

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 013847	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/21/2025
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NAME OF PROVIDER OR SUPPLIER MCCORDSVILLE SENIOR LIVING LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 6311 W CR 900 N MCCORDSVILLE, IN 46055
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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>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00451324.</p> <p>Complaint IN00451324 - No deficiencies related to the allegations are cited.</p> <p>Survey date: January 21, 2025</p> <p>Facility number: 013847</p> <p>Residential Census: 115</p> <p>McCordsville Senior Living LLC was found to be in compliance with 410 IAC 16.2-5 in regards to the Investigation of Complaint IN00451324.</p> <p>Quality review completed on January 22, 2025.</p>	R 000		

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