

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 004130	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/12/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RIVEROAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1244 VAIL ST PRINCETON, IN 47670
--	--

(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 a Post Survey Revisit (PSR) to the Investigation of Complaint IN00426756 completed on January 23, 2024.</p> <p>This visit was in conjunction with the Investigation of Nursing Home Complaint IN00427116 and Residential Complaint IN00427116.</p> <p>Complaint IN00426756 - Corrected.</p> <p>Complaint IN00427116 - No deficiencies related to the allegations are cited.</p> <p>Survey date: February 12, 2024</p> <p>Facility number: 004130</p> <p>Residential Census: 32</p> <p>Riveroaks Health Campus was found to be in compliance with 410 IAC 16.2-5 in regard to PSR to the Investigation of Complaint IN00426756.</p> <p>Quality review completed February 13, 2024.</p>	{R 000}		
---------	--	---------	--	--

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

TITLE

(X6) DATE