STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155138	A. BUILDING _____ B. WING _____	C 05/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRICKYARD HEALTHCARE - CHURCHMAN CARE CENTER	**2860 CHURCHMAN AVE INDIANAPOLIS, IN 46203**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00404528, IN00404732, IN00406772, IN00407221, IN00407851, and IN00407722. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00404528 - No deficiencies related to the allegations are cited. Complaint IN00404732 - No deficiencies related to the allegations are cited. Complaint IN00406772 - No deficiencies related to the allegations are cited. Complaint IN00407221 - No deficiencies related to the allegations are cited. Complaint IN00407851 - No deficiencies related to the allegations are cited. Complaint IN00407722 - No deficiencies related to the allegations are cited. Survey dates: May 8 and 9, 2023 Facility number: 000063 Provider number: 155138 AIM number: 100266210 Census Bed Type: SNF/NF: 80 Total: 80 Census Payor Type: Medicare: 2 Medicaid: 76	F 000		

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155138	A. BUILDING _____ B. WING _____	C 05/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRICKYARD HEALTHCARE - CHURCHMAN CARE CENTER	**2860 CHURCHMAN AVE INDIANAPOLIS, IN 46203**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 Other: 2 Total: 80 Brickyard Healthcare - Churchman Care Center was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaints IN00404528, IN00404732, IN00406772, IN00407221, IN00407851, IN00407722 and the COVID-19 Focused Infection Control Survey. Quality review completed May 10, 2023.	F 000		