

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 013733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/21/2025
NAME OF PROVIDER OR SUPPLIER AVIVA MERRILLVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 7900 RHODE ISLAND STREET MERRILLVILLE, IN 46410		
(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 IN00458929.</p> <p>Complaint IN00458929 - No deficiencies related to the allegations are cited.</p> <p>Survey date: May 21, 2025</p> <p>Facility number: 013733</p> <p>Residential Census: 57</p> <p>Aviva Merrillville was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00458929.</p> <p>Quality review completed on 5/22/25.</p>	R 000		

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

TITLE

(X6) DATE