

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>013896</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/16/2023</b>
NAME OF PROVIDER OR SUPPLIER  <b>WOODLAND TERRACE OF NEW PALESTINE LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4400 TERRACE DRIVE</b> <b>NEW PALESTINE, IN 46163</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>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00403471.</p> <p>Complaint IN00403471 - No deficiencies related to the allegations are cited.</p> <p>Survey date: March 16, 2023</p> <p>Facility number: 013896</p> <p>Residential Census: 82</p> <p>Woodland Terrace of New Palestine was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00403471.</p> <p>Quality review completed on March 17, 2023</p>	R 000		

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

TITLE

(X6) DATE