Printed: 04/02/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155362	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2026
NAME OF PROVIDER OR SUPPLIER: Brickyard Healthcare - Merrillville Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 8800 Virginia Place Merrillville, IN 46410	

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, record review, and interview, the facility failed to ensure residents had a clean and homelike environment related to dirty bed linens on made beds for 4 of 7 resident beds observed on the Advanced Alzheimer's Care Unit (AACU). (Residents E, H, F, and G)Finding includes:During observations of the bed linen, on the AACU on 1/15/26 at 9:42 a.m. through 9:50 a.m., with the AACU Supervisor the following was observed:Resident E's bed had been made with a bottom sheet, top sheet and blanket. There was a moderate amount of a brown substance located on the top sheet that was hanging over the side of the bed. The AACU Supervisor acknowledged the brown substance. CNA 1 entered the room and indicated the night shift had made the resident's bed.Resident H's bed had been made with a bottom sheet sheet, top sheet and bed cover. The top sheet and cover were removed and there were brown stains on the bottom sheet.Resident F's bed had been made with a bottom sheet, top sheet and bed cover. The top sheet and cover were removed and there were food crumbs in the bed on the bottom sheet and a brown substance on the pillow case.Resident G's bed had been made with a bottom sheet and a bath blanket cover. The bath blanket was removed and there were brown stains on the bottom sheet.During an interview on 1/15/26 at 9:50 a.m., the AACU Supervisor indicated the four beds had soiled linens and were made without the linen being changed by the night shift.During an interview on 1/15/26 at 11:42 a.m., the Administrator indicated she had notified the night shift staff and was informed they had not made the beds and the day shift staff were interviewed and they informed her they had not made the beds. She indicated the residents may have made the beds. She indicated there was no facility policy for changing the linen.a. During an observation on 1/15/26 at 1:00 p.m., Resident E was ambulating in the hall. She entered her room and walked past her bed, which was not neatly made, looked out the window, then left the room and ambulated down the hall. No attempt was made to remake the bed.Resident E's record was reviewed on 1/15/26 at 12:18 p.m The diagnoses included, but were not limited to, Alzheimer's disease.An admission Minimum Data Set (MDS) assessment, dated 12/29/25, indicated a severely impaired cognitive status and required supervision for toileting and dressing, was dependent on staff for bed mobility, bathing and transfers and was independent for ambulation. She was occasionally incontinent of bowel and bladder.A Care Plan, dated 12/24/25, indicated assistance was required for activities of daily living (ADL's) and she would make her own bed at times. The interventions indicated one to two staff members were required to assist with ADL's and short and simple instructions were required for her to self complete the ADL of bathing.A Care Plan, dated 1/6/26, indicated she had impaired cognitive function/dementia or impaired thought processes. The interventions indicated to ask yes/no questions to determine the resident's needs, cue, reorient and supervision as needed, task segmentation was required and tasks were to be broken up into one step at a time.b. During an interview on 1/15/26 at 12:59 a.m., CNA 1 assisted Resident H to her room via a wheelchair. CNA 1 indicated the resident was unable to ambulate.Resident H's record was reviewed on 1/15/26 at 12:45 p.m. The (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	diagnoses included, but were not limited to, vascular dementia.A Quarterly MDS assessment, dated 12/21/25, indicated a severely impaired cognitive status and was dependent on staff for toileting, showers, dressing, bed mobility, transfers, and ambulation. She was frequently incontinent of bowel and bladder.A Care Plan, dated 8/14/25, indicated one to two staff members were required to assist the resident with ADL's.A Care Plan, dated 9/17/25, indicated there was limited physical mobility and she required restorative active range of motion and a walking program.A Care Plan, dated 8/14/25, indicated an impaired cognitive function or impaired thought processes. Tasks were to broken down to one step at a time.There was no care plan that indicated the resident made her own bed.c. During an observation on 1/15/26 at 1:02 p.m., Resident F was sitting in the dining room. There was no verbal response to verbalization. The resident just stared with attempted communication.Resident F's record was reviewed on 1/15/26 at 12:34 p.m. The diagnoses included, but were not limited to, dementia and bi-polar.A Quarterly MDS assessment, dated 10/28/25, indicated maximum assistance was required for oral care, toileting, dressing, and sitting to standing movement. Moderate care was required for hygiene, bed mobility and transfers. She was frequently incontinent of bowel and bladder.A Care Plan, dated 9/1/25, indicated one to two staff members were required for bathing, bed mobility, dressing and toileting. A Care Plan, dated 1/2/25, indicated an impaired cognitive function. The staff were to cue, reorient, and supervise as needed.There was no care plan that indicated the resident made her own bed.d. During an observation on 1/15/26 at 1:02 p.m., Resident G was sitting at a table in the dining room.Resident G's record was reviewed on 1/15/26 at 12:45 p.m. The diagnoses included, but were not limited to, Alzheimer's disease.A Quarterly MDS assessment, dated 12/4/25, indicated a severely impaired cognitive status, was dependent on staff for showers, toileting, and dressing, required supervision for bed mobility, was independent for transfers and ambulation, and was frequently incontinent of bowel and bladder.A Care Plan, dated 9/24/25, indicated an impaired cognitive status. The interventions indicated one though, idea, question, or command was to be give at a time.An ADL Care Plan, dated 9/29/25, indicated one-two staff assistance was required for ADL care.There was no care plan that indicated the resident made his own bed.This citation relates to Intake 2689569.3.1-19(f)(5)