

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 010416	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/29/2015
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NAME OF PROVIDER OR SUPPLIER BROOKDALE CARMEL	STREET ADDRESS, CITY, STATE, ZIP CODE 301 EXECUTIVE DR CARMEL, IN 46032
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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 Investigation of Complaints IN00186251 and #N00188028.</p> <p>Complaint IN00186251- Unsubstantiated due to lack of evidence. Complaint IN00188028- Unsubstantiated due to lack of evidence.</p> <p>Survey dates: December 28 & 29, 2015</p> <p>Facility number: 010416 Provider number: 010416 AIM number: N/A</p> <p>Census bed type: Residential- 52 Total- 52</p> <p>Census payor type: Other- 52 Total- 52</p> <p>Sample: 3</p> <p>Brookdale Carmel was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaints IN00186251 and IN00188028.</p> <p>Quality Review was completed by 21662 on January 4, 2016.</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____