

Indiana Department of Health

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| 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 07/08/2024 |
| 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 a State Residential Licensure Survey.</p> <p>Survey date: July 8, 2024</p> <p>Facility number: 004001</p> <p>Residential Census: 32</p> <p>Windsor Ridge was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.</p> <p>Quality review completed on July 11, 2024.</p> | R 000 | | |

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

TITLE

(X6) DATE