

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 004376	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/13/2014
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NAME OF PROVIDER OR SUPPLIER SEYMOUR PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 2288 NICHOLAS CT SEYMOUR, IN 47274
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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>INITIAL COMMENTS</p> <p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: August 12 and 13, 2014</p> <p>Facility number: 004376 Provider number: 004376 AIM number: NA</p> <p>Survey team: Julie Dover, RN TC Rita Bittner, RN Tammy Forthofer, RN (8/13, 2014)</p> <p>Census bed type: Residential: 20 Total: 20</p> <p>Census payor type: Other: 20 Total: 20</p> <p>Sample: 7</p> <p>Seymour Place was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.</p> <p>Quality Review 08/15/14 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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