

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>012309</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/12/2019</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CROWNPOINTE OF CARMEL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>11610 TECHNOLOGY DR CARMEL, IN 46032</b>
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(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><b>INITIAL COMMENTS</b></p> <p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: September 11 and 12, 2019.</p> <p>Facility number: 012309</p> <p>Residential Census: 38</p> <p>Crown Point of Carmel was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.</p> <p>Quality Review was completed on September 16, 2019.</p>	R 000		

Indiana State Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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