

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>014775</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/23/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>AUBURN SENIOR LIVING, LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1675 W SEVENTH STREET</b> <b>AUBURN, IN 46706</b>		
(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 IN00438805.</p> <p>Complaint IN00438805-No Federal/State deficiencies related to the allegations are cited.</p> <p>Survey date: August 23, 2024</p> <p>Facility number: 014775</p> <p>Residential Census: 82</p> <p>Auburn Senior Living, LLC was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00438805.</p> <p>Quality review completed August 26, 2024.</p>	R 000		

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

TITLE

(X6) DATE