

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/10/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/24/2017
NAME OF PROVIDER OR SUPPLIER PARENTS AND FRIENDS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1709 FARRAND AVE LA PORTE, IN 46350		
(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	
{W 000}	<p>INITIAL COMMENTS</p> <p>This visit was for a post-certification revisit to a fundamental recertification and state licensure survey conducted on January 13, 2017.</p> <p>Dates of Survey: February 23 and 24, 2017.</p> <p>Facility number: 000849 Provider number: 15G331 AIM number: 100243820</p> <p>Parents and Friends, Inc. was found to be in compliance with 42 CFR, part 483, subpart I, and 460 IAC 9 in regard to the post-certification revisit to the recertification and state licensure survey. Quality Review of this report completed by #15068 on 3/9/17.</p>	{W 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.