

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 07/31/2026
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 the Investigation of Intakes 470323, 470838, 470843, 470936 and 470993. Intake 470323 - No deficiencies related to the allegations are cited. Intake 470838 - No deficiencies related to the allegation is cited. Intake 470843 - No deficiencies related to the allegation is cited. Intake 470936 - No deficiencies related to the allegations are cited. Intake 470993 - No deficiencies related to the allegations are cited. Survey date: July 30 and 31, 2026 Facility number: 012007 Residential Census: 66	R 0000			

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FORM APPROVED

OMB NO. 0938-0391

River Crossing Assisted Living Community was found to be in compliance with 410 IAC (Indiana Administrative Code) 16.2-5 in regard to the Investigation of Intakes 470323, 470838, 470843, 470936 and 470993.

Quality review completed on August 6, 2026.

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 instructions.)

LABORATORY DIRECTOR'S OR
PROVIDER/SUPPLIER REPRESENTATIVE'S
SIGNATURE

TITLE

(X6) DATE