

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 05/06/2024	
NAME OF PROVIDER OR SUPPLIER CROWNPOINTE OF ANDERSON		STREET ADDRESS, CITY, STATE, ZIP CODE 2727 CROWNPOINTE CIRCLE, ANDERSON, , 46012					
(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 IN00432691 and IN00432826. Complaint IN00432691 - No deficiencies related to the allegations are cited. Complaint IN00432826 - No deficiencies related to the allegations are cited. Survey dates: 5/3/24 and 5/6/24 Facility number: 012129 Residential Census: 45 Crownpointe of Anderson was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00432691 and IN00432826. Quality review completed May 9, 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.)							

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