

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 07/10/2026
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 Intakes 470275 and 470516. Intake 470275 - No deficiencies related to the allegations are cited. Intake 470516 - No deficiencies related to the allegations are cited. Survey date: July 10, 2026 Facility number: 005729 Residential Census: 40 Crownpointe of Indianapolis was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Intakes 470275 and 470516. Quality review completed July 13, 2026.	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.)				

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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