STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE WOODS	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 472341. Intake 472341 - No deficiencies related to the allegations are cited. Survey dates: October 15 and 16, 2026 Facility number: 010409 Residential Census: 54 Keystone Woods compliance with 410 IAC 16.2-5 in regard to the Investigation of Intake 472341. Quality review completed October 26, 2026. This visit was for the Investigation of Intake 472341. Intake 472341 - No deficiencies related to the allegations are cited. Survey dates: October 15 and 16, 2026 Facility number: 010409	R 0000		

	Residential Census: 54 Keystone Woods compliance with 410 IAC 16.2-5 in regard to the Investigation of Intake 472341. Quality review completed October 26, 2026.			

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