STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155076	A. BUILDING _____ B. WING _____	C 10/28/2024

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

(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	F 000		

This visit was for the Investigation of Complaints IN00444550, IN00444849, IN00444876, IN00444882, and IN00446042.

Complaint IN00444550 - No deficiencies related to the allegations are cited.

Complaint IN00444849 - No deficiencies related to the allegations are cited.

Complaint IN00444876 - No deficiencies related to the allegations are cited.

Complaint IN00444882 - No deficiencies related to the allegations are cited.

Complaint IN00446042 - No deficiencies related to the allegations are cited.

Survey dates: October 24, 25 and 28, 2024

Facility number: 000031
Provider number: 155076
AIM number: 100266150

Census Bed Type:
SNF/NF: 77
Total: 77

Census Payor Type:
Medicare: 1
Medicaid: 54
Other: 22
Total: 77

Brickyard Healthcare- Brookview Care Center was found to be in compliance with 42 CFR Part

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
	155076	A. BUILDING _____ B. WING _____	C 10/28/2024

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

(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 1 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaints IN00444550, IN00444849, IN00444876, IN00444882, and IN00446042. Quality review completed on October 28, 2024.	F 000		