

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>005729</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/29/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CROWNPOINTE OF INDIANAPOLIS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7365 E 16TH ST INDIANAPOLIS, IN 46219</b>
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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><b>INITIAL COMMENTS</b></p> <p>This visit was for the Investigation of Complaints IN00156700 and IN00156718.</p> <p>Complaint IN00156700- Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00156718- Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey Dates: September 26 and 29, 2014</p> <p>Facility number: 005729 Provider number: 005729 AIM number: NA</p> <p>Survey team: Chuck Stevenson RN</p> <p>Census bed type: Residential: 59 Total: 59</p> <p>Census payor type: Medicaid: 56 Other: 3 Total: 59</p> <p>Sample: 3</p> <p>Crownpointe of Indianapolis was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaints IN00156700 and IN00156718.</p> <p>Quality Review 09/30/14 by Lisa McColly</p>	R 000		

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

TITLE

(X6) DATE