

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

PRINTED: 12/09/2024  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                      |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>155680</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>12/03/2024</b> |
|---|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOMEWOOD HEALTH CAMPUS</b>     |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2494 N LEBANON ST</b><br><b>LEBANON, IN 46052</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><b>INITIAL COMMENTS</b></p> <p>This visit was for the Investigation of Complaints IN00446787, IN00447790 and IN00447985.</p> <p>Complaint IN00446787 - No deficiencies related to the allegations are cited.<br/>Complaint IN00447790 - No deficiencies related to the allegations are cited.<br/>Complaint IN00447985 - No deficiencies related to the allegations are cited.</p> <p>Survey dates: December 2 and 3, 2024.</p> <p>Facility number: 002703<br/>Provider number: 155680<br/>AIM number: 200309250</p> <p>Census Bed Type:<br/>SNF/NF: 42<br/>SNF: 14<br/>Residential: 33<br/>Total: 89</p> <p>Census Payor Type:<br/>Medicare: 6<br/>Medicaid: 32<br/>Other: 18<br/>Total: 56</p> <p>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.</p> <p>Quality review was completed on December 6, 2024.</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.