

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/04/2026	
NAME OF PROVIDER OR SUPPLIER KEYSTONE WOODS		STREET ADDRESS, CITY, STATE, ZIP CODE 2335 N MADISON AVE, ANDERSON, , 46011					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...			(X5) COMPLETION DATE	
R 0000	INITIAL COMMENTS This visit was for the Investigation of Intake 467409. Intake 467409 - No deficiencies related to the allegations are cited. Survey date: February 4, 2026 Facility number: 010409 Residential Census: 54 Keystone Woods compliance with 410 IAC 16.2-5 in regard to the Investigation of Intake 467409. Quality review completed February 5, 2026.	R 0000					
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	