

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 013039	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/01/2015
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NAME OF PROVIDER OR SUPPLIER ALLISONVILLE MEADOWS ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 10410 ALLISONVILLE ROAD FISHERS, IN 46038
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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>INITIAL COMMENTS</p> <p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: November 30 & December 1, 2015</p> <p>Facility number: 013039 Provider number: 013039 AIM number: N/A</p> <p>Census bed type: Residential: 124 Total: 124</p> <p>Census payor type: Other: 124 Total: 124</p> <p>Sample: 10</p> <p>Allisonville Meadows Assisted Living was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.</p> <p>Quality review completed by 30576 on December 3, 2015</p>	R 000		

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