

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 004686	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/29/2021
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NAME OF PROVIDER OR SUPPLIER HAMILTON PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 2116 BUTLER RD FORT WAYNE, IN 46815
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(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 Complaint IN00349839.</p> <p>Complaint IN00349839- Substantiated. No State Residential Findings related to the allegations were cited.</p> <p>Survey date: March 29, 2021</p> <p>Facility number: 004686</p> <p>Residential Census: 19</p> <p>Hamilton Place was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00349839.</p> <p>Quality review completed March 29, 2021</p>	R 000		

Indiana State Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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