

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>014281</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 11/21/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>HERITAGE ASSISTED LIVING OF YORKTOWN</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1400 S PATRIOT DRIVE YORKTOWN, IN 47396</b>
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(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 Investigation of Complaint IN00419023 completed on October 10, 2023.</p> <p>Complaint IN00419023 - Corrected</p> <p>Survey date: November 21, 2023</p> <p>Facility number: 014281</p> <p>Residential Census: 9</p> <p>Heritage Assisted Living of Yorktown was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to Investigation of Complaint IN00419023.</p> <p>Quality review completed November 27, 2023.</p>	{R 000}		

Indiana Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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