| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING<br>B. WING | 09/07/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PINE KNOLL ASSISTED LIVING CENTER | 607 WILSON CREEK RD, LAWRENCEBURG, , 47025 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES... | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION... | (X5) COMPLETION DATE |
|---|---|---|---|---|
| R 0000 | INITIAL COMMENTS<br><br>This visit was for a State Residential Licensure Survey.<br><br>Survey dates: September 6 and 7, 2022<br><br>Facility number: 001142<br><br>Residential Census: 23<br><br>Pine Knoll Assisted Living Center was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.<br><br>Quality review completed on September 8, 2022. | R 0000 | | |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| | | |