

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 012181	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/09/2024
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NAME OF PROVIDER OR SUPPLIER AVIVA VALPARAISO	STREET ADDRESS, CITY, STATE, ZIP CODE 1300 VALE PARK RD VALPARAISO, IN 46383
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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 Complaint IN00443733.</p> <p>Complaint IN00443733 - No deficiencies related to the allegations are cited.</p> <p>Survey date: October 9, 2024</p> <p>Facility number: 012181</p> <p>Residential Census: 81</p> <p>Aviva Valparaiso was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00443733.</p> <p>Quality review completed on 10/10/24.</p>	R 000		

Indiana Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE