

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 014168	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/28/2024
NAME OF PROVIDER OR SUPPLIER GRAND VALLEY GARDENS ASSISTED LIVING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 1151 S HUBERT CIRCLE WEST MARTINSVILLE, IN 46151		
(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 the Investigation of Complaint IN00434698.</p> <p>Complaint IN00434698 - No deficiencies related to the allegations are cited.</p> <p>Survey date: June 28, 2024</p> <p>Facility number: 014168</p> <p>Residential Census: 44</p> <p>Grand Valley Gardens Assisted Living Facility was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00434698.</p> <p>Quality review completed July 2, 2024.</p>	R 000		

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

TITLE

(X6) DATE