

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>004168</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>06/24/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>THE RESIDENCE AT WATERFORD CROSSING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1212 WATERFORD CIR GOSHEN, IN 46526</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 a Post Survey Revisit to the State Residential Licensure Survey completed on April 30, 2015.</p> <p>Survey dates: June 23 and 24, 2015</p> <p>Facility number: 004168 Provider number: 004186 AIM number: N/A</p> <p>Residential Census: 46</p> <p>Sample: 5</p> <p>The Residence At Waterford Crossing was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to the State Residential Licensure Survey.</p>	{R 000}		

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