PRINTED: 02/21/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/02/2025		
NAME OF PROVIDER OR SUPPLIER RIVER CROSSING ASSISTED LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP COD 2400 MARKET ST CHARLESTOWN, IN 47111				
(X4) ID PREFIX TAG R 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
Bldg. 00	Survey. Survey date: Januar Facility number: 01 Residential Census: This State Resident accordance with 41	2007 71 ial Finding is cited in	R 00	000			
R 0273 Bldg. 00	Based on observation interview, the facility was maintained in a This deficient pract 71 of 71 residents of Findings include: 1. During a tour of a.m., the following - In the stand-alone slices in a cloudy like of turkey slices in a 12/24/24. - The vents over the	nal Services - Deficiency on, record review and ty failed to ensure the kitchen a safe and sanitary manner. tice had the potential to affect currently residing at the facility. The kitchen on 1/2/25 at 9:11 tissues were observed: refrigerator, a bag of ham quid was dated 12/15/24. A bag cloudy liquid was dated e cook top, griddle, and deep ting of tan colored grease and	R 02	273	All fridges were inspected any additional items not dated correctly and none were found Dish machine inspected for properation and was working properly. Cooking line was cleaned underneath. FRONT Cook's line cleaned ON 1/03/2 and back will be cleaned when longer high pressure gas line i installed and logged on daily cleaning log. The dietary manais monitoring logs for dish machine and cleaning tasks daily. All residents have the potential be affected by the alleged defipractice.	DF 024 0 s ager	01/30/2025

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

TITLE (X6) DATE

Richard Pedersen Executive Director 01/25/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

State Form Event ID: FTC811 Facility ID: 012007 If continuation sheet Page 1 of 4

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 01/02/2025		
NAME OF PROVIDER OR SUPPLIER RIVER CROSSING ASSISTED LIVING COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP COD 2400 MARKET ST CHARLESTOWN, IN 47111				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
	- The 2 drip pans ur accumulation of focunder the griddle had was an inch and a had which almost spilled out. - There were multip floor under the deep was a claration of the puddle was a claration of each shift by shift ended at 2:00 p. 2. During an interview indicated all cooks the kitchen. The kittend of each shift by shift ended at 2:00 p. 2. During a second 2:10 p.m., the same observed. At this this indicated that lefton hours. He then disciplicated turkey. The defor the day. The review of the frindicated the follow - The second shift completed. - The first shift cool 1/2/25, indicated stated the follow - The first shift cool 1/2/25, indicated stated the completed.	der the cook top had an old debris, and the drip pan old liquid and food debris that alf from the top of the pan, dout of the pan when pulled le french fries scattered on the ofryer. le white colored streaks oft side of the stove. The white on the floor by the stove. In ear piece of plastic with a nuck on it. on 1/2/25 at 9:30 a.m., Cook 3 were responsible for cleaning then was to be cleaned at the the kitchen staff and their o.m. tour of the kitchen on 1/2/25 at issues as above were me the Executive Director (ED) ters should be discarded at 72 arded the sliced ham and ay shift kitchen staff had left		Dietary staff were educated of dating process, dish machine operation and logging temps, cleaning procedures and completing cleaning log on 1/24/2025. Exhaust hood cleaby outside company on 1/28 /2025mand scheduled every months thereafter. Longer hipressure gas line will be instant on fryer to allow cleaning behavior	and aned 6 gh alled aind. er for 8 er. tation ied	

State Form Event ID: FTC811 Facility ID: 012007 If continuation sheet Page 2 of 4

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/02/2025			
NAME OF PROVIDER OR SUPPLIER RIVER CROSSING ASSISTED LIVING COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP COD 2400 MARKET ST CHARLESTOWN, IN 47111					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION ed for 1/2/25.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE COMPLETION		
	and Rinse Cycle ter had not been compl 12/15/24, 12/20/24, The review of the E and Rinse Cycle ter shift had not been c 12/31/24. The review of the E and Rinse Cycle ter shift had not been c 12/31/24. The review of the E and Rinse Cycle ter evening shifts had not 1/2/25. During an interview indicated the dishw completed in a spot During an interview Aide 4 indicated shift the wash and rinse a supposed to be.	December Dish Machine Wash inperature log for the day shift eted for 12/6/24 through and 12/23/24 through 12/28/24. December Dish Machine Wash inperature log for the evening completed for 12/22/24 through inperature log the day and not been completed for 1/1/25 To on 1/2/25 at 9:20 a.m., Cook 3 asher temperature log was					
	foods stored in the dated, labeled with than 72 hours from useRefrigerated le hours shall be disca	refrigerator shall be wrapped, a use by date that is no more					
	included, but was n ensure that food pre in a safe and sanitar	For Kitchen Sanitation of limited to, "Guideline: To epared in the facility is done so by manner. Procedure: The ger will monitor food safety					

State Form Event ID: FTC811 Facility ID: 012007 If continuation sheet Page 3 of 4

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
			B. WI	NG	_	01/02/	/2025
NAME OF PROVIDER OR SUPPLIER RIVER CROSSING ASSISTED LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP COD 2400 MARKET ST CHARLESTOWN, IN 47111			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	FICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	daily basis" The current policy fincluded, but was no	e Dietary Department on a For Warewashing-Dishmachine of limited to, "Record either itizer level on the Dishmachine zer Log"					

State Form Event ID: FTC811 Facility ID: 012007 If continuation sheet Page 4 of 4