STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155751	A. BUILDING _____ B. WING _____	C 07/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW LAKES	**200 MEADOW LAKE DR MOORESVILLE, IN 46158**

(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
F 000	INITIAL COMMENTS This visit was for the Investigation of Nursing Home Complaints IN00438596, IN00438774, and IN00438851. This visit included the Investigation of Residential Complaint IN00436887. Complaint IN00438596 - No deficiencies related to the allegations are cited. Complaint IN00438774 - No deficiencies related to the allegations are cited. Complaint IN00438851 - No deficiencies related to the allegations are cited. Complaint IN00436887 - No deficiencies related to the allegations are cited. Survey date: July 29, 2024 Facility number: 004831 Provider number: 155751 AIM number: 200809750 Census Bed Type: SNF/NF: 97 NF: 10 Residential: 43 Total: 150 Census Payor Type: Medicare: 13 Medicaid: 68 Other: 26 Total: 107 Meadow Lakes was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC	F 000		

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	(X3) DATE SURVEY COMPLETED
	155751	A. BUILDING _____ B. WING _____	C 07/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW LAKES	**200 MEADOW LAKE DR MOORESVILLE, IN 46158**

(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
F 000	Continued From page 1 16.2-3.1 in regard to the Investigation of Nursing Home Complaints IN00438596, IN00438774, and IN00438851. Quality review completed July 30, 2024.	F 000		