STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155412	A. BUILDING _____ B. WING _____	C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENWOOD HEALTH AND LIVING COMMUNITY	937 FRY RD 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	F 000		

This visit was for Investigation of Complaints IN00452417, IN00452728, IN00452250, IN00451622, and IN00452194. This visit included a COVID-19 Focused Infection Control Survey.

Complaint IN00452417 - No deficiencies related to the allegations are cited.

Complaint IN00452728 - No deficiencies related to the allegations are cited.

Complaint IN00452250 - No deficiencies related to the allegations are cited.

Complaint IN00451622 - No deficiencies related to the allegations are cited.

Complaint IN00452194 - No deficiencies related to the allegations are cited.

Survey dates: February 12 and 13, 2025

Facility number: 000509
Provider number: 155412
AIM number: 100266620

Census Bed Type:
SNF/NF: 106
Total: 106

Census Payor Type:
Medicare: 9
Medicaid: 60
Other: 37
Total: 106

Greenwood Health and Living Community was

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155412	A. BUILDING _____ B. WING _____	C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENWOOD HEALTH AND LIVING COMMUNITY	**937 FRY RD 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 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 IN00452417, IN00452728, IN00452250, IN00451622, IN00452194 and the COVID-19 Focused Infection Control Survey. Quality review completed February 14, 2025.	F 000		