

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 004392	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/29/2024
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NAME OF PROVIDER OR SUPPLIER DIGBY PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 167 CR W 240 S LAFAYETTE, IN 47905
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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>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaints IN00435729 and IN00443898</p> <p>Complaint IN00435729-No deficiencies related to the allegations are cited.</p> <p>Complaint IN00443898-No deficiencies related to the allegations are cited.</p> <p>Survey dates: October 28 and 29, 2024.</p> <p>Facility number: 004392</p> <p>Residential Census: 39</p> <p>Digby Place was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey and the Investigation of Complaints IN00435729 and IN00443898.</p> <p>Quality review was completed on November 1, 2024.</p>	R 000		

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