

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>012161</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/07/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>AZALEA HILLS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3700 LAFAYETTE PKWY</b> <b>FLOYDS KNOBS, IN 47119</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 IN00426740.</p> <p>Complaint IN00426740 - Substantiated - No deficiencies related to the allegations are cited.</p> <p>Survey date: February 7, 2024</p> <p>Facility Number: 012161</p> <p>Residential Census: 45</p> <p>Azalea Hills was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00426740.</p> <p>Quality review completed on February 12, 2024.</p>	R 000		

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

TITLE

(X6) DATE