

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 014383	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/03/2025
NAME OF PROVIDER OR SUPPLIER LEGACY LIVING LEASING JASPER, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1850 WEST STATE ROAD 56 JASPER, IN 47546		
(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 IN00456188.</p> <p>Complaint IN00456188: No deficiencies related to the allegation(s) are cited.</p> <p>Survey date: April 3, 2025</p> <p>Facility number: 014383</p> <p>Residential Census: 92</p> <p>Legacy Living Leasing Jasper, LLC was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00456188.</p> <p>Quality review completed on April 7, 2025.</p>	R 000		

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

TITLE

(X6) DATE