

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 004352	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/10/2013
NAME OF PROVIDER OR SUPPLIER JEWEL HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 607 VIRGINIA AVE MADISON, IN 47250		
(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 State Residential Licensure Survey.</p> <p>Survey Dates: July 8, 9, and 10, 2013</p> <p>Facility number: 004352 Provider number: 004352 AIM number: NA</p> <p>Survey team: Diana Sidell RN</p> <p>Census bed type: Residential: 34 Total: 34</p> <p>Census payor type: Other: 34 Total: 34</p> <p>Sample: 7</p> <p>Jewel House was found to be in compliance with 410 IAC 16.2 in regard to the State Licensure Survey.</p> <p>Quality Review 07/11/13 by Lisa McColly</p>	R 000			

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TITLE

(X6) DATE

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