STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154020	A. BUILDING **01** B. WING _____	R **03/04/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIONAL MENTAL HEALTH CENTER	**8555 TAFT ST** **MERRILLVILLE, IN 46410**

(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) COMPLETION DATE
{E 000}	Initial Comments A Post Survey Revisit (PSR) to the Emergency Preparedness Survey that exited on 01/28/2025 was conducted by the Indiana Department of Health in accordance with 42 CFR 482.15. Survey Date: 03/04/2025 Facility Number: 005184 Provider Number: 154020 AIM Number: 100273510A At this PSR survey, Regional Mental Health Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 482.15. The facility has 16 certified beds. At the time of the survey, the census was 4. Quality Review completed 03/05/25	{E 000}		
{K 000}	INITIAL COMMENTS A Post Survey Revisit (PSR) to the Life Safety Code Recertification Survey that exited on 01/28/2025 was conducted by the Indiana Department of Health in accordance with 42 CFR 482.41(b). Survey Date: 03/04/2025 Facility Number: 005184 Provider Number: 154020 AIM Number: 100273510A At this PSR, Regional Mental Health Center was found in compliance with Requirements for	{K 000}		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154020	A. BUILDING **01** B. WING _____	R **03/04/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIONAL MENTAL HEALTH CENTER	**8555 TAFT ST** **MERRILLVILLE, IN 46410**

(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) COMPLETION DATE
{K 000}	Continued From page 1 Participation in Medicare/Medicaid, 42 CFR Subpart 482.41(b), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies. This two-story facility was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and patient sleeping rooms. The In-Patient Unit is located on the second floor and has a capacity of 16. The census was 4 at the time of this survey. Quality Review completed 03/05/25	{K 000}		