STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155138	A. BUILDING _____ B. WING _____	C 10/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-INDIANAPOLIS	2860 CHURCHMAN AVE INDIANAPOLIS, IN 46203

(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	INITIAL COMMENTS	F 000		

This visit was for the Investigation of Complaints IN00364297, IN00362605, IN00362988, IN00363290, IN00363868, and IN00364065.

Complaint IN00364297 - Substantiated. No deficiencies related to the allegations are cited.

Complaint IN00362605 - Unsubstantiated due to lack of evidence.

Complaint IN00362988 - Unsubstantiated due to lack of evidence.

Complaint IN00363290 - Substantiated. No deficiencies related to the allegations are cited.

Complaint IN00363868 - Unsubstantiated due to lack of evidence.

Complaint IN00364065- Unsubstantiated due to lack of evidence.

Survey dates: October 7, 8, and 12, 2021

Facility number: 000063
Provider number: 155138
AIM number: 100266210

Census Bed Type:
SNF/NF: 73
Total: 73

Census Payor Type:
Medicaid: 61
Other: 12
Total: 73

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155138	A. BUILDING _____ B. WING _____	C 10/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-INDIANAPOLIS	2860 CHURCHMAN AVE INDIANAPOLIS, IN 46203

(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 Golden Living Center - Indianapolis was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaints IN00364297, IN00362605, IN00362988, IN00363290, IN00363868, and IN00364065. Quality Review completed on October 13, 2021.	F 000		