

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 014775	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/03/2024
NAME OF PROVIDER OR SUPPLIER AUBURN SENIOR LIVING, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1675 W SEVENTH STREET AUBURN, IN 46706		
(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 IN00430407.</p> <p>Complaint IN00430407 - No deficiencies related to the allegations are cited.</p> <p>Survey date: April 3, 2024</p> <p>Facility number: 014775</p> <p>Residential Census: 80</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 IN00430407.</p> <p>Quality review completed April 3, 2024.</p>	R 000		

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

TITLE

(X6) DATE