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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155193	A. BUILDING ______ B. WING ______	C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENWOOD HEALTHCARE CENTER	**377 WESTRIDGE BLVD GREENWOOD, IN 46142**

(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	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00363226, IN00363019, IN00362863, IN00362114, IN00362164, IN00361697, and IN00359372. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00363226 - Unsubstantiated due to lack of evidence. Complaint IN00363019 - Unsubstantiated due to lack of evidence. Complaint IN00362863 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00362114 - Unsubstantiated due to lack of evidence. Complaint IN00362164 - Unsubstantiated due to lack of evidence. Complaint IN00361697 - Unsubstantiated due to lack of evidence. Complaint IN00359372 - Unsubstantiated due to lack of evidence. Survey dates: September 20, 21, 22, and 23, 2021. Facility number: 00101 Provider number: 155193 AIM number: 100291290 Census Bed Type: SNF/NF: 190 Total: 190	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 Census Payor Type: Medicare: 13 Medicaid: 132 Other: 45 Total: 190 Greenwood Healthcare Center 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 IN00363226, IN00363019, IN00362863, IN00362114, IN00362164, IN00361697, IN00359372 and the COVID-19 Focused Infection Control Survey. Quality Review completed on September 24, 2021.	F 000		