

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/13/2023  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155816</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>06/07/2023</b>	
NAME OF PROVIDER OR SUPPLIER  <b>ARLINGTON PLACE HEALTH CAMPUS</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>1635 N ARLINGTON AVE</b> <b>INDIANAPOLIS, IN 46218</b>			
(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
{F 000}	<p>INITIAL COMMENTS</p> <p>This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaints IN00406352 and IN00406606 with unrelated deficiencies cited which was completed on 4/26/23. This visit was in conjunction with a PSR to the Investigation of Complaints IN00408462 and IN00408256 completed on 5/24/2023</p> <p>Complaint IN00406352 - Corrected Complaint IN 00406606 - Corrected Unrelated deficiency-Corrected Complaint IN00408462 - Corrected Complaint IN00408256 - Corrected</p> <p>Survey date: June 7, 2023</p> <p>Facility number: 013005 Provider number: 155816 AIM number: 201256400</p> <p>Census Bed Type: SNF/NF:31 SNF: 20 Total:51</p> <p>Census Payor Type: Medicare: 19 Medicaid: 26 Other: 6 Total: 51</p> <p>Arlington Place Healthcare was found to be in compliance with 42 CFR Part 483 Subpart B and 410 IAC 16.2-3.1 in regard to the PSR to the Investigation of Complaint IN00406352 and IN00406606 and unrelated deficiency.</p>			{F 000}			

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155816</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>06/07/2023</b>
NAME OF PROVIDER OR SUPPLIER  <b>ARLINGTON PLACE HEALTH CAMPUS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1635 N ARLINGTON AVE</b> <b>INDIANAPOLIS, IN 46218</b>		
(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	
{F 000}	Continued From page 1 Quality review completed on June 12, 2023	{F 000}			