

Indiana State Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 001143 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 07/19/2023 |
|---|---|---|---|--|
| NAME OF PROVIDER OR SUPPLIER PORTAGE MANOR HEALTH CARE FACILITY | | STREET ADDRESS, CITY, STATE, ZIP CODE 3016 PORTAGE AVE SOUTH BEND, IN 46628 | | |
| (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) |
| R 000 | INITIAL COMMENTS This visit was for the Investigation of Complaint IN00412732. Complaint IN00412732 - No deficiencies related to the allegations are cited. Survey date: July 19, 2023 Facility number: 001143 Residential Census: 21 Portage Manor Health Care Facility was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00412732. Quality review completed 7/24/2023. | | R 000 | |

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

TITLE

(X6) DATE