

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>014377</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/24/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>HERITAGE WOODS OF NEWBURGH</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4211 GRIMM ROAD</b> <b>NEWBURGH, IN 47630</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 IN00412866.</p> <p>Complaint IN00412866 - No deficiencies related to the allegations are cited.</p> <p>Survey date: July 24, 2023</p> <p>Facility number: 014377</p> <p>Residential Census: 112</p> <p>Heritage Woods of Newburgh was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00412866.</p> <p>Quality review completed on July 27, 2023.</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_