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

PRINTED: 07/09/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED
		155680	B. WING _			R-C
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, Z	IP CODE	07/08/2024
				2494 N LEBANON ST		
HOMEWOOD HEALTH CAMPUS				LEBANON, IN 46052		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICII	ACTION SHOULD BE TO THE APPROPRIA	
{F 000}	INITIAL COMMENTS		{F 0	00}		
	State Licensure surve Complaints IN004175 completed on May 21 Review Date: July 8, 2 Facility Number: 0027 Provider Number: 155 AIM Number: 200309 Homewood Health Ca compliance with 42 C 410 IAC 16.2-3.1, in rethe Recertification and	, 2024. 2024 703 5680				

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.