STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 155188 ISTREET ADDRESS, CITY, STATE, ZIP CODE OREENFIELD HEALTHCARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 200 GREEN MEADOWS DR GREENFIELD, IN 46140 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)			ID HUMAN SERVICES					FORM APPROVED OMB NO. 0938-0391	
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ABURATORY DIRECTOR S OR PROVIDER/SUPPORE REPRESENTATIVES STATUPE TO E TO E TO E									

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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