

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 016149	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 10/08/2024
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NAME OF PROVIDER OR SUPPLIER CHAPTERS LIVING OF SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 955 HICKORY ROAD SOUTH BEND, IN 46615
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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 a Post Survey Revisit (PSR) to the State Residential Licensure Survey completed on 8/13/2024.</p> <p>Survey dates: 10/8/2024</p> <p>Facility number: 016149</p> <p>Residential Census: 7</p> <p>Chapters Living of South Bend was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to the State Residential Licensure Survey.</p> <p>Quality Review completed on 10/10/2024</p>	{R 000}		

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