

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 000312	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/13/2014
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ROSEWOOD MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 5200 S BURLINGTON DR MUNCIE, IN 47302
---	---

(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 a State Residential Licensure Survey.</p> <p>Survey Date: February 13, 2014</p> <p>Facility number: 000312 Provider number: 000312 AIM number: N/A</p> <p>Survey Team: Toni Maley, BSW, TC Ginger McNamee, RN Karen Lewis, RN</p> <p>Census bed type: Residential: 36 Total: 36</p> <p>Census payor type: Other: 36 Total: 36</p> <p>Sample: 7</p> <p>Rosewood Manor was found to be in compliance with 410 IAC 16.2 in regard to the State Residential Licensure Survey.</p> <p>Quality Review 02/14/14 by Lisa McColly</p>	R 000		

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