STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155763	A. BUILDING _____ B. WING _____	R 12/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH RIDGE VILLAGE NURSING & REHABILITATION CENTE	600 TRAIL RIDGE RD ALBION, IN 46701

(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 a Post Survey Revisit (PSR) to the Covid-19 Infection Control Survey conducted on 10/20/2020.

Survey dates: December 17, 2020

Facility number: 011296
Provider number: 155763
AIM number: 20112961

Census Bed Type:
SNF/NF: 31
Total: 31

Census Payer Type:
Medicare: 17
Medicaid: 12
Other: 2
Total: 31

North Ridge Village was found to be in compliance with 42 CFR Part 483 Subpart B and 410 IAC 16.2-3.1 in regard to the PSR to the Covid-19 Infection Control Survey.

Quality review completed December 17, 2020

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