

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>012229</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/25/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>HEARTH AT JUDAY CREEK LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>6330 N FIR RD GRANGER, IN 46530</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><b>INITIAL COMMENTS</b></p> <p>This survey was for the Investigation of Complaint IN00125051.</p> <p>Complaint IN00125051 - Unsubstantiated due to lack of evidence.</p> <p>Survey dates: June 24-25, 2013</p> <p>Facility number: 012229 Provider number: 012229 AIM number: N/A</p> <p>Survey team: Honey Kuhn, RN</p> <p>Census bed type: Residential: 107 Total: 107</p> <p>Census payor type: Private: 107 Total: 107</p> <p>Sample: 3</p> <p>Hearth at Juday Creek was found to be in compliance with 410 IAC 16.2 in regard to the Investigation of Complaint IN00125051.</p> <p>Quality Review 06/25/13 by Lisa McColly</p>	R 000			

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TITLE

(X6) DATE

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