

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015004	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/21/2023
--	---	---	---

NAME OF PROVIDER OR SUPPLIER GLASSWATER CREEK OF WHITESTOWN	STREET ADDRESS, CITY, STATE, ZIP CODE 5829 NEW HOPE BOULEVARD WHITESTOWN, IN 46075
---	--

(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 IN00406162.</p> <p>Complaint IN00406162 - No deficiencies related to the allegations are cited.</p> <p>Survey date: June 21, 2023.</p> <p>Facility number: 015004</p> <p>Residential Census: 41</p> <p>Glasswater Creek of Whitestown was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00406162.</p> <p>Quality review completed on June 21, 2023.</p>	R 000		

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