

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 012497	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/13/2019
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NAME OF PROVIDER OR SUPPLIER SENIOR SUITES AT THE LELAND, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 900 SOUTH A STREET RICHMOND, IN 47374
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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 a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00306119.</p> <p>Complaint IN00306119 - Unsubstantiated due to lack of evidence.</p> <p>Survey dates: November 12 and 13, 2019</p> <p>Facility number: 012497</p> <p>Residential Census: 101</p> <p>Senior Suites at the Leland was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey and Complaint Investigation.</p> <p>Quality review completed November 15, 2019</p>	R 000		

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