

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 012129	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/27/2025
NAME OF PROVIDER OR SUPPLIER CROWNPOINTE OF ANDERSON		STREET ADDRESS, CITY, STATE, ZIP CODE 2727 CROWNPOINTE CIRCLE ANDERSON, IN 46012		
(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 Complaints IN00458992 and IN00459679.</p> <p>Complaint IN00458992 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00459679 - No deficiencies related to the allegations are cited.</p> <p>Survey date: May 27, 2025</p> <p>Facility number: 012129</p> <p>Residential Census: 43</p> <p>Crownpointe of Anderson was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaints IN00458992 and IN00459679.</p> <p>Quality review completed May 29, 2025.</p>	R 000		

Indiana Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE