

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 014079	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/24/2023
NAME OF PROVIDER OR SUPPLIER DEMAREE CROSSING ASSISTED LIVING AND MEMO		STREET ADDRESS, CITY, STATE, ZIP CODE 1255 DEMAREE ROAD GREENWOOD, IN 46143		
(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>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaints IN00402595, IN00403442, and IN00403627.</p> <p>Complaint IN00402595 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00403442 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00403627 - No deficiencies related to the allegations are cited.</p> <p>Survey date: March 23 and 24, 2023</p> <p>Facility number: 014079</p> <p>Residential Census: 57</p> <p>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.</p> <p>Quality review completed March 29, 2023.</p>	R 000		

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

TITLE

(X6) DATE