STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING _____ B. WING _____	R-C 06/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	**445 GRADLE DRIVE CARMEL, IN 46032**

(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) COMPLETION DATE
{G 000}	INITIAL COMMENTS	{G 000}		

This was a re-visit for the Federal complaint survey completed on 3-17-2015 that resulted in an extended survey.

Survey Dates: 6-9 and 6-10-2015

Complaint #: IN00160254; Substantiated - Federal deficiencies related to the allegation were cited. Unrelated deficiencies were cited.

Facility #: 012508

Medicaid Vendor #: 201050820

Current Census: 17 Skilled
26 Home Health Aide only
43 Total

Six (6) Conditions of Participation and twenty-one (21) standard level deficiencies were found corrected during this survey.

Foster Healthcare was found to be in compliance with the Conditions of Participation 42 CFR 484.

Foster Healthcare is precluded from providing a home health aide training and competency evaluation program for a period of 2 years beginning 3-17-2015 for being found out of compliance with the Conditions of Participation 42 CFR 484.14 Organization, Services, and Administration; 484. 18 Acceptance of Patients, Plan of Care, Medical Supervision; 484.30 Nursing Services; 484.36 Health Aide Services; 484.48 Clinical Records; and 484.55

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{G 000}	Continued From page 1 Comprehensive Assessment of Patients. QR:JE 6/12/15	{G 000}		