

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 011906	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/18/2024
NAME OF PROVIDER OR SUPPLIER COBBLESTONE CROSSINGS HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 1850 E HOWARD WAYNE DR TERRE HAUTE, IN 47802		
(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 IN00431313.</p> <p>Complaint IN00431313 - No deficiencies related to the allegations are cited.</p> <p>Survey dates: April 17 and 18, 2024</p> <p>Facility number: 011906</p> <p>Residential Census: 21</p> <p>Cobblestone Crossings Health Campus was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00431313.</p> <p>Quality review completed on April 23, 2024.</p>	R 000		

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

TITLE

(X6) DATE