STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155193	A. BUILDING _____ B. WING _____	C 03/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENWOOD HEALTHCARE CENTER	**377 WESTRIDGE BLVD 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 IN00399187, IN00399228, IN00399621, IN00400806, IN00401810, IN00401854, IN00402848, IN00402294, IN00403429, IN00403313, IN00403612, and IN00403989. Complaint IN00399187 - No deficiencies related to the allegations are cited. Complaint IN00399228 - No deficiencies related to the allegations are cited. Complaint IN00399621 - No deficiencies related to the allegations are cited. Complaint IN00400806 - No deficiencies related to the allegations are cited. Complaint IN00401810 - No deficiencies related to the allegations are cited. Complaint IN00401854 - No deficiencies related to the allegations are cited. Complaint IN00402848 - No deficiencies related to the allegation are cited. Complaint IN00402294 - No deficiencies related to the allegations are cited. Complaint IN00403429 - No deficiencies related to the allegations are cited. Complaint IN00403313 - No deficiencies related to the allegations are cited. Complaint IN00403612 - No deficiencies related	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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155193	A. BUILDING _____ B. WING _____	C 03/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENWOOD HEALTHCARE CENTER	377 WESTRIDGE BLVD 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	Continued From page 1 to the allegations are cited. Complaint IN00403989 - No deficiencies related to the allegations are cited. Survey dates: March 13, 14, and 15, 2023 Facility number: 000101 Provider number: 155193 AIM number: 100291290 Census Bed Type: SNF/NF: 169 Total: 169 Census Payor Type: Medicare: 9 Medicaid: 120 Other: 40 Total: 169 Greenwood Healthcare Center 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 IN00399187, IN00399228, IN00399621, IN00400806, IN00401810, IN00401854, IN00402848, IN00402294, IN00403429, IN00403313, IN00403612, and IN00403989. Quality review completed March 15, 2023.	F 000		