STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155834	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brickyard Healthcare - Willow Springs Care Center	2002 West 86th Street Indianapolis, IN 46260

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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review, the facility failed to accurately transcribe a physician's order for 1 of 1 resident reviewed for pharmacy services. (Resident H) The deficient practice was corrected on 12/8/25, prior to the start of the survey, and was therefore past noncompliance.Findings include:The clinical record for Resident H was reviewed on 6/1/26 at 11:45 a.m. The diagnoses included, but were not limited to, endocarditis, cellulitis, and infection in the knee.A hospital discharge instruction, dated 10/14/25, indicated to administer ceftriaxone (a third-generation cephalosporin antibiotic) 2 grams (gm) IV (intravenous) push every 24 hours for cellulitis for 14 days.A physician order, with a start date of 10/14/25 and an end date of 10/15/25, indicated to administer ceftazidime (a third-generation cephalosporin antibiotic) 2 gm IV every 24 hours for an infection in the knee.A physician order, with a start date of 10/15/25 and an end date of 10/23/25, indicated to administer ceftazidime 2 gm IV every 24 hours for an infection in the knee for 6 weeks.A physician order, with a start date of 10/23/25 and an end date of 11/17/25, indicated to administer ceftazidime 2 gm IV every 24 hours for cellulitis and endocarditis for 6 weeks.The clinical record indicated the wrong antibiotic was ordered (ceftazidime) compared to the hospital discharge instructions (ceftriaxone).A nursing progress note, dated 11/14/25, indicated the facility nurse spoke with a nurse from the infectious disease office related to the resident's antibiotics. Resident H's antibiotics were to be held until further notice.A nursing progress note, dated 11/17/25, indicated the facility nurse spoke with a nurse from the infectious disease office. Orders were received to discontinue Resident H's IV and antibiotics.A nursing progress note, dated 11/18/25, indicated the infectious disease office staff requested Resident H's medical records regarding the previous antibiotic medications ordered.During an interview, on 6/3/26 at 1:52 p.m., Nurse 3 from the ordering infectious disease physician's office indicated that ceftazidime was ordered and administered by the facility instead of the intended ceftriaxone.During an interview, on 6/4/26 at 9:39 a.m., the Director of Nursing (DON) indicated a medication error had occurred. The medication was transcribed incorrectly. The admitting nurse entered the wrong medication into the system and there was no second nurse verification completed.During an interview, on 6/5/26 at 9:17 a.m., the DON indicated the facility did not have a policy on transcribing medications. Their process was one nurse should enter the orders, and another nurse should check the orders to verify they were the correct orders.An article, titled Comparison of Ceftazidime and Ceftriaxone Spectrum of Activity, last updated 8/5/25, was retrieved on 6/8/26 from the Dr Oracle website at https://www.drooracle.ai/articles/250447/is-ceftazidime-a-third-generation-cephalosporin-antibiotic-more-broad-The guidance included: .Ceftazidime has a broader spectrum of activity than ceftriaxone specifically due to its superior activity against Pseudomonas aeruginosa, while ceftriaxone has better coverage against certain Gram-positive organisms and anaerobes.A current facility policy, titled Medication Errors, dated 2025 and received from the DON on 6/4/26 at 10:05 a.m., indicated .It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by ensuring residents receive care and services safely in an environment free of significant medication errors. Medication error means the observed or identified preparation or administration of medications or (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	biologicals which are not in accordance with prescriber's order; manufacturers specifications (not recommendations) regarding the preparation and administration of the medication or biological; or accepted professional standards and principles which apply to professionals providing services .The facility shall ensure medications will be administered as follows: a. According to physician's orders This deficient practice was corrected by 12/8/25 after the facility implemented a systemic plan that included the following actions: all residents with antibiotic orders were reviewed, audits of the antibiotics orders were completed and were on-going, in-servicing education to staff related to transcribing medications were completed, the facility implemented a new transcription process and procedure, and ongoing monitoring by Quality Assurance and Performance Improvement (QAPI).This citation relates to intake 2675455.410 IAC (Indiana Administrative Code)16.2-3.1-25(g)(1)