

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>012141</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/29/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>SUNRISE ON OLD MERIDIAN</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>12130 OLD MERIDAN ST CARMEL, IN 46032</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) COMPLETE DATE
R 000	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for the Investigation of Complaint IN00107734.</p> <p>Complaint IN00107734-Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey Dates: May 29 2012</p> <p>Facility number: 012141 Provider number: 012141 AIM number: NA</p> <p>Survey team: Chuck Stevenson, RN</p> <p>Census bed type: Residential: 85 Total:85</p> <p>Census payor type: Other: 85 Total: 85</p> <p>Sample: 3</p> <p>Sunrise on Old Meridian was found to be in compliance with 410 IAC 16.2 in regard to the Investigation of Complaint IN00107734.</p> <p>Quality review completed on May 31, 2012 by Bev Faulkner, RN</p>	R 000		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE