

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 R-C 07/02/2024
--	---	---	--

NAME OF PROVIDER OR SUPPLIER DIGBY PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 167 CR W 240 S LAFAYETTE, IN 47905
--	--

(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 Investigation of Complaint IN00435149 completed on May 30, 2024.</p> <p>Complaint IN00435149 - Corrected.</p> <p>Survey date: July 2, 2024</p> <p>Facility number: 004392</p> <p>Residential Census: 36</p> <p>Digby Place was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to the Investigation of Complaint IN00435149.</p> <p>Quality review was completed on July 8, 2024.</p>	{R 000}		

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