

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>012938</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/08/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>BICKFORD OF GREENWOOD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3021 STELLA DRIVE</b> <b>GREENWOOD, IN 46143</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 the Investigation of Complaint IN00437358.</p> <p>Complaint IN00437358 - No deficiencies related to the allegations are cited.</p> <p>Survey date: July 8, 2024</p> <p>Facility number: 012938</p> <p>Residential Census: 38</p> <p>Bickford of Greenwood was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00437358.</p> <p>Quality review completed July 9, 2024.</p>	R 000			

Indiana Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE