Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	001136	A. BUILDING: ________ B. WING ________	C **05/04/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE PARK RESIDENTIAL CARE	**2075 RIPLEY ST** **LAKE STATION, IN 46405**

(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	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00407403 and IN00407461. Complaint IN00407403 - No deficiencies related to the allegations are cited. Complaint IN00407461 - No deficiencies related to the allegations are cited. Survey dates: May 3 & 4, 2023 Facility number: 001136 Residential Census: 91 Lake Park Residential Care was found to be in compliance with 410 IC 16.2-5 in regard to the Investigation of Complaints IN00407403 and IN00407461. Quality review completed on 5/5/23.	R 000		

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