

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 011840	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/30/2015
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NAME OF PROVIDER OR SUPPLIER SUMMIT PLACE WEST	STREET ADDRESS, CITY, STATE, ZIP CODE 55 N MISSION DR INDIANAPOLIS, IN 46214
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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 a State Residential Licensure Survey.</p> <p>Survey dates: April 30, 2015.</p> <p>Facility Number: 011840 Provider Number: 011840 AIM Number: N/A</p> <p>Census bed type: Residential: 43 Total: 43</p> <p>Census payor type: Medicaid: 27 Private: 16 Total: 43</p> <p>Summit Place West was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.</p>	R 000		

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