| 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 03/22/2021 |

| 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 | F 000 | | |

This visit was for the Investigation of Complaints IN00348396, IN00349220, IN00349436, IN00349442, IN00349656, IN00349773, and IN00349823.

Complaint IN00348396- Substantiated. No deficiencies related to the allegations were cited.

Complaint IN00349220- Substantiated. No deficiencies related to the allegations were cited.

Complaint IN00349436 - Unsubstantiated due to lack of evidence.

Complaint IN00349442 - Unsubstantiated due to lack of evidence.

Complaint IN00349656- Substantiated. No deficiencies related to the allegations were cited.

Complaint IN00349773- Substantiated. No deficiencies related to the allegations were cited.

Complaint IN00349823 - Unsubstantiated due to lack of evidence.

Survey dates: March 16, 17, 18, 19 and 22, 2021

Facility number: 000101
Provider number: 155193
AIM number: 100291290

Census Bed Type:
SNF/NF: 194
Total: 194

Census Payor Type:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| 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 | Continued From page 1<br>Medicare: 13<br>Medicaid: 122<br>Other: 59<br>Total: 194<br><br>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.<br><br>Quality Review completed on March 23, 2021. | F 000 | | |