STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	03/23/2023

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 IN00399781, IN00399797, IN00401150 and IN00403914. Complaint IN00399781 - No deficiencies related to the allegations are cited. Complaint IN00399797 - No deficiencies related to the allegations are cited. Complaint IN00401150 - No deficiencies related to the allegations are cited. Complaint IN00403914 - No deficiencies related to the allegations are cited. Survey dates: March 21, 22 and 23, 2023 Facility number: 012007 Residential Census: 89 River Crossing Assisted Living Community was found to be in compliance with 410 IAC 16.2-5	R 0000		

	in regard to the Investigation of Complaints IN00399781, IN00399797, IN00401150 and IN00403914. Quality review completed on March 27, 2023.			

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