

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 03/24/2023	
NAME OF PROVIDER OR SUPPLIER DEMAREE CROSSING ASSISTED LIVING AND MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1255 DEMAREE ROAD, GREENWOOD, , 46143					
(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 IN00402595, IN00403442, and IN00403627. Complaint IN00402595 - No deficiencies related to the allegations are cited. Complaint IN00403442 - No deficiencies related to the allegations are cited. Complaint IN00403627 - No deficiencies related to the allegations are cited. Survey date: March 23 and 24, 2023 Facility number: 014079 Residential Census: 57	R 0000					

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Demaree Crossing Assisted Living and Memory Care was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaints IN00402595, IN00403442, and IN00403627.

Quality review completed March 29, 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