

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

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| STATEMENT OF DEFICIENCIES AND<br>PLAN OF CORRECTIONS                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                         |                                  | (X2) MULTIPLE<br>CONSTRUCTION<br><br>A. BUILDING<br><br>B. WING |  | (X3) DATE SURVEY<br>COMPLETED<br><br>03/24/2025 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>CROWNPOINTE OF ANDERSON                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP<br>CODE<br><br>2727 CROWNPOINTE CIRCLE,<br>ANDERSON, , 46012 |                                  |                                                                 |  |                                                 |  |
| (X4) ID<br>PREFIX TAG                                                                                                                                                                                                                             | SUMMARY STATEMENT OF<br>DEFICIENCIES...                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID PREFIX<br>TAG                                                                              | PROVIDER'S PLAN OF CORRECTION... |                                                                 |  | (X5)<br>COMPLETION<br>DATE                      |  |
| R 0000                                                                                                                                                                                                                                            | <p>INITIAL COMMENTS</p> <p>This visit was for the<br/>Investigation of Complaint<br/>IN00454698.</p> <p>Complaint IN00454698 - No<br/>deficiencies related to the<br/>allegations are cited.</p> <p>Survey date: March 24, 2025</p> <p>Facility number: 012129</p> <p>Residential Census: 46</p> <p>Crownpointe of Anderson was<br/>found to be in compliance with<br/>410 IAC 16.2-5 in regard to the<br/>Investigation of Complaint<br/>IN00454698.</p> <p>Quality review completed March<br/>25, 2025.</p> | 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<br>PROVIDER/SUPPLIER REPRESENTATIVE'S<br>SIGNATURE                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                               | TITLE                            |                                                                 |  | (X6) DATE                                       |  |