

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

PRINTED: 05/19/2025  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155769</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>05/13/2025</b>	
NAME OF PROVIDER OR SUPPLIER  <b>MORRISON WOODS HEALTH CAMPUS</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>4100 N MORRISON RD</b> <b>MUNCIE, IN 47304</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) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaints IN00459013, IN00458824, IN00458071, IN00457070, and IN00456549 .</p> <p>Complaint IN00459013- No deficiencies related to the allegations were cited.</p> <p>Complaint IN00458824- No deficiencies related to the allegations were cited.</p> <p>Complaint IN00458071- No deficiencies related to the allegations were cited.</p> <p>Complaint IN00457070- No deficiencies related to the allegations were cited.</p> <p>Complaint IN00456549- No deficiencies related to the allegations were cited.</p> <p>Survey dates: May 12 and 13, 2025</p> <p>Facility Number: 011596 Provider Number: 155769 AIM Number: 200901690</p> <p>Census Bed Type: SNF/NF: 21 SNF: 21 NF: 14 Residential: 60 Total: 116</p> <p>Census Payor Type: Medicare: 21 Medicaid: 14 Other: 21 Total: 56</p>			F 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.

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F 000	Continued From page 1  Morrison Woods Health Campus was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaints IN00459013, IN00458824, IN00458071, IN00457070, and IN00456549.  Quality review completed May 16, 2025.	F 000			