

Indiana State 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 12/09/2022
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NAME OF PROVIDER OR SUPPLIER COBBLESTONE CROSSINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1850 E HOWARD WAYNE DR TERRE HAUTE, IN 47802
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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 Residential Complaint IN00395993.</p> <p>Complaint IN00395993 - Unsubstantiated due to lack of evidence.</p> <p>Survey dates: December 08 and 09, 2022</p> <p>Facility number: 011906</p> <p>Residential Census: 26</p> <p>Cobblestone Crossing Health Campus was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Residential Complaint IN00395993.</p> <p>Quality review completed on December 21, 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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