PRINTED: 05/29/2024 FORM APPROVED

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
012141		<u> </u>	B. WING		05/24/2024		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 12130 OLD MERIDIAN ST							
SUNRISE ON OLD MERIDIAN CARMEL, IN 46032							
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
R 000	00 INITIAL COMMENTS		R 000				
	This visit was for a St Survey.	ate Residential Licensure					
	Survey dates: May 23 and 24, 2024.						
	Facility number: 012141						
	Residential Census: 56						
	Sunrise on Old Meridian was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.						
	Quality review was completed on May 28, 2024.						
	Facility number: 0121 Residential Census: 5 Sunrise on Old Merid compliance with 410 State Residential Lice	41 56 ian was found to be in IAC 16.2-5 in regard to the ensure Survey.					

Indiana Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE