

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>014094</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/14/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>WICKSHIRE WEST LAFAYETTE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3575 SENIOR PLACE</b> <b>WEST LAFAYETTE, IN 47906</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 the Investigation of Complaint IN00389818.</p> <p>Complaint IN00389818 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: September 13 and 14, 2022</p> <p>Facility number: 014094</p> <p>Residential Census: 61</p> <p>Wickshire West Lafayette was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00389818.</p> <p>Quality review was completed on September 19, 2022.</p>	R 000		

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

TITLE

(X6) DATE