

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 012309	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 12/16/2015
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NAME OF PROVIDER OR SUPPLIER CROWNPOINTE OF CARMEL	STREET ADDRESS, CITY, STATE, ZIP CODE 11610 TECHNOLOGY DR CARMEL, IN 46032
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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 the Post Survey Revisit (PSR) to the Investigation of Complaint IN00182622 completed on 11-12-15.</p> <p>Complaint IN00182622 Corrected</p> <p>Survey Date: December 16, 2015</p> <p>Facility number: 012309 Provider number: 012309 AIM number: NA</p> <p>Census bed type: Residential: 36 Total: 36</p> <p>Census payor type: Other: 36 Total: 36</p> <p>Sample: 3</p> <p>Crownpointe of Carmel was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to the Investigation of Complaint IN00182622.</p> <p>Quality Review was completed by 21662 on December 17, 2015.</p>	{R 000}		

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

TITLE

(X6) DATE