

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 010235	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/03/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER CHAPMAN PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 3110 E COLISEUM BLVD FORT WAYNE, IN 46805
--	---

(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 a State Residential Licensure Survey.</p> <p>Survey dates: July 2 and 3, 2019.</p> <p>Facility number: 010235</p> <p>Residential Census: 45</p> <p>Chapman Place was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.</p> <p>Quality review completed July 3, 2019.</p>	R 000		

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