

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

PRINTED: 08/30/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155788	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/27/2024
NAME OF PROVIDER OR SUPPLIER GREENWOOD MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 N STATE ROAD 135 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 IN00437249, IN00440875, and IN00441764. This visit included a Covid-19 Focused Infection Control Survey. Complaint IN00437249 - No deficiencies related to the allegations are cited. Complaint IN00440875 - No deficiencies related to the allegations are cited. Complaint IN00441764 - No deficiencies related to the allegations are cited. Survey date: August 27, 2024 Facility number: 012564 Provider number: 155788 AIM number: 201018510 Census Bed Type: SNF/NF: 117 SNF: 20 Total: 137 Census Payor Type: Medicare: 13 Medicaid: 80 Other: 44 Total: 137 Greenwood Meadows 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 IN00437249, IN00440875, IN00441764 and the Covid-19 Focused Infection Control Survey.	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 Quality review completed August 28, 2024.	F 000			