

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>005722</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/24/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>HEARTH AT STONES CROSSING LLC THE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2339 S SR 135 GREENWOOD, IN 46143</b>
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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><b>INITIAL COMMENTS</b></p> <p>This visit was for the Investigation of Complaint IN00152179.</p> <p>Complaint IN00152179 - Unsubstantiated due to lack of evidence.</p> <p>Survey date: July 24, 2014</p> <p>Facility number: 005722 Provider number: 005722 AIM number: N/A</p> <p>Survey team: Diana Zgonc, RN-TC</p> <p>Census bed type: Residential: 113 Total: 113</p> <p>Census payor type: Other: 113 Total: 113</p> <p>Sample: 3</p> <p>Hearth at Stones Crossing was found to be in compliance with 410 IAC 16.2 in regard to the Investigation of Complaint IN00152179.</p> <p>Quality Review 07/25/14 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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