

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 06/21/2024
NAME OF PROVIDER OR SUPPLIER CROWNPOINTE OF HARTFORD CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 100 INDEPENDENCE PARKWAY, HARTFORD CITY, , 47348			
(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 IN00433050, IN00433060, and IN00434750. Complaint IN00433050 - No deficiencies related to the allegations are cited. Complaint IN00433060 - No deficiencies related to the allegations are cited. Complaint IN00434750 - No deficiencies related to the allegations are cited. Survey dates: June 20 and 21, 2024 Facility number: 013578 Residential Census: 26 Crownpointe of Hartford City was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaints IN00433050, IN00433060, and IN00434750.	R 0000			

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FORM APPROVED

OMB NO. 0938-0391

	Quality review completed June 26, 2024.			
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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 SIGNATURE	TITLE	(X6) DATE
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