CENTERS FOR MEDICARE & MEDICARD SERVICES OMB MO.00860 MEDICARE & MEDICARD SERVICES OMB MO.00860 VICIN INVERTIGATION NUMBER: VICIN MUMBER: VICIN MEDICARE & MEDICARD NUMBER: SIMMARY STATEMENT OF DEFICIENCIES PROWNSBURG MEADOWS SIMMARY STATEMENT OF DEFICIENCIES PROWNSBURG MEADOWS SIMMARY STATEMENT OF DEFICIENCIES PROWNSBURG MEADOWS SIMMARY STATEMENT OF DEFICIENCIES PROWNSBURG NA 6012 PROWNSBURG NA 6012 PROWNSBURG NA 6012 SIMMARY STATEMENT OF DEFICIENCIES PROWNSBURG NA 6012 P		-	ID HUMAN SERVICES				FORM	MAPPROVED	
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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.

PRINTED: 12/03/2021

DEPARTMENT OF HEALTH AND HUMAN SERVICES										
		MEDICAID SERVICES). 0938-0391					
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		JLTIPLE CONSTRUCTION DING			(X3) DATE SURVEY COMPLETED			
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	Ι			BROWNSBURG, IN 46112						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CC CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE			
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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: N8Q012

Facility ID: 011367

If continuation sheet Page 2 of 2

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