

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>004016</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>01/11/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>MONROE PLACE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2770 S ADAMS RD BLOOMINGTON, IN 47403</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 a Residential COVID-19 Quality Assurance Walk Through.</p> <p>Survey date: January 11, 2021</p> <p>Facility number: 004016</p> <p>Residential Census: 35</p> <p>Monroe Place was found to be in compliance with 410 IAC 16.2-5 in regard to the Residential COVID-19 Quality Assurance Walk Through.</p> <p>Quality Review completed on January 12, 2021.</p>	R 000		

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

TITLE

(X6) DATE