

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>010682</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/30/2023</b>
NAME OF PROVIDER OR SUPPLIER  <b>WYNDMOOR OF MARION, LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2452 W KEM RD</b> <b>MARION, IN 46952</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>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00409084.</p> <p>Complaint IN00409084 - No deficiencies related to the allegations are cited.</p> <p>Survey date: May 30, 2023</p> <p>Facility number: 010682</p> <p>Residential Census: 77</p> <p>Wyndmoor of Marion, LLC was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00409084.</p> <p>Quality review completed June 1, 2023.</p>	R 000			

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

TITLE

(X6) DATE