

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 R-C 09/16/2024
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 Post Survey Revisit (PSR) for the Investigation of Complaint IN00440174 completed on 8/5/24.</p> <p>Complaint IN00440174 - corrected</p> <p>Survey dates: September 16, 2024</p> <p>Facility number: 014383</p> <p>Residential Census: 95</p> <p>Legacy Living Leasing Jasper, LLC was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR for the Investigation of Complaint IN00440174 survey.</p> <p>Quality review completed on September 19, 2024.</p>	{R 000}			

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

TITLE

(X6) DATE