

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 08/23/2023	
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 the Investigation of Complaint IN00415289. Complaint IN00415289 - No deficiencies related to the allegation is cited. Survey dates: August 22 and 23, 2023 Facility number: 012007 Residential Census: 83 River Crossing Assisted Living Community was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00415289. Quality review completed on August 28, 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 instructions.)							
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE			(X6) DATE	