

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 002858	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/15/2025
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NAME OF PROVIDER OR SUPPLIER MORNING POINTE OF FRANKLIN	STREET ADDRESS, CITY, STATE, ZIP CODE 75 S MILFORD DR FRANKLIN, IN 46131
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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>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00462935.</p> <p>Complaint IN00462935 - No deficiencies related to the allegations are cited.</p> <p>Survey date: July 15, 2025</p> <p>Facility number: 002858</p> <p>Residential Census: 38</p> <p>Morning Pointe of Franklin was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00462935.</p> <p>Quality review completed July 17, 2025.</p>	R 000		

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