

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>014602</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/02/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>ST PAUL'S</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3602 SOUTH IRONWOOD DRIVE</b> <b>SOUTH BEND, IN 46614</b>		
(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) COMPLETE DATE
R 000	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for the Investigation of Complaint IN00455562.</p> <p>Complaint IN00455562 - No deficiencies related to the allegations are cited.</p> <p>Survey date: April 2, 2025</p> <p>Facility number: 014602</p> <p>Residential Census: 86</p> <p>St. Paul's was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00455562.</p> <p>Quality Review completed on 4/3/2025</p>	R 000		

Indiana Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE