

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 013510	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/16/2025
NAME OF PROVIDER OR SUPPLIER WOODLAND TERRACE OF CARMEL		STREET ADDRESS, CITY, STATE, ZIP CODE 689 PRO MED LANE CARMEL, IN 46032		
(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 IN00460086.</p> <p>Complaint IN00460086-No deficiencies related to the allegations are cited.</p> <p>Survey date: July 16, 2025</p> <p>Facility number: 013510</p> <p>Census Bed Type: Residential: 96 Total: 96</p> <p>Census Payor Type: Private: 96 Total: 96</p> <p>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review was completed on July 18, 2025.</p>	R 000		

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

TITLE

(X6) DATE