

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

PRINTED: 07/26/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155193	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/22/2021
NAME OF PROVIDER OR SUPPLIER GREENWOOD HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaints IN00358106, IN00357941, IN00357651, and IN00357616.</p> <p>Complaint IN00358106 - Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00357941 - Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00357651 - Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00357616 - Unsubstantiated due to lack of evidence.</p> <p>Survey dates: July 21 and 22, 2021</p> <p>Facility number: 000101 Provider number: 155193 AIM number: 100291290</p> <p>Census Bed Type: SNF/NF: 185 Total: 185</p> <p>Census Payor Type: Medicare: 8 Medicaid: 127 Other: 50 Total: 185</p> <p>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 IN00358106, IN00357941, IN00357651, and IN00357616.</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.

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

PRINTED: 07/26/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155193	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/22/2021
NAME OF PROVIDER OR SUPPLIER GREENWOOD HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 Quality Review completed on July 23, 2021.	F 000			