

Indiana 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 08/20/2024
NAME OF PROVIDER OR SUPPLIER SENIOR SUITES AT THE LELAND, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 900 SOUTH A STREET RICHMOND, IN 47374		
(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 IN00441085.</p> <p>Complaint IN00441085 - No deficiencies related to the allegations are cited.</p> <p>Survey date: August 20, 2024</p> <p>Facility number: 012497</p> <p>Residential Census: 93</p> <p>Senior Suites at the Leland was found to be in compliance with 410 IAC 16.2-5 in regards to the Investigation of Complaint IN00441085.</p> <p>Quality review completed on August 21, 2024.</p>	R 000			

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

TITLE

(X6) DATE