

Indiana Department of Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>014518</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>04/24/2024</b> |
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>WOODLAND TERRACE OF DANVILLE</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>200 S ARBOR LANE</b><br><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 |
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| R 000              | <p><b>INITIAL COMMENTS</b></p> <p>This visit was for the Investigation of Residential Complaints IN00429679 and IN00429693.</p> <p>Complaint IN00429679 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00429693 - No deficiencies related to the allegations are cited.</p> <p>Survey dates: April 24, 2024</p> <p>Facility number: 014518</p> <p>Residential Census: 48</p> <p>Woodland Terrace of Danville was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Residential Complaints IN00429679 and IN00429693.</p> <p>Quality review completed on April 26, 2024.</p> | R 000         |                                                                                                                 |                    |

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| Indiana Department of Health<br>LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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