

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>R</b> <b>09/16/2013</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 Post Survey Revisit for a State Licensure Survey completed on August 14, 2013.</p> <p>Survey Dates: September 16, 2013</p> <p>Facility Number: 010409 Provider Number: 010409 AIM Number: N/A</p> <p>Survey Team: Karen K. Koeberlein, RN, TC Toni Maley, BSW</p> <p>Census Bed Type: Residential: 60 Total: 60</p> <p>Census Payor Type: Medicaid: 33 Other: 27 Total: 60</p> <p>Sample: 3</p> <p>Keystone Woods was found to be in compliance with 410 IAC 16.2 in regard to the post survey revisit to the state licensure survey.</p>	{R 000}		

Indiana State Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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