STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY AT ELKHART	1129 PARKWAY AVENUE, ELKHART, , 46516

(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 a Post Survey Revisit (PSR) to the Investigation of Complaints IN00405377, IN00405001, IN00404253, IN00403940 and IN00403437 conducted on 4/06/2023. This visit was in conjunction with the Post Survey Revisit (PSR) to the State Residential Licensure Survey completed on 2/15/23. Complaint IN00405377 - Corrected. Complaint IN00405001 - Corrected. Complaint IN00404253 - Corrected. Complaint IN00403940 - Corrected. Complaint IN00403437 - Corrected. Survey dates: 5/18/2023	R 0000		

	Facility number: 014916 Residential Census: 37 Harmony at Elkhart was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to the Complaint Investigation. Quality review completed 5/31/23.			

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