

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  013401	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 12/21/2023
NAME OF PROVIDER OR SUPPLIER  <b>BRECKENRIDGE COMMONS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE  <b>2009 NORTH HOSPITAL BLVD</b> <b>SULLIVAN, IN 47882</b>		
(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 IN00421590.</p> <p>Complaint IN00421590- No deficiencies related to the allegations are cited.</p> <p>Survey date: December 21, 2023</p> <p>Facility number: 013401</p> <p>Residential Census: 22</p> <p>Breckenridge Commons was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00421590.</p> <p>Quality review completed on December 28, 2023.</p>	R 000		

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

TITLE

(X6) DATE