| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155378 | A. BUILDING _____ B. WING _____ | R-C 04/19/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SIGNATURE HEALTHCARE AT PARKWOOD | 1001 N GRANT ST LEBANON, IN 46052 |

| (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 a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on February 6, 2024. This visit included a PSR to the Investigation of Complaints IN00423010, IN00425810 and IN00427356 completed on February 6, 2024. This visit was in conjunction with the PSR to Complaint IN00430091 completed on March 22, 2024.<br><br>Complaint IN00423010 - Corrected.<br>Complaint IN00425810 - Corrected.<br>Complaint IN00427356 - Corrected.<br>Complaint IN00430091 - Corrected.<br><br>Survey dates: April 18 and 19, 2024.<br><br>Facility number: 000468<br>Provider number: 155378<br>AIM number: 100290270<br><br>Census Bed Type:<br>SNF/NF: 81<br>Total: 81<br><br>Census Payor Type:<br>Medicare: 4<br>Medicaid: 66<br>Other: 11<br>Total: 81<br><br>Signature Healthcare of Parkwood was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the PSR to the Recertification and State Licensure Survey and the Investigation of Complaints IN00423010, IN00425810 and IN00427356. | {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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| **SIGNATURE HEALTHCARE AT PARKWOOD** | **1001 N GRANT ST LEBANON, IN 46052** |

| (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<br>Quality review was completed on April 23, 2024. | {F 000} | | |