

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 013510	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/16/2023
NAME OF PROVIDER OR SUPPLIER WOODLAND TERRACE OF CARMEL		STREET ADDRESS, CITY, STATE, ZIP CODE 689 PRO MED LANE CARMEL, IN 46032		
(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>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00410234.</p> <p>Complaint IN00410234 - No deficiencies related to the allegations are cited.</p> <p>Survey date: June 16, 2023</p> <p>Facility number: 013510</p> <p>Residential Census: 89</p> <p>Woodland Terrace of Carmel was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00410234.</p> <p>Quality review was completed on June 22, 2023.</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE