

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>012938</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R-C 04/25/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>BICKFORD OF GREENWOOD</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3021 STELLA DRIVE 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 the State Residential Licensure Survey completed on March 6, 2024.</p> <p>Survey dates: April 25, 2024</p> <p>Facility number: 012938</p> <p>Residential Census: 38</p> <p>Bickford of Greenwood was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to the State Residential Licensure Survey.</p> <p>Quality review completed April 26, 2024.</p>	{R 000}		

Indiana Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE