

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

PRINTED: 12/05/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155196</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>11/30/2017</b>	
NAME OF PROVIDER OR SUPPLIER  <b>ALTENHEIM HEALTH &amp; LIVING COMMUNITY</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>3525 E HANNA AVE</b> <b>INDIANAPOLIS, IN 46237</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 Recertification and State Licensure Survey completed on 10/19/2017. This visit included a PSR to the State Residential Licensure survey completed on 10/19/2017</p> <p>This visit was done in conjunction with a PSR to the Investigation of Complaint IN00245044 completed on 11/15/17.</p> <p>Complaint IN00245044 - corrected.</p> <p>Survey date: November 30, 2017</p> <p>Facility number: 000103 Provider number: 155196 AIM number: 100290000</p> <p>Census bed type: SNF: 34 SNF/NF: 46 Residential: 82 Total: 162</p> <p>Census Payor type: Medicare: 18 Medicaid: 28 Other: 34 Total: 80</p> <p>Altenheim Health &amp; Living Community 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 Recertification and State Licensure Survey.</p> <p>Quality Review completed on December 04,</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.

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

PRINTED: 12/05/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155196</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>11/30/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALTENHEIM HEALTH &amp; LIVING COMMUNITY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3525 E HANNA AVE</b> <b>INDIANAPOLIS, IN 46237</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 2017.	{F 000}			