STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT NOBLESVILLE SENIOR LIVING	7235 RIVERWALK WAY N, NOBLESVILLE, , 46062

(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 the Investigation of Intake 469306. Intake 469306 - State deficiencies related to the allegations are cited at R0059. Survey date: May 13 & 14, 2026 Facility number: 004417 Residential Census: 94 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed May 22, 2026.	R 0000	The submission of this Plan of Correction does not constitute admission by this provider of any conclusion set forth in the statement of deficiencies or any violation of regulations. This provider respectfully requests that the 2567 Plan of Correction be considered for desk review in lieu of Post Survey Review.	
R 0059	Residents' Rights - Noncompliance 410 IAC 16.2-5-1.2(cc) (cc) Residents have the right to choose with whom they associate. The facility shall provide reasonable visiting hours, which should include at least twelve (12)	R 0059	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The Executive Director met with Resident B's	06/12/2026

	hours a day, and the hours shall be made available to each resident. Policies shall also provide for emergency visitation at other hours. The facility shall not restrict visits from the resident ' s legal representative or spiritual advisor, except at the request of the resident. Based on record review and interview, the facility failed to protect the residents' right to have visitors of their own choosing for 1 of 4 residents reviewed for resident rights. (Resident B) Findings include: Resident B's clinical record was reviewed on 5/13/26 at 12:49 p.m. Diagnoses included unspecified Alzheimer's disease, recurrent major depressive disorder, unspecified anxiety, and unspecified suicide attempt. A 3/3/26 resident rights acknowledgement was signed by the resident's spouse. A 3/17/26 cognition service plan indicated Resident B was severely cognitively impaired and had mild confusion with unpredictable behaviors. Interventions included requiring moderate emotional support (3/17/26). A 4/21/26 behavior service plan		spouse on Friday, May 15, 2026, and communicated there are no restrictions on her visitation with her husband located in Memory Care. The residents' wife began visiting her husband without any restrictions on Friday, May 15, 2026. 2. 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 other residents were affected by the alleged deficient practice. The community staff and IDT were reeducated on the Communities Resident Rights Policy. 3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: The Facility Staff and IDT were reeducated to the communities Resident Rights Policy. An audit was completed in IDT of the community’s	

	indicated Resident B had the potential to be verbally and physically aggressive in situations and had suicidal ideation. Interventions included caregivers identifying coping skills and support systems (4/21/26) and psychiatric consultations as ordered (4/21/26). A 4/21/26 progress note indicated Resident B was found in his room with a belt around his neck. Resident B was transferred to a psychiatric hospital for evaluation and treatment. His family provided transportation. A 5/7/26 progress note indicated Resident B returned to the facility via a transportation company. During an interview, on 5/13/26 at 12:35 p.m., Resident B's spouse indicated the Memory Care Director advised her Resident B could not have visitors after returning from the psychiatric hospital. Resident B's spouse indicated she wished to visit him and was distressed by not being able to visit. On 5/14/26 at 10:19 a.m., CNA 4 indicated she was the staff member who found Resident B with a belt around his neck. CNA 4 indicated Resident B's family was asked by		residents to ensure all residents received visitation without restrictions. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place: The Executive Director and/or designee will audit all residents in the weekly IDT meeting to ensure visitation is taking place for all residents without restrictions. These audits will take place one time per week for 60-days. The systemic changes will be completed by June 12, 2026.	

management not to visit since he returned from his psychiatric hospital stay.

On 5/14/26 at 10:20 a.m., QMA 5 indicated she was aware Resident B's family was asked by management not to visit since he returned from his psychiatric hospital stay.

On 5/14/26 at 10:28 a.m., the Memory Care Director indicated the Executive Director chose to restrict Resident B's family from visiting due to notes from the psychiatric hospital. The Memory Care Director indicated she would seek the Executive Director's permission prior to allowing the family to visit.

On 5/14/26 at 10:47 a.m., the Executive Director indicated he restricted the family from visiting Resident B due to information he received from the psychiatric hospital. The information indicated Resident B became aggressive after visits with his family and restrictions had been put in place at the hospital. The Executive Director had spoken with Resident B's family prior to his return and indicated the facility wanted to evaluate and assess Resident B to determine his needs before they visited. The family had agreed to this plan.

Review of the psychiatric hospital notes, provided by the

DON on 5/14/26 at 11:00 a.m., indicated Resident B's wife visited the psychiatric hospital on 4/24/26, 4/26/26, 4/27/26, and 5/4/26 without noted concerns. The visits on 5/1/26 and 5/3/26 were noted that Resident B had increased agitation and/or anxiety after the visit ended.

A 5/7/26 psychiatric hospital discharge summary included the following recommendations: maintain structured and stable environment with redirection and reassurance as needed and encourage regular family interaction and supportive visits, as patient responds positively to time spent with wife.

During an interview, on 5/14/26 at 12:45 p.m., the Director of Nursing indicated the Executive Director chose to restrict Resident B's family from visiting. She indicated the facility utilized the discharge summary from the psychiatric hospital to ensure continuity of care. The facility reviewed all notes, orders, and follow-up recommendations to ensure the residents receive the best care possible. She indicated she would not prevent Resident B's family from visiting him if they came to the facility.

During an interview, on 5/14/26 at 12:58 p.m., the Executive Director indicated the facility reviewed the discharge

summary from the psychiatric hospital to ensure continuity of care. The facility reviewed all notes, orders, and follow-up recommendations to ensure the residents receive the best care possible. The Executive Director indicated he had been in contact with Resident B's family and they had agreed to his plan of restricting visits while Resident B was being assessed for behaviors. The Executive Director's plan was to contact the family on 5/15/26 to set up a visit with Resident B so the facility could evaluate his behavior after the visit concluded. The Executive Director indicated he was confident in his decision to restrict visits based on the information he received from the psychiatric hospital.

A current facility policy, approved 12/24, titled, "Resident Rights Policy", provided by the Executive Director on 5/14/26 at 11:16 a.m., indicated the following: "Each resident residing in this community has the right and will be afforded the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the community without interference, coercion, discrimination, or reprisal ... Resident rights include but are

	not limited to: exercise his/her rights ...visit and be visited by others from outside the community ..."			

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 SIGNATUREDavid Pruett	TITLEExecutive Director	(X6) DATE06/05/2026