

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>002999</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  R-C <b>04/02/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>HEARTH AT WINDERMERE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>9745 OLYMPIA DR FISHERS, IN 46038</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 visit was for a Post Survey Revisit (P.S.R.) to the Investigation of Complaint IN00100885 completed 12/29/11.</p> <p>Complaint number IN00100885 corrected.</p> <p>Survey Date: April 2, 2012</p> <p>Facility number: 002999 Provider number: 002999 AIM number: NA</p> <p>Survey team: Chuck Stevenson RN</p> <p>Census bed type: Residential: 107 Total:107</p> <p>Census payor type: Other: 107 Total: 107</p> <p>Sample: 3</p> <p>Hearth at Windemere was found to be in compliance with 410 IAC 16.2 in regard to the P.S.R to the Investigation of Complaint IN00100885.</p> <p>Quality review completed 4/2/12 Cathy Emswiller RN</p>	{R 000}		

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TITLE

(X6) DATE

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