

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 000105	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 04/12/2022
--	---	---	--

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260
--	--

(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 IN00373411 completed on February 24, 2022.</p> <p>Complaint IN00373411 - Corrected.</p> <p>Survey date: April 12, 2022</p> <p>Facility number: 000105</p> <p>Residential Census: 58</p> <p>Marquette was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to Investigation of Complaint IN00373411.</p> <p>Quality review was completed on April 14, 2022.</p>	{R 000}		

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