

Indiana Department of Health

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| 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 03/22/2024 |
| 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 Complaint IN00429714.</p> <p>Complaint IN00429714 - No deficiencies related to the allegations are cited.</p> <p>Survey date: March 22, 2024</p> <p>Facility number: 014079</p> <p>Residential Census: 61</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 Complaint IN00429714.</p> <p>Quality review completed March 22, 2024.</p> | R 000 | | | |

Indiana Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE