

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>C</b> <b>02/01/2024</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</b> <b>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 the Investigation of Complaint IN00425994.</p> <p>Complaint IN00425994 - No deficiencies related to the allegations are cited.</p> <p>Survey date: February 1, 2024</p> <p>Facility number: 014281</p> <p>Residential Census: 28</p> <p>Heritage Assisted Living of Yorktown was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00425994.</p> <p>Quality review completed February 5, 2024.</p>	R 000		

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