STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELWOOD HEALTH AND LIVING	2300 PARKVIEW LN, ELWOOD, , 46036

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
F 0000	INITIAL COMMENTS Paper compliance to the Annual Recertification and State Licensure Survey and the Investigation of Complaints IN00449079, IN00449973, and IN00452205 completed on February 17, 2025. Review Date: March 11, 2025 Facility number: 000372 Provider number: 155522 AIM number: 100289060 Elwood Health and Living was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1, in regard to the paper review to the Recertification and State Licensure Survey and the Investigation of Complaints IN00449079, IN00449973, and IN00452205.	F 0000		
R 0000	INITIAL COMMENTS Paper compliance to the State Residential Licensure Survey completed on February 17, 2025. Review Date: March 11, 2025 Facility number: 000372 Elwood Health and Living was found to be in compliance with 410 IAC 16.2-5 in regard to the paper	R 0000		

	review to the State Residential Licensure Survey.			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

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