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 03/14/2024

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 IN00424987, IN00428474, IN00428569, IN00428773, and IN00429205.

Complaint IN00424987 - No deficiencies related to the allegations are cited.

Complaint IN00428474 - No deficiencies related to the allegations are cited.

Complaint IN00428569 - No deficiencies related to the allegations are cited.

Complaint IN00428773 - No deficiencies related to the allegations are cited.

Complaint IN00429205 - No deficiencies related to the allegations are cited.

Survey date: March 14, 2024

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

Census Bed Type:
SNF/NF: 65
Total: 65

Census Payor Type:
Medicare: 2
Medicaid: 50
Other: 13
Total: 65

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

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 03/14/2024

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 IN00424987, IN00428474, IN00428569, IN00428773, and IN00429205. Quality review completed on March 15, 2024	F 000		