

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

PRINTED: 06/07/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155066		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/04/2024	
NAME OF PROVIDER OR SUPPLIER EDGEWATER WOODS				STREET ADDRESS, CITY, STATE, ZIP CODE 1809 N MADISON AVE ANDERSON, IN 46011			
(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	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaints IN00433401, IN00434175, IN00434381, IN00433523, and IN00435886.</p> <p>Complaint IN00433401 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00434175- No deficiencies related to the allegations are cited.</p> <p>Complaint IN00434381 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00433523 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00435886 - No deficiencies related to the allegations are cited.</p> <p>Survey dates: May 31 and June 3 and 4, 2024</p> <p>Facility number: 000026 Provider number: 155066 AIM number: 100274820</p> <p>Census Bed Type: SNF/NF: 65 Total: 65</p> <p>Census Payor Type: Medicare: 2 Medicaid: 55 Other: 8 Total: 65</p> <p>Edgewater Woods was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC</p>			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 16.2-3.1 in regard to the Investigation of Complaints IN00433401, IN00434175, IN00434381, IN00433523 and IN00435886. Quality review completed June 6, 2024.	F 000			