

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 004686	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 06/16/2021
--	---	---	--

NAME OF PROVIDER OR SUPPLIER HAMILTON PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 2116 BUTLER RD FORT WAYNE, IN 46815
---	---

(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 Post Survey Revisit (PSR) to Investigation of Complaint IN00353691 completed on May 27, 2021.</p> <p>Complaint IN00353691 - Corrected</p> <p>Survey dates: June 16, 2021</p> <p>Facility number: 004686</p> <p>Residential Census: 20</p> <p>Hamilton Place was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to Investigation of Complaint IN00353691.</p> <p>Quality reiew completed June 16, 2021</p>	{R 000}		

Indiana State Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------