

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/17/2024	
NAME OF PROVIDER OR SUPPLIER 1019 BELLE'S PLACE OF CRAWFORDSVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 100 BICKFORD LN, CRAWFORDSVILLE, , 47933					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...			(X5) COMPLETION DATE	
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00448594. Complaint IN00448594- No deficiencies related to the allegations are cited. Survey date: December 16, and 17, 2024 Facility number: 003674 Residential Census: 22 1019 Belle's Place of Crawfordsville was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00448594. Quality review completed on December 19, 2024.	R 0000					
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)							
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S			TITLE		(X6) DATE		

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FORM APPROVED

OMB NO. 0938-0391

SIGNATURE		
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