

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 013335	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/24/2023
NAME OF PROVIDER OR SUPPLIER HARRISON'S CROSSING HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 395 8TH AVENUE TERRE HAUTE, IN 47804		
(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 Residential Complaint IN00412256.</p> <p>Complaint IN00412256 - No deficiencies related to the allegations are cited.</p> <p>Survey date: August 24, 2023</p> <p>Facility number: 013335</p> <p>Residential Census: 34</p> <p>Harrison's Crossing Health Campus was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Residential Complaint IN00412256.</p> <p>Quality review completed on August 31, 2023.</p>	R 000		

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

TITLE

(X6) DATE