

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155754	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/12/2013
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NAME OF PROVIDER OR SUPPLIER HUBBARD HILL ESTATES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 28070 CR 24 ELKHART, IN 46517
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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) COMPLETION DATE
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F000000	<p>This visit was for the investigation of Complaint #IN00125480.</p> <p>Complaint #IN00125480 - Unsubstantiated. No deficiencies cited.</p> <p>Survey Date: April 11, 12, 2013</p> <p>Facility Number: 001131 Provider Number: 155754 AIM Number: 200823940</p> <p>Survey team: Julie Wagoner, RN, TC</p> <p>Census bed type: SNF: 57 SNF/NF: 06 Residential: 98 Total: 161</p> <p>Census payor type: Medicare: 21 Medicaid: 06 Other: 134 Total: 161</p> <p>Sample: 06</p> <p>The facility is in compliance with 410 IAC 16.2.</p>	F000000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Quality review completed on April 19, 2013, by Brenda Meredith, R.N.				