

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>000103</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/25/2024</b>
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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>
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(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><b>INITIAL COMMENTS</b></p> <p>This visit was for the Investigation of Complaint IN00435698.</p> <p>Complaint IN00435698 - No deficiencies related to the allegations are cited.</p> <p>Survey date: June 25, 2024</p> <p>Facility number: 000103</p> <p>Residential Census: 62</p> <p>Altenheim Health and Living Community was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00435698.</p> <p>Quality review completed June 27, 2024.</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_