

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 R-C 05/09/2023
NAME OF PROVIDER OR SUPPLIER BROOKDALE CARMEL		STREET ADDRESS, CITY, STATE, ZIP CODE 301 EXECUTIVE DR 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) COMPLETE DATE
{R 000}	<p>INITIAL COMMENTS</p> <p>This visit was for a Post Survey Revisit (PSR) to Investigation of Complaint IN00400382 completed on February 3, 2023.</p> <p>Complaint IN00400382 - Corrected.</p> <p>Survey date: May 9, 2023</p> <p>Facility number: 010416</p> <p>Residential Census: 50</p> <p>Brookdale Carmel was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to Investigation of Complaint IN00400382.</p> <p>Quality review was completed on May 12, 2023.</p>	{R 000}		

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

TITLE

(X6) DATE