

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>010065</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/09/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>EASTLAKE TERRACE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3109 E BRISTOL ELKHART, IN 46514</b>
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(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 IN00184292.</p> <p>Complaint IN00184292- Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey date: November 9, 2015.</p> <p>Facility number: 010065 Provider number: 010065 AIM number: N/A</p> <p>Residential census: 76</p> <p>Sample: 3</p> <p>Eastlake Terrace was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00184292.</p> <p>QR completed by 14454 on November 16, 2015.</p>	R 000		

Indiana State Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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