

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>012938</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/18/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>BICKFORD OF GREENWOOD</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3021 STELLA DRIVE GREENWOOD, IN 46143</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) COMPLETE DATE
R 000	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for the Investigation of Complaints IN00422071, IN00425112, and IN00425928.</p> <p>Complaint IN00422071 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00425112 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00425928 - No deficiencies related to the allegations are cited.</p> <p>Survey date: January 18, 2024</p> <p>Facility number: 012938</p> <p>Residential Census: 36</p> <p>Bickford of Greenwood was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaints IN00422071, IN00425112, and IN00425928.</p> <p>Quality review completed January 19, 2024.</p>	R 000		

Indiana Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE