STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155109	A. Building B. Wing	09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brickyard Healthcare - Twelfth Street Care Center	811 E 12th Street Mishawaka, IN 46544

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to serve food at a safe temperature from 1 of 1 kitchen observed. (Main Kitchen) This had the potential to affect 55 out 55 residents who received their meals from the kitchen. Finding includes:During an observation of the breakfast meal service on 9/9/2025 at 8:03 A.M., the breakfast temperature log had not been filled out but meal trays had been given to residents. The CDM tempted a cup of milk and the temperature had been 44 degrees Fahrenheit. During the observation, 4 meal trays with cups of milk were taken from the kitchen window and delivered to residents. During an interview on 9/9/2025 at 8:04 A.M., the Certified Dietary Manager indicated the milk temperature was out of range and should not have been served. During an interview on 9/9/2025 at 8:05 A.M., the Chef 4 indicated everything that would be served at breakfast, including milk, had a temperature checked prior to meal service, but he had forgotten to fill out the temperature log. During an interview on 9/9/2025 at 8:07 A.M., RN 3 indicated she had served all twelve residents in the dining hall the milk that had been sitting in front of the residents. RN 3 indicated she had poured the milk from the gallon of milk sitting in a bowl of ice on the drink cart in the dining hall. RN 3 indicated she had nothing to do with temping milk and the kitchen had been responsible for that task. During an observation on 9/9/2025 at 8:09 A.M., the CDM checked a temperature of the milk sitting in a bowl of ice on the drink cart in the dining hall. The CDM indicated the temperature of the milk had been 54 degrees Fahrenheit, and had been out of range of safe serving temperatures and should not have been served. On 9/10/2025 at 9:20 A.M., the Executive Director provided an undated policy titled, Record of Food Temperatures and indicated it was the policy currently used by the facility. The policy indicated, . It is the policy of this facility to record food temperatures daily to ensure food is at proper serving temperatures before trays are assembled . 1. Food temperatures will be checked on all items prepared in the dietary department . 4. Potentially hazardous cold food temperatures will be kept at or below 41 degrees Fahrenheit . 14. Food temperatures will be verified using a thermometer which is both clean, sanitized and calibrated to ensure accuracy 3.1-21(a)(2)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation and interview, the facility failed to protect a resident's right to privacy for 1 of 1 resident reviewed for resident rights. (Resident 48) The facility also failed to ensure residents' dignity was maintained related to unprofessional verbal statements made by contracted staff for 3 of 5 residents reviewed for dignity. (Residents 5, 40 and 27)Findings include:1. During an observation on 9/12/2025 at 12:05 P.M., the surveyor knocked on Resident 48's door and the roommate opened the door all the way. Resident 48 was laying in bed naked except for a brief. The privacy curtain was open and the window curtain was partially open. CNA 12, who was providing care, turned to see who was at the door, turned back to Resident 48, and then turned to the door again. The surveyor had to instruct CNA 12 to pull the privacy curtain. During an interview on 9/12/2025 at 12:42 P.M., CNA 12 indicated she pulled the curtain to remind the roommate to use her walker when she gets up. She further indicated the privacy curtain and window curtain should have been closed. During an interview on 9/12/2025 at 1:15 P.M., the DON indicated the privacy and window curtain should have been closed. On 9/12/2025 at 12:57 P.M., the ED provided a policy, dated 2024, and titled, Promoting/Maintaining Resident Dignity. The policy indicated, .All staff members are involved in providing care to residents to promote and maintain resident dignity and .Maintain resident privacy 2. The clinical record of Resident 5 was reviewed on 9/10/2025 at 10:20 A.M. The resident's diagnoses included, but were not limited to: dementia, epilepsy, bipolar disorder, depression, anxiety, restless leg syndrome, chronic pain, post-traumatic stress disorder, borderline personality disorder and mild intellectual abilities. A Social Services note, dated 9/3/2025 at 4:47 P.M., indicated Resident 5 was tearful after a visit with the doctor. An e-mailed statement from the visiting Medical Doctor, dated 9/9/2025, indicated the visiting provider had an interaction on 9/3/2025 with an unnamed resident who told him she had lost 70 pounds when the provider congratulated her and told her she must have been a porker. The visiting MD indicated he had seen another resident for a routine visit and noted she had tattoos. The provider indicated, there were no naked people or obscene tattoos so she must be right, and also repeated a tasteless joke about an amputee at the license bureau needing a new license. During an interview, on 9/8/2025 at 7:28 P.M., Resident 5 indicated on 9/3/2025, a visiting doctor was here whom she did not know. Resident 5 indicated this visiting provider was looking for Resident 40 and she informed him there were 2 residents named with the name he was looking for the bigger one was in a wheelchair. Resident 5 indicated the visiting doctor said, it seems like all the bigger residents were in wheelchairs. Then, the resident told the provider she had lost over 70 pounds and he said, oh, you must have been a porker and I am just picking on you, I will stop assaulting you. 3. The clinical record for Resident 40 was reviewed on 9/10/2025 at 10:19 A.M. The resident's (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	diagnoses included, but were not limited to: diabetes mellitus, morbid obesity, chronic obstructive pulmonary disease, depression, anxiety, venous insufficiency and hypertension. A review of alleged verbal abuse report, reported by Resident 40 to the Director of Nursing (DON), indicated on 9/3/2025, the Medical Doctor (MD) asked Resident 40 if she had any naked tattoos and Resident 40 indicated to the DON she was a little creeped out. Resident 40 indicated to the DON what upset her about the encounter with the MD was him repeating a joke he had told about Resident 40's friend who also lived at the facility. During an interview, on 9/11/2025 at 11:10 A.M., the Social Services Director (SSD) indicated Resident 40 had a history of trauma. The SSD indicated there was a verbal incident on 9/3/2025 with a visiting medical provider. The visiting medical provider had joked about other people in the facility, and the situation made Resident 40 feel uncomfortable. The SSD indicated the resident would be going to a new therapist and a new psychiatrist through [provider name], so she had extra support through those resources. Resident 40 indicated to the SSD she has no further concerns since the medical provider of concern was no longer coming to the facility. 4. The clinical record for Resident 27 was reviewed on 9/11/2025 at 11:40 A.M. The resident's diagnoses included, but were not limited to: diabetes mellitus, neuropathy, hypertension, bullous pemphigoid and anxiety. During an interview, on 9/10/2025 at 9:39 A.M., Resident 27 indicated on 9/3/2025 she had been outside in the smoking area when the physician made inappropriate remarks about overweight residents. Resident 27 indicated she did not recall exactly what was said but indicated the physician used the word porker and it caused her to feel angry. During an interview on 9/11/2025 at 11:37 A.M., Resident 39 indicated he was witness to the incident that happened on 9/3/2025. Resident 39 indicated he and 2 other residents were outside the facility smoking when a doctor came out and looked for another resident. Resident 39 indicated the visiting provider made a reference to all of the fat people at the facility. Resident 39 indicated Resident 27 became very upset after this comment by the provider. Resident 39 indicated the doctor had never been at the facility before, was not familiar with any of the residents they were aware of, and they were shocked at his behavior. Resident 39 indicated he did not have any concerns currently as the provider was not returning to the facility. On 9/9/2025 at 8:30 A.M., the Administrator provided a policy titled, Abuse, Neglect and Exploitation, dated 2022 and indicated the policy was the one currently used by the facility. The policy indicated, .verbal abuse means the use of.communication.that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability.Identifying, correcting and intervening in situations in which abuse.is more likely to occur with the deployment of trained and qualified.staff.and assure that the staff have knowledge of the individual residents' care needs and behavioral symptoms. 3.1-3(p)(4)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview, the facility failed to ensure medications were stored appropriately related to opened and undated medications and failed to ensure medication carts were locked (100 hall) for 1 of 2 medication carts reviewed and medications were not stored in the pantry refrigerator for 1 of 2 medication rooms reviewed. (200 hall)Findings include:1.During an observation of the 200 hall medication cart on 9/10/2025 at 10:48 A.M. with Employee 15, the following was observed:There were 5 opened and undated bottles of polyethylene glycol.During an interview, on 9/10/2025 at 10:56 A.M., QMA 15 indicated the opened bottles of polyethylene glycol should have had open dates.2. Upon entrance to the facility, on 9/8/2025 at 5:55 P.M., the 100 hall medication cart was observed to be unlocked and a laptop was opened with resident information visible to passersby. During an interview, on 9/8/2025 at 5:58 P.M., RN 5 indicated she had left to attend to a resident's needs and she should have locked the medication cart and closed the laptop. On 9/9/2025 at 8:05 A.M., the Administrator provided a policy titled, Medication Storage, dated 2025 and indicated the policy was the one currently used by the facility. The policy indicated .all medications housed on our premises .to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security .Charts are kept on each refrigerator and temperature levels are recorded daily by the charge nurse or other designee . 3. During an observation of the 200 Hall Pantry with the Certified Dietary Manager (CDM) on 8/8/2025 at 6:05 P.M., a bottle of Gavilyte (medication for colostomy prep) was found in the refrigerator door. During an interview on 8/8/2025 at 6:06 P.M., the CDM indicated Resident medications should not be stored in pantry refrigerators. During an interview on 8/8/2025 at 6:10 P.M., LPN 3 indicated resident medications that require refrigeration should be in the medication refrigerator in the locked medication room. On 9/9/2025 at 8:05 A.M., the Administrator provided a policy titled, Medication Storage, dated 2025 and indicated the policy was the one currently used by the facility. The policy indicated .all medications housed on our premises .to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security .Charts are kept on each refrigerator and temperature levels are recorded daily by the charge nurse or other designee .3.1-25(j)3.1- 25(m)3.1 -25 (n)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to respect the right of a resident/resident's POA (Power of Attorney) to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers related to a WanderGuard (bracelet device which alarms at exit doors) for 1 of 1 resident reviewed for a WanderGuard. (Resident 11)Finding includes:During an interview on 9/10/2025 at 9:45 A.M., CNA 8 indicated they had been employed at the facility for fours years and regularly worked with Resident 11. CNA 8 indicated they had never seen Resident 11 confused, and Resident 11 was slow to respond, but had always been able to make his needs known. Resident 11 had seemed more depressed recently and CNA 8 indicated it was related to death of Resident 11's roommate and Resident 11's inability to leave the facility due to a WanderGuard.During a confidential interview in the course of the survey, Anonymous Employee (AE) 14 indicated they had worked with Resident 11 regularly. AE 14 indicated they had never observed Resident 11 confused and had concerns about Resident 11's WanderGuard. AE 14 had been present when the POA expressed they did not want Resident 11 to be restricted with the WanderGuard, but all the documentation in the record would indicate Resident 11's POA was agreeable. AE 14 indicated the Social Services Director (SSD) inquired about Resident 11's medication compliance, and SSD indicated medication compliance was required for the removal of Resident 11's WanderGuard. AE 14 indicated they had expressed concern that giving Resident 11 a condition to have his WanderGuard removed was a violation of Resident 11's rights to the SSD, but nothing had been done and no facility staff had followed up after the conversation. AE 14 described Resident 11 as always being alert and oriented, no issues making needs known to staff, but the resident was slow to respond and sometimes had difficulty finding his words. AE 14 indicated Resident 11 had regularly been noncompliant with his medications and interactions with staff the resident had not been familiar with increased his non-compliance. AE 14 indicated Resident 11 did not like to be told to do anything, especially by women. AE 14 indicated they were not present for any conversation with Resident 11 or his POA when the facility had promised a two-week time frame, but both Resident 11 and the POA had complained about not having the WanderGuard off after two weeks multiple times. AE 14 indicated they had never witnessed the resident threatening staff before the incident or after.On 9/10/2025 at 2:24 P.M., Resident 11 was alert to person, place, time and situation and reported living at the facility for over a decade. Resident 11 was observed to be slow to respond and had a hard time finding his answer for who the current President of the United States was. Although the Resident could not find the name, he was able to reply with blond hair and red hat. During an interview on 9/10/2025 at 2:25 p.m., Resident 11 indicated his only concern had been that he wanted the monitor (WanderGuard) on his ankle taken off. Resident 11 described an incident that happened six weeks prior when he had left the facility and staff had tried to stop him. He indicated he had not understood what was happening because he had always been permitted to go to the park whenever he had wanted. Resident 11 regretted not following staff commands related to going back into the building and signing himself out. Resident 11 indicated staff who he had not known had told him and his POA the ankle WanderGuard would only be for two weeks and that had been at least six weeks prior. Resident 11 indicated the POA had expressed to the facility staff that the WanderGuard should be removed, but at the end of the meetings, the staff had convinced his POA he was confused and the ankle monitor remained on Resident 11. During an interview on 9/10/2025 at 3:38 P.M., Resident 11's POA indicated her father had lived at the facility for 13 years and had always been allowed to leave without signing himself out. At baseline, the POA described her father as having had delayed responses but had not been confused and had always been able to communicate his needs to her and staff. The POA indicated she had a concern related to the facility requiring her father to wear (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a WanderGuard when she had not believed it was necessary. The POA indicated after the incident, her father had not been confused and described her father as angry related to the WanderGuard and nothing else. The POA expressed concern that the [NAME] President of Operations (VPO), who was the interim Executive Director on the date of the incident, was rude to her on the date of the incident and during the Care Plan meeting on 6/24/2025. The POA indicated she had a concern related to what was being added to the chart and felt the only information going into the Resident 11's medical record was being added by staff that had not known her father, and the information was not an accurate representation of her father or how her father was immediately after the incident. The POA indicated she had not been agreeable to the WanderGuard and had only agreed to the WanderGuard because she had been told it was temporary and would be removed after two weeks. During the 6/24/2025 Care Plan meeting, it was communicated to Resident 11 and his POA that the WanderGuard would remain until Resident 11 passed an assessment and was compliant with his medications. The POA indicated at the end of July, the Interim Administrator had called her and reported the resident had received an assessment to evaluate his cognition and the resident had passed with flying colors with a score of 28 out 30 correct answers and that the facility had only been waiting for the resident to been seen by doctor before the WanderGuard would be removed. The POA indicated the WanderGuard was never removed and my father had done everything the facility asked, including passing a test and he still had been restricted from leaving. The POA indicated she had been at the facility two weeks prior and met with the Interim Executive Director, who was new but was the same person who had called her to report Resident 11 had passed the assessment, as well as the SSD to demand the WanderGuard be removed. During that meeting, the POA indicated she had been told that if she wanted the WanderGuard removed, she would need to take her father to an assisted living facility. The POA indicated that conversation had been upsetting because her father had lived at the facility for 13 years without any other incident related leaving the facility and does not have money to pay for assisted living.During a meeting on 9/11/2025 at 1:45 P.M., the VPO indicated she had been the acting Executive Director at the time of the incident. The VPO indicated the resident had been impulsive and darted out into the street when two staff members had tried to stop him. The VPO denied Resident 11 had been unfamiliar with the staff and expressed concerns related to Resident 11's safety. The VPO indicated after dinner, around 6:30 or 6:45 P.M., she had received a phone call from the Administrator in Training who had described Resident 11 as refusing to move from the center of the entrance to the facility and had darted into on-coming traffic while on his electric scooter. After darting into the street, Resident 11 was then reported as driving down the middle of the street on his scooter with cars driving in both directions around the resident. The VPO indicated she called the police because not only was the resident impulsive, but it had also been dark and the amount of light had been a real concern and she had been worried he would be hit by a car. The VPO denied knowing Resident 11 was slow to respond at baseline or had any difficulty finding his words and found the resident was confused when she had assessed him. The VPO indicated the POA had always been agreeable to the WanderGuard and had not expressed concern. The VPO indicated, the facility's nursing staff did not have the knowledge or skill set to assess a resident's true cognition. The VPO indicated the facility had never bargained with Resident 11 or the POA.An interview was completed on 9/11/2025 at 2:15 P.M. with the Regional Healthcare Facility Administrator (RHFA), who had been the Interim Executive Director at the time the facility and had reported Resident 11's assessment score of 28 out of 30 to the resident's POA and who had been present at the July Care Plan Meeting. The RHFA indicated while the resident had passed his Mini Mental Assessment, the facility had a Risk meeting and found Resident 11 was still unsafe and would still be required to wear the WanderGuard. The RHFA indicated the POA had recently questioned her and SSD about the WanderGuard, but they had not told the resident's POA if she wanted to remove the WanderGuard the resident would need to be moved to assisted living. The RHFA denied there had been any bargaining in the July Care Plan meeting. During an interview on 9/11/2025 at 2:15 P.M., the SSD indicated he had not been at the facility at the time (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the incident. The SSD denied any bargaining had been done with Resident 11 or his POA. The SSD indicated medication compliance was to help the resident be less angry so the resident's mental assessment could be completed. The SSD did acknowledge Resident 11's POA had concerns related to the WanderGuard, but after the facility had explained their reasoning and concern for Resident 11's safety, he believed the POA was agreeable.During an interview on 9/12/2025 at 10:04 A.M., CNA 17 indicated she had been employed at the facility for three years and regularly worked with Resident 11. CNA 17 indicated she had been responsible for Resident 11 the day of the incident, and had not noted the resident to be confused prior to the incident. CNA 17 indicated the only time she had witnessed Resident 11 to be confused had been when he had some type of infection and confusion was how the staff had identified the resident had an infection because confusion was unusual for Resident 11. CNA 17 denied being present for the start of the incident, but had been the staff member that walked back to the facility with Resident 11 after the incident. CNA 17 indicated when she caught up to Resident 17 and asked him to go back to the facility, Resident 11 immediately complied. CNA 17 described Resident 17 as calm, not angry, and did not appear to be confused while they went back to the facility. CNA 17 indicated it was daylight outside at the time of the incident and it had not been close to sunset or dusk and light had not been a concern. CNA 17 indicated Resident 17 did become angry after staff had tried to put the WanderGuard on the resident. CNA 17 denied the resident had ever made threats of violence toward staff before or after the incident . CNA 17 indicated Resident 11 had always been slow to respond to questions, but when given time, had always been able to answer correctly. CNA 17 indicated Resident 11 had not been receptive to staff that were not known to the resident, and Resident 11's non-compliance with meals, medications and showers were always worse when he had been assigned an unfamiliar staff member. CNA 17 indicated she had reported to the Administrator in Training the day the WanderGuard was placed on Resident 11 that he did not need the WanderGuard and the incident had been situational because Resident 11 had always been allowed to leave without signing out and Resident 11 was not familiar with the Administrator in Training or the nurse that had been involved in the situation. CNA 17 denied knowledge of any conditions or bargaining with Resident 11 or his POA, but did indicate the resident's POA had been in the facility multiple times expressing concern about the WanderGuard to staff and leadership. During an interview on 9/12/2025 at 9:02 A.M., the Certified Dietary Manager (CDM) indicated the facility's Administrator had asked her to make a statement to the Survey Team regarding Resident 11's June and July Care Plan meetings for which the CDM had been present. The CDM indicated the facility staff had never given Resident 11 or his POA a timeline for when the WanderGuard would be removed in either the June or July Care plan meeting and witnessed the SSD re-explain there would be no time frame for the WanderGuard numerous times to the resident's POA in both meetings. The CDM indicated Resident 11's POA had not been agreeable to the WanderGuard and had been forceful about not wanting Resident 11 to have the WanderGuard in both the June and the July Care Plan meetings. The CDM indicated in the June and July Care Plan meeting, the facility staff had bargained with Resident 11's POA when they told the POA there would be conditions to remove the WanderGuard other than the cognitive assessment. In the June Care Plan meeting, facility staff had told Resident 11's POA the resident would have to be compliant with his medications to have the WanderGuard removed. In the July Care Plan meeting, the facility staff had told Resident 11's POA the resident had to be compliant with all medications and treat therapy staff well before he would be reassessed. The CDM indicated she was unsure why Resident 11 would be required to treat any staff well because the resident had a right to treat staff however he chose without fear of retaliation. During an interview on 9/12/2025 at 9:15 A.M., the VPO indicated Resident 11 was required to treat therapy staff well in order for the WandGuard to be removed. Resident 11's record review was completed on 9/12/2025 at 10:30 A.M., diagnoses included, but were not limited to: cerebral infarction, vascular dementia, major depressive disorder, hypertension, chronic kidney disease, anemia and chronic obstructive pulmonary disease.A Quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated Resident 11 had clear (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	speech, was able to make himself understood and understood others, and had no hearing or vision problems. A Brief Interview for Mental Status (BIMS) assessment indicated an assessment was not administered due to the resident rarely being understood. He had not had any physical or verbal behaviors and had not rejected any care or had wandered. Resident 11 had not had a WanderGuard or any alarm or restraint. Care Plan meeting minutes dated 6/24/2025, indicated nursing, dietary, social worker, resident, resident representative, administration and nursing administration had been present. The family/resident concerns were, Family has questions about WanderGuard, medications, and whether resident is taking his medications. Family would like WanderGuard to be re-evaluated after med-compliance. Resident has agreed to start taking his medications.A Mini-Mental State Examination (MMSE) (30-point screening tool used to measure cognitive impairment) dated 7/28/2025, indicated the resident had a score of 24 out of 30. An interpretation of the MMSE, attached to Resident 11's MMSE, indicated he had no cognitive impairment.Care Plan meeting minutes dated 7/29/2025, indicated nursing, dietary, social worker, resident and resident representatives had been in the Care Plan meeting. The resident/family had expressed concerns about residents' independence. The Interdisciplinary Team review noted, Nursing: Resident is taking his medications which is an improvement at this time. WanderGuard reviewed with resident, his family was in attendance. Developed a plan of care and options for safety. His son and daughter were receptive but understood our need for safety. Will continue to monitor, WanderGuard stays intact, will have risk call and complete assessment and review.An ad hov (as needed) BIMS assessment dated , 7/29/2025, indicated the resident had moderate cognitive impairment.A Social Services note dated, 8/01/2025, indicated the administrator contacted Resident's POA for a status update on the WanderGuard. It was reported to the POA Resident 11's WanderGuard would stay on due to the history and severity of the prior event and to promote his safety. The POA asked about the resident's recent assessments and medication compliance, and it was explained to her the Wanderguard would need to remain on to monitor his safety. Resident 11's POA acknowledged and stated she would come and speak with her father that night.A Care Plan, dated, 6/23/2025, indicated Resident 11 was at risk for elopement and had a goal to his safety maintained through the review. The Care Plan had one intervention, WanderGuard on left ankle.A Care Plan, revised on 6/6/2024, indicated Resident 11 had incidents of refusing care, medications, treatments and showers. The goal was for the behavior to stop with staff intervention. Interventions included, but were not limited to: Come back at a different time to provide care if I refuse. Ask resident if he would like a different staff member to provide care and observe for compliance, document and report noncompliance to MD and educate as needed.A Care Plan dated, 12/8/2020 and last revised on 3/30/2021, indicated Resident 11 had behaviors including making sexually inappropriate comments towards staff, watching sexually inappropriate shows in common areas with fellow residents present, hiding medications from staff and isolating himself in his room. The goal was for the resident's behavior's to improve with staff intervention. Interventions included, but were not limited to: notify physician if behaviors interviewed with activities of daily living, staff to observe resident to be sure he swallows medications and verbally redirect me when making inappropriate comments.Resident 11's record lacked the documentation to indicate his POA had not been agreeable to the WanderGuard after meeting with facility staff, or the resident had any other Care Plans related to behaviors, the WanderGuard or being verbally and physically aggressive toward staff. The resident's record lacked any notes or behavior monitoring to indicate the resident had been physically or verbally aggressive to staff, had been impulsive, or attempted to the leave the facility since the WanderGuard had been placed on the resident's ankle. 3.1-4(d)

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	155109	A. Building B. Wing	09/12/2025

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview, observation and record review, the facility failed to notify the physician of a resident's low blood pressure for 1 of 5 residents who were reviewed for medications and treatments. (Resident 39)Finding includes:The clinical record of Resident 39 was reviewed on 9/10/2025 at 3:13 P.M. The resident's diagnoses included, but were not limited to: chronic obstructive pulmonary disease, acute and chronic respiratory failure with hypoxia, anxiety, depression, opioid dependence and mild cognitive impairment.A Quarterly Minimum Data Set (MDS) assessment, dated 7/3/2025, indicated Resident 39 was cognitively intact and had received an antidepressant, an anticoagulant, an opioid and a diuretic. A Physician's Order, dated 1/13/2025, indicated blood pressure checks were to be completed every shift to monitor for blood pressure drops. The September 2025 Medication Administration Record (MAR) indicated Resident 39 had a blood pressure measurement of 79 over 44 (normal adult = 120 over 80) on the night shift of September 1, 2025. Resident 39's clinical record failed to evidence provider notification of the blood pressure measurement on the night shift of 9/1/2025. During an interview, on 9/11/2025 at 9:07 A.M., QMA 6 indicated if a resident had a low blood pressure, she would have notified the nurse in charge and charted the blood pressure in the Electronic Medical Record (EMR). During an interview, on 9/11/2025 at 9:08 A.M., RN 5 indicated if a resident's blood pressure had been low, she would have first checked the resident and assessed the resident. RN 5 indicated she would have looked at the resident's medication list to see if they have Midodrine (a prescription medication used to treat certain types of low blood pressure). RN 5 indicated if the blood pressure was out of the normal for the resident, she would have notified the provider. During an interview, on 9/11/2025 at 9:19 A.M., the Director of Nursing (DON) indicated if a resident's blood pressure was out of their normal range, the nurse should have notified the physician. The DON indicated if the resident did not have vital sign notification parameters, the nurse should have used their nursing judgement. The DON confirmed there were no nursing notes documenting provider notification. On 9/11/2025 at 10:20 A.M., the DON provided a policy titled, Notification of Changes, dated 2024 and indicated the policy was the one currently used by the facility. The policy indicated, .The facility must .consult with the resident's physician .when there is a change requiring such notification. Circumstances requiring notification include .Significant change in the resident's physical, mental, or psychosocial condition such as deterioration in health, mental or psychosocial status. This may include .clinical complications .3.1-5 (a)(2)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, record review and interview, the facility failed to follow a physician's order for a hypotensive medication for 1 of 3 residents reviewed for medication administration. (Resident 9)Finding includes:During an observation of medication administration on 9/10/2025 at 9:33 A.M. with QMA resident 9 was administered Midodrine Hydrochloride 5mg (milligrams) by mouth. Resident 9's blood pressure was142/58 mm/Hg (millimeters per mercury).A record review was completed for Resident 9 on 9/11/2025 at 11:24 A.M. Diagnoses included, but were not limited to: acute on chronic systolic heart failure, sick sinus syndrome, hypertension and stage 4 chronic kidney disease.A Physician's Order, dated 6/13/2025 indicated Resident 9 was to be administered Midodrine Hydrochloride 5mg by mouth three times per day. Additional instructions also indicated to hold Midodrine Hydrochloride 5mg if the resident's systolic blood pressure was greater than 140 mm/Hg.A review of Resident 9's EMAR (Electronic medication administration record) indicated the resident had been administered Midodrine Hydrochloride 5mg by mouth when the resident's systolic blood pressures were greater than 140 mm/Hg on the following dates and shifts:On 7/8/2025 evening shift, Resident 9's blood pressure reading was 141/71 mm/Hg.On 7/9/2025 evening shift, Resident 9's blood pressure reading was 143/67 mm/Hg.On 7/21/2025 evening shift, Resident 9's blood pressure reading was 146/74 mm/Hg.On 7/28/2025 morning shift, Resident 9's blood pressure reading was 169/62 mm/Hg.On 7/29/2025 day shift, Resident 9's blood pressure reading was 151/69 mm/Hg.On 7/30/2025 morning shift, Resident 9's blood pressure reading was 167/80 mm/Hg.On 7/31/2025 morning shift, Resident 9's blood pressure reading was 167/75 mm/Hg,On 8/4/2025 morning shift, Resident 9's blood pressure reading was 144/77 mm/Hg and on evening shift Resident 9's blood pressure reading was 141/51 mm/Hg.On 8/5/2025 morning shift, Resident 9's blood pressure reading was 144/73 mm/Hg and on day shift Resident 9's blood pressure reading was 169/70 mm/Hg.On 8/6/2025 morning shift, Resident 9's blood pressure reading was 167/74 mm/Hg.On 8/7/2025 day shift, Resident 9's blood pressure reading was 160/69 mm/Hg and on evening shift Resident 9's blood pressure reading was 141/60 mm/Hg.On 8/21/2025 evening shift, Resident 9's blood pressure reading was 141/75 mm/Hg.On 8/26/2025 day shift, Resident 9's blood pressure reading was 144/69 mm/Hg and on evening shift Resident 9's blood pressure reading was 146/72 mm/Hg.On 8/27/2025 evening shift, Resident 9's blood pressure reading was 160/70 mm/Hg.On 8/28/2025 morning shift, Resident 9's blood pressure reading was 155/65 mm/Hg and on day shift Resident 9's blood pressure reading was 160/79 mm/Hg.On 8/31/2025 evening shift, Resident 9's blood pressure reading was 146/74 mm/Hg.On 9/1/2025 morning shift, Resident 9's blood pressure reading was 165/75 mm/Hg and on day shift Resident 9's blood pressure reading was 144/68 mm/Hg.On 9/2/2025 morning shift, Resident 9's blood pressure reading was 144/80 mm/Hg and on evening shift Resident 9's blood pressure reading was 149/71 mm/Hg.9/3/2025 morning shift, Resident 9's blood pressure reading was 148/60 mm/Hg.On 9/4/2025, morning shift, Resident 9's blood pressure reading was 144/70 mm/Hg and on day shift Resident 9's blood pressure reading was 158/78 mm/Hg.On 9/9/2025 morning shift, Resident 9's blood pressure reading was 158/71 mm/Hg and on day shift Resident 9's blood pressure reading was 155/80 mm/Hg.On 9/10/2025 morning shift, Resident 9's blood pressure reading was 142/58 mm/Hg.A Physicians Order, dated 9/10/2025, indicated to monitor the resident for any adverse reactions related to Midodrine Hydrochloride 5mg being administered and blood pressure was not in parameters every two hours until 9/10/2025 at 11:59 P.M.During an interview, on 9/12/2025 at 9:23 A.M. the DON indicated Resident 9 should not have received the Midodrine Hydrochloride when his systolic blood pressure had been greater than 140 mm/Hg.On 9/11/2025 a policy was requested regarding following physician's orders but one was not provided prior to the survey exit.

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	155109	A. Building B. Wing	09/12/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to safely transfer a resident which resulted in the resident falling for 1 of 1 resident reviewed for falls. (Resident 7)Finding includes:A record review for Resident 7 was completed on 9/10/2025 at 1:41 P.M. Diagnoses included, but were not limited to, urinary tract infection, type 2 diabetes mellitus, mild cognitive impairment, major depressive disorder, and chronic pain disorder. An admission Minimum Data Set (MDS) assessment, dated 7/31/2025, indicated Resident 7's cognition was intact, had functional limitations of the upper extremities on one side, used a wheelchair, required substantial to maximal assist for transfers and had one fall prior to reentry to the facility and no falls since reentry. A Care Plan problem, initiated on 7/28/2025, indicated Resident 7 had an Activities of Daily Living deficit with an intervention, revised on 9/5/2025, that required assist of 2 staff for transfers. Nursing Progress Notes, dated 8/26/2025, indicated Resident 7 was transferred with assist of one staff. His legs became weak and he was lowered to the floor. The note indicated the resident would be a 2 person transfer henceforth. No care plan updates were found in the record. A Nursing Progress Note, dated 9/4/2025, indicated Resident 7 and CNA 9 fell during a transfer from the wheelchair to bed. CNA 9 transferred the resident alone. Resident 7 hit his head and was sent to the emergency room (ER) where sutures were required to close the wound above his right eyebrow. During an interview on 9/11/2025 at 9:04 A.M., CNA 8 indicated Resident 7 was a 2 person transfer and staff get care information about the residents from the electronic medical record Kardex. During an interview on 9/11/2025 at 9:58 A.M., LPN 2 indicated she was working the day Resident 7 had gone to the ER. She indicated he was transferred with assist of 1 and no gait belt. During an observation on 9/11/2025 at 9:04 A.M., Resident 7 was transferred from he wheelchair to bed using a mechanical lift and 2 staff members. There was a note taped to the window next to his bed indicating Resident 7 was a 2 person assist for transfers. During an interview on 9/11/2025 at 9:16 A.M., the DON indicated the mechanical lift was a nursing judgment because Resident 7 indicated at times felt like he could not stand. The mechanical lift was not on the care plan and should have been added to individualize the care plan to meet the resident's needs. During an interview on 9/11/2025 at 1:42 P.M., CNA 9, who was the person that transferred Resident 7 on 9/4/2025, indicated at the time he was a 1 person transfer. During the transfer the resident's legs became weak and the floor was wet when they both went down. When she needed to know how to care for a resident, she would get report from the previous shift, or check the electronic medical record Kardex. Therapy had not addressed falls on 8/26/2025 or 9/4/2025. During an interview on 9/11/2025 at 2:09 P.M., the Director of Therapy indicated transfers was a task therapy was working on with Resident 7. After the 8/26/2025 fall, there were no changes in the transfer assist per discussion with the family and Interdisciplinary Team. The family's and resident's concern was he cannot go home if he is a 2 person transfer and they had been educated on the risks of a 1 person transfer. The discussion was not entered into the record. After the 9/4/20205 fall he became a 2 person transfer. During an interview on 9/11/2025 at 2:18 P.M., Regional Director of Clinical Operations (RDCO) 2 indicated after the fall on 8/26/2025, the family wanted to investigate possible medical reasons for his intermittent weakness. They started to monitor his blood sugars and a referral for a neurological consult was obtained. On 9/12/2025 at 1:15 P.M., RDCO 2 provided a policy, dated 2024, and titled, Fall Prevention Program. The policy indicated, .review the resident's care plan and update as indicated 3.1-45(2)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interview, and record review, the facility failed to monitor nutritional status for 1 of 2 residents reviewed for nutrition. (Resident 4)Finding includes:A record review was completed on 9/11/2025 at 10:11 A.M. for Resident 4. Diagnoses included, but were not limited to, unspecified dementia and adult failure to thrive.An admission Minimum Data Set (MDS) assessment, dated 8/28/2025, indicated Resident 4's cognition was intact, needed set up/clean up assist for eating, and had no swallowing or chewing issues.A Physician Order, dated 8/20/2025, indicated Resident 4's diet was regular with regular texture and no salt packet.A Care Plan, initiated on 8/21/2025, indicated Resident 4 had a nutritional problem related to self-reported chewing issue with prior unspecified weight loss. Staff were to monitor and signs or symptoms of dysphagia (difficulty swallowing) and serve diet as ordered.admission and September weights could not be found in the record. During an interview on 9/8/2025 at 7:15 P.M. Resident 4 indicated she had lost weight but wasn't sure how much. She indicated the physician told her she was taking too much thyroid medicine.A weight of 117 pounds prior to admission was noted in the dietician's note.During an observation on 9/11/2025 at 12:53 P.M., Resident 4's lunch tray still had 50% of her lunch untouched. She indicated she hated the food and did not want a substitute.During an observation on 9/12/2025 at 9:02 A.M., Resident 4's breakfast was almost completely untouched. Only a few bites were taken and she indicated she wasn't hungry.During an interview on 9/12/202 at 9:12 A.M., the Certified Dietary Manager (CDM) indicated the resident refused to be weighed and several attempts had been made. The CDM indicated documentation of attempts and resident refusals, as well as physician notification, were not in the chart.During an interview on 9/12/2025 at 10:21 A.M., Regional Director of Clinical Operations 10 indicated the care plan showed she refused showers and the scale was in the shower room, so if she didn't go in the shower room she would not be able to be weighed. The refusals should have been documented.On 9/12/2025 at 12:57 P.M., the ED provided a policy, dated 2024, and titled, Weight Monitoring. The policy indicated, .Observations pertinent to the resident's weight status should be recorded in the medical record as appropriate 3.1-46(1)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview and record review, the facility failed to maintain the cleanliness of a resident's personal refrigerator for 1 of 1 personal refrigerator observed. (Resident 2) Finding includes: During an observation on 9/9/2025 at 1:06 P.M., Resident 2's personal refridgerator had pop splattered and spilled on all sides of the inside of the fridge, on the inside door and on the shelf of the fridge. A container with grapes was removed and pop spilled onto the floor because pop accumulated on the lid of the grapes. There had not been a received on date or use by date on the grapes. An opened jar of nacho cheese had not been labaled with an opened on date or used by date. During an interview on 9/9/2025 at 1:08 P.M., Resident 2 indicated nobody checked the temperature of his fridge or cleaned it out. He believed his sister had been the one cleaning the fridge in the past. During an interview on 9/9/2025 at 1:10 P.M., the Executive Director (ED) indicated Resident 2's personal fridge was dirty and should not have been and all opened food should have an opened on or used by date. On 9/12/2024 at 12:53 P.M., the ED provided an undated policy titled, Resident Refrigerators, and identified it as the policy currently used by the facility. The policy indicated, .Staff/resident or family shall clean the refrigerator . Leftovers shall be dated upon receipt and discarded within three days 3.1-19(f)

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	155109	A. Building B. Wing	09/12/2025

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to provide at least 60 square feet per resident in 22 multiple occupancy resident rooms for 2 of 2 units (100 and 200). (Rooms 100, 101, 103, 104, 108, 109, 110, 111, 112, 114, 116, 118, 204, 205, 206, 207, 211, 213, 215 and 226) In addition, the facility failed to ensure 100 square feet per resident in single resident rooms was provided. (rooms [ROOM NUMBERS]) Finding includes: During an environmental tour, conducted on 9/11/2025 between 11:00 A.M. - 11:45 A.M., the following multiple rooms were observed to contain less than 80 square feet per resident. The following rooms were certified SNF/NF (Skilled Nursing Facility/ Nursing Facility) for three beds and measured from 70.5 - 72 square feet per resident: room [ROOM NUMBER], 2 beds, 211.5 total square feet, 105.75 square feet per resident.room [ROOM NUMBER], 2 beds, 216 total square feet, 108 square feet per resident.room [ROOM NUMBER], 2 beds, 216 total square feet, 108 square feet per resident.room [ROOM NUMBER], 2 beds, 216 total square feet, 108 square feet per resident.room [ROOM NUMBER], 2 beds, 216 total square feet, 108 square feet per resident.room [ROOM NUMBER], 2 beds, 216 total square feet, 108 square feet per resident.room [ROOM NUMBER], 2 beds, 216 total square feet, 108 square feet per resident.room [ROOM NUMBER], 2 beds, 216 total square feet, 108 square feet per resident.room [ROOM NUMBER], 2 beds, 212.9 total square feet, 108.45 square feet per resident.room [ROOM NUMBER], 2 beds, 2 beds, 215.3 total square feet, 107.55 square feet per resident.room [ROOM NUMBER], 2 beds, 213.6 total square feet, 108.8 square feet per resident.room [ROOM NUMBER], 2 beds, 213.6 total square feet, 108.8 square feet per resident.room [ROOM NUMBER]. , 2 beds, 213.6 total square feet, 108.8 square feet per resident.room [ROOM NUMBER], 2 beds, 213.6 total square feet, 108.8 square feet per resident.room [ROOM NUMBER], 2 beds, 216 total square feet, 108 square feet per resident.2. The following resident rooms were certified SNF/NF for 2 beds and measured between 70.5 and 71.5 square feet per resident.room [ROOM NUMBER], 1 bed, 141 total square feet, 141 total square feet per resident.room [ROOM NUMBER], 1 bed, 144 total square feet, 144 total square feet per resident.room [ROOM NUMBER], 1 bed, 143 total square feet, 143 total square feet per resident.room [ROOM NUMBER], 1 bed, 143 total square feet, 143 total square feet per resident.3. The following resident rooms were certified SNF/NF for one bed and measured less than 100 square feet.room [ROOM NUMBER], 1 bed 91.6 total square feet, 91.6 square feet per resident.room [ROOM NUMBER], 1 bed, 91.6 total square feet, 91.6 square feet per resident.During an interview with the Administrator, on 9/11/2025 at 1:40 P.M., she confirmed these were the rooms which had the room variance waivers and did not provide the required square footage.