STATEMENT OF DEFICIENCIES X1) PRO		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BUILDING 00		00	COMPLETED	
		155751	B. W	B. WING		03/18/2025	
			1	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	L.			ADDRESS, CITY, STATE, ZIP COD		
MEADOV	VIAKES				ESVILLE, IN 46158		
IVIEADOV	V LANES			WOOR			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0000							
Bldg. 00							
	This visit was for a	Recertification and State	F 00	000	The submission of this plan of		
	Licensure Survey. 7	This visit included the			correction does not indicate ar	า	
	-	mplaint IN00455526 and a State			admission by Meadow Lakes		
	Residential Licensu	re Survey.			Nursing Facility that the finding	gs	
					and allegations contained here	ein	
		5526 - No deficiencies related to			are an accurate and true		
	the allegations are c	rited.			representation of the quality of	f	
					care and environment provide	d to	
	Survey dates: March	h 10, 11, 12, 13, 14, 17, and 18,			the residents of this facility. Th	is	
	2025				facility recognizes its obligation	n to	
					provide legally and medically		
	Facility number: 00	4831		necessary care and serv		а	
	Provider number: 1:	55751			safe environment for its residents		
	AIM number: 2008	09750		in an economic and safe		ner.	
					The facility herby maintains it i	s in	
	Census Bed Type:				substantial compliance with th	е	
	SNF/NF: 114			requirements of participat		or	
	SNF: 4				Nursing facilities. To this end,	this	
	Residential: 46				plan of correction shall serve a	as	
	Total: 164				the credible allegation of		
					compliance with all state		
	Census Payor Type	:			requirements governing the		
	Medicare: 20				management of this facility. It i	is	
	Medicaid: 76				thus submitted as a matter of		
	Other: 22				statue only.		
	Total: 118						
		reflect State Findings cited in			This facility respectfully reque	sts	
	accordance with 41	0 IAC 16.2-3.1.			from the Department a desk		
					review. If anything, further is		
	Quality review com	pleted March 20, 2025.			needed the facility will provide		
					department documentation up		
					request for paper compliance/	desk	
					review.		
			1				

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

TITLE

(X6) DATE

Mac McCallum Executive Director 04/08/2025

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: VQ7H11 Facility ID: 004831 If continuation sheet Page 1 of 9

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	a. building <u>00</u>			COMPLETED	
		155751	B. W	B. WING 03/			2025	
				GENEER	A DDDDGG GITW GTATE JID GOD	<u> </u>		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD			
MEADOW LAKES					EADOW LAKE DR			
MEADOV	V LAKES			MOORI	ESVILLE, IN 46158			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
F 0554	483.10(c)(7)							
SS=D	Resident Self-Adn	nin Meds-Clinically Approp						
Bldg. 00								
	Based on observation	on, interview, and record	F 05	554	F 554: Resident Self-Admin		04/14/2025	
	review, the facility	failed to ensure a			Meds-Clinically Approp			
	self-medication adn	ninistration assessment was			1 What corrective action(s)	will		
	completed for 1 of 1	l random observations of			be accomplished for those			
	_	he bedside. (Resident 71)			residents found to have been			
					affected by the deficient practi	ce.		
	Findings include:							
	-				1 Resident 71's MAR and	plan		
	On 3/11/25 at 10:30	a.m., a medication cup with 1			of care were reviewed and upo	-		
	large white tablet w	as observed on the bedside			by the IDT to honor the preference of self-administration by the			
	table of Resident 71	. Resident 71 indicated it was						
	her stomach medica	tion and the nurses always left		Resident. All Nurses were				
	it for her to take after	er she had finished her meal.			educated on medication storage	ge,		
					medication administration and	_		
	Resident 71's clinica	al record was reviewed on			obtaining a physician order for	•		
	3/11/25 at 11:30 a.n	n. The diagnosis included, but			self-administration where			
	was not limited to, g	gastroesophageal reflux		applicable.				
	disease. The clinical	l record lacked documentation						
	of a self-medication	administration assessment.			2 How other residents hav	ing		
					the potential to be affected by	the		
	Current physician of	rders, dated 3/1/25 through			same deficient practice will be			
	3/17/25, indicated R	Resident 71's medications			identified and what corrective			
	included, but were r	not limited to, simethicone (for			action(s) will be taken.			
	gas) tablet 125 milli	igrams 4 times a day.						
					1 All Residents have the			
	During an interview	on 3/17/25 at 10:25 a.m., the			potential to be affected by this			
	Director of Nursing	Services (DNS) indicated			practice.			
	there had not been a	self-medication						
	administration asses	ssment completed for Resident			2 Alert residents will be			
		edication was just a gas pill and			informed of their right to			
	_	get sick if she took it before			self-administer medications up	on		
	her meal so they let	her keep it with her until after			admission. The clinical IDT wil	I		
	she ate.				review all Resident requests			
					individually and upon request.			
	On 3/18/25 at 10:43	a.m., the DNS provided the						
	facility's policy, "M	edication			3 What measures will be p	ut		
Administration-Medication Pass Procedure" with				into place and what systemic				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155751		A. BUILDING B. WING	00 00	COMPLETED 03/18/2025				
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 200 MEADOW LAKE DR MOORESVILLE, IN 46158					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE				
F 0641 SS=D Bldg. 00	a revised date of 7/2 policy currently being review of the policy	023, and indicated it was the ng used by the facility. A indicated, " 11. Observed not left at bedside"		changes will be made to ensure that the deficient practice does recur. 1 DNS or Designee will complete an audit five times weekly x4 weeks, then twice weekly for 4 weeks, then monthly ong to ensure all alert Residents were preference for self-administration have an updated care plan, physician order and Resident education completed. The plate revised, as warranted. 4 How the corrective action will be monitored to ensure the deficient practice will not recurred; what quality assurance program will be put into place. 1 For quality assurance, the DNS or designee will review a findings daily, with subsequent corrective action and education identified staff. 2 Findings will be reported the QA meeting monthly or unsubstantial compliance has be determined.	kly poing pith a pion n will n(s) e r, ne ny t n for			
		and record review, the facility accuracy of the Minimum Data	F 0641	F 641: Accuracy of Assessme 1. What corrective action(s) w				

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155751	B. WING 03/18/2025				/2025
				CTDEET A	ADDRESS CITY STATE ZIR COD		
NAME OF F	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
MEADON	MEADOW LAKES						
MEADOV	V LAKES			MOORE	ESVILLE, IN 46158		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Set assessment for a	a resident determined to have			accomplished for those reside	nts	
	a Level II PASARE	and a serious mental illness			found to have been affected b	y the	
	for 1 of 1 resident r	eviewed for Resident			deficient practice.		
	Assessment. (Resid	ent 62)			1. Resident 62's PASSR and p	olan	
					of care were reviewed and up	dated	
	Findings include:				by the IDT to reflect the status	of	
					the Resident. The Director of		
	Resident 62's clinic	al record was reviewed on			Social Services/Social Service	es	
	3/18/25 at 11:00 a.r	n. The diagnoses included, but			Assistant were educated on le	vel	
	were not limited to,	anxiety, psychotic disorder			1 & 2 completion, along with		
	with delusions and	anorexia nervosa.			Intellectual, Mental Disability o	or	
					related conditions. The IDT ha	ıs	
	A Level II PASAR	R (Preadmission Screening and		corrected the MDS coding based			
	Resident Review) v	vas completed in January 2023,		on the Level 2 recommendations			
	and indicated the re	sident had a serious mental	and incorporated it into the				
	illness.			president's plan of care.			
			2. How other residents having the		the		
	The Significant Cha	ange Minimum Data Set (MDS)	potential to be affected by the				
	assessment, dated 2	/23/25, indicated No to	same deficient practice will be				
	Resident 62 having	a Level II PASARR and no to	identified and what corrective				
	the resident having	a serious mental illness.			action(s) will be taken.		
			All Residents have the potential				
	During an interview	on 3/18/25 at 10:35 a.m., the			to be affected by this practice.		
	Social Services Ass	sistant indicated the Significant			2. All Residents with a PASSF	₹	
	Change MDS asses	sment, dated 2/23/25, for			indicating a Level 2 have beer	า	
	Resident 62 should	have been coded Yes to			reviewed for accurate coding a	and	
	having a Level II P.	ASARR and Yes to the resident			appropriate care plans by the	IDT.	
	having a serious me	ental illness.			3. What measures will be put into		
					place and what systemic chan	ges	
	On 3/18/25 at 1:20	p.m., the facility provided a			will be made to ensure that the	Э	
	copy of the RAI Ve	ersion 3.0 Manual, page 5,			deficient practice does not rec	ur.	
	dated October 2023	, and indicated it was the			1. DNS or Designee will comp	lete	
	policy currently being used by the facility. A				an audit five times weekly x4		
	review of the RAI manual did not indicate coding		1		weeks, then twice weekly for 4	ļ	
	of the Level II PAS	ARR.			weeks, then weekly for 4 weel	κs,	
					then monthly ongoing to ensu	re all	
	3.1-31(d)				Resident PASSR's are comple		
					accurately and reflect the		
					Residents plan of care. The pl	an	
				will be revised, as warranted.			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/10/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPL	ETED
		155751				03/18/	2025
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER				ADOW LAKE DR		
MEADOV	V LAKES				ESVILLE, IN 46158		
		OTT A TEL VENT OF DEPLOYENCE	ı		,		(775)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	DATE
					4. How the corrective action(s) be monitored to ensure the deficient practice will not recur		
					i.e., what quality assurance		
					program will be put into place.		
					 For quality assurance, the D or designee will review any 	JN S	
					findings daily, with subsequen	t	
					corrective action and educatio		
					identified staff.		
					2. Findings will be reported at	the	
					QA meeting monthly or until		
					substantial compliance has be	en	
					determined.		
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing						
			F 06	557	F 657: Care Plan Timing and		04/14/2025
	Based on observation and interview, the facility				Revision 1 What corrective action(s)	will	
		f revised the comprehensive			be accomplished for those		
		ent with significant weight			residents found to have been		
		ents reviewed for nutrition.			affected by the deficient		
	(Resident 47)				practice.1 Resident 48's		
	Findings include:				Nutritional plan of care and interventions were reviewed a updated by the IDT to reflect the		
	On 3/11/25 from 9:2	20 a.m. to 9:45 a.m.,. Resident 47			status of the Resident. All		
		l with breakfast on her tray			interventions to prevent weigh	t	
		No staff were present with the			loss have been deemed		
	resident.				appropriate by the physician a		
	On 3/14/25 from 9:25 a.m. to 9:50 a.m., Resident 47				IDT. 2 How other residents		
		25 a.m. to 9:50 a.m., Resident 4/ I with breakfast on her tray			having the potential to be affective		
		No staff were present with the			by the same deficient practice be identified and what correcti		
	resident.	to said were present with the			action(s) will be taken.1 All		
					Residents have the potential to		

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Event ID:

VQ7H11 Facility ID: 004831

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155751		A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/18/2025		
NAME OF PROVIDER OR SUPPLIER MEADOW LAKES			200 ME	ADDRESS, CITY, STATE, ZIP COD EADOW LAKE DR ESVILLE, IN 46158			
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE				(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		0 a.m. Resident 47's clinical			affected by this practice.2	All	
		ed. The diagnoses included, but			Residents that trigger for an		
		, hemiplegia, adult failure to			undesired weight loss will be		
	thrive, and unspeci	fied protein-calorie			reviewed by the IDT, Register	ed	
	malnutrition.				dietician and physician. Upon		
					review all interventions will be		
		S (Minimum Data Set)			reviewed and updated where		
		3/10/25, indicated the resident			applicable within the care plar		
	_	or more weight loss in the last			care plans will be review weel	-	
	_	ss of ten percent or more in the			by the IDT team in Nutritional	at	
	last 6 months.				risk meetings for weight		
	The Functional Assessment, dated 3/10/25, indicated the resident required supervision or				improvement and stability.3		
					What measures will be put int		
					place and what systemic char	-	
	touching assistance	for eating.			will be made to ensure that th	е	
	T F II II N	D			deficient practice does not	•11	
	_	trition Review, dated 3/11/25,			recur.1 DNS or Designee v	VIII	
		ent had a five percent or more			complete an audit five times		
		ast month or weight loss of ten the last six months, was not on			weekly x4 weeks, then twice	Leb e	
	_	bed weight loss program, and	weekly for 4 weeks, then weekly for 4 weeks, then monthly ongoing				
		een reviewed and updated.			to ensure all Resident PASSF	-	
	the care plan had be	een reviewed and updated.			are completed accurately and		
	A Nutrition Care P	lan, reviewed on 3/11/25,			reflect the Residents plan of c		
		onal care plan interventions			The plan will be revised, as	aic.	
	since 8/1/23.	onar care plan interventions			warranted.4 How the corre	ctive	
	Since 0/ 1/23.				action(s) will be monitored to	Olivo	
	- On 9/4/24, the res	sident weighed 154 lbs (pounds)			ensure the deficient practice v	vill	
	· ·	esident weighed 146 lbs, which			not recur, i.e., what quality	•	
		weight loss in one month.			assurance program will be pu	t into	
	_	esident weighed 152 lbs			place.1 For quality assurar		
		esident weighed 144 lbs, which			the DNS or designee will revie		
		weight loss in one month.			any findings daily, with		
	_	sident weighed 123 lbs, which			subsequent corrective action	and	
		t weight loss in six months.			education for identified staff.2		
		-			Findings will be reported at th		
	On 3/14/25 at 2:25	p.m., the DON provided the			meeting monthly or until		
	Resident Weight M	Ionitoring policy with a revised			substantial compliance has be	een	
	date of, 9/2024, and	d indicated this was the current			determined.		
	weight monitoring	policy used by the facility. A					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VQ7H11 Facility ID: 004831

If continuation sheet Page 6 of 9

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155751		(X2) MULTIPLI A. BUILDING B. WING	E CONSTRUCTION B 00	(X3) DATE SURVEY COMPLETED 03/18/2025	
	PROVIDER OR SUPPLIER		200	ET ADDRESS, CITY, STATE, ZIP COD MEADOW LAKE DR DRESVILLE, IN 46158	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES OF THE AP	LD BE COMPLETION
F 0677 SS=D	unexplained weight condition and must Interdisciplinary Te During an interview DON indicated the loss and new interview on the nutrition care 3.1-35(d)(2)(B) 483.24(a)(2)	on 3/17/25 at 10:30 a.m., the resident had significant weight entions had not been updated			
Bldg. 00	Based on observation review, the facility (Activities of Daily resident for 1 of 1 rd A resident was not at Findings include: On 3/11/25 at 10:19 observed in her room long whiskers on her child wept and indicated sad. She indicated swhiskers and she was it made her feel to During an interview indicated the reside shaved.	on, interview, and record failed to provide ADL's Living) for a dependent esidents reviewed for ADL's. shaved. (Resident 48)	F 0677	F 677: ADL Care Provide Dependent Residents 1. What corrective action(accomplished for those refound to have been affect deficient practice. 1. Resident 48's chin and were inspected for unnechair. All hair deemed unnewas immediately removed Resident 48's plan of care reviewed and updated by to reflect the status for as with ADLs specific to facinare. 2. How other residents hapotential to be affected by same deficient practice widentified and what correctaction(s) will be taken. 1. All Residents have the to be affected by this prace. 2. All Residents were reviunnecessary facial hair, care and removal and hair care and	(s) will be esidents ted by the face essary eccessary d. e was the IDT esistance all hair eving the y the fill be etive potential etice. Elewed for offered

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING B. WING	00	COMPLETED 03/18/2025			
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 200 MEADOW LAKE DR MOORESVILLE, IN 46158					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION FREFIX FREFIX				
	were not limited to, thrive, and unspecif malnutrition. The Functional Assindicated the resider maximal assistance including shaving. A current Activity of a start date of 7/28/2	d. The diagnoses included, but hemiplegia, adult failure to fied protein-calorie essment, dated 3/10/25, at required substantial or to maintain personal hygiene, of Daily Living care plan, with 23 indicated the resident was a with grooming and hygiene.		care plans updated to reflect to desired statis of the Resident. 3. What measures will be put place and what systemic char will be made to ensure that the deficient practice does not rect. A daily care companions' program has been implement daily rounding and observation Residents have been assigned IDT member. Daily rounding woccur at varied times to ensure ADL care is completed for all Residents. 2. ED or Designee will complete an audit at varied times five times weekly for 4 weeks, then twice weekly for 4 weeks, then monthly one to ensure all Resident ADL care plans are accurate and up to related to Resident hair care preference. The plan will be revised, as warranted. 4. How the corrective action(she monitored to ensure the deficient practice will not recuive., what quality assurance program will be put into place 1. For quality assurance, the for designee will review any findings daily, with subsequer corrective action and education identified staff. 2. Findings will be reported at QA meeting monthly or until substantial compliance has be determined.	into nges e cur. ed for n. All d an vill e ete mes kly going are date c) will r, DNS at on for the			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/10/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155751		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 03/18/2025	
	PROVIDER OR SUPPLIEI	R	200 MI	ADDRESS, CITY, STATE, ZIP COD EADOW LAKE DR RESVILLE, IN 46158	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE COMPLETION
R 0000					
Bldg. 00	Survey. This visit state Licensure Sur Complaint IN0045: Complaint IN0045: the allegations are of Survey dates: Marc 2025 Facility number: 00 Residential Census Meadow Lakes was	5526 - No deficiencies related to cited ch 10, 11, 12, 13, 14, 17, and 18, 04831 : 46 s found to be in compliance -5 in regard to the State	R 0000	The submission of this plat correction does not indicate admission by Meadow Lak Nursing Facility that the fir and allegations contained are an accurate and true representation of the qualicare and environment provide legally and medicate necessary care and service safe environment for its rein an economic and safe in The facility herby maintain substantial compliance with requirements of participating Nursing facilities. To this explan of correction shall sent the credible allegation of compliance with all state requirements governing the management of this facility thus submitted as a matter statue only. This facility respectfully refrom the Department a decreview. If anything, further needed the facility will provide partment documentation request for paper compliant review.	te an kes hadings herein ty of vided to v. This ation to ally se in a sidents nanner. si it is in th the on for end, this eve as se y. It is r of equests sk is vide n upon

State Form Event ID: VQ7H11 Facility ID: 004831 If continuation sheet Page 9 of 9