

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>012007</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R-C 09/06/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>RIVER CROSSING ASSISTED LIVING COMMUNITY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2400 MARKET ST CHARLESTOWN, IN 47111</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{R 000}	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for a Post Survey Revisit (PSR) to Investigation of Complaint IN00382220 completed on 7/19/22.</p> <p>Complaint IN00382220 - Corrected</p> <p>Survey date: September 6, 2022</p> <p>Facility number: 012007</p> <p>Residential Census: 84</p> <p>River Crossing Assisted Living was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to Investigation of Complaint IN00382220.</p> <p>Quality review completed on September 8, 2022.</p>	{R 000}		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE