

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>010937</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>08/23/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>ASSISTED LIVING AT HARTSFIELD VILLAGE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>10002 COLUMBIA AVE MUNSTER, IN 46321</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 State Residential Licensure Survey.</p> <p>Survey dates: August 22 and 23, 2019.</p> <p>Facility number: 010937</p> <p>Residential Census: 86</p> <p>Assisted Living at Hartsfield Village was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.</p> <p>Quality review completed on 8/26/19.</p>	R 000		

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

TITLE

(X6) DATE