

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>002392</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  R-C <b>01/06/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>TERRACE AT TOWNE CENTRE, THE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>7252 ARTHUR BOULEVARD MERRILLVILLE, IN 46410</b>		
(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 a Post Survey Revisit (PSR) to the investigation of complaint IN00082333.</p> <p>Complaint IN00082333 corrected</p> <p>Survey Date: January 6, 2011</p> <p>Facility Number: 002392 Provider Number: 002392 Aim Number: N/A</p> <p>Survey Team: Sheila Sizemore, RN</p> <p>Census Bed Type: Residential: 47 Total: 47</p> <p>Census Payor Type: Other: 47 Total: 47</p> <p>Sample: 03</p> <p>The Terrace at Towne Centre, was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to the investigation of complaint IN00082333.</p> <p>Quality review completed 1-7-11 Cathy Emswiller RN</p>	{R 000}		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE