STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
1019 BELLE'S PLACE OF CRAWFORDSVILLE	100 BICKFORD LN, CRAWFORDSVILLE, , 47933

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey dates: May 20 and 21, 2025 Facility number: 003674 Residential Census: 28 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on June 3, 2025.	R 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of violation of any regulations. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegations of Compliance effective 1/24/2025	
R 0092	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(i)(1-2) (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire	R 0092	No residents were affected, all 28 had the protentional to be affected. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. No residents were affected.	06/13/2025

	alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on record review and interview, the facility failed to ensure fire drills had been completed quarterly on all shifts and failed to ensure the fire department had been invited to participate in a fire drill for 12 of 12 months (May 2024 through April 2025). Findings include: On 5/20/25 at 10:40 a.m., review of the facility's fire drill records, dated May 2024 through April 2025, indicated the following: a. A fire drill document, dated		What measures will be put into place or what systematic changes the facility will make to ensure that the deficient practice does not recur: 1019 created a schedule that ensures quarterly fire drills on each shift totaling 12 fire drills annually. The form was updated to include signatures of staff participation. ED reached out to local Fire Department for coordination of fire drill and will continue on a semi-annual basis. How the corrective actions will be monitored to ensure the deficient practice will not recure, i.e., what quality assurance program will be put into place. ED will monitor the said schedule monthly to ensure the drills are being done in compliance with regulations. By what date the systemic changes will be completed. June 14, 2025	

	5/8/24, indicated the drill had been conducted at 2:30 p.m. b. A fire drill document, dated 6/12/24, indicated the drill had been conducted at 2:41 p.m. c. A fire drill document, dated 7/10/24, indicated the drill had been conducted at 2:30 p.m. d. A fire drill document, dated 8/14/24, indicated the drill had been conducted at 2:00 p.m. e. The records lacked documentation that a fire drill had been conducted for September 2024. f. A fire drill document, dated 10/23/24, indicated the drill had been conducted at 6:45 a.m.. g. A fire drill document, dated 11/6/24, indicated the drill had been conducted at 7:15 a.m. h. The records lacked documentation that a fire drill had been conducted for December 2024. i. The records lacked documentation that a fire drill had been conducted for January 2025. j. The records lacked documentation that a fire drill had been conducted for February 2025. k. A fire drill document, dated			

	3/18/25, indicated the drill had been conducted at 11:15 a.m. I. The records lacked documentation that a fire drill had been conducted for April 2025. The record lacked documentation of the local fire department had been invited to participate in a fire drill at the facility. During an interview, on 5/20/25 at 10:25 a.m., the Administrator (ADM) indicated she was not aware that fire drills had not been conducted per the regulations. She had noticed that the fire department had not participated in a drill and was going to contact them in June 2025 to invite them to participate. During an interview, on 5/20/25 at 2:48 p.m., the Director of Nursing (DON) indicated the fire drill record indicated all of the drills, except the October 2024 drill, had taken place on the first (day) shift. On 5/20/24 at 1:50 p.m., the Corporate Consultant provided a document, with a revision date of 11/1/24, titled, "Emergency Preparedness," and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedure...8. Fire/evacuation drills for staff and residents should be			

conducted on a regular schedule and at different times different shifts."

Based on record review and interview, the facility failed to ensure fire drills had been completed quarterly on all shifts and failed to ensure the fire department had been invited to participate in a fire drill for 12 of 12 months (May 2024 through April 2025).

Findings include:

On 5/20/25 at 10:40 a.m., review of the facility's fire drill records, dated May 2024 through April 2025, indicated the following:

a. A fire drill document, dated 5/8/24, indicated the drill had been conducted at 2:30 p.m.

b. A fire drill document, dated 6/12/24, indicated the drill had been conducted at 2:41 p.m.

c. A fire drill document, dated 7/10/24, indicated the drill had been conducted at 2:30 p.m.

d. A fire drill document, dated 8/14/24, indicated the drill had been conducted at 2:00 p.m.

e. The records lacked documentation that a fire drill had been conducted for September 2024.

f. A fire drill document, dated

	10/23/24, indicated the drill had been conducted at 6:45 a.m.. g. A fire drill document, dated 11/6/24, indicated the drill had been conducted at 7:15 a.m. h. The records lacked documentation that a fire drill had been conducted for December 2024. i. The records lacked documentation that a fire drill had been conducted for January 2025. j. The records lacked documentation that a fire drill had been conducted for February 2025. k. A fire drill document, dated 3/18/25, indicated the drill had been conducted at 11:15 a.m. l. The records lacked documentation that a fire drill had been conducted for April 2025. The record lacked documentation of the local fire department had been invited to participate in a fire drill at the facility. During an interview, on 5/20/25 at 10:25 a.m., the Administrator (ADM) indicated she was not aware that fire drills had not been conducted per the regulations. She had noticed that the fire department had not			

	participated in a drill and was going to contact them in June 2025 to invite them to participate. During an interview, on 5/20/25 at 2:48 p.m., the Director of Nursing (DON) indicated the fire drill record indicated all of the drills, except the October 2024 drill, had taken place on the first (day) shift. On 5/20/24 at 1:50 p.m., the Corporate Consultant provided a document, with a revision date of 11/1/24, titled, "Emergency Preparedness," and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedure...8. Fire/evacuation drills for staff and residents should be conducted on a regular schedule and at different times different shifts."			
R 0095	Administration and Management -Noncompliance 410 IAC 16.2-5-1.3(l)(1-2) (l) In facilities that are required under IC 12-10-5.5 to submit an Alzheimer's and dementia special care unit disclosure form, the facility must designate a director for the Alzheimer's and dementia special care unit. The director shall have an earned degree from an educational institution in a health care, mental health, or social service profession or be a licensed	R 0095	No residents were affected. All 23 of 28 had the potential to be affected. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. No residents were affected. What measures will be put into	06/13/2025

	health facility administrator. The director shall have a minimum of one (1) year work experience with dementia or Alzheimer's residents, or both, within the past five (5) years. Persons serving as a director for an existing Alzheimer's and dementia special care unit at the time of adoption of this rule are exempt from the degree and experience requirements. The director shall have a minimum of twelve (12) hours of dementia-specific training within three (3) months of initial employment as the director of the Alzheimer's and dementia special care unit and six (6) hours annually thereafter to: (1) meet the needs or preferences, or both, of cognitively impaired residents; and (2) gain understanding of the current standards of care for residents with dementia. Based on interview and record review, the facility failed to ensure a state required dementia unit disclosure form had been completed. This deficiency has the potential to affect 23 of 28 residents residing at the facility. Findings include: On 5/20/25 at 10:30 a.m., the entrance conference materials lacked documentation of a state required dementia unit disclosure form.		place or what systemic changes the facility will make to ensure that the deficient practice does not recur 1019 will complete the state required dementia unit disclosure form. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e, what quality assurance programs will be put into place With the completion of the form, the facility is compliant. By what date the systemic changes will be completed June 13, 2025	

	During an interview, on 5/20/25 at 10:52 a.m., the Administrator (ADM) indicated she was not aware that a dementia unit disclosure form was needed to be completed, due to the facility having memory care/dementia residents. The facility was a secure facility and the doors were locked at all times and could only be unlocked by a key fob. During an interview, on 5/21/25 at 9:53 a.m., the Director of Nursing (DON) indicated there were 23 of the 28 total residents that were considered memory care residents. This was calculated to 82% of the facility census being memory care residents. During an interview, on 5/21/25 at 9:55 a.m., the Corporate Consultant indicated there was a statement in the admission agreement that indicated the facility was a secure facility and that the doors to the facility would be locked at all times. At the same time, she indicated there was not a specific policy related to the need for a dementia unit disclosure document to be completed. The facility would follow the state regulations for completion of the form. Based on interview and record review, the facility failed to ensure a state required			

dementia unit disclosure form had been completed. This deficiency has the potential to affect 23 of 28 residents residing at the facility.

Findings include:

On 5/20/25 at 10:30 a.m., the entrance conference materials lacked documentation of a state required dementia unit disclosure form.

During an interview, on 5/20/25 at 10:52 a.m., the Administrator (ADM) indicated she was not aware that a dementia unit disclosure form was needed to be completed, due to the facility having memory care/dementia residents. The facility was a secure facility and the doors were locked at all times and could only be unlocked by a key fob.

During an interview, on 5/21/25 at 9:53 a.m., the Director of Nursing (DON) indicated there were 23 of the 28 total residents that were considered memory care residents. This was calculated to 82% of the facility census being memory care residents.

During an interview, on 5/21/25 at 9:55 a.m., the Corporate Consultant indicated there was a statement in the admission agreement that indicated the facility was a secure facility and that the doors to the facility

	would be locked at all times. At the same time, she indicated there was not a specific policy related to the need for a dementia unit disclosure document to be completed. The facility would follow the state regulations for completion of the form.			
R 0151	Sanitation & Safety Standards -Noncompliance 410 IAC 16.2-5-1.5(h) (h) Any pet housed in a facility shall have periodic veterinary examinations and required immunizations. Based on interview and record review, the facility failed to obtain and keep pet vaccination and health records on file for 1 of 1 resident who had a dog that resided at the facility (Resident 521). Findings include: During the entrance conference, on 5/20/25 at 10:25 a.m., the Administrator indicated they had a dog who belonged to a resident in the building. The dog was the only pet in the facility. Resident 521's census information indicated she had a move in date of 8/9/24. Resident 521's move in agreement was reviewed on	R 0151	No residents were affected. All 1 of 1 resident had the potential to be affected. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. No residents were affected. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. Shot records were submitted. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e, what quality assurance program will be put into place.	06/13/2025

	5/21/25 at 2:10 p.m. The agreement indicated the resident paid a non-refundable pet deposit and the resident would " ...observe and abide by all pet policies and procedures and governmental laws and regulations applicable to the premises ...." The resident signed the move in agreement on 8/9/24. During an interview, on 5/20/25 at 1:53 p.m., the Corporate Consultant indicated they did not have any health records currently in the building for Resident 521's dog. She was aware the facility should maintain health records and vaccination records for any pets in the building. The facility had reached out to the family to obtain the records but had not heard anything back yet. On 5/20/25 at 1:50 p.m., the Corporate Consultant provided a document titled, "1019 Senior Living," dated December 2023, and indicated it was the currently policy being used by the facility. The policy indicated, " ...7. The community should maintain a health record for all pets documenting the veterinary name, phone number, address, shots, and dates ...." Based on interview and record review, the facility failed to obtain and keep pet vaccination and health records on file for 1		Shot records will be checked quarterly at service plan meeting. By what date the systemic changes will be completed. June 13, 2025	

	of 1 resident who had a dog that resided at the facility (Resident 521). Findings include: During the entrance conference, on 5/20/25 at 10:25 a.m., the Administrator indicated they had a dog who belonged to a resident in the building. The dog was the only pet in the facility. Resident 521's census information indicated she had a move in date of 8/9/24. Resident 521's move in agreement was reviewed on 5/21/25 at 2:10 p.m. The agreement indicated the resident paid a non-refundable pet deposit and the resident would " ...observe and abide by all pet policies and procedures and governmental laws and regulations applicable to the premises ...." The resident signed the move in agreement on 8/9/24.			

	During an interview, on 5/20/25 at 1:53 p.m., the Corporate Consultant indicated they did not have any health records currently in the building for Resident 521's dog. She was aware the facility should maintain health records and vaccination records for any pets in the building. The facility had reached out to the family to obtain the records but had not heard anything back yet. On 5/20/25 at 1:50 p.m., the Corporate Consultant provided a document titled, "1019 Senior Living," dated December 2023, and indicated it was the currently policy being used by the facility. The policy indicated, " ...7. The community should maintain a health record for all pets documenting the veterinary name, phone number, address, shots, and dates ...."			
R 0273	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(f) (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and interview, the facility failed to ensure the frozen foods	R 0273	No residents were affected. All 28 residents had the potential to be affected. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. No residents were affected What measures will be put into	06/13/2025

	contained use by dates during 1 of 1 dietary service area observation. Findings include: On 5/20/25 at 9:50 a.m., during observation of the facility kitchen with the Dietary Manager. Several bags of frozen food was undated. Open bag of frozen broccoli was not dated. On 5/20/25 at 9:55 a.m., during an interview, the Dietary Manager acknowledged the frozen foods were not dated and she did not know the length of time the foods had been in the freezer. On 5/20/25 at 10:00 a.m., observed an ice scoop had been stored in the ice within the ice dispenser. On 5/20/25 at 10:05 a.m., during an interview, the Dietary Manager indicated the ice scoop should be placed in the designated holder and not left in the ice. On 5/20/25 at 10:10 a.m., observed the dishwasher temperature logs for the month of April. The record lacked evidence of dish washing temperature logs from 5/1/25 to 5/21/25. On 5/20/25 at 10:05 a.m., during interview, the Dietary		place or what systemic changes the facility will make to ensure that he deficient practice does not recur. All food was inspected, undated food was destroyed. Ice scoop was placed in proper receptacle and a new scoop was ordered. Dishwasher temp log was initiated. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Dietary Manager will monitor all food labeling with weekly food delivery. Ed to monitor log monthly. Ice scoop placement to be monitored daily for 2 weeks and weekly for 2 weeks by ED or designee. Dishwasher log to be monitored weekly by ED or designee. By what date the systemic changes will be completed. June 13, 2025	

Manager indicated the staff had not made new copies of the temperature logs and no one had recorded temperatures for the month of May.

On 5/20/25 at 1:12 p.m., the Administrator indicated the facility did not have a policy and follows the Indiana retail guidelines.

The Indiana Retail Food Establishment guidelines indicated, "...Except as specified in subsection (d), refrigerated, ready-to-eat, potentially hazardous food prepared and held in a retail food establishment for more than twenty-four (24) hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded ...."

The Indiana Retail Food Establishment guidelines indicated "...In-use utensils; between-use storage in a clean, protected location if the utensils, such as ice scoops, are used only with a food that is not potentially hazardous ...."

The Indiana Retail Food Establishment guidelines indicated "...water temperature measuring devices on warewashing machines shall have a numerical scale, printed record ...."

Based on observation and

interview, the facility failed to ensure the frozen foods contained use by dates during 1 of 1 dietary service area observation.

Findings include:

On 5/20/25 at 9:50 a.m., during observation of the facility kitchen with the Dietary Manager. Several bags of frozen food was undated. Open bag of frozen broccoli was not dated.

On 5/20/25 at 9:55 a.m., during an interview, the Dietary Manager acknowledged the frozen foods were not dated and she did not know the length of time the foods had been in the freezer.

On 5/20/25 at 10:00 a.m., observed an ice scoop had been stored in the ice within the ice dispenser.

On 5/20/25 at 10:05 a.m., during an interview, the Dietary Manager indicated the ice scoop should be placed in the designated holder and not left in the ice.

On 5/20/25 at 10:10 a.m., observed the dishwasher temperature logs for the month of April. The record lacked evidence of dish washing temperature logs from 5/1/25 to 5/21/25.

On 5/20/25 at 10:05 a.m., during interview, the Dietary Manager indicated the staff had not made new copies of the temperature logs and no one had recorded temperatures for the month of May.

On 5/20/25 at 1:12 p.m., the Administrator indicated the facility did not have a policy and follows the Indiana retail guidelines.

The Indiana Retail Food Establishment guidelines indicated, "...Except as specified in subsection (d), refrigerated, ready-to-eat, potentially hazardous food prepared and held in a retail food establishment for more than twenty-four (24) hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded ...."

The Indiana Retail Food Establishment guidelines indicated "...In-use utensils; between-use storage in a clean, protected location if the utensils, such as ice scoops, are used only with a food that is not potentially hazardous ...."

The Indiana Retail Food Establishment guidelines indicated "...water temperature measuring devices on warewashing machines shall have a numerical scale, printed

	record ...."			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE