

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>010409</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/18/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>KEYSTONE WOODS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2335 N MADISON AVE ANDERSON, IN 46011</b>
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(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for a State Residential Licensure Survey.</p> <p>Survey Date: September 18, 2014</p> <p>Facility Number: 010409 Provider Number: 010409 AIM Number: N/A</p> <p>Survey Team: Tina Smith-Staats, RN-TC Ginger McNamee, RN Karen Lewis, RN</p> <p>Census bed type: Residential: 62 Total: 62</p> <p>Census payor type: Medicaid: 36 Other: 26 Total: 62</p> <p>Sample: 7</p> <p>Keystone Woods was found to be in compliance with 410 IAC16.2-5 in regard to the State Residential Survey.</p> <p>Quality Review 09/19/14 by Lisa McColly</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_