STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155680	A. BUILDING _____ B. WING _____	C 12/03/2024

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
F 000	INITIAL COMMENTS	F 000		

This visit was for the Investigation of Complaints IN00446787, IN00447790 and IN00447985.

Complaint IN00446787 - No deficiencies related to the allegations are cited.
Complaint IN00447790 - No deficiencies related to the allegations are cited.
Complaint IN00447985 - No deficiencies related to the allegations are cited.

Survey dates: December 2 and 3, 2024.

Facility number: 002703
Provider number: 155680
AIM number: 200309250

Census Bed Type:
SNF/NF: 42
SNF: 14
Residential: 33
Total: 89

Census Payor Type:
Medicare: 6
Medicaid: 32
Other: 18
Total: 56

Homewood Health Campus 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 IN00446787, IN00447790 and IN00447985.

Quality review was completed on December 6, 2024.

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