

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>013510</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/30/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>WOODLAND TERRACE OF CARMEL</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>689 PRO MED LANE</b> <b>CARMEL, IN 46032</b>		
(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 IN00426856.</p> <p>Complaint IN00426856-No deficiencies related to the allegations are cited.</p> <p>Survey date: January 30, 2024</p> <p>Facility number: 013510</p> <p>Residential: 77</p> <p>Woodland Terrace of Carmel was found to be in compliance with 42 CFR 483, Subpart B and 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00426856.</p> <p>Quality review was completed on February 2, 2024.</p>	R 000		

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

TITLE

(X6) DATE