

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 05/16/2024
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 IN00433763 and IN00434096. Complaint IN00433763 - No deficiencies related to the allegations are cited. Complaint IN00434096 - No deficiencies related to the allegations are cited. Survey date: May 16, 2024 Facility number: 014079 Residential Census: 64 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 IN00433763 and IN00434096. Quality review completed May 20, 2024.	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

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instructions.)		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE