

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 011804	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 11/04/2013
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NAME OF PROVIDER OR SUPPLIER HEARTH AT SYCAMORE VILLAGE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 611 W COUNTY LINE RD S FORT WAYNE, IN 46814
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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 the Post Survey Revisit (PSR) to the Investigation of Complaints IN00136220, and IN00136406.</p> <p>Complaint IN00136220- Corrected.</p> <p>Complaint IN00136406- Corrected.</p> <p>Survey date: November 4, 2013</p> <p>Facility number: 011804 Provider number: 011804 AIM number: NA</p> <p>Survey team: Christine Fodrea, RN, TC</p> <p>Census bed type: Residential: 101 Total: 101</p> <p>Census payor type: Other: 101 Total: 101</p> <p>Sample: 4</p> <p>The Hearth at Sycamore Village was found to be in compliance with 410 IAC 16.2 in regard to the PSR to the Investigation of Complaints IN00136220 and IN00136406.</p> <p>Quality review completed on November 5, 2013 by Randy Fry RN.</p>	{R 000}		

Indiana State Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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