

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>010887</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C 11/21/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>VIRGINIA PLACE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE  <b>8253 VIRGINIA ST MERRILLVILLE, IN 46410</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>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00383084.</p> <p>Complaint IN00383084 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey date: November 21, 2022</p> <p>Facility number: 010887</p> <p>Residential Census: 26</p> <p>Virginia Place was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00383084.</p> <p>Quality review completed on 11/28/22.</p>	R 000		

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

TITLE

(X6) DATE