

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>013389</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/11/2022</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WYNDMOOR ASSISTED LIVING LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1465 EAST CROSSING BLVD</b> <b>TERRE HAUTE, IN 47802</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
R 000	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for the Investigation of Complaint IN00384939.</p> <p>Complaint IN00384939 - Substantiated. No State Residential deficiencies related to the allegations are cited.</p> <p>Survey date: August 11, 2022</p> <p>Facility number: 013389</p> <p>Residential Census: 135</p> <p>Wyndmoor Assisted Living LLC was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00384939.</p> <p>Quality review completed on August 15, 2022.</p>	R 000		

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