

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>013555</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/13/2023</b>
NAME OF PROVIDER OR SUPPLIER  <b>GRAND EMERALD PLACE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4010 S IRONWOOD DR</b> <b>SOUTH BEND, IN 46614</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 the Investigation of Complaint IN00420498 and IN00418375.</p> <p>Complaint IN00420498 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00418375 - No deficiencies related to the allegations are cited.</p> <p>Survey date: 11/13/2023</p> <p>Facility number: 0013555</p> <p>Residential Census: 58</p> <p>Grand Emerald Place was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00420498 and IN00418375.</p> <p>Quality review completed 11/16/23.</p>	R 000		

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

TITLE

(X6) DATE