

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>010890</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/08/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRENTWOOD AT LAPORTE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2002 ANDREW AVE</b> <b>LA PORTE, IN 46350</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 IN00443769.</p> <p>This visit was in conjunction with a Post Survey Revisit (PSR) to the Investigation of Complaint IN00440038 completed on August 13, 2024.</p> <p>Complaint IN00443769 - No deficiencies related to the allegations are cited.</p> <p>Survey date: October 8, 2024</p> <p>Facility number: 010890</p> <p>Residential Census: 93</p> <p>Brentwood at Laporte was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00443769.</p> <p>Quality review completed on 10/10/24.</p>	R 000		

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

TITLE

(X6) DATE