

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>001143</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/19/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>PORTAGE MANOR HEALTH CARE FACILITY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3016 PORTAGE AVENUE SOUTH BEND, IN 46628</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><b>INITIAL COMMENTS</b></p> <p>This visit was for the Investigation of Complaint IN00088318.</p> <p>Complaint IN00088318 - Substantiated. No deficiencies related to the allegation are cited.</p> <p>Survey date: April 19, 2011</p> <p>Facility Number: 001143 Provider Number: 001143 AIM Number: N/A</p> <p>Survey Team: Sandra Haws RN TC Bobbie Costigan RN</p> <p>Census Bed Type: Residential: 125 Total: 125</p> <p>Census Payor Type: Other: 125 Total: 125</p> <p>Sample: 3</p> <p>Portage Manor Health Care Facility was found to be in compliance with 410 IAC 16.2 in regard to the Investigation of Complaint IN00088318.</p> <p>Quality review 4/20/11 by Suzanne Williams, RN</p>	R 000		

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TITLE

(X6) DATE

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