Resident 49's door and a three drawer cart with action(s) will be taken;

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Event ID:

ZLYD11

Facility ID: 000094

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLETED		
		155178	B. W	B. WING		05/27/2025		
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	ROVIDER OR SUPPLIER	8			TANGLEWOOD LN			
BRICKY	ARD HEALTHCARE	- FOUNTAINVIEW CARE CENT	ER		WAKA, IN 46545			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5)	
PREFIX							COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	PPE supplies noted	outside of the resident's room.			All residents have the potentia	ıl to		
					be affected by the alleged def	cient		
		d review was completed on		practice. All residents				
		5/21/2025 at 9:26 A.M. Diagnoses included, but			assessed/reviewed to ensure			
		neurogenic bladder,			enhance barrier compliance p	er		
	_	ety disorder, dysphagia, and			policy.			
	major depressive di	sorder.			what measures will b			
					put into place and what systemic			
	•	's order, dated, 5/23/2025,			changes will be made to ensu			
	indicated Resident 49 was in EBP related to an indwelling catheter and gown and gloves should				that the deficient practice does	s not		
					recur;			
be worn for high contact resident care.		ntact resident care.			All staff educated on enhance	d		
	.	'd d TD 5 5/01/0005			barrier policy. Residents with			
	During an interview with the UM on 5/21/2025 at				enhanced barrier orders will b			
	11:03 A.M., the UM indicated she had only worn gloves while repositioning the resident's Foley				reviewed/observed by IP and/			
					nurse management team 5x/w			
	catheter and should	have worn a gown as well.			4 weeks, then 3x/wk x 2 mont			
	On 5/27/2025 at 10	20 A M the Director of			then weekly x 3 months to ens	sure		
	On 5/27/2025 at 10:30 A.M., the Director of Nursing (DON) provided an undated policy, titled,				compliance per policyhow the corrective			
	"Enhanced Barrier Precautions" and identified it							
	as the policy currently used by the facility. The				action(s) will be monitored to ensure the deficient practice w	vill		
	policy indicated, "b. an order for EBP will be obtained for residents with any of the following: Wounds and/or indwelling medical devices				not recur, i.e., what quality	/III		
					assurance program will be put	t into		
					place;	, II ILO		
		-			DNS/Designee will present the	2		
	(central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized				summaries of the audits to the			
					Quality assurance committee			
		High-contact resident care			monthly for 6 months. Therea	ıfter.		
		g. Device care or use: central			if determined by the quality	,		
	lines, urinary cathet	_			assurance committee that furt	her		
	,				monitoring is needed, audits w			
	3.1-18 (a)				continue.			
F 0921	483.90(i) Safe/Functional/Sanitary/Comfortable Environ							
SS=E								
Bldg. 00		-						
	Based on observation, record review and		F 0	921	F921		06/25/2025	
	interview, the facili	ty failed to provide a safe and			Safe/Functional/Sanitary/Comf			
	sanitary environment for 7 of 19 rooms reviewed				ortable Environment		1	

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		155178	B. W	NG		05/27/2025		
				_				
NAME OF I	PROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP COD			
			609 W TANGLEWOOD LN					
BRICKY	ARD HEALTHCARE	E - FOUNTAINVIEW CARE CENTE	₽R	R MISHAWAKA, IN 46545				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE			ID	DDOVIDED'S DI AN OF CODDECTION		X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPI	LETION	
TAG				TAG	DEFICIENCY)	DA	TE	
	for the environment. (Room 105, 112, 114, 115,				what corrective action	n(s)		
	117, 118 and 119)				will be accomplished for those	` '		
117, 110 min 113)					residents found to have been			
	Findings include:		affected by the deficient pract			ce:		
	8				100 Unit:	,		
	On 5/22/2025, begi	nning at 10:30 A.M., the			1.Gouges in walls repaired	in		
		erved on the 100 Unit:			rooms 105, 112,			
		multiple gouges in the wall near			2.Blinds have been repaire	,		
		nd the bed of the resident			or replaced in rooms 112, 11			
	nearest to the winde				3.Closet doors have been			
- Room 112 had 4 to 5 gouges on the north		1 4 to 5 gouges on the north			repaired in rooms 114, 115, 1	17.		
wall, basketball sized. The window blinds had 3					118, 119	,		
	horizontal slats that were broken and partially							
missing.				how other residents				
- Room 114 had a broken closet door.				having the potential to be affect	ted			
- Room 115 had a broken closet door.				by the same deficient practice				
- Room 117 had a broken closet door and the		l a broken closet door and the			be identified and what correcti	l l		
window blinds		e non-functional.			action(s) will be taken;			
	- Room 118 had	l a broken closet door.			All residents have the potent	ial		
	- Room 119 had	l a broken closet door.			to be affected by the alleged			
					deficient practice. ED and			
	During an interview	v, on 5/22/2025 at 2:28 P.M., the			Maintenance Director will			
	Area Maintenance	Director indicated 24 rooms a			complete a facility walk			
	month were toured	to identify problems. The			through to inspect and			
	Area Maintenance	Director indicated the facility			determine if any other			
	utilized a "TELS" (technilogial system to			residents have gauges in wa	ls,		
	streamline building	maintence) system to submit			broken blinds, or broken clos			
	work orders and all	staff should have been			doors.			
	submitting requests	(regarding the broken and						
	damaged items abo	ve). The Area Maintenance			what measures will b	e		
	Director indicated t	the damaged and disrepaired			put into place and what syster	nic		
	items needed to be	repaired and remedied.			changes will be made to ensu	e		
					that the deficient practice does	not		
	On 5/23/2025 at 10:08 A.M., the Director of				recur;			
	Nursing (DON) provided a policy titled, "Facility				ED/designee educated			
	Maintenance Guidelines and Procedure," undated				Maintenance Staff regarding			
	_	olicy was the one currently			the Resident Environmental			
	used by the facility. The policy indicated "				Quality policy prior to the da	te		
	provide a clean, c	comfortable			of compliance. All staff have			
environmentMaintenance will attempt to repa		ntenance will attempt to repair			been re-educated about the			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION				DATE	DATE	
	items as soon as pos	ssible"			use of the TELS system for			
					creating new work orders.			
	3.1-19 (e)				how the corrective action(s) will be monitored to ensure the deficient practice on the recur, i.e., what quality assurance program will be puplace Resident Advocates to performance in the recursion of the	t into		
					observations and audits of t resident rooms 3 times per week x 4 weeks, then weekly 2 months, then monthly x 3 months.	/ x		
					The results of these audits volume be brought to QAPI monthly months or until 100% compliance is achieved x 3 consecutive months. Result the audits will be adapted or	x 6 s of		
					adjusted as needed to maint compliance.	ain		

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