DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/25/2024 FORM APPROVED OMB NO. 0938-039

CENTERS FOR MEDICARE & MEDICAID SERVICES ONID NO. 0736-039							
STATEMENT OF DEFICIENCIES X1) PROVIDER/S		X1) PROVIDER/SUPPLIER/CLIA	JER/CLIA (X2) MULTIPLE CONSTRUCTION		(X3) DATE	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING 00		COMP	COMPLETED	
		155368	B. WING		05/03	05/03/2024	
		100000	B. WING		00/00	72024	
NAME OF BROWNER OF GUIDN IED				STREET ADDRESS, CITY, STATE, ZIP COD			
NAME OF PROVIDER OR SUPPLIER			712	712 W 2ND ST			
TODD-DICKEY NURSING AND REHABILITATION				LEAVENWORTH, IN 47137			
TODD DIONET NONOING AND NETWORK THON				ELIVERWORTH, IIV 47 107			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	ID PROVIDER'S PLAN OF CORRECT		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOU	ULD BE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APP DEFICIENCY)	ROPRIATE	DATE	
F 0000							
1 0000							
B							
Bldg. 00							
	This visit was for for a Recertification and State		F 0000	F 0000 Todd-Dickey Nursing and			
	Licensure survey.			Rehabilitation is respectf	s respectfully		
				requesting face to face II	DR as the		
	Survey Dates: April 29, 30, May 1, 2, and 3, 2024				facility disagrees with the scope and severity assigned for F 745.		
	Survey Survey 11pm 25, 86, 11mg 1, 2, mm 8, 202			, ,			
	Facility number: 000490			and severity assigned to			
	Provider number: 155368						
	AIM number: 100291320						
	Census bed type:						
	SNF/NF: 60						
	Total: 60						
	Company maryon trans						
	Census payor type: Medicaid: 42		1				
	Other: 18						
	Total: 60						
	Todd Dielroy Norr	ing and Dahahilitation is in					
	_	sing and Rehabilitation is in	1				
	•	ance with 42 CFR Part 483,					
	*	IAC 16.2-3.1, regarding the					
	Recertification and	l State Licensure Survey.					
	Quality review cor	mpleted on May 8, 2024.					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclodays 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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GGQ111 Facility ID:

000490

If continuation sheet