

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 003915	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/06/2011
NAME OF PROVIDER OR SUPPLIER AUTUMN PARK ASSISTED LIVING COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 5045 WEST 52ND STREET INDIANAPOLIS, IN 46254		
(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 investigation of complaint numbers IN00088211 and IN00088262.</p> <p>Complaint IN00088211 unsubstantiated due to lack of evidence</p> <p>Complaint IN00088262 unsubstantiated due to lack of evidence</p> <p>Survey date: 4/6/2011</p> <p>Facility number: 003915 Provider number: n/a AIM number: n/a</p> <p>Survey team: Rhonda Stout</p> <p>Census bed type: Residential: 51 Total: 51</p> <p>Census payor type: Other: 51 Total: 51</p> <p>Sample: 3</p> <p>Autumn Park Assisted Living was found to be in compliance with 42 CFR part 483, subpart B and 410 IAC 16.2 in regard to the investigation of complaint numbers IN00088211 and IN00088262.</p> <p>Quality review completed 4-11-11 Cathy Emswiller RN</p>	R 000		

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TITLE

(X6) DATE

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