

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>000501</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/05/2022</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GRACE VILLAGE HEALTH CARE FACILITY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>337 GRACE VILLAGE DR WINONA LAKE, IN 46590</b>
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(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 IN00390992.</p> <p>Complaint IN00390992 - Substantiated. No State Residential Findings related to the allegations were cited.</p> <p>Survey dates: October 4 &amp; 5, 2022</p> <p>Facility number: 000501</p> <p>Residential Census: 51</p> <p>Grace Village Health Care Facility was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00390992.</p> <p>Quality review completed on 10/6/22.</p>	R 000		

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