

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 003673	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/01/2024
NAME OF PROVIDER OR SUPPLIER UNIVERSITY PLACE HEALTH CENTER AND ASSISTE		STREET ADDRESS, CITY, STATE, ZIP CODE 1750 LINDBERG RD WEST LAFAYETTE, IN 47906		
(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 Complaints IN00439882, IN00442669 and IN00442936.</p> <p>Complaint IN00439882-No deficiencies related to the allegations are cited.</p> <p>Complaint IN00442669-No deficiencies related to the allegations are cited.</p> <p>Complaint IN00442936-No deficiencies related to the allegations are cited.</p> <p>Survey dates: September 27, 30 and October 1, 2024</p> <p>Facility number: 003673</p> <p>Residential Census: 79</p> <p>University Place Health Center and Assisted Living was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaints IN00439882, IN00442669 and IN00442936.</p> <p>Quality review was completed on October 4, 2024.</p>	R 000		

Indiana Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE