

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 012940	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 10/07/2014
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NAME OF PROVIDER OR SUPPLIER BICKFORD OF CROWN POINT	STREET ADDRESS, CITY, STATE, ZIP CODE 140 E 107TH AVENUE CROWN POINT, IN 46307
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(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 a Post Survey Revisit (PSR) to the Investigation of Complaint IN00154780 completed on 08/21/14.</p> <p>Complaint IN00154780-Corrected.</p> <p>Survey Date: October 7, 2014</p> <p>Facility number: 012940 Provider number: 012940 AIM number: N/A</p> <p>Survey team: Regina Sanders, RN, TC</p> <p>Census by bed type: Residential: 25 Total: 25</p> <p>Census Payor type: Other: 25 Total: 25</p> <p>Residential Sample: 5</p> <p>Bickford of Crown Point was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to the Investigation of Complaint IN00154780.</p> <p>Quality review completed on October 7, 2014, by Janelyn Kulik, RN.</p>	{R 000}		

Indiana State Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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