

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>014518</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/13/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WOODLAND TERRACE OF DANVILLE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 S ARBOR LANE</b> <b>DANVILLE, IN 46122</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 IN00398524.</p> <p>Complaint IN00398524 - Unsubstantiated due to lack of evidence.</p> <p>Survey date: January 13, 2023.</p> <p>Facility number: 014518</p> <p>Residential Census: 36</p> <p>Woodland Terrace of Danville was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00398524.</p> <p>Quality review completed on January 19, 2023.</p>	R 000		

Indiana State Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE