

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>013582</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R-C <b>11/07/2022</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CROWNPOINTE OF LEBANON</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>610 CROWNPOINTE DRIVE LEBANON, IN 46052</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 Post Survey Revisit (PSR) to Investigation of Complaint IN00390245 completed on September 22, 2022.</p> <p>Complaint IN00390245 - Corrected.</p> <p>Survey date: November 07, 2022</p> <p>Facility number: 013582</p> <p>Residential Census: 49</p> <p>Crownpointe of Lebanon was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to Investigation of Complaint IN00390245.</p> <p>Quality review was completed on November 9, 2022.</p>	{R 000}		

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