

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 07/09/2024
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 Complaint IN00436438. Complaint IN00436438 - No deficiencies related to the allegations are cited. Survey date: July 9, 2024 Facility number: 010409 Residential Census: 57 Keystone Woods compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00436438. Quality review completed July 15, 2024.	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	