

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 12/02/2024</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 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 Post Revisit Survey (PSR) to the Investigation of Complaint IN00444035 completed on October 9, 2024</p> <p>Complaint IN00444035 - Corrected.</p> <p>Survey date: December 2, 2024</p> <p>Facility number: 014281</p> <p>Residential Census: 29</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 the Investigation of Complaint IN00444035.</p> <p>Quality review completed December 5, 2024.</p>	{R 000}		

Indiana Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE