

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 01/24/2025	
NAME OF PROVIDER OR SUPPLIER CROWNPOINTE OF INDIANAPOLIS		STREET ADDRESS, CITY, STATE, ZIP CODE 7365 E 16TH ST, INDIANAPOLIS, , 46219					
(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 Complaints IN00450974 and IN00451449. Complaint IN00450974 - No deficiencies related to the allegations are cited. Complaint IN00451449 - No deficiencies related to the allegations are cited. Survey date: January 24, 2025 Facility number: 005729 Residential Census: 28 Crownpointe of Indianapolis was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaints IN00450974 and IN00451449. Quality review completed on January 28, 2025.	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			TITLE			(X6) DATE	

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PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		
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