

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>000312</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>12/10/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>ROSEWOOD MANOR</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>5200 S BURLINGTON DR</b> <b>MUNCIE, IN 47302</b>		
(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) COMPLETE DATE
{R 000}	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for a Post Survey Revisit (PSR) to the Residential COVID-19 Quality Assurance Walk Through Survey completed on September 10, 2020.</p> <p>Survey dates: December 10, 2020</p> <p>Facility number: 000312</p> <p>Residential Census: 25</p> <p>Rosewood Manor was found to be in compliance with 410 IAC 16.2-5 in regards to the PSR to the Residential COVID-19 Quality Assurance Walk Through.</p> <p>Quality review completed on December 22, 2020.</p>	{R 000}		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE