STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSINGS AT BANTA POINTE SENIOR LIVING	6510 U.S. 31 SOUTH, INDIANAPOLIS, , 46227

(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. This visit included the Investigation of Intakes 466956 and 467067. Intake 466956 - State deficiencies related to the allegations are cited at R241. Intake 467067 - No deficiencies related to the allegations are cited. Survey dates: February 2 and 3, 2026 Facility number: 014018 Residential Census: 55 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed February 6, 2026.	R 0000	THIS PLAN OF CORRECTION CONSTITUTES THE CROSSINGS AT BANTA POINTE'S WRITTEN ALLEGATION OF COMPLIANCE FOR THE ALLEGED DEFICIENCY'S CITED. SUBMISSION OF THIS PLAN OF CORRECTION IS NOT AN ADMISSION THAT A DEFICIENCY EXISTS OR THAT ONE WAS CITED CORRECTLY. THIS PLAN OF CORRECTION IS SUBMITTED TO MEET REQUIREMENTS ESTABLISHED BY STATE AND FEDERAL LAW. THE CROSSINGS AT BANTA POINTE RESPECTFULLY REQUEST A DESK REVIEW FOR THIS PLAN OF CORRECTION IN LIEU OF AN ON SITE REVISIT.	

R 0090	Administration and Management - Deficiency 410 IAC 16.2-5-1.3(g)(1-6) (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval	R 0090	TAG: R 090 ADMINISTRATION AND MANAGEMENT - DEFICIENCY 1. WHAT CORRECTIVE ACTION(S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE? RESIDENT #62, AND #34 WERE TEMPORARILY RELOCATED TO OTHER ROOMS AS A SAFETY PRECAUTION. RESIDENT #62 HAS CHOSEN TO REMAIN IN THE NEW ROOM, AND RESIDENT #34 HAS BEEN RETURNED TO HIS ROOM. NO OTHER RESIDENTS WERE AFFECTED BY THE DEFICIENT PRACTICE. 2. HOW OTHER RESIDENTS, HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE, WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTION(S) WILL BE TAKEN? ALL RESIDENTS HAVE THE POTENTIAL TO BE	02/26/2026

	prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request Based on observation, record review, and interview, the facility failed to report an unusual occurrence to Indiana Department of Health (IDOH). A broken water pipe and associated water damage resulted in the displacement of 3 of 55 residents who had to be relocated to other rooms. (Room 16, Room 17, Room 18)		AFFECTED. FACILITY STAFF WILL BE IN-SERVICED ON THE PROPER REPORTING OF UNUSUAL OCCURRENCES TO ENSURE COMPLIANCE GOING FORWARD. 3. WHAT MEASURES WILL BE PUT INTO PLACE AND WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR? FACILITY STAFF WILL BE EDUCATED ON THE PROPER PROCEDURE OF REPORTING UNUSUAL OCCURRENCES. AN AUDIT CHECKLIST HAS BEEN CREATED TO MONITOR FOR COMPLIANCE IN REGARD TO UNUSUAL OCCURRENCES. 4. HOW WILL THE CORRECTIVE ACTION(S) BE MONITORED? THE EXECUTIVE DIRECTOR OR THEIR DESIGNEE WILL BE RESPONSIBLE FOR MONITORING THE REPORTING OF UNUSUAL	

	Finding includes: During an interview on 2/2/26 at 8:45 a.m., the Executive Director (ED) indicated a pipe had burst on 1/21/26, causing water damage in the maintenance room with the potential to effect Rooms 16, 17, and 18. Several residents were moved to different room as a safety precaution. The ED was not sure if it had been reported to the Indiana Department of Health (IDOH). On 2/2/26 from 9:15 a.m. until 9:45 a.m., during the initial facility tour the main level was observed. Blue tape was observed at the base of the floor in the front of Rooms 16, 17, and 18. During an interview on 2/2/26 at 9:33 a.m., the Director of Nursing indicated she was not sure if the unusual occurrence had been reported to IDOH. On 2/2/26 at 10:00 a.m., in the front lobby observed the ceiling to have an area that was covered with plastic and taped to the ceiling. A small drip of clear liquid was observed dripping into a trash can on the floor below the covered plastic area. The area on the ceiling measured approximately two feet long and two feet wide. During an interview at that time, the office manager indicated the		OCCURRENCES. MONITORING WILL TAKE PLACE WEEKLY FOR A PERIOD OF THREE MONTHS, AND WILL BE BROUGHT TO THE FACILITIES QAPI PROGRAM. ANY IDENTIFIED CONCERNS WILL BE PROMPTLY ADDRESSED. COMPLETION DATE: 2/26/26	

area was being dried out at that time.

During an interview on 2/2/26 at 12:12 p.m., the ED indicated the incident regarding the burst pipe should have been reported.

On 2/2/26 at 12:12 p.m., the Executive Director provided a policy titled Incident Reporting and Investigation, dated 5/2/22 and indicated it was the current policy being used by the facility. A review of the policy indicated "...II. Definitions: A. Incident: (i) An unusual or unexpected event that is not consistent with the routine operation of the community or routine care of or services provided to a resident."

Based on observation, record review, and interview, the facility failed to report an unusual occurrence to Indiana Department of Health (IDOH). A broken water pipe and associated water damage resulted in the displacement of 3 of 55 residents who had to be relocated to other rooms. (Room 16, Room 17, Room 18)

Finding includes:

During an interview on 2/2/26 at 8:45 a.m., the Executive Director (ED) indicated a pipe had burst on 1/21/26, causing water damage in the maintenance room with the potential to effect Rooms 16,

	17, and 18. Several residents were moved to different room as a safety precaution. The ED was not sure if it had been reported to the Indiana Department of Health (IDOH). On 2/2/26 from 9:15 a.m. until 9:45 a.m., during the initial facility tour the main level was observed. Blue tape was observed at the base of the floor in the front of Rooms 16, 17, and 18. During an interview on 2/2/26 at 9:33 a.m., the Director of Nursing indicated she was not sure if the unusual occurrence had been reported to IDOH. On 2/2/26 at 10:00 a.m., in the front lobby observed the ceiling to have an area that was covered with plastic and taped to the ceiling. A small drip of clear liquid was observed dripping into a trash can on the floor below the covered plastic area. The area on the ceiling measured approximately two feet long and two feet wide. During an interview at that time, the office manager indicated the area was being dried out at that time. During an interview on 2/2/26 at 12:12 p.m., the ED indicated the incident regarding the burst pipe should have been reported. On 2/2/26 at 12:12 p.m., the			

	Executive Director provided a policy titled Incident Reporting and Investigation, dated 5/2/22 and indicated it was the current policy being used by the facility. A review of the policy indicated "...II. Definitions: A. Incident: (i) An unusual or unexpected event that is not consistent with the routine operation of the community or routine care of or services provided to a resident."			
R 0116	Personnel - Noncompliance 410 IAC 16.2-5-1.4(a) (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. Based on interview and record review, the facility failed to obtain a pre-employment background check on 1 of 5 staff members reviewed. (Server 3) Finding Includes: On 2/2/26 at 9:00 a.m., an employee record review indicated Server 3's date of hire was 11/1/25. Server 3's record lacked a pre-employment	R 0116	R116 PERSONNEL - NONCOMPLIANCE 1. WHAT CORRECTIVE ACTION(S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE? No residents were directly affected by the noncompliance practice. The BOM performed a background check while State was in the building, which came back clear. 2. HOW OTHER RESIDENTS, HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE, WILL BE IDENTIFIED AND WHAT	02/26/2026

	background check. On 2/3/26 at 9:24 a.m., the Business Office Manager provided a copy of an undated facility policy titled Step 5: Pre-Board and indicated it was the policy currently being used by the facility. A review of the policy indicated, "Complete the Pre-Employment Checks and Verifications. All Positions Requirements: Background Screening." During an interview with the Business Office Manager on 2/3/26 at 10:15 a.m., indicated that a pre-employment background check should have been completed for Server 3. Based on interview and record review, the facility failed to obtain a pre-employment background check on 1 of 5 staff members reviewed. (Server 3) Finding Includes: On 2/2/26 at 9:00 a.m., an employee record review indicated Server 3's date of hire was 11/1/25. Server 3's record lacked a pre-employment background check. On 2/3/26 at 9:24 a.m., the Business Office Manager provided a copy of an undated facility policy titled Step 5: Pre-Board and indicated it was		CORRECTIVE ACTION(S) WILL BE TAKEN? All residents have the potential to be affected. All facility staff will be in-serviced on Pre-Hire requirements, including required Background Checks. 3. WHAT MEASURES WILL BE PUT INTO PLACE AND WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR? The Business Office Manager will do a 100% audit of all employee files to ensure the proper documentation is in place. The BOM will audit new employee files weekly to ensure compliance. 4. HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED? The BOM, or their designee, will be responsible for monitoring all new hire checklists to ensure background checks have	

	the policy currently being used by the facility. A review of the policy indicated, "Complete the Pre-Employment Checks and Verifications. All Positions Requirements: Background Screening." During an interview with the Business Office Manager on 2/3/26 at 10:15 a.m., indicated that a pre-employment background check should have been completed for Server 3.		been completed prior to orientation. Monitoring will take place weekly for three months, and will be brought to the facility QAPI meeting. 5. COMPLETION DATE: 2/26/26	
R 0118	Personnel - Deficiency 410 IAC 16.2-5-1.4(c) (c) Any unlicensed employee providing more than limited assistance with the activities of daily living must be either a certified nurse aide or a home health aide. Existing facilities that are not licensed on the date of adoption of this rule and that seek licensure within one (1) year of adoption of this rule have two (2) months in which to ensure that all employees in this category are either a certified nurse aide or a home health aide.	R 0118	R118 PERSONNEL - DEFICIENCY 1. WHAT CORRECTIVE ACTION(S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE? No residents were directly affected by the noncompliant practice. The DON notified the employee immediately, who completed her license renewal within 24 hours.	02/26/2026

	Based on interview and record review, the facility failed to ensure a staff member had a valid Certified Nurse Aide (CNA) certification prior to working in the capacity as a CNA for 1 of 10 CNAs reviewed for CNA certification status. (CNA 5) Findings include: On 2/2/26 at 1:00 p.m., the Business Office Manager (BOM) provided the facility's current employee list that included staff member's name, job title, and employment start date. A review of the document indicated CNA 5 was hired on 12/15/25 and the job responsibility was that of a CNA. On 2/2/26 at 1:10 p.m., the BOM provided a copy of CNA 5's State of Indiana's professional licensure document. A review of the document indicated CNA 5 had renewed the Certified Nurse Aide certification on 1/4/24 and it had expired on 12/21/25. CNA 5's file lacked an active/valid CNA certification. During an interview on 2/3/26 at 10:15 a.m., the BOM indicated CNA 5 was a current employee and worked in the capacity of a CNA. On 2/3/26 at 10:31 a.m., the BOM provided a copy of the		2. HOW OTHER RESIDENTS, HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE, WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTION(S) WILL BE TAKEN? All residents have the potential to be affected. All facility staff will be in-serviced on required licensing policies to ensure compliance going forward. 3. WHAT MEASURES WILL BE PUT INTO PLACE AND WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR? The Business Office Manager will do a 100% audit of all employee licenses to ensure all licensed employees are current with INPLA. The BOM created an audit checklist and will monitor the list weekly, sending out reminders to management to ensure compliance with licensing is completed, or the	

	Professional Licensure and Certification Check policy, dated 9/1/13, and indicated it was the current policy in use by the facility. A review of the document indicated, "...will ensure all certifications and professional licenses are reviewed timely...Employees who fail to renew their certification or professional license prior to expiration will be removed from the schedule...subject to disciplinary action under the facility's employee misconduct policies..." On 2/3/26 at 11:00 a.m., the DON provided a copy of CNA 5's Job Description. A review of the document indicated, "...Qualifications: Certified in the state practice required...successful completion of State Approved Nurse Aide Training and Competency Evaluation Program; Name must appear on State Registry as Nurse Aide in good standing...adheres to established employee policies..." The document was signed by CNA 5 on 12/15/25. Based on interview and record review, the facility failed to ensure a staff member had a valid Certified Nurse Aide (CNA) certification prior to working in the capacity as a CNA for 1 of 10 CNAs reviewed for CNA		individual is removed from the schedule until such a time that a current license can be confirmed. 4. HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED? The BOM, or their designee, will be responsible for monitoring all employee licenses to ensure renewal is completed prior to expiration. Monitoring will take place weekly for three months, and will be brought to the facilities QAPI program. Any identified concerns will be promptly addressed with the responsible individual(s). 5. COMPLETION DATE: 2/26/26	

	certification status. (CNA 5) Findings include: On 2/2/26 at 1:00 p.m., the Business Office Manager (BOM) provided the facility's current employee list that included staff member's name, job title, and employment start date. A review of the document indicated CNA 5 was hired on 12/15/25 and the job responsibility was that of a CNA. On 2/2/26 at 1:10 p.m., the BOM provided a copy of CNA 5's State of Indiana's professional licensure document. A review of the document indicated CNA 5 had renewed the Certified Nurse Aide certification on 1/4/24 and it had expired on 12/21/25. CNA 5's file lacked an active/valid CNA certification. During an interview on 2/3/26 at 10:15 a.m., the BOM indicated CNA 5 was a current employee and worked in the capacity of a CNA. On 2/3/26 at 10:31 a.m., the BOM provided a copy of the Professional Licensure and Certification Check policy, dated 9/1/13, and indicated it was the current policy in use by the facility. A review of the document indicated, "...will ensure all certifications and			

	professional licenses are reviewed timely...Employees who fail to renew their certification or professional license prior to expiration will be removed from the schedule...subject to disciplinary action under the facility's employee misconduct policies..." On 2/3/26 at 11:00 a.m., the DON provided a copy of CNA 5's Job Description. A review of the document indicated, "...Qualifications: Certified in the state practice required...successful completion of State Approved Nurse Aide Training and Competency Evaluation Program; Name must appear on State Registry as Nurse Aide in good standing...adheres to established employee policies..." The document was signed by CNA 5 on 12/15/25.			
R 0148	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(e)(1-4) (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and	R 0148	TAG: R 148 – SANITATION AND SAFETY STANDARDS, - DEFICIENCY 1. WHAT CORRECTIVE ACTION(S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE?	02/26/2026

	implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on observation, interview, and record review, the facility failed to ensure potentially hazardous materials were kept secure behind locked doors to prevent resident's access to the hazardous materials for 8 of 55 self-mobile cognitively impaired residents residing in the facility. Findings include: On 2/2/26 from 9:00 a.m., to 9:15 a.m., during the initial tour of the facility with the Director of Nursing (DON) the beauty shop door located next to Room 31 was unlocked and opened. A resident was inside the beauty shop unattended with the hair dryer on her head and running.		RESIDENT 47 WAS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE, THE DON REMAINED WITH THE RESIDENT UNTIL THE BEAUTICIAN RETURNED TO THE BEAUTY SHOP FOR SUPERVISION. NO OTHER RESIDENTS WERE AFFECTED BY THE DEFICIENT PRACTICE. 2. HOW OTHER RESIDENTS, HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE, WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTION(S) WILL BE TAKEN? ALL RESIDENTS HAVE THE POTENTIAL TO BE AFFECTED. FACILITY STAFF, AND THE BEAUTICIAN WILL BE IN-SERVICED ON THE FACILITIES CHEMICAL STORAGE AND SAFETY POLICY TO ENSURE COMPLIANCE GOING FORWARD. 3. WHAT MEASURES WILL BE PUT INTO	

	The following was observed: - A large can of aerosol hairspray half full. The hairspray was located in the beauticians work area and easily accessible. The label on the hairspray indicated "keep out of reach.." - A tube of hair thickening mousse half full. The mousse was located in the beauticians work area and was easily accessible The label on the mousse indicated "keep out of reach.." - A pair of sharp scissors approximately six inches long was observed in a drawer that was unlocked and easily accessible - A large glass three quarters of the way full contained a blue liquid substance holding several used hair combs was observed on the beauticians work area and was easily accessible. - An electric razor that was plugged into an outlet, was observed in the beauticians work area. The razor was easily accessible. - A half full spray bottle of spic and span cleaner was observed at the beauticians desk. The label on the cleaner indicated "keep out of reach.." On 2/2/26 at 9:20 a.m., the		PLACE AND WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR? FACILITY STAFF, AND THE BEAUTICIAN WILL BE EDUCATED ON THE FACILITIES SANITATION AND SAFETY POLICY TO ENSURE CHEMICALS ARE NEVER LEFT UNATTENDED IN RESIDENT AREAS. COMPLIANCE WILL BE MONITORED THROUGH FACILITY SAFETY ROUNDS. 4. HOW WILL THE CORRECTIVE ACTION(S) BE MONITORED? THE EXECUTIVE DIRECTOR OF THEIR DESIGNEE WILL BE RESPONSIBLE FOR THE MONITORING OF ONGOING COMPLIANCE WITH THE STORAGE OF CHEMICALS IN RESIDENT AREAS THROUGH WEEKY FACILITY ROUNDS. MONITORING WILL TAKE PLACE WEEKLY FOR THREE MONTHS	

	DON indicated eight self mobile, cognitively impaired residents resided in the facility. On 2/3/26 11:35 p.m., the Executive Director provided a policy titled Chemical Storage and Safety policy and indicated it was the current policy being used by the facility. A review of the policy indicated "For resident safety, all chemicals shall never be left unattended in resident areas." Based on observation, interview, and record review, the facility failed to ensure potentially hazardous materials were kept secure behind locked doors to prevent resident's access to the hazardous materials for 8 of 55 self-mobile cognitively impaired residents residing in the facility. Findings include: On 2/2/26 from 9:00 a.m., to 9:15 a.m., during the initial tour of the facility with the Director of Nursing (DON) the beauty shop door located next to Room 31 was unlocked and opened. A resident was inside the beauty shop unattended with the hair dryer on her head and running. The following was observed: - A large can of aerosol		AND WILL BE BROUGHT TO THE FACILITIES QAPI PROGRAM. ANY IDENTIFIED CONCERNS WILL BE PROMPTY ADDRESSED WITH THE RESPONSIBLE INDIVIDUAL(S). 5. COMPLETION DATE: 2/26/26	

	hairspray half full. The hairspray was located in the beauticians work area and easily accessible. The label on the hairspray indicated "keep out of reach.." - A tube of hair thickening mousse half full. The mousse was located in the beauticians work area and was easily accessible The label on the mousse indicated "keep out of reach.." - A pair of sharp scissors approximately six inches long was observed in a drawer that was unlocked and easily accessible - A large glass three quarters of the way full contained a blue liquid substance holding several used hair combs was observed on the beauticians work area and was easily accessible. - An electric razor that was plugged into an outlet, was observed in the beauticians work area. The razor was easily accessible. - A half full spray bottle of spic and span cleaner was observed at the beauticians desk. The label on the cleaner indicated "keep out of reach.."			

	On 2/2/26 at 9:20 a.m., the DON indicated eight self mobile, cognitively impaired residents resided in the facility. On 2/3/26 11:35 p.m., the Executive Director provided a policy titled Chemical Storage and Safety policy and indicated it was the current policy being used by the facility. A review of the policy indicated "For resident safety, all chemicals shall never be left unattended in resident areas."			
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 ensure a pet, who routinely visited the facility, had received an updated rabies vaccination and a periodic veterinary wellness examination as required, for 1 of 4 pets, reviewed for pet vaccination records. (Resident 58) Finding includes: On 2/2/26 at 1:15 p.m., the	R 0151	TAG: R-151, - SANITATION AND SAFETY STANDARDS, NON-COMPLIANCE 1. WHAT CORRECTIVE ACTION(S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE? NO RESIDENTS WERE DIRECTLY AFFECTED BY THE NONCOMPLIANT PRACTICE. 2. HOW OTHER RESIDENTS, HAVING THE POTENTIAL TO BE AFFECTED BY THE	02/26/2026

	Director of Nursing (DON) provided a list of residents who housed pets and a list of pets who routinely visited residents in the facility. A review of the document indicated Resident 58's family members routinely brought an eight-year-old canine to visit the resident. On 2/2/26 at 1:30 p.m., Resident 58's visiting canine's record was reviewed. A review of the document indicated the pet had received the K-9 rabies vaccine (3 year vaccination dose) and a veterinarian exam was conducted on 8/12/21. The document also indicated the next rabies vaccination and exam was due on 8/11/24. The documentation lacked a subsequent rabies vaccination and veterinarian exam after 8/12/21. During an interview on 2/3/26 at 10:30 a.m., the Activity Director indicated Resident 58's family routinely brought the eight-year-old canine into the facility to visit with Resident 58. The facility lacked documentation that indicated the canine had a current rabies vaccination and veterinarian exam for the canine. The facility's documentation indicated the canine was past due for it's rabies vaccine and veterinarian exam.		SAME DEFICIENT PRACTICE, WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTION(S) WILL BE TAKEN? ALL RESIDENTS HAVE THE POTENTIAL TO BE AFFECTED. STAFF WILL BE IN-SERVICED IN REGARD TO THE FACILITIES PET POLICY TO ENSURE COMPLIANCE GOING FORWARD. 3. WHAT MEASURES WILL BE PUT INTO PLACE AND WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR? THE LIFE ENRICHMENT DIRECTOR CONDUCTED A 100% AUDIT OF ALL FACILITY HOUSED PETS, AND PETS THAT FREQUENTLY VISIT THE FACILITY TO ENSURE THAT ALL APPROPRIATE RECORDS WERE PRESENT. 4. HOW WILL THE CORRECTIVE ACTION(S) BE	

	On 2/3/26 at 9:15 a.m. the Executive Director provided a copy of the Pets and Animals policy, date 2/20/15, and indicated it was the current policy use by the facility. A review of the document indicated, "...All animals that visit on a periodic basis must be under the care of a licensed veterinarian and have evidence of appropriate immunizations and freedom from infection...documentation must be...kept on file..." On 2/3/26 at 4:00 p.m., a review of the Rabies Vaccinations Requirements located at 345 IAC 1-5-2 indicated, "...all dogs...3 months of age and older must be vaccinated against rabies..." Based on interview and record review, the facility failed to ensure a pet, who routinely visited the facility, had received an updated rabies vaccination and a periodic veterinary wellness examination as required, for 1 of 4 pets, reviewed for pet vaccination records. (Resident 58) Finding includes: On 2/2/26 at 1:15 p.m., the Director of Nursing (DON) provided a list of residents who housed pets and a list of pets who routinely visited residents in the facility. A review of the		MONITORED? THE EXECUTIVE DIRECTOR OR THEIR DESIGNEE WILL BE RESPONSIBLE FOR MONITORING ALL FACILITY HOUSED PETS, OR PETS THAT FREQUENTLY VISIT THE CAMPUS TO ENSURE PROPER RECORDS ARE PRESENT. MONITORING WILL TAKE PLACE WEEKLY FOR THREE MONTHS, AND WILL BE BROUGHT TO THE FACILITIES QAPI PROGRAM . ANY IDENTIFIED CONCERNS WILL BE PROMPTLY ADDRESSED WITH THE RESPONSIBLE INDIIVIDUAL(S). 5. COMPLETION DATE: 2/26/26	

	document indicated Resident 58's family members routinely brought an eight-year-old canine to visit the resident. On 2/2/26 at 1:30 p.m., Resident 58's visiting canine's record was reviewed. A review of the document indicated the pet had received the K-9 rabies vaccine (3 year vaccination dose) and a veterinarian exam was conducted on 8/12/21. The document also indicated the next rabies vaccination and exam was due on 8/11/24. The documentation lacked a subsequent rabies vaccination and veterinarian exam after 8/12/21. During an interview on 2/3/26 at 10:30 a.m., the Activity Director indicated Resident 58's family routinely brought the eight-year-old canine into the facility to visit with Resident 58. The facility lacked documentation that indicated the canine had a current rabies vaccination and veterinarian exam for the canine. The facility's documentation indicated the canine was past due for it's rabies vaccine and veterinarian exam. On 2/3/26 at 9:15 a.m. the Executive Director provided a copy of the Pets and Animals policy, date 2/20/15, and indicated it was the current			

	policy use by the facility. A review of the document indicated, "...All animals that visit on a periodic basis must be under the care of a licensed veterinarian and have evidence of appropriate immunizations and freedom from infection...documentation must be...kept on file..." On 2/3/26 at 4:00 p.m., a review of the Rabies Vaccinations Requirements located at 345 IAC 1-5-2 indicated, "...all dogs...3 months of age and older must be vaccinated against rabies..."			
R 0187	Physical Plant Standards - Deficiency 410 IAC 16.2-5-1.6(k) (k) Hot water temperature for all bathing and hand washing facilities shall be controlled by an automatic control valve. Water temperature at point of use must be maintained between one hundred (100) degrees Fahrenheit and one hundred twenty (120) degrees Fahrenheit. Based on observation, interview, and record review, the facility failed to ensure water temperatures were maintained between one hundred (100) degrees Fahrenheit and one hundred and twenty (120) degrees Fahrenheit for 8 of 10	R 0187	TAG: R 187 – PHYSICAL PLANT STANDARDS - DEFICIENCY 1. WHAT CORRECTIVE ACTION(S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE? NO RESIDENT WAS DIRECTLY AFFECTED BY THE NON COMPLIANT PRACTICE.	02/26/2026

	apartments observed. (Apartment 8, Apartment 81, Apartment 51, Apartment 56, Apartment 64, Apartment 70, Apartment 75, Apartment 78) Findings include: During a facility tour on 2/3/26 at 8:18 a.m., with the Maintenance Director the following was observed: 1. On 2/3/26 at 8:24 a.m., Apartment 8's water temperatures were observed. The hot water temperature at the kitchen sink was 125 degrees Fahrenheit. 2. On 2/3/26 at 8:26 a.m., Apartment 81's water temperatures were observed. The hot water temperature at the kitchen sink was 126 degrees Fahrenheit. 3. On 2/3/26 at 8:28 a.m., Apartment 78's water temperatures were observed. The hot water temperature at kitchen sink was 124 degrees Fahrenheit. 4. On 2/3/26 at 8:30 a.m., Apartment 75's water temperatures were observed. The hot water temperature at the kitchen sink was 125 degrees Fahrenheit. 5. On 2/3/26 at 8:33 a.m., Apartment 70's water		2. HOW OTHER RESIDENTS, HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE, WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTION(S) WILL BE TAKEN? ALL RESIDENTS HAVE THE POTENTIAL TO BE AFFECTED. FACILITY STAFF WILL BE IN-SERVICED ON THE FACILITIES WATER TEMPERATURE POLICY TO ENSURE COMPLIANCE GOING FORWARD. 3. WHAT MEASURES WILL BE PUT INTO PLACE AND WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR? THE MAINTENANCE DIRECTOR WILL CONDUCT AN AUDIT OF RESIDENT ROOMS, AND COMMON AREAS TO ENSURE WATER TEMPERATURES FALL WITHIN MANDATED TEMPERATURE RANGES, (100-120	

	temperatures were observed. The hot water temperature at the kitchen sink was 127 degrees Fahrenheit. 6. On 2/3/26 at 8:35 a.m., Apartment 64's water temperatures were observed. The hot water temperature at the kitchen sink was 131 degrees Fahrenheit. 7. On 2/3/26 at 8:41 a.m., Apartment 56's water temperatures were observed. The hot water temperature at the bathroom sink was 126 degrees Fahrenheit. 8. On 2/3/26 at 8:45 a.m., Apartment 51's water temperatures were observed. The hot water temperature at the bathroom sink was 124 degrees Fahrenheit. During an interview on 2/3/26 at 8:18 a.m., the Maintenance Director indicated the hot water temperatures were to be monitored and maintained between 100 degrees Fahrenheit and 120 degrees Fahrenheit. On 2/3/26 at 11:05 a.m., the Executive Director provided a facility policy undated, "TEIS MASTERS, F-689 Accidents-Water Temperatures." and indicated it was the policy currently being used by the facility. A review of the policy		DEGREES FAHRENHEIT). THE MAINTENANCE DIRECTOR WILL MONITOR WATER TEMPERATURE THROUGH WEEKLY ROUNDING USING THE FACILITIES WATER TEMPERATURE LOG. 4. HOW WILL THE CORRECTIVE ACTION(S) BE MONITORED? THE MAINTENANCE DIRECTOR OR THEIR DESIGNEE WILL BE RESPONSIBLE FOR THE MONITORING OF FACILITY WATER TEMPERATURE TO ENSURE THEY FALL WITHIN FACILITY GUIDELINES. MONITORING WILL TAKE PLACE WEEKLY FOR THREE MONTHS, AND WILL BE BROUGHT TO THE FACILITIES QAPI PROGRAM. ANY IDENTIFIED CONCERNS WILL BE PROMPTLY ADDRESSED WITH THE RESPONSIBLE INDIVIDUAL(S). 5. COMPLETION DATE:	

	indicated, "State Regulations: " ... F689 is typically enforced by the State Department of Health. Each state will have its own regulation on maximum water temperature allowed, but it typically will fall between 105 to 115 degrees F [Fahrenheit]. Check with your Surveyor ..." Based on observation, interview, and record review, the facility failed to ensure water temperatures were maintained between one hundred (100) degrees Fahrenheit and one hundred and twenty (120) degrees Fahrenheit for 8 of 10 apartments observed. (Apartment 8, Apartment 81, Apartment 51, Apartment 56, Apartment 64, Apartment 70, Apartment 75, Apartment 78) Findings include: During a facility tour on 2/3/26 at 8:18 a.m., with the Maintenance Director the following was observed: 1. On 2/3/26 at 8:24 a.m., Apartment 8's water temperatures were observed. The hot water temperature at the kitchen sink was 125 degrees Fahrenheit. 2. On 2/3/26 at 8:26 a.m., Apartment 81's water temperatures were observed. The hot water temperature at the kitchen sink was 126		2/26/26	

	degrees Fahrenheit. 3. On 2/3/26 at 8:28 a.m., Apartment 78's water temperatures were observed. The hot water temperature at kitchen sink was 124 degrees Fahrenheit. 4. On 2/3/26 at 8:30 a.m., Apartment 75's water temperatures were observed. The hot water temperature at the kitchen sink was 125 degrees Fahrenheit. 5. On 2/3/26 at 8:33 a.m., Apartment 70's water temperatures were observed. The hot water temperature at the kitchen sink was 127 degrees Fahrenheit. 6. On 2/3/26 at 8:35 a.m., Apartment 64's water temperatures were observed. The hot water temperature at the kitchen sink was 131 degrees Fahrenheit. 7. On 2/3/26 at 8:41 a.m., Apartment 56's water temperatures were observed. The hot water temperature at the bathroom sink was 126 degrees Fahrenheit.			

	8. On 2/3/26 at 8:45 a.m., Apartment 51's water temperatures were observed. The hot water temperature at the bathroom sink was 124 degrees Fahrenheit. During an interview on 2/3/26 at 8:18 a.m., the Maintenance Director indicated the hot water temperatures were to be monitored and maintained between 100 degrees Fahrenheit and 120 degrees Fahrenheit. On 2/3/26 at 11:05 a.m., the Executive Director provided a facility policy undated, "TElS MASTERS, F-689 Accidents-Water Temperatures." and indicated it was the policy currently being used by the facility. A review of the policy indicated, "State Regulations: " ... F689 is typically enforced by the State Department of Health. Each state will have its own regulation on maximum water temperature allowed, but it typically will fall between 105 to 115 degrees F [Fahrenheit]. Check with your Surveyor ..."			
R 0216	Evaluation - Noncompliance 410 IAC 16.2-5-2(c)(1-4)(d) (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment	R 0216	R-216, - EVALUATION - NONCOMPLIANCE 1. WHAT CORRECTIVE ACTION(S) WILL BE ACCOMPLISHED FOR	02/26/2026

	shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on record review and interview, the facility failed to obtain a baseline admission weight for 1 of 7 residents reviewed for weights. (Resident C) Finding includes: On 2/2/26 at 10:00 a.m., Resident C's clinical record was reviewed. Resident C's clinical record lacked documentation of weight upon admission. During an interview on 2/3/26 at 8:50 a.m., the DON (Director of Nursing) indicated Resident C should have had a weight upon admitting to the facility or had a documented refusal to have the weight obtained.		THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE? RESIDENT 44 WAS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE. RESIDENT 44 IMMEDIATELY HAD HIS WEIGHT TAKEN AND DOCUMENTED. NO OTHER RESIDENTS WERE AFFECTED BY THIS DEFICIENT PRACTICE. 2. HOW MANY OTHER RESIDENTS, HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE, WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTION(S) WILL BE TAKEN? ALL RESIDENTS, INCLUDING NEWLY ADMITED INDEPENDENT, AND ASSISTED LIVING RESIDENTS HAVE THE POTENTIAL TO BE AFFECTED. STAFF WILL BE IN-SERVICED ON NEWLY ADMITTED INDEPENDENT LIVING TO ASSISTED LIVING RESIDENT, AND THE	

	On 2/3/26 at 11:10 a.m., the DON provided a copy of a policy titled Handling an Internal Resident Transfer, dated 7/8/24, and indicated it was the current policy in use by the facility. A review of the policy indicated that for internal transfers between lines of service, appropriate state-required clinical documentation was to be included with the transfer process. Based on record review and interview, the facility failed to obtain a baseline admission weight for 1 of 7 residents reviewed for weights. (Resident C) Finding includes: On 2/2/26 at 10:00 a.m., Resident C's clinical record was reviewed. Resident C's clinical record lacked documentation of weight upon admission. During an interview on 2/3/26 at 8:50 a.m., the DON (Director of Nursing) indicated Resident C should have had a weight upon admitting to the facility or had a documented refusal to have the weight obtained. On 2/3/26 at 11:10 a.m., the DON provided a copy of a policy titled Handling an Internal Resident Transfer, dated 7/8/24, and indicated it was the current policy in use by the facility. A		PROPER DOCUMENTATION NEEDED AT THE TIME OF ADMISSION. 3. WHAT MEASURES WILL BE PUT INTO PLACE AND WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR? CLINICAL FACILITY STAFF WERE RE-EDUCATED ON NEW ADMITS, AND INTERNAL INDEPENDENT LIVING TO ASSISTED LIVING TRANSFERS, TO ENSURE PROPER DOCUMENTATION. DON WILL AUDIT ALL NEW ADMISSIONS, AND TRANSFERS FROM INDEPENDENT LIVING TO ASSISTED LIVING FOR 72 HOURS AFTER ADMISSION FOR A PERIOD OF THREE MONTHS. 4. HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED? DON, OR THEIR DESIGNEE WILL BE	

	review of the policy indicated that for internal transfers between lines of service, appropriate state-required clinical documentation was to be included with the transfer process.		RESPONSIBLE FOR MONITORING NEW ADMITS, AND INTERNAL TRANSFERS FROM INDEPENDENT LIVING TO ASSISTED LIVING TO ENSURE PROPER DOCUMENTATION IS RECORDED, FOR 72 HOURS AFTER ADMISSION, OR TRANSFER FOR A PERIOD OF THREE MONTHS, AND WILL BE BROUGHT TO THE FACILITIES QAPI PROGRAM. ANY IDNETIFIED CONCERNS WILL BE PROMPTLY ADDRESSED WITH THE RESPONSIBLE INDIVIDUAL(S). 5. COMPLETION DATE: 2/26/26	
R 0241	Health Services - Offense 410 IAC 16.2-5-4(e)(1) (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be	R 0241	TAG: R-241, - HEALTH SERVICES, OFFENSE 1. WHAT CORRECTIVE ACTION(S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE?	02/26/2026

	administered by licensed nursing personnel or qualified medication aides. Based on interview and record review, the facility failed to ensure only qualified personnel administered medications for 1 of 3 residents reviewed for medication administration. A HHA (Home Health Aide), who was not licensed to administer medications, gave medications to a resident. (HHA 4 and Resident C) Finding includes: On 2/2/26 at 10:00 a.m., Resident C's clinical record was reviewed. Resident C's diagnosis included, but was not limited to, legal blindness. On 2/2/26 at 11:00 a.m., a facility reportable incident, submitted to the Indiana State Department of Health on 12/30/25, was reviewed and indicated the following: - On 12/25/25 HHA 4 administered Resident C's daily medications. - A telephone text message screenshot from 12/25/25 indicated HHA 4 notified the QMA (Qualified Medication Aide) on duty that HHA 4 had assisted giving Resident C's medications. The message from HHA 4 to the QMA on duty read,		RESIDENT 44 WAS AFFECTED BY THIS DEFICIENT PRACTICE. RESIDENT 44 WAS IMMEDIATELY EVALUATED WITH NO APPARENT INJURIES, OR ADVERSE REACTION. RESIDENT WAS MONITORED WITH NO INJURY, OR ADVERSE REACTION. 2. HOW OTHER RESIDENTS, HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE, WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTION(S) WILL BE TAKEN? ALL RESIDENTS HAVE THE POTENTIAL TO BE AFFECTED. CLINICAL STAFF WILL BE TRAINED ON MEDICATION ADMINISTRATION, AND SCOPE OF PRACTICE TO ENSURE COMPLIANCE GOING FORWARD. 3. WHAT MEASURES WILL BE PUT INTO PLACE AND WHAT SYSTEMIC CHANGES WILL BE MADE TO	

	" I gave [Resident C]'s meds for you". Staff notified the DON (Director of Nursing). - HHA 4 admitted to having administered Resident C's medication on 12/25/25. During an interview on 2/2/26 at 1:10 p.m., the DON indicated that HHA 4 had acted out of the employee's scope of practice by giving Resident C's medications. During an interview on 2/2/26 at 1:20 p.m., the ED (Executive Director) indicated that HHA 4 had acted out of the employee's scope of practice by giving Resident C's medications. On 2/3/26 at 11:25 a.m., Resident C's Resident Self-Medication Management Evaluation, dated 12/19/25, was reviewed and indicated the family ordered Resident C's medications and set up medications for the resident in a dispenser in Resident C's room The evaluation further indicated Resident C was able to self-administer medications with the presence/assistance of a qualified staff member. This citation relates to Intake 466956. Based on interview and record review, the facility failed to ensure only qualified personnel		ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR? CLINICAL STAFF HAVE BEEN RE-EDUCATED RELATIVE TO MEDICATION ADMINISTRATION, AND SCOPE OF PRACTICE. 4. HOW WILL THE CORRECTIVE ACTION(S) BE MONITORED? DON, OR THEIR DESIGNEE WILL MONITOR MEDICATION ADMINISTRATION TO ENSURE ONGOING COMPLIANCE WITH FACILITY POLICY. MONITORING FOR PROPER MEDICATION ADMINISTRATION WILL TAKE PLACE ONE TIME PER WEEK FOR THREE MONTHS, AND WILL BE BROUGHT TO THE FACILITIES QAPI PROGRAM. ANY IDENTIFED CONCERNS WILL BE PROMPTLY ADDRESSED WITH THE RESPONSIBLE INDIVIDUAL(S). 5. COMPLETION DATE: 2/26/26	

administered medications for 1 of 3 residents reviewed for medication administration. A HHA (Home Health Aide), who was not licensed to administer medications, gave medications to a resident. (HHA 4 and Resident C)

Finding includes:

On 2/2/26 at 10:00 a.m., Resident C's clinical record was reviewed. Resident C's diagnosis included, but was not limited to, legal blindness.

On 2/2/26 at 11:00 a.m., a facility reportable incident, submitted to the Indiana State Department of Health on 12/30/25, was reviewed and indicated the following:

- On 12/25/25 HHA 4 administered Resident C's daily medications.

- A telephone text message screenshot from 12/25/25 indicated HHA 4 notified the QMA (Qualified Medication Aide) on duty that HHA 4 had assisted giving Resident C's medications. The message from HHA 4 to the QMA on duty read, " I gave [Resident C]'s meds for you". Staff notified the DON (Director of Nursing).

	- HHA 4 admitted to having administered Resident C's medication on 12/25/25. During an interview on 2/2/26 at 1:10 p.m., the DON indicated that HHA 4 had acted out of the employee's scope of practice by giving Resident C's medications. During an interview on 2/2/26 at 1:20 p.m., the ED (Executive Director) indicated that HHA 4 had acted out of the employee's scope of practice by giving Resident C's medications. On 2/3/26 at 11:25 a.m., Resident C's Resident Self-Medication Management Evaluation, dated 12/19/25, was reviewed and indicated the family ordered Resident C's medications and set up medications for the resident in a dispenser in Resident C's room The evaluation further indicated Resident C was able to self-administer medications with the presence/assistance of a qualified staff member. This citation relates to Intake 466956.			

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 SIGNATURETim Cooper	TITLEExecutive Director	(X6) DATE02/20/2026