

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>014213</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/04/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>HERITAGE WOODS OF NOBLESVILLE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>9600 E 146TH STREET</b> <b>NOBLESVILLE, IN 46060</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 IN00453265 and IN00449822.</p> <p>Complaint IN00453265 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00449822 - No deficiencies related to the allegations are cited.</p> <p>Survey dates: March 3 and 4, 2025</p> <p>Facility number: 014213</p> <p>Residential Census: 125</p> <p>Heritage Woods of Noblesville was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00453265 and IN00449822.</p> <p>Quality review completed March 6, 2025.</p>	R 000		

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

TITLE

(X6) DATE