STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155367	A. BUILDING _____ B. WING _____	C 07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRICKYARD HEALTHCARE -SYCAMORE VILLAGE CARE CENTER	**2905 W SYCAMORE ST KOKOMO, IN 46901**

(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 IN00462028, IN00462583, IN00456155, IN00456251, IN00456687 and IN00456912.

Complaint IN00462028-No deficiencies related to the allegations were cited.

Complaint IN00462583-No deficiencies related to the allegations were cited.

Complaint IN00456155-No deficiencies related to the allegations were cited.

Complaint IN00456251-No deficiencies related to the allegations were cited.

Complaint IN00456687-No deficiencies related to the allegations were cited.

Complaint IN00456912-No deficiencies related to the allegations were cited.

Survey dates: July 1 and 2, 2025

Facility number: 000258
Provider number: 155367
AIM number: 100289160

Census bed type:
SNF/NF: 102
Total: 102

Census payor type:
Medicare: 3
Medicaid: 93
Other: 6
Total: 102

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
	155367	A. BUILDING _____ B. WING _____	C 07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRICKYARD HEALTHCARE -SYCAMORE VILLAGE CARE CENTER	**2905 W SYCAMORE ST KOKOMO, IN 46901**

(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 Brickyard Healthcare-Sycamore Village Care Center was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regards to the Investigation of Complaints IN00462028, IN00462583, IN00456155, IN00456251, IN00456687 and IN00456912. Quality review was completed on July 3, 2025.	F 000		