

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>003283</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/14/2022</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WELLINGTON AT SOUTHPORT THE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7212 US HWY 31 S</b> <b>INDIANAPOLIS, IN 46227</b>
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(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) COMPLETE DATE
R 000	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for the Investigation of Complaint IN00389817.</p> <p>Complaint IN00389817 - Substantiated. No deficiencies related to the allegation are cited.</p> <p>Survey date: September 14, 2022</p> <p>Facility number: 003283</p> <p>Residential Census: 59</p> <p>The Wellington at Southport was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00389817.</p> <p>Quality review completed September 16, 2022.</p>	R 000		

Indiana State Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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