DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							FORM APPROVED OMB NO. 0938-0391		
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		155230	B. WING _				01/20/2022		
NAME OF PROVIDER OR SUPPLIER				STREE	TADDRESS, CITY, STATE, ZIP COD	E			
ROSEBUD VILLAGE					HESTER BLVD IOND, IN 47374				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOU		N SHOULD B	D BE COMPLETION		
F 000	INITIAL COMMENTS		FC	00					
	This visit was for a COVID- 19 Focused Infection Control Survey.								
	Survey date: January 20, 2022								
	Facility number: 000135 Provider number: 155230 AIM number: 100266820								
	Census Bed Type: SNF/NF: 76 Total: 76								
	Census Payor Type: Medicare: 9 Medicaid: 61 Other: 6 Total: 76								
	with 42 CFR Part 483	found to be in compliance 8, Subpart B and 410 IAC the COVID-19 Focused /ey.							
	Quality review comple	eted on January 21, 2022							
	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATU	RF		TITLE			X6) DATE	

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

(X6) DATE

PRINTED: 01/24/2022

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.