STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155821	A. BUILDING _____ B. WING _____	C 10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN TRACE HEALTH & LIVING COMMUNITY	**3154 SOUTH STATE ROAD 135 GREENWOOD, IN 46143**

(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	F 000		

This visit was for the Investigation of Complaints IN00419431, IN00419077, and IN00419942.

Complaint IN00419431 - No deficiencies related to the allegations are cited.

Complaint IIN00419077 - No deficiencies related to the allegations are cited.

Complaint IN00419942 - No deficiencies related to the allegations are cited.

Survey date: October 19, 2023

Facility number: 013185
Provider number: 155821
AIM number: 201221460

Census Bed Type:
SNF: 45
SNF/NF: 51
Residential: 64
Total: 160

Census Payor Type:
Medicare: 14
Medicaid: 43
Other: 39
Total: 96

Aspen Trace Health and Living Community was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaints IN00419431, IN00419077, and IN00419942.

Quality review completed October 20, 2023.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155821	A. BUILDING _____ B. WING _____	C 10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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