

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/20/2025	
NAME OF PROVIDER OR SUPPLIER GREENBRIAR VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 8800 SPOON DR, INDIANAPOLIS, , 46219					
(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 a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00452888, IN00452820, and IN00452670. Complaint IN00452888 - No deficiencies related to the allegation(s) are cited. Complaint IN00452820 - No deficiencies related to the allegation(s) are cited. Complaint IN00452670 - No deficiencies related to the allegation(s) are cited. Survey Dates: February 18, 19, and 20, 2025 Facility Number: 011799 Residential Census: 98 Greenbriar Village was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey and the Investigation of	R 0000					

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Complaints IN00452888, IN00452820, and IN00452670.			
Quality review completed on February 21, 2025.			

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
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