STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CROSSING ASSISTED LIVING COMMUNITY	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 Complaints IN00446173, IN00445399, and IN00443684. Complaint IN00446173 - No deficiencies related to the allegations were cited. Complaint IN00445399 - No deficiencies related to the allegations were cited. Complaint IN00443684 - No deficiencies related to the allegations were cited. Survey dates: November 6 and 7, 2024. Facility number: 012007 Residential Census: 73 River Crossing Assisted Living Community was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaints IN00446173, IN00445399, and IN00443684.	R 0000		

	Quality review completed on November 14, 2024.			

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