

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>014706</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/05/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SWEET GALILEE AT THE WIGWAM</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1315 JOHN STREET ANDERSON, IN 46016</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 IN00409766.</p> <p>Complaint IN00409766 - No deficiencies related to the allegations are cited.</p> <p>Survey date: June 5, 2023.</p> <p>Facility number: 014706</p> <p>Residential Census: 71</p> <p>Sweet Galilee at the Wigwam was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00409766.</p> <p>Quality review completed June 6, 2023.</p>	R 000		

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