

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 013367	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/11/2015
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NAME OF PROVIDER OR SUPPLIER CRESTWOOD SOUTH ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 8809 MADISON AVENUE INDIANAPOLIS, IN 46227
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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 an Initial State Licensure Survey.</p> <p>Survey dates: June 10 and 11, 2015</p> <p>Facility number: 013367 Provider number: 013367 AIM number: N/A</p> <p>Census bed type: Residential: 181 Total: 181</p> <p>Sample: 07</p> <p>Crestwood South Assisted Living was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-5 in regard to the Initial State Licensure Survey.</p>	R 000		

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