

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/05/2023  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>155522</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01</b><br><br>B. WING _____                    |                                                                                                                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><br><b>06/29/2023</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ELWOOD HEALTH AND LIVING</b>   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                            |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2300 PARKVIEW LN</b><br><b>ELWOOD, IN 46036</b> |                                                                                                                          |                                                                        |                            |
| (X4) ID<br>PREFIX<br>TAG                                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                            |  | ID<br>PREFIX<br>TAG                                                                         | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |                                                                        | (X5)<br>COMPLETION<br>DATE |
| {K 000}                                                               | <p>INITIAL COMMENTS</p> <p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 05/24/23 was conducted by the Indiana Department of Health in accordance 42 CFR Subpart 483.90(a).</p> <p>Survey Date: 06/29/23</p> <p>Facility Number: 000372<br/>Provider Number: 155522<br/>AIM Number: 100289060</p> <p>At this Life Safety Code Survey, Elwood Health and Living, was found in compliance with the Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.90(a).</p> <p>The facility has 92 certified beds. At the time of survey the census was 56</p> <p>Quality Review completed on 06/30/23</p> |                                                                            |  | {K 000}                                                                                     |                                                                                                                          |                                                                        |                            |
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                            |  | TITLE                                                                                       |                                                                                                                          | (X6) DATE                                                              |                            |

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.