

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 003674	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 08/03/2022
NAME OF PROVIDER OR SUPPLIER CRAWFORDSVILLE BICKFORD COTTAGE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 100 BICKFORD LN CRAWFORDSVILLE, IN 47933		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00385957.</p> <p>Complaint IN00385957- Unsubstantiated due to lack of evidence.</p> <p>Survey date: August 3, 2022</p> <p>Facility number: 003674</p> <p>Residential Census: 18</p> <p>Crawfordsville Bickford Cottage LLC was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00385957.</p> <p>Quality review completed on August 15, 2022.</p>	R 000			

Indiana State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE