STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155680	A. BUILDING **03** B. WING _____	R **11/16/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEWOOD HEALTH CAMPUS	**2494 N LEBANON ST** **LEBANON, IN 46052**

(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
{K 000}	INITIAL COMMENTS A Post Survey Revisit (PSR) to the Pre-occupancy Survey conducted on 10/23/23 for a new one-story addition to the 300 wing that includes eleven resident rooms to be numbered #313 through #323, a day room, a med-prep room, and an office was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 11/16/23 Facility Number: 002703 Provider Number: 155680 AIM Number: 200309250 At this PSR survey, Homewood Health Campus was found in compliance with Requirements for Participation in Medicare, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The building was surveyed with Chapter 19 Existing Health Care Occupancies. The original one-story facility was determined to be of Type V (111) construction was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor, all areas open to the corridor and has hard wired smoke detectors in resident sleeping rooms. The facility has a capacity of 68 and had a census of 56 at the time of this survey. All areas where residents have customary access were sprinklered all areas providing facility services were sprinklered.	{K 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155680	A. BUILDING **03** B. WING _____	R **11/16/2023**

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HOMEWOOD HEALTH CAMPUS	**2494 N LEBANON ST** **LEBANON, IN 46052**

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{K 000}	Continued From page 1 Quality Review completed on 11/17/23	{K 000}		