

Indiana 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  <b>C</b> <b>06/24/2025</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 State Residential Licensure Survey. This visit included the Investigation of Complaint IN00460318.</p> <p>Complaint IN00460318-No deficiencies related to the allegations are cited.</p> <p>Survey dates: June 23 &amp; 24, 2025</p> <p>Facility number: 013582</p> <p>Residential Census: 54</p> <p>Crownpointe of Lebanon was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey and the Investigation of Complaint IN00460318.</p> <p>Quality review was completed on June 25, 2025.</p>	R 000		

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