

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/07/2023
NAME OF PROVIDER OR SUPPLIER RIVER CROSSING ASSISTED LIVING COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 2400 MARKET ST, CHARLESTOWN, , 47111			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE	
R 0000	INITIAL COMMENTS This visit was for a Post Survey Revisit (PSR) to Investigation of Complaints IN00408817 and IN00408888 completed on 5/24/23. Complaint IN00408817 - Corrected Complaint IN00408888 - Corrected Survey date: July 7, 2023 Facility number: 012007 Residential Census: 85 River Crossing Assisted Living was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to Investigation of Complaints IN00408817 and IN00408888. Quality review completed on July 10, 2023.	R 0000			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See

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instructions.)		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE