STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155076	A. BUILDING 00 B. WING	03/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - BROOKVIEW CARE CENTER	7145 E 21ST STREET INDIANAPOLIS, IN 46219

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00453279 and Complaint IN00454054. Complaint IN00453279 -- No deficiencies related to the allegations are cited. Complaint IN00454054 -- Federal/state deficiencies related to the allegations are cited at F550 and F625. Survey date: March 3 and 4, 2025 Facility number: 000031 Provider number: 155076 AIM number: 100266150 Census Bed Type: SNF/NF: 79 Total: 79 Census Payor Type: Medicare: 2 Medicaid: 64 Other: 13 Total: 79 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 7, 2025.	F 0000		
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights Based on interview and record review, the facility failed to ensure a resident's call light was	F 0550	Preparation, submission and implementation of this Plan of Correction does not constitute an	03/22/2025

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

Breque Norris | Executive Director | 03/19/2025

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	responded to in a timely manner, resulting in the resident experiencing anxiety, related to concerns regarding her health for 1 of 3 resident reviewed for staffing to meet resident needs. (Resident C) Findings include: In an interview with Resident C on 3-4-25 at 10:10 a.m., she indicated she has resided at the facility for about 6 years and typically was treated very well by staff and staff typically were very attentive to her, including with call light response. "About two or so weeks ago, [I] had been sent to ER [emergency room] for a nosebleed. After I got back here, around 4:00 a.m., my heart started thumping real hard and I turned on my call light to have the nurse come and check on me and get my vital signs. Not a soul showed up until after the day shift got here, somewhere around 7:00 a.m. It kind of scared me and my roommate. Who knows what could have happened to me? And it worries me that this type of thing could happen to someone else, too, that might be worse off than me." She indicated in the over five years she has been here, nothing like this has occurred before or since. She shared she had spoken to "several people" in management, including the new Director of Nursing (DON) who assured her things will be better. On 3-4-25 at 11:58 a.m., the Corporate Nurse provided a copy of a "Grievance Form," dated 2-20-25, which indicated the Social Services Designee received a grievance from Resident C, on 2-20-25, regarding her call light not being responded to by facility staff, from when she activated it at 4:00 a.m., until 7:00 a.m., on 2-20-25. This concern was shared with the DON. The form documented the DON resolved the concern on 2-21-25, with an explanation provided of,		admission or agreement with the facts and conclusions set forth in the survey report. Our Plan of Correction was prepared and executed to continuously improve care quality and comply with all applicable federal and state requirements. The facility respectfully requests a desk review of our responses to this survey. **F550** ***-what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice*** Resident C call light was answered. ***-how other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken*** All residents have the potential to be affected by the deficient practice. Audit completed of all resident call lights to ensure they are answered timely. ***-what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur*** Education completed with all staff regarding Call lights: Accessibility and Timely Response. Ongoing audit on various shifts to be completed by ED or designee	

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	"Employees were written up after complete thorough investigation was done." In an interview with the DON on 3-4-25 at 12:15 p.m., she indicated she had spoken with Resident C on 2-20-25, about her call light not being answered for several hours. She indicated both Resident C and her roommate were both very alert and oriented and did not have a history of telling lies about the staff. "I met with the nurse and aide that worked the night before [2-19-25 into 2-20-25]. Both of them said they didn't think her call light was on. The nurse wrote a statement on the write-up, but refused to sign it. I explained to both of them this type of thing is considered neglect and it is taken very seriously. They understand they are at the point where if anything else happens, they will be terminated. I decided not to terminate them, but to give them an opportunity for improvement." On 3-4-25 at 12:37 p.m., the DON provided copies of documents entitled, "3 Step Employee Memorandum," for Licensed Practical Nurse (LPN) 4 and Certified Nurse Aide (CNA) 5. The documents indicated, "Describe the incident in detail...Failed to answer call light in a timely manner," and indicated this was a "failure to perform assigned duties in an appropriate manner or at assigned times." In the section identified as "Corrective Action To Be Taken (State corrective action you feel the employee may take to eliminate the problem.), it indicated for both employees, "You must do purposely [sic] rounding on shift. All call lights must be answered in a timely manner. All assigned job duties must be completed on shift. Notify work colleague when taking scheduled break." LPN 4 handwrote a comment of, "Resident's light		to monitor completion of timely call light answering. This audit to be completed 5X weekly X 4 weeks, 3 times weekly X 4 weeks, and weekly to completed 6 months. ***-how the corrective action will be monitored to ensure that deficient practice will not recur; I.e., what quality assurance program will be put into place*** The results of these audits to be reviewed at QAPI x 6 months to track for any trends. If any identified, will continue audits based on QAPI recommendations, otherwise will review on a prn basis. ***-by what date the systemic changes for each deficiency will be completed*** 3.22.25	

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	was not on. Call light sounds on East Wing. East Wing nurse stated she did not see light. I also have two halls at night so am not on hall at all times." The signature line for LPN 4 was unsigned by LPN 4, but had a handwritten notation of, "Refused to Sign." CNA 5's document did not have any employee comment, but in the employee signature area of the document, it indicated the counseling was conducted by phone. Both documents were signed by two facility supervisors. In an interview on 3-4-25 at 2:20 p.m., with the Corporate Nurse, she indicated education was conducted on responding to call lights with the nurse and aide at the time of their counseling. The remainder of the staff were receiving education on this topic from the Executive Director and the new DON on a one-on-one basis, to be able to set goals individually with each employee. She indicated the Executive Director and DON "are about half-way through the employee list at this point" and there will be an all-staff meeting on 3-6-25, which was planned prior to this survey, to address a number of issues, including but not limited to, responding to call lights in a timely manner. The clinical record of Resident C was reviewed on 3-3-25 at 3:38 p.m. Her diagnoses included, but were not limited to congestive heart failure, diabetes with neuropathy, morbid obesity and end stage renal with dialysis. Her most recent Minimum Data Set assessment, dated 12-30-24, indicated she was cognitively intact. This citation is related to Complaint IN00454054. 3.1-3(t)			

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F 0625 SS=D Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr Based on interview and record review, the facility failed to provide 1 of 3 residents, reviewed for transfers, a copy of the facility's bed hold policy prior to transferring to an area hospital. (Resident D) Findings include: The clinical record of Resident D was reviewed on 3-4-25 at 10:57 a.m. Her diagnoses included, but were not limited to, Wernicke's encephalopathy, CVA (cardiovascular accident or stroke) with left sided hemiparesis and hemiplegia, dysphagia (difficulty swallowing), gastrostomy (gastric feeding tube), and moderate protein-calorie malnutrition. A review of Resident D's progress notes indicated she had pulled out her gastric feeding tube, on 3-2-25, and was sent to an area hospital to have it replaced. A document, identified as a nursing home to hospital transfer form, was completed on 3-2-25 at 5:50 a.m. It indicated the reason for the transfer as "Resident pulled out G-tube." The clinical record failed to have a copy of the bed hold policy in place and was unable to be provided by the facility prior to the exit of the survey. In an interview on 3-4-25 at 10:25 a.m., with Registered Nurse (RN) 3, she indicated when a resident was sent out to the emergency room, the nursing staff were to complete and send with the resident a copy of the bed hold policy and the state transfer paperwork.	F 0625	Preparation, submission and implementation of this Plan of Correction does not constitute an admission or agreement with the facts and conclusions set forth in the survey report. Our Plan of Correction was prepared and executed to continuously improve care quality and comply with all applicable federal and state requirements. The facility respectfully requests a desk review of our responses to this survey. **F625** ***-what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice*** Resident D was provided with the facility bed hold policy. ***-how other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken*** All residents have the potential to be affected by the deficient practice. Audit completed of all residents transferred to an area hospital in the previous 30 days to ensure they were provided with the facility bed hold policy. ***-what measures will be put into place and what systemic***	03/22/2025

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	In an interview with the Corporate Nurse on 3-4-25 at 2:17 p.m., she indicated the facility does not have a specific policy regarding the use of the transfer-discharge paperwork, but follows the state and federal regulations and utilizes the state paperwork, including the bed hold documentation. "We are to send that with the resident to the hospital and keep a copy for the chart." This citation is related to Complaint IN00454054. 3.1-12(a)(25)(A) 3.1-12(a)(25)(B)		***changes will be made to ensure that the deficient practice does not recur*** Education completed with all staff regarding Bed Hold Notice Policy. Ongoing audit to be completed by DNS or designee to ensure residents are provided the bed hold policy upon transfer. This audit to be completed 5X weekly X 4 weeks, 3 times weekly X 4 weeks, and weekly to completed 6 months. ***-how the corrective action will be monitored to ensure that deficient practice will not recur, I.e., what quality assurance program will be put into place*** The results of these audits to be reviewed at QAPI x 6 months to track for any trends. If any identified, will continue audits based on QAPI recommendations, otherwise will review on a prn basis. ***-by what date the systemic changes for each deficiency will be completed*** 3.22.25	