

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 011478	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/04/2015
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NAME OF PROVIDER OR SUPPLIER COUNTRY CHARM	STREET ADDRESS, CITY, STATE, ZIP CODE 3177 MERIDIAN PARKE DR GREENWOOD, IN 46142
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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>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00162353.</p> <p>Complaint IN00162353 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey date: February 4, 2014</p> <p>Facility number: 011478 Provider number: 011478</p> <p>Survey team: Marcy Smith, RN - TC Jessica Parsley, RN</p> <p>Census bed type: Residential: 88 Total: 88</p> <p>Census payor type: Medicaid: 51 Other: 37 Total: 88</p> <p>Sample: 3</p> <p>Country Charm was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00162353.</p> <p>Quality Review 02/05/15 by Lisa McColly</p>	R 000		

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