

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155076	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/20/2024
NAME OF PROVIDER OR SUPPLIER Brickyard Healthcare - Brookview Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7145 E 21st Street Indianapolis, IN 46219	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>34850</p> <p>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)</p> <p>Findings include:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>3.1-37(a)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>51750</p> <p>Based on observation, interview, and record 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.</p> <p>Findings include:</p> <p>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. [NAME] 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.</p> <p>On 12/17/24 at 11:40 a.m., the kitchen was entered for a second tour and [NAME] 2 was observed with a full goatee without a beard restraint.</p> <p>On 12/19/24 at 10:20 a.m., the kitchen was entered and [NAME] 2 was observed wearing a beard restraint covering his goatee.</p> <p>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.</p> <p>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 .</p> <p>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 .</p> <p>3.1-21(i)(3)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>40287</p> <p>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)</p> <p>Findings include:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>51750</p> <p>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.</p> <p>An observation conducted on 12/17/24 at 2:35 p.m., revealed Resident 48's call light was still missing its button cover.</p> <p>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.</p> <p>On 12/20/24 at 1:50 p.m. the [NAME] President of Risk and Regulatory (VPRR) indicated there was not a specific call light policy and it would fall under standards of care.</p> <p>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 .</p> <p>3.1-19(u)(1)</p>