STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155178	A. Building B. Wing	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brickyard Healthcare - Fountainview Care Center	609 W Tanglewood LN Mishawaka, IN 46545

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 observation, interview, and record review, the facility failed to ensure 1 of 3 residents reviewed for diets were provided with their preferred diet (Resident B).Finding includes:On 2/17/26 from 12:30 P.M. to 1:10 P.M., Resident B was observed in the common area being fed by Certified Nursing Assistant (CNA) 4. The meal ticket on the resident's tray indicated she was on a full liquid diet. CNA was feeding the resident a meal of beef broth, yogurt, magic cup supplement, mighty shake supplement, chocolate pudding, and juice. Resident B was taking the liquid diet via a spoon and straw without difficulty.During an observation on 2/18/26 at 8:30 A.M., Resident B was in the 200 Hall common area dining room and was being fed breakfast by CNA 5. The meal consisted of cream of wheat cereal, yogurt, broth, and juice. CNA 5 indicated he often assisted the resident with meals and she normally did very well and did not seem to have any eating concerns such as choking, spitting up, or coughing.On 2/17/26 at 12:40 P.M., Resident B's Power of Attorney (POA) was present for the lunch meal and indicated the resident could eat soft foods and wanted the resident's diet changed from a liquid diet to a mechanical soft diet. The POA indicated the resident had been on soft foods before a recent hospitalization due to dehydration and malnutrition. Resident B's POA indicated the diet was changed to a liquid diet while the resident was in the hospital. The POA indicated the resident's family had been asking for a diet change but were told by the facility that they would not change the diet order. Resident B's POA indicated the family frequently fed the resident soft foods such as mashed potatoes and cottage cheese and the resident had no swallowing difficulty. Resident B's POA indicated in a recent care plan meeting, the family was told they would have to sign a waiver of responsibility for feeding the resident foods other than what was allowed on a liquid diet and provided by the facility.During an interview, on 2/17/26 at 10:25 A.M. the Therapy Department Manager indicated Resident C had gone out to the hospital twice recently and each time, upon return, had been evaluated by Speech Therapy. The Therapy Department Manager indicated Resident B could not follow commands so she did not meet the criteria for a diet change. There was no indication that the resident's swallowing capabilities had been evaluated thoroughly when she had returned from her most recent hospital stay.During an interview, on 2/17/26 at 3:45 P.M., the Director of Nursing indicated the facility had to follow physician orders so Resident B was on a full liquid diet as ordered. The Director of Nursing indicated the resident had been evaluated by physical therapy and since the resident could not follow commands, physical therapy a swallow study could not be performed for the resident. It was unclear why the physical therapy department was making decisions regarding swallow study testing. In addition, the Director of Nursing indicated the facility had had multiple meetings with Resident B's family regarding their desire for Resident B to be on soft diet and indicated the family had refused to sign a waiver that would have allowed the family to feed the resident what they wanted to feed her. Finally, the Director of Nursing indicated that Speech Therapy was scheduled to perform a swallow study test the following (continued on next page)

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

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	day, on 2/18/26, per the family's request.During an observation of a swallow study test on 2/18/26 at 10:45 A.M., the Speech Therapist indicated the resident had been on a soft mechanical diet before her most recent hospitalization for dehydration. The Speech Therapist indicated the resident was placed on a liquid diet in the hospital because of poor intakes and the hospital had been trying to get increased calories into the resident. The Speech Therapist indicated the liquid diet was not due to a swallowing concern but rather the resident's nutritional status. The Speech Therapist completed the swallow study test and immediately initiated a pureed diet for the resident.Resident B's clinical record was reviewed on 2/17/26 at 3:31 P.M. Resident B was admitted to the facility with diagnoses that included but were not limited to Alzheimer's Disease, hypertension, emphysema, chronic obstructive pulmonary disease (COPD), Right eye blindness, polyneuropathy, hearing loss, dementia, acute kidney failure, and signs and symptoms concerning food and fluid intake.Review of the Resident's face sheet indicated her daughter was her Power of Attorney.A Nutrition assessment dated [DATE], indicated the facility was to encourage food and fluid intakes for the resident.A Hospital Inpatient Nutrition Services consult note dated 2/6/26 at 10:08 A.M., indicated the resident was admitted to the ER on [DATE] for hypernatremia and that the Registered Dietician intervention was needed for an evaluation. The note indicated the resident was on a full liquid diet to promote nutritional intake and that Resident B had been improving her oral intakes and had had a good oral nutrition supplement intake.A Care Plan meeting note dated 2/13/2026 at 2:35 P.M., indicated Resident B's family had requested a meeting and the family had discussed their concerns about the resident's current diet and orders that had followed the resident from the hospital. The family indicated that they were able to feed their mother cottage cheese, pudding, and yogurt in the hospital. They indicated that she was able to eat these types of food items with no problems. The Administrator informed the family that she could have the facility legal team complete a waiver for family going against medical advice. Physician Orders included but were not limited to a full liquid diet dated 2/8/2026, and discontinued on 2/18/2026, followed by a regular diet of pureed texture initiated on 2/18/2026 at 11:25 A.M.On 2/23/26 at 11:11 A.M., Director of Nursing 2 provided the policy titled, Resident Rights, dated 2025 and indicated it was the current facility policy. The policy indicated the resident had the right to self-determination and the resident representative had the right to exercise the resident's right to the extent those rights were delegated to the resident representative. The policy indicated the resident had the right of self-determination and the facility must promote and facilitate resident self-determination. This Citation relates to Intakes 2737137 and 2738679.1.3-20(a)

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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 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure 1 of 3 dependent residents reviewed for hydration was provided adequate fluids to maintain hydration.(Resident B).Finding includes:During an observation on 2/17/26 at 9:40 A.M., Resident B was observed in the 200 Hall common area seated in a reclining wheelchair in front of a television. There were no fluids available for the resident.During an observation on 2/17/26 at 9:43 A.M, no water had been passed to the resident in her room.On 2/17/26 at 10:04 A.M., Resident B was observed in the 200 Hall common area with no fluids available to her.On 2/17/25 at 11:26 A.M., Resident B remained in common area with no fluids available to her.During a dining observation on 2/17/26 from 12:30 P.M. to 1:10 P.M. Certified Nursing Assistant (CNA) 4 fed Resident B her lunch tray, which consisted of a liquid diet of broth, yogurt, magic cup, a mighty shake, chocolate pudding, and juice. The resident's family came and took over feeding the resident during the meal time. CNA 4 indicated she had not given the resident any fluids between breakfast and lunch.On 2/18/26 at 9:00 A.M., Resident B was observed in the 200 Hall common area in her reclining wheelchair chair by the television and there were no fluids beside her. At 9:05 A.M., no fluids had been passed in the resident's room. During an observation on 2/18/25 at 11:20 A.M., Resident B remained in the 200 Hall common area and there were no fluids available to her.During an interview on 2/17/26 at 9:28 A.M., Resident B's family member indicated the facility had not pushed fluids for the resident, which had resulted in a recent hospitalization for dehydration and elevated sodium levels. The family member indicated that he or one of his siblings had came to the facility daily to feed their mother because the staff did not feed her enough and the facility had not offered her enough fluids. The family member indicated earlier in the month, they were unable to come to the facility due to their illnesses to feed their mother and she had became dehydrated. The facility felt it was due to the lack of staff offering her adequate fluids. The family member indicated the facility continued to not offer fluids after the resident had returned to the facility.During an interview with Certified Nursing Assistant (CNA) 4, she indicated she had not given the resident fluids between breakfast and lunch.Resident B's clinical record was reviewed on 2/17/26 at 3:31 P.M. Resident B was admitted to the facility with diagnoses that included but were not limited to Alzheimer's Disease, hypertension, emphysema, chronic obstructive pulmonary disease (COPD), Right eye blindness, polyneuropathy, hearing loss, dementia, acute kidney failure, and signs and symptoms concerning food and fluid intake.A Nutrition assessment dated [DATE], indicated the facility was to encourage food and fluid intake.An Emergency Department note from a local hospital dated 2/3/26 at 3:12 P.M., indicated the resident had been admitted to the hospital and was very dehydrated with a dry oral cavity, significant abnormal lab results including an elevated sodium level of 170 and a low potassium level of 3.0. The note indicated the resident was admitted to the hospital from [DATE] to 2/5/26 where treatment included, but was not limited to, receiving intravenous (IV) fluids for dehydration.Resident B's Care Plans included but were not limited to the following:The Resident has dehydration or potential for fluid deficit related to diuretic use, dated 12/10/25. The Care Plan indicated the resident would be free of symptoms of dehydration.A policy titled, Hydration, dated 2025, was provided by Director of Nursing 2 on 2/17/26 at 3:24 P.M. The policy indicated that the facility would offer each resident sufficient fluid, including water and consistent with the residents' needs and preferences to maintain proper hydration and health. Sufficient meaning the amount of fluid needed to prevent dehydration and maintain health.This Citation relates to Intake 2737137 and Intake 27388679. 1.3-46(b)