DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES				FORM APPROVE OMB NO. 0938-039	
F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/13/2021	
	155230				
ROVIDER OR SUPPLIER	•	ST	TREET ADDRESS, CITY, STATE, ZIP CO		
VILLAGE					
(X4) ID         SUMMARY STATEMENT OF DEFICIENCIES           PREFIX         (EACH DEFICIENCY MUST BE PRECEDED BY FULL           TAG         REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE COMPLE		(X5) COMPLETIO DATE
INITIAL COMMENTS		F 000			
This visit was for a C Control Survey.	OVID- 19 Focused Infection				
Survey date: Septer	nber 13, 2021.				
Provider number: 155	5230				
Census Bed Type: SNF/NF: 76 Total: 76					
Census Payor Type: Medicare: 8 Medicaid: 60 Other: 8 Total: 76					
with 42 CFR Part 483 16.2-3.1 in regard to	3, Subpart B and 410 IAC the COVID-19 Focused				
Quality review comple	eted on September 15, 2021				
	ROVIDER OR SUPPLIER SUMMARY ST (EACH DEFICIENC REGULATORY OR INITIAL COMMENTS This visit was for a C Control Survey. Survey date: Septem Facility number: 0001 Provider number: 155 AIM number: 100266 Census Bed Type: SNF/NF: 76 Total: 76 Census Payor Type: Medicare: 8 Medicaid: 60 Other: 8 Total: 76 Rosebud Village was with 42 CFR Part 483 16.2-3.1 in regard to Infection Control Surve	F DEFICIENCIES CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         ISSUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         INITIAL COMMENTS         This visit was for a COVID- 19 Focused Infection Control Survey.         Survey date:       September 13, 2021.         Facility number:       100266820         Census Bed Type:         SNF/NF: 76 Total:       76         Census Payor Type:         Medicaid: 60 Other: 8	pF DEFICIENCIES CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE A. BUILDING	PF DEFICIENCIES CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING         155230       B. WING         SOVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP O 2050 CHESTER BLVD RICHMOND, IN 47374         SUMMARY STATEMENT OF DEFICIENCIES (EACH OBERCIENCY WIST BE PRECIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       D PREFIX TAG       PROVIDER'S PLAN OF (EACH OBRECTIVE ACT) DEFICIENC         INITIAL COMMENTS       F 000         This visit was for a COVID- 19 Focused Infection Control Survey.       F 000         Survey date: September 13, 2021.       F 000         Facility number: 100266820       Census Bed Type: SNF/NF: 76 Total: 76       F 000         Census Bed Type: SNF/NF: 76 Total: 76       Census Payor Type: Medicare: 8 Medicaid: 60 Other: 8 Total: 76       F 000         Rosebud Village was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the COVID-19 Focused Infection Control Survey.       I	PERCENCIES CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.       (X2) MULTIPLE CONSTRUCTION A BUILDING       (X3) DATA CONTINUES         NUMBER       155230       B. WING       0         NULLAGE       STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374       0         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PROVIDER'S PLAN OF CORRECTION (EACH OCRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         INITIAL COMMENTS       F 000         This visit was for a COVID- 19 Focused Infection Control Survey.       F 000         Survey date: September 13, 2021.       F 000         Facility number: 000135 Provider number: 155230 AIM number: 100266820       F 000         Census Bed Type: SNF/NF: 76 Total: 76       Census Payor Type: Medicare: 8 Medicard: 60 Other: 8 Total: 76         Rosebud Village was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the COVID-19 Focused Infection Control Survey.       Image: Control Survey.

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

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