

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 014910	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/11/2023
NAME OF PROVIDER OR SUPPLIER LAKE MEADOWS SENIOR ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 11570 E 126TH STREET FISHERS, IN 46037		
(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>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00398694.</p> <p>Complaint IN00398694 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey date: January 11, 2023</p> <p>Facility number: 014910</p> <p>Residential Census: 116</p> <p>Lake Meadows Senior Assisted Living was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00398694.</p> <p>Quality review completed on January 12, 2023</p>	R 000		

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

TITLE

(X6) DATE