

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>013163</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R-C 08/16/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>MEADOW BROOK SENIOR LIVING</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>11011 VILLAGE SQUARE LANE FISHERS, IN 46038</b>		
(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}	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00384914 completed on 7/20/22.</p> <p>Complaint IN00384914 - corrected.</p> <p>Survey Date: August 16, 2022</p> <p>Facility Number: 013163</p> <p>Residential: 80</p> <p>Meadow Brook Senior Living was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to the Investigation of Complaint IN00384914.</p> <p>Quality review completed on August 16, 2022</p>	{R 000}		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE