

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>005722</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R-C 09/05/2023</b>
NAME OF PROVIDER OR SUPPLIER  <b>INDEPENDENCE VILLAGE OF GREENWOOD</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2339 S STATE ROAD 135 GREENWOOD, IN 46143</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{R 000}	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for a Post Survey Revisit (PSR) to Investigation of Complaint IN00410792 completed on July 31, 2023, which resulted in an unrelated deficiency.</p> <p>Survey date: September 5, 2023</p> <p>Facility number: 005722</p> <p>Residential Census: 81</p> <p>Independence Village of Greenwood was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to the unrelated deficiency cited during the Investigation of Complaint IN00410792.</p> <p>Quality review completed September 7, 2023.</p>	{R 000}		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE