

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 013212	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/14/2024
NAME OF PROVIDER OR SUPPLIER BARRINGTON OF CARMEL, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 1335 S GUILFORD ROAD 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 the Investigation of Complaint IN00442610.</p> <p>Complaint IN00442610 - No deficiencies related to the allegations are cited.</p> <p>Survey date: November 14, 2024</p> <p>Facility number: 013212</p> <p>Residential Census: 75</p> <p>The Barrington of Carmel was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00442610.</p> <p>Quality review was completed on November 15, 2024.</p>	R 000		

Indiana Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE