STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST PAUL'S	3602 SOUTH IRONWOOD DRIVE, SOUTH BEND, , 46614

(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 Post Survey Revisit (PSR) to the Investigation of Complaint IN00463291 completed on 7/18/2025. Complaint IN00463291- Corrected Survey date: August 25, 2025 Facility number: 014602 Residential Census: 95 St. Paul's was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to the Investigation of Complaint IN00463291. Quality Review completed on 8/26/2025. This visit was for the Post Survey Revisit (PSR) to the Investigation of Complaint IN00463291 completed on 7/18/2025. Complaint IN00463291-	R 0000		

	Corrected Survey date: August 25, 2025 Facility number: 014602 Residential Census: 95 St. Paul's was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to the Investigation of Complaint IN00463291. Quality Review completed on 8/26/2025.			

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