

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>001143</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/14/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>PORTAGE MANOR HEALTH CARE FACILITY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE  <b>3016 PORTAGE AVE SOUTH BEND, IN 46628</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>INITIAL COMMENTS</p> <p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: August 13 &amp; 14, 2018</p> <p>Facility number: 001143</p> <p>Residential Census: 132</p> <p>Portage Manor Health Care Facility was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.</p> <p>Quality Review was completed on August 22, 2018.</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE