

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>004376</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/13/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>SHIELDS HOUSE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2288 NICHOLAS CT SEYMOUR, IN 47274</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 the investigation of the Complaint Number IN00084569.</p> <p>Complaint number IN00084569- Substantiated- No state residential findings related to the allegation are cited.</p> <p>Survey date: January 13, 2011</p> <p>Facility Number: 004376 Provider Number: 004376 AIM Number: NA</p> <p>Survey team: Melinda Lewis RN TC Marla Potts RN</p> <p>Census Bed Type: Residential: 24 Total: 24</p> <p>Census Payor Type: Other: 24 Total: 24</p> <p>Sample: 3</p> <p>Shields House was found to be in compliance with 410 IAC 16.2-5 in regard to the investigation of Complaint number IN00084569.</p> <p>Quality review completed 1-14-11 Cathy Emswiller RN</p>	R 000		

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TITLE

(X6) DATE

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