STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155166	A. BUILDING _____ B. WING _____	C 02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALPARAISO CARE & REHABILITATION	**606 WALL STREET VALPARAISO, IN 46383**

(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) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00423998, IN00425190, IN00427407, and IN00427530. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00423998 - No deficiencies related to the allegations are cited. Complaint IN00425190 - No deficiencies related to the allegations are cited. Complaint IN00427407 - No deficiencies related to the allegations are cited. Complaint IN00427530 - No deficiencies related to the allegations are cited. Survey dates: February 5 and 6, 2024 Facility number: 000083 Provider number: 155166 AIM number: 100289670 Census Bed Type: SNF/NF: 124 Total: 124 Census Payor Type: Medicare: 7 Medicaid: 102 Other: 15 Total: 124 Valparaiso Care and Rehabilitation Center was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaints IN00423998,	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155166	A. BUILDING _____ B. WING _____	C 02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALPARAISO CARE & REHABILITATION	**606 WALL STREET VALPARAISO, IN 46383**

(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) COMPLETION DATE
F 000	Continued From page 1 IN00425190, IN00427407, and IN00427530 and the COVID-19 Focused Infection Control Survey. Quality review completed on 2/8/24.	F 000		