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	12/20/2024

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 a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00449216. Complaint IN00449216 - No deficiencies related to the allegations are cited. Survey dates: December 16, 17, 18, 19, and 20, 2024 Facility number: 000031 Provider number: 155076 AIM number: 100266150 Census Bed Type: SNF/NF: 74 Total: 74 Census Payor Type: Medicaid: 46 Other: 28 Total: 74 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on December 30, 2024.	F 0000	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 as a means to continuously improve the quality of care and comply with all applicable federal and state requirements. The facility respectfully requests a desk review of our responses to this survey.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on interview and record review, the facility failed to ensure a medication was administered as ordered for 1 of 1 resident reviewed for dialysis. (Resident 71)	F 0684	Medication order for Resident 71 was updated. All new admissions/readmissions have the potential to be affected. A 30-day lookback of all admissions	01/13/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brandy Coomer	RN	01/08/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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	Findings include: The clinical record for Resident 71 was reviewed on 12/20/24 at 2:00 p.m. The diagnoses included, but were not limited to, amputation of right leg and renal dialysis. A hospital discharge, dated 9/17/24, indicated the resident was to receive one tablet of 500/125 milligrams of amoxicillin clavulanate at bedtime in the evening after dialysis, and one tablet of 500 milligrams of amoxicillin one hour prior to appointment. A physician order, dated 12/6/24, indicated the resident was to receive four tablets of 500 milligrams of amoxicillin one hour prior to dialysis every Tuesday, Thursday, and Saturday. The December 2024 Medication Administration Record indicated the resident had received the 500 milligrams of amoxicillin one hour prior to dialysis every Tuesday, Thursday and Saturday. An interview was conducted with the Director of Nursing on 12/19/24 at 2:36 p.m. She indicated the resident had a recent hospitalization, and the staff activated the wrong amoxicillin order. The resident should be receiving one tablet of 500/125 milligrams of amoxicillin clavulanate at bedtime in the evening after dialysis. 3.1-37(a)		was conducted to ensure all medication orders are accurate. All licensed staff educated on medication orders. DNS/designee will audit all medication orders for all new admissions to ensure accuracy. This audit will be conducted 5x weekly for 4 weeks, then 3 new admissions weekly for 4 weeks, then 2 new admissions weekly for 4 months. Any negative findings will be corrected immediately. Results of all audits will be reviewed monthly at QAPI for the next 6 months to identify any trends or patterns. If any issues are identified, audits will continue based on IDT recommendation, otherwise will review on a PRN basis.	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview, and record	F 0812	Unlabeled refrigerated food was discarded. Frozen food was	01/13/2025

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	review the facility failed to label refrigerated food with date opened, appropriately store frozen food, appropriately restrain facial hair of dietary staff with the use of a beard restraint, and store personal belongings away from drying rack of clean dishes. This had the potential to affect 67 of 74 residents in the facility. Findings include: A tour of the kitchen was conducted, on 12/16/24 on 10:20 a.m., with the Dietary Manager (DM). Inspection of the walk-in freezer revealed packaging of frozen corn dogs left open to air. The DM indicated that the packaging should not be open to air. Inspection of refrigerated foods revealed three bags of undated bags of lettuce, visible discoloration of lettuce was present in one of three bags. The DM indicated the date must have rubbed off the bags of lettuce and discarded them. Cook 2 had a full goatee and was not wearing a beard restraint while in the kitchen. A jacket was observed hanging on a chair adjacent to a drying rack of clean dishes. The DM indicated that the jacket belonged to one of the facility's cooks and it should not be there. On 12/17/24 at 11:40 a.m., the kitchen was entered for a second tour and Cook 2 was observed with a full goatee without a beard restraint. On 12/19/24 at 10:20 a.m., the kitchen was entered and Cook 2 was observed wearing a beard restraint covering his goatee. An interview was conducted with the DM, on 12/19/24 at 10:22 a.m., regarding the use of beard restraints. The DM indicated their policy states facial hair was to be a quarter of an inch to require the use of a beard restraint.		closed and stored properly. Dietary staff donned a beard restraint. Personal belongings were immediately moved away from clean dishes. All residents served from the kitchen have the potential to be affected. Dietary staff educated on food storage and hygiene practices. ED/designee will audit refrigerated items to ensure they are labeled with a date opened, frozen foods for proper storage, ensure hair restraints are in place, and no personal belongings are near clean dishes. These audits will be conducted 5x weekly for 4 weeks, then 3x weekly for 4 weeks, then 2x weekly for 4 months. Any negative findings will be corrected immediately. Results of all audits will be reviewed monthly at QAPI for the next 6 months to identify any trends or patterns. If any issues are identified, audits will continue based on IDT recommendation, otherwise will review on a PRN basis.	

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	A policy for Dietary Employee Personal Hygiene, dated 2022, was provided by the Director of Nursing on 12/19/24 at 10:38 a.m. The policy states, "...Hair restraints... a. All dietary staff must wear hair restraints (e.g., hairnet, hat and/or beard restraint) to prevent hair from contacting food. b. Head coverings must be clean..." A policy for Food Safety Requirements, dated 2024, was provided by the Director of Nursing on 12/19/24 at 10:38 a.m. The policy states, "Facility staff shall inspect all food, food products, and beverages for safe transport and quality upon delivery/receipt and ensure timely and proper storage ... iv. Labeling, dating, and monitoring refrigerated food, including, but not limited to leftovers, so it is used by its use-by date, or frozen (where applicable)/discarded; and v. Keeping foods covered or in tight containers..." 3.1-21(i)(3)			
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ Based on observation, interview, and record review, the facility failed to have a functional call light in a resident's room and timely replace cove base at the base of a toilet for 2 of 7 residents observed for environment. (Resident 13 and 48) Findings include: 1. On 12/17/24 at 1:46 p.m., Resident 13's bathroom was observed. The elevated concrete base of the toilet was exposed and missing the cove base. Resident 13 indicated that it looked dirty and had been that way for "a while".	F 0921	The call light was immediately replaced for Resident 48. Cove base at the base of the toilet for Residents 13 and 48 was replaced. All residents have the potential to be affected. All resident rooms/bathrooms were audited to assure call light was functioning and toilets have cove base in place. All staff educated on a safe, functional, sanitary, comfortable environment.	01/13/2025

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	On 12/20/24 at 11:06 a.m., an environmental tour was conducted with the Maintenance Supervisor (MS). Resident 13's bathroom was observed, the elevated concrete toilet base was missing the cove base. During an interview on 12/20/24 at 11:45 a.m., the MS indicated the concrete base had been painted in November 2024 and then repainted again recently. Replacement of the cove base must have been missed. He did not believe there was a work order to replace the cove base. 2. On 12/16/24 at 3:40 p.m. an observation of Resident 48's room revealed their call light was missing its button cover. An observation conducted on 12/17/24 at 2:35 p.m., revealed Resident 48's call light was still missing its button cover. An interview was conducted, on 12/18/24 at 1:57 p.m., with Certified Nurse Aide (CNA) 1. CNA 1 pushed Resident 48's call light and indicated the call light was broken and would be getting a new one. On 12/20/24 at 1:50 p.m. the Vice President of Risk and Regulatory (VPRR) indicated there was not a specific call light policy and it would fall under standards of care. On 12/20/24 at 1:50 p.m., the Executive Director provided the current Facility Maintenance Guidelines and Procedure which read, "...Staff should place items they find in the normal course of their day in the TELS [sic] Work Order System when found as well as placing items in the system when residents make requests..."		ED/designee will audit 10 random resident rooms to ensure a functioning call light is in place and resident bathrooms to ensure cove base at base of toilet is intact. These audits will be conducted weekly for 4 weeks, then 5 random res rooms weekly for 4 weeks, then 3 random res roooms weekly for 4 months. Any negative findings will be corrected immediately. Results of all audits will be reviewed monthly at QAPI for the next 6 months to identify any trends or patterns. If any issues are identified, audits will continue based on IDT recommendation, otherwise will review on a PRN basis.	

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	3.1-19(u)(1)			