

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 09/28/2022
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NAME OF PROVIDER OR SUPPLIER DEMAREE CROSSING ASSISTED LIVING AND MEMO	STREET ADDRESS, CITY, STATE, ZIP CODE 1255 DEMAREE ROAD GREENWOOD, IN 46143
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(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 IN00388461.</p> <p>Complaint IN00388461 - Substantiated. No deficiencies related to allegation are cited.</p> <p>Survey date: September 28, 2022</p> <p>Facility number: 014079</p> <p>Residential Census: 62</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 IN00388461.</p> <p>Quality review completed September 30, 2022.</p>	R 000		

Indiana State Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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