

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 001143	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/17/2013
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NAME OF PROVIDER OR SUPPLIER PORTAGE MANOR HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3016 PORTAGE AVE SOUTH BEND, IN 46628
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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>INITIAL COMMENTS</p> <p>This survey was for a State Residential Licensure Survey.</p> <p>Survey dates: October 15, 16, 17, 2013</p> <p>Facility number: 001143 Provider number: 001143 AIM number: N/A</p> <p>Survey team: Sharon Ewing, RN-TC Shauna Carlson, RN Julie Baumgartner, RN Shelly Miller-Vice, RN Pam Williams, RN</p> <p>Census bed type: Residential 127 Total 127</p> <p>Census payor type: Private 4 Other 123 Total 127</p> <p>Residential sample: 7</p> <p>Portage Manor Health Care Facility was found to be in compliance with 410 IAC 16.2 in regard to the State Residential Licensure Survey.</p> <p>Quality Review 10/18/13 by Lisa McColly</p>	R 000		

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