STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013039	A. BUILDING: _____ B. WING _____	02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLISONVILLE MEADOWS ASSISTED LIVING	10410 ALLISONVILLE ROAD 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) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey Date: February 16, 2024 Facility Number: 013039 Residential: 121 Allisonville Meadows Assisting Living was found to be in compliance with 410 IAC 16.2 in regards to the State Residential Licensure Survey. Quality review completed on February 19, 2024	R 000		