| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING<br>B. WING | 07/16/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNRISE ON OLD MERIDIAN | 12130 OLD MERIDIAN ST, CARMEL, , 46032 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES... | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION... | (X5) COMPLETION DATE |
|---|---|---|---|---|
| R 0000 | INITIAL COMMENTS<br><br>This visit was for the Investigation of Complaints IN00458254 and IN00456587.<br><br>Complaint IN00458254-No deficiencies related to the allegations are cited.<br><br>Complaint IN00456587-No deficiencies related to the allegations are cited.<br><br>Survey date: July 16, 2025<br><br>Facility number: 012141<br><br>Residential Census: 72<br><br>Sunrise on Old Meridian was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00458254 and IN00456587.<br><br>Quality review was completed on July 18, 2025. | R 0000 | | |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

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