

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 004001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/17/2023
NAME OF PROVIDER OR SUPPLIER WINDSOR RIDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2700 WATERS EDGE PKWY JEFFERSONVILLE, IN 47130		
(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>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00408178.</p> <p>Complaint IN00408178 - No deficiencies related to the allegations are cited.</p> <p>Survey dates: May 16 and 17, 2023</p> <p>Facility number: 004001</p> <p>Residential Census: 35</p> <p>Windsor Ridge was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00408178.</p> <p>Quality review completed on May 18, 2023.</p>	R 000			

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

TITLE

(X6) DATE