

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 012798	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/05/2023
NAME OF PROVIDER OR SUPPLIER CROWNPOINTE OF GREENFIELD		STREET ADDRESS, CITY, STATE, ZIP CODE 831 SWOPE STREET GREENFIELD, IN 46140		
(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 IN00416518.</p> <p>Complaint IN00416518 - No deficiencies related to the allegations are cited.</p> <p>Survey date: September 5, 2023</p> <p>Facility number: 012798</p> <p>Residential Census: 48</p> <p>Crownpointe of Greenfield was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00416518.</p> <p>Quality review completed on September 6, 2023</p>	R 000		

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

TITLE

(X6) DATE