

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>013128</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>02/06/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CENTURY FIELDS RETIREMENT COMMUNITY LP</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>825 N MERIDIAN ST GREENTOWN, IN 46936</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 a State Residential Licensure Survey.</p> <p>Survey Dates: January 31, 2017 and February 1, 2, 3, and 6, 2017</p> <p>Facility number: 013128 Provider number: 013128</p> <p>Residential Census: 31</p> <p>Sample: 10</p> <p>Century Fields Retirement Community was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.</p> <p>Quality Review was completed on 02/08/17.</p>	R 000		

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

TITLE

(X6) DATE