

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 012007	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
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NAME OF PROVIDER OR SUPPLIER RIVER CROSSING ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 MARKET ST CHARLESTOWN, IN 47111
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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 a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00188547.</p> <p>Complaint IN00188547 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: December 28, 29 and 30, 2015</p> <p>Facility number: 012007 Provider number: 012007 AIM number: N/A</p> <p>Residential Census: 101</p> <p>Sample: 7</p> <p>River Crossing Assisted Living 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 IN00188547.</p> <p>QR completed by 34849 on December 31, 2015.</p>	R 000		

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