Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	016149	A. BUILDING: ______ B. WING ______	R-C 07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAPTERS LIVING OF SOUTH BEND	**955 HICKORY ROAD** **SOUTH BEND, IN 46615**

(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}	INITIAL COMMENTS This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaints IN00457398 and IN00458551completed on 5/1/2025. This visit was in conjunction with a Recertification and State Licensure Survey and Investigation of Complaint IN00459606 completed on 7/2/2025. Complaint IN00457398 - Corrected. Complaint IN00458551 - Corrected. Survey dates: July 1 and 2, 2025. Facility number: 016149 Residential Census: 15 Chapters Living of South Bend was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to the Investigations of Complaint IN00457398 and IN00458551. Quality Review completed on 7/8/2025	{R 000}		

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