

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

PRINTED: 03/24/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155193	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/22/2021
NAME OF PROVIDER OR SUPPLIER GREENWOOD HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaints IN00348396, IN00349220, IN00349436, IN00349442, IN00349656, IN00349773, and IN00349823.</p> <p>Complaint IN00348396- Substantiated. No deficiencies related to the allegations were cited.</p> <p>Complaint IN00349220- Substantiated. No deficiencies related to the allegations were cited.</p> <p>Complaint IN00349436 - Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00349442 - Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00349656- Substantiated. No deficiencies related to the allegations were cited.</p> <p>Complaint IN00349773- Substantiated. No deficiencies related to the allegations were cited.</p> <p>Complaint IN00349823 - Unsubstantiated due to lack of evidence.</p> <p>Survey dates: March 16, 17, 18, 19 and 22, 2021</p> <p>Facility number: 000101 Provider number: 155193 AIM number: 100291290</p> <p>Census Bed Type: SNF/NF: 194 Total: 194</p> <p>Census Payor Type:</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 Medicare: 13 Medicaid: 122 Other: 59 Total: 194 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 Complaint. IN00348396, IN00349220, IN00349436, IN00349442, IN00349656, IN00349773, and IN00349823. Quality Review completed on March 23, 2021.	F 000			