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

PRINTED: 10/14/2021 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER SOUTHPOINTE HEALTHCARE CENTER SOUTHPOINTE HEALTHCARE CENTER SOUTHPOINTE HEALTHCARE CENTER SINCE TADDRESS, CITY, STATE, ZIP CODE 4994 WAR ADMIRAL DRIVE INDIANAPOLIS, IN 48237 STREET ADDRESS, CITY, STATE, ZIP CODE 4994 WAR ADMIRAL DRIVE INDIANAPOLIS, IN 48237 STREET ADDRESS ADMIRATORY OR LISC IDEMTIFYING INFORMATION) PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DAME OF THE CROSS-REFERENCED TO THE APPROPRIATE DAME OF THE CROSS-REFERENCED TO THE APPROPRIATE DAME OF STREET ADDRESS ADMIRATORY OR LISC IDEMTIFYING INFORMATION) PROJECT OTHER APPROPRIATE DAME OF THE CROSS-REFERENCED TO THE APPROPRIATE DAME	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			
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		Quality Review compl	eted on October 13, 2021.					

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.