

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/02/2022
NAME OF PROVIDER OR SUPPLIER WOODRIDGE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 17650 GENERATIONS DR SOUTH BEND, IN 46635		
(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 IN0000393551.</p> <p>This visit was in conjunction with a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 11/2/22.</p> <p>Complaint IN00393551 - Substantiated. No State Residential Findings related to the allegations were cited.</p> <p>Survey date: October 27, 28 and 31, 2022 and November 1 and 2, 2022</p> <p>Facility number: 001148</p> <p>Residential Census: 53</p> <p>Woodridge Village was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00393551.</p> <p>Quality review completed 11/10/22.</p>	R 000		

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

TITLE

(X6) DATE