

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

PRINTED: 02/17/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155412		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/13/2025	
NAME OF PROVIDER OR SUPPLIER GREENWOOD HEALTH AND LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>INITIAL COMMENTS</p> <p>This visit was for Investigation of Complaints IN00452417, IN00452728, IN00452250, IN00451622, and IN00452194. This visit included a COVID-19 Focused Infection Control Survey.</p> <p>Complaint IN00452417 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00452728 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00452250 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00451622 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00452194 - No deficiencies related to the allegations are cited.</p> <p>Survey dates: February 12 and 13, 2025</p> <p>Facility number: 000509 Provider number: 155412 AIM number: 100266620</p> <p>Census Bed Type: SNF/NF: 106 Total: 106</p> <p>Census Payor Type: Medicare: 9 Medicaid: 60 Other: 37 Total: 106</p> <p>Greenwood Health and Living Community was</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 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			