

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>012263</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/17/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>HEARTH AT TUDOR GARDENS LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>11755 N MICHIGAN RD</b> <b>ZIONSVILLE, IN 46077</b>
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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><b>INITIAL COMMENTS</b></p> <p>This visit was for the Investigation of Complaint #IN00148985.</p> <p>Complaint #IN00148985 - Unsubstantiated due to lack of evidence.</p> <p>Survey dates: July 17, 2014</p> <p>Facility number: 012263 Provider number: 012263 AIM number: n/a</p> <p>Survey team: Michelle Carter, RN</p> <p>Census bed type: Residential- 108 Total- 108</p> <p>Census payor type: Other- 108 Total- 108</p> <p>Sample- 5</p> <p>The Hearth at Tudor Gardens was found to be in compliance with 410 IAC 16.2 in regard to the Investigation of Complaint #IN00148985.</p> <p>Quality Review 07/18/14 by Lisa McColly</p>	R 000		

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