

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 C 08/09/2021
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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 the Investigation of Complaint IN00358138.</p> <p>Complaint IN00358138 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey date: 8/9/21</p> <p>Facility number: 012940</p> <p>Residential Census: 58</p> <p>Bickford of Crown Point was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00358138.</p> <p>Quality review completed on 8/9/21.</p>	R 000		

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

TITLE

(X6) DATE