DEPARTMENT OF HEALTH AND HUMAN SERVICES						FORM APPROVED	
		MEDICAID SERVICES				O. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		COM	(X3) DATE SURVEY COMPLETED	
		155157			R-C 05/02/2022		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD			
BRICKYA	RD HEALTHCARE - RICH	IMOND CARE CENTER		1042 OAK DR RICHMOND, IN 47374			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS		F 0	000			
	Paper compliance to the Investigation of Complaint IN00375610 completed on April 4, 2022						
	Review Date: May 2, 2022						
	Facility Number: 000 Provider Number: AIM Number: 100	0077 155157 0266490					
	be in compliance with B and 410 IAC 16.2-3	 Richmond was found to 42 CFR Part 483, Subpart 3.1, in regard to the paper the Complaint Investigation. 					
	Quality review completed on May 2, 2022						
		SUPPLIER REPRESENTATIVE'S SIGNATU		TITLE		(X6) DATE	

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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