DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES					FORM APPROVED OMB NO. 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED R-C 06/01/2023		
		155157					
NAME OF PROVIDER OR SUPPLIER BRICKYARD HEALTHCARE - RICHMOND CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1042 OAK DR RICHMOND, IN 47374			
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ION SHOULD BE COMPLETION HE APPROPRIATE DATE		
F 000	INITIAL COMMENTS		F 000	0			
	Paper compliance to the Investigation of Complaint IN00404542, IN00404629, and IN00405188 completed on April 5, 2023						
	Review Date: June 1, 2023						
	Facility Number:000077Provider Number:155157AIM Number:100266490						
	410 IAC 16.2-3.1, in I	FR Part 483, Subpart B and					
	Quality review completed on June 1, 2023						
		SUPPLIER REPRESENTATIVE'S SIGNATU		TITLE	(X6) D		

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.

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