

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/24/2023  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |   |   |                      |   |
|--|---|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                     |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>155821</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>10/19/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ASPEN TRACE HEALTH &amp; LIVING COMMUNITY</b> |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>3154 SOUTH STATE ROAD 135<br/>GREENWOOD, IN 46143</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) COMPLETION DATE |   |
| F 000  | <p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaints IN00419431, IN00419077, and IN00419942.</p> <p>Complaint IN00419431 - No deficiencies related to the allegations are cited.</p> <p>Complaint IIN00419077 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00419942 - No deficiencies related to the allegations are cited.</p> <p>Survey date: October 19, 2023</p> <p>Facility number: 013185<br/>Provider number: 155821<br/>AIM number: 201221460</p> <p>Census Bed Type:<br/>SNF: 45<br/>SNF/NF: 51<br/>Residential: 64<br/>Total: 160</p> <p>Census Payor Type:<br/>Medicare: 14<br/>Medicaid: 43<br/>Other: 39<br/>Total: 96</p> <p>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.</p> <p>Quality review completed October 20, 2023.</p> | 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.

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