

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING | X3) DATE SURVEY COMPLETED<br>02/16/2015 |
|--|---|--|---|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>ALLISONVILLE MEADOWS ASSISTED LIVING | STREET ADDRESS, CITY, STATE, ZIP CODE<br>10410 ALLISONVILLE ROAD<br>FISHERS, IN 46038 |
|--|---|

| (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 |
|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

|         |  |         |  |  |
|---------|--|---------|--|--|
| R000000 | <p>This visit was for the Investigation of Complaint IN00163856.</p> <p>Complaint IN00163856 - Substantiated. State deficiency related to the allegation is cited at R0273.</p> <p>Date of survey:<br/>February 16, 2015</p> <p>Facility Number: 013039<br/>AIM Number: 013039<br/>Provider Number: NA</p> <p>Survey Team:<br/>Mary Jane G. Fischer RN, TC</p> <p>Census Bed Type:<br/>Residential: 114</p> <p>Census Payor Type:<br/>Other: 114</p> <p>Sample: 4</p> <p>This State finding is cited in accordance with 410 IAC 16.2-5.</p> <p>Quality Review was completed by Tammy Alley RN on February 8, 2015.</p> | R000000 |  |  |
|---------|--|---------|--|--|

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.

|  |   |   |  |   |  |   |  |
|--|---|---|--|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                         |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                          |  | X3) DATE SURVEY COMPLETED<br>02/16/2015 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>ALLISONVILLE MEADOWS ASSISTED LIVING |   |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>10410 ALLISONVILLE ROAD<br>FISHERS, IN 46038 |  |   |  |
| (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  |  |   |  |
| R000273  | <p>410 IAC 16.2-5-5.1(f)<br/>Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24.<br/>Based on observation, interview and record review the dietary staff were observed with gloved hands, touching counter surface's and food handling without performing handwashing during 1 of 1 lunch preparation's. This deficient practice had the potential to affect 114 of 114 residents who received meals from the kitchen.</p> <p>Findings include:</p> <p>During the Kitchen and Food Service observation's on 02-16-15 at 10:45 a.m., the follow deficient practice's related to cross contamination with food handling were observed.</p> <p>Kitchen staff #1 was observed washing hands prior to donning gloves. The staff member ran hands beneath the stream of water but for less than 20 seconds. The staff member dried his hands and then placed the paper towel into the receptacle and turned off the water. Gloves were donned and the staff member proceeded to the food preparation area. He then picked up the bottom section of a pallet</p> | R000273   | <p><b>What corrective action will be accomplished for those residents found to have been affected by the deficient practice:</b></p> <ul style="list-style-type: none"> <li>·In-service will be completed by all dietary staff members 2-24-15 on hand washing, infection control, and safe food handling.</li> <li>·In-service held by Registered Dietician for all dietary staff members 2-18-5 and 2-24-15 to review policy for hand washing and glove usage. Registered Dietician also gave examples and demonstration of proper usage.</li> </ul> <p><b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</b></p> <ul style="list-style-type: none"> <li>·No resident was harmed by this deficient practice. All residents have the potential to be affected.</li> <li>·In-service all dietary staff hand washing, infection control, safe food handling, and glove policy.</li> <li>·Review policy and protocol in dining room with residents in resident council meeting for glove use and hand washing.</li> <li>·Audits completed on Cooks and Servers by General Manager and Designee at different meal times 7 x a week for 4 weeks.</li> </ul> | 03/02/2015  |  |   |  |

|  |   |   |  |   |  |   |  |
|--|---|---|--|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                         |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                          |  | X3) DATE SURVEY COMPLETED<br>02/16/2015 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>ALLISONVILLE MEADOWS ASSISTED LIVING |   |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>10410 ALLISONVILLE ROAD<br>FISHERS, IN 46038 |  |   |  |
| (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  |  |   |  |
|  | and placed it in the Conduction Unit in order to warm it. He continued to place the pallet's into the device until all units were filled. He then proceeded to the counter where sandwiches were prepared. He opened a loaf of bread and placed two pieces of bread in the toaster. After the bread was toasted he picked up one slice of bread with his left hand and picked up a spatula by the handle with his right hand. He dipped the spatula into a white mixture and spread the mixture across the surface of the slice of bread and then placed the bread onto a plate. He then picked up the other slice of bread, dipped the spatula into the white mixture and spread it across the slice of bread and placed the bread onto the plate. The staff member then, with gloved hands put his fingers into the plastic container of turkey slices, picked up two slices and placed the slices onto the bread. He then reached over to the container in which cooked bacon had been placed and picked out a few slices of bacon and placed the bacon onto the bread. The staff member then put his fingers into the plastic container of lettuce, picked up a piece of lettuce and placed it on the sandwich. He then placed his fingers into the plastic container in which there were pickles and placed a few pickles onto the plate adjacent to the bread. He then picked up the one slice of bread and |   | Then audits will be completed 4x a week for 4 weeks.<br>·Have the Quality Assurance team assigned to review overall sanitation, hand washing, glove usage, and quality of service. Quality Assurance team members from the Dietary, Nursing, Marketing, Business Office, Maintenance, and Activities department. Quality Assurance team will review quarterly for the next four quarters.<br><br>·What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:<br>·Purchased additional equipment when preparing food such as tongs and cereal dispensers.<br>·In-service all dietary staff members on safe food handling. This in-service is to be completed by 2-24-15.<br>·In-service all dietary staff members on infection control. This in-service is to be completed by 2-24-15.<br>·Registered Dietician in-service all staff members 2-18-15 and 2-24-15 to review policy for hand washing and glove usage.<br>·Food Service Manager/Designees will monitor meals each day to ensure overall sanitation, hand washing, usage, |   |  |   |  |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING | X3) DATE SURVEY COMPLETED<br>02/16/2015 |
|--|---|--|---|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>ALLISONVILLE MEADOWS ASSISTED LIVING | STREET ADDRESS, CITY, STATE, ZIP CODE<br>10410 ALLISONVILLE ROAD<br>FISHERS, IN 46038 |
|--|---|

| (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 |
|--------------------|--|---------------|---|----------------------|
|                    | <p>placed it on top of the meat, bacon and lettuce, picked up the plate and placed it on the top shelf surface of the steam table. The kitchen staff member repeated this sandwich preparation for 6 sandwiches after which time he took off the gloves and without washing his hands donned a new set of plastic gloves. Four additional sandwiches were prepared before the staff member once again took off the gloves and donned a new set of plastic gloves without washing his hands.</p> <p>The staff member then picked up a large metal pan which contained multiple loaf sections. The cook indicated the staff member would slice the meatloaf now and then would serve it later in the day. The staff member indicated kitchen paper had been placed in each metal loaf pan which made removing the contents of the pan "a little easier and it absorbs the grease." He took the edges of the paper and attempted to remove the meatloaf from the pan. When unable to completely remove the meatloaf he took his gloved hands and removed the contents with his gloved hands and placed the meatloaf onto a cutting board. Once he had the meatloaf removed from the metal load pan he picked up a knife by it's handle and began to cut the meatloaf into slices. Upon completion, he pushed the loaf together and replaced</p> |               | <p>and quality of service is provided per policy<br/><b>How the corrective action will bemonitored to ensure the deficient practice will not reoccur:</b></p> <ul style="list-style-type: none"> <li>·Auditscompleted on Cooks and Servers by General Manager and Designee at differentmeal times 7 x a week for 4 weeks. Thenaudits will be completed 4x a week for 4 weeks.</li> <li>·QualityAssurance audits will be conducted monthly by a team member designated by theGeneral Manager. If 95% is not achievedthen an action plan will be developed. Quality Assurance team will reviewquarterly for the next four quarters.</li> <li>·Holdmonthly in-service training on hand washing with dietary staff members everymonth for the next 3 months to ensure staff has been properly trained on handwashing.</li> <li>·Quarterlytraining sessions with the Registered Dietician to review policies and practicein the dietary department for the next four quarters.</li> </ul> <p>We request paper compliance</p> |                      |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING | X3) DATE SURVEY COMPLETED<br>02/16/2015 |
|--|---|--|---|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>ALLISONVILLE MEADOWS ASSISTED LIVING | STREET ADDRESS, CITY, STATE, ZIP CODE<br>10410 ALLISONVILLE ROAD<br>FISHERS, IN 46038 |
|--|---|

| (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 |
|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

|  |  |  |  |  |
|--|--|--|--|--|
|  | <p>the slices into the metal loaf pan. This continued for 6 loaf pans of meatloaf.</p> <p>During this observation Server #2 entered the kitchen. The server reached for a ceramic bowl with her fingertips inside the bowl and removed it from the counter. She then walked over to where plastic container's of cereal had been placed, opened the container, placed the bowl into the cereal and dipped out an amount. The server then exited the kitchen with the cereal and served the resident. Server #2 was observed placing a cloth napkin onto a counter surface, and then pick up utensils with bare hands, touching the tines of the fork and cutting surface of the knife, positioned the utensils onto the cloth napkin and rolled the napkin around the utensils. She continued to situate the utensils onto the cloth napkins for 4 additional observations. The server exited the kitchen area and returned to the dishwashing area with dirty dishware. She then proceeded to the food preparation area, picked up a plate, which the cook identified as antipasta salad and proceed to the dining room and serve the resident. The server returned to the kitchen, proceeded to the dessert cart, picked up two cookies with her bare fingers, placed them on a plate and returned to the dining room.</p> |  |  |  |
|--|--|--|--|--|

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING | X3) DATE SURVEY COMPLETED<br>02/16/2015 |
|--|---|--|---|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>ALLISONVILLE MEADOWS ASSISTED LIVING | STREET ADDRESS, CITY, STATE, ZIP CODE<br>10410 ALLISONVILLE ROAD<br>FISHERS, IN 46038 |
|--|---|

| (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 |
|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

|  |  |  |  |  |
|--|--|--|--|--|
|  | <p>Server #3 entered the kitchen and picked up an ice cream scoop. The server entered the freezer, placed a scoop of ice cream into a bowl, exited the freezer, placed the bowl of ice cream onto the surface of the food preparation area, walked over to the dishwashing area with the dirty ice cream scoop, placed the scoop onto the dish washing rack, returned to the preparation area, picked up the bowl of ice cream and exited the kitchen.</p> <p>Server #4 entered the kitchen and proceeded to the food preparation area. He picked up a plastic bag which contained dinner rolls. With bare hands he removed two rolls from the plastic bag and placed them into a warmer. Upon completion of warming the dinner rolls, he picked up each one and placed them on separate plate's with his hands and exited the kitchen to the dining area.</p> <p>A resident requested a Chef salad. The cook, with gloved hands picked up pieces of lettuce and placed the lettuce onto a plate. The cook then picked up a handful of ham, placed the ham onto the counter surface, picked up a knife by the handle and began to chop the meat into slices. She then placed the knife onto the counter surface, picked up the meat with</p> |  |  |  |
|--|--|--|--|--|

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br>02/16/2015 |
|--|---|--|---|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>ALLISONVILLE MEADOWS ASSISTED LIVING | STREET ADDRESS, CITY, STATE, ZIP CODE<br>10410 ALLISONVILLE ROAD<br>FISHERS, IN 46038 |
|--|---|

| (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 |
|--------------------|---|---------------|---|----------------------|
|                    | <p>both hands and placed the meat onto the bed of lettuce. The cook removed her gloves, walked over to the handwashing sink, ran her hands under the stream of water, less than 20 seconds, dried her hands, turned of the water with the paper towels and disposed of the paper towel into the waste can.</p> <p>The cook then indicated she would need to help in preparing the cheeseburgers for the Memory Care Unit. The cook donned gloves, and then picked up 6 plates and placed the plates adjacent to the steam table. The hamburger buns were placed onto individual plates. The cook picked up a set of tongs and placed 6 meat patties onto the grill. She then picked up 6 slices of cheese with her gloved hands and placed the cheese onto the meat patty. After the cheese began to melt, the cook took a spatula, and placed each meat patty onto the hamburger bun. She then, with gloved hands, picked up pieces of lettuce and placed the lettuce onto the cheese and then placed the top of the buns onto the sandwich.</p> <p>There were multiple observations of the Server's who entered the kitchen with dirty tableware and utensils, walked over to the dishwashing area, placed the items onto the counter and dishwashing racks and then returned to the food preparation</p> |               |   |                      |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br>02/16/2015 |
|--|---|--|---|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>ALLISONVILLE MEADOWS ASSISTED LIVING | STREET ADDRESS, CITY, STATE, ZIP CODE<br>10410 ALLISONVILLE ROAD<br>FISHERS, IN 46038 |
|--|---|

| (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 |
|--------------------|---|---------------|---|----------------------|
|                    | <p>area, picked up lunch meals which were ready for the residents, and exited the kitchen to the dining room.</p> <p>A review of the facility policy on 02-16-15 at 3:00 p.m., titled, "Hand Washing," and dated 04-2014, indicated the following:</p> <p>"Policy - An essential component of infection control is hand washing. All staff members must wash their hands after each resident contact for which hand washing is indicated by accepted professional practice."</p> <p>"Procedure 1. Wet hands, wrists and forearms with warm running water. 2. Apply antibacterial soap to palm of hand; join hands, palm to palm, working up lather on hands, wrists and forearms for a minimum of twenty (20) seconds. 3. Interlock fingers and work them back and forth and from side to side; cover all areas between fingers with soap. 4. To cleanse nails and fingertips, cup the fingertips within the palm of the hands and rub vigorously. Make sure cuticles are also thoroughly cleaned. Use a fingernail brush as necessary. 5. Dry hands carefully with paper towels. 6. Shut off water with paper towels."</p> <p>Review of a subsequent policy on</p> |               |   |                      |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                         |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                          |  | X3) DATE SURVEY COMPLETED<br>02/16/2015 |  |
|--|--|---|---|---|--|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>ALLISONVILLE MEADOWS ASSISTED LIVING |  |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>10410 ALLISONVILLE ROAD<br>FISHERS, IN 46038 |  |   |  |
| (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  |  |   |  |
|  | <p>02-16-15 at 3:00 p.m., titled "Plastic Gloves," and dated 10-2008, indicated the following:</p> <p>"Policy - It is the policy of this community to provide food in a safe manner while following the proper health codes outlined by the county/government agencies."</p> <p>"Procedure 1. Disposable, plastic gloves shall be used when handling ready to eat food items. 2. Food employees shall minimize bare hand and arm contact with exposed food that is not in a ready to eat form. 3. Use tongs or other utensils wherever possible. This however, does not replace hand washing. Hands shall be washed in between each glove use. 4. Gloves should be removed when leaving the food preparation area within the kitchen, after touching your body, after coughing and/or sneezing. 5. Gloves are never to be worn in the dining room to serve or bus tables unless required under the universal precaution situations. 6. Gloves shall be changed and hands washed when moving from one duty to another throughout the food preparation and daily routines to prevent cross contamination."</p> <p>This State tag relates to Complaint IN00163856</p> |   |   |   |  |   |  |

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

PRINTED: 03/04/2015

FORM APPROVED

OMB NO. 0938-0391

|  |  |  |  |                            |  |
|--|--|--|--|----------------------------|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____   |                            | X3) DATE SURVEY<br>COMPLETED<br>02/16/2015 |
| NAME OF PROVIDER OR SUPPLIER<br><br>ALLISONVILLE MEADOWS ASSISTED LIVING |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>10410 ALLISONVILLE ROAD<br>FISHERS, IN 46038                                    |                            |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG                                  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |  |
|  |  |  |  |                            |  |