| 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 07/22/2021 |

| 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<br><br>This visit was for the Investigation of Complaints IN00358106, IN00357941, IN00357651, and IN00357616.<br><br>Complaint IN00358106 - Unsubstantiated due to lack of evidence.<br><br>Complaint IN00357941 - Unsubstantiated due to lack of evidence.<br><br>Complaint IN00357651 - Unsubstantiated due to lack of evidence.<br><br>Complaint IN00357616 - Unsubstantiated due to lack of evidence.<br><br>Survey dates: July 21 and 22, 2021<br><br>Facility number: 000101<br>Provider number: 155193<br>AIM number: 100291290<br><br>Census Bed Type:<br>SNF/NF: 185<br>Total: 185<br><br>Census Payor Type:<br>Medicare: 8<br>Medicaid: 127<br>Other: 50<br>Total: 185<br><br>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. | F 000 | | |

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 |
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|---|---|---|---|---|
| F 000 | Continued From page 1<br><br>Quality Review completed on July 23, 2021. | F 000 | | |