STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	11/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKHART PLACE ASSISTED LIVING	2024 COUNTY ROAD 24, ELKHART, , 46517

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00394291. This visit was in conjunction with a Post Survey Revisit (PSR) to the Investigation of Complaint IN00383576 completed on September 7, 2022. This visit was in conjunction with a Post Survey Revisit (PSR) to the Investigation of Complaint IN00390431 completed on September 27, 2022. Complaint IN00394291 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00383576 - Corrected. Complaint IN00390431 - Corrected. Survey date: November 10, 2022	R 0000		

	Facility number: 004353 Residential Census: 39 Elkhart Place was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00394291. Quality review completed 11/16/22.			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE