STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	05/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEMAREE CROSSING ASSISTED LIVING AND MEMORY CARE	1255 DEMAREE ROAD, GREENWOOD, , 46143

(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 469439. Intake 469439 - State deficiencies related to the allegations are cited at R27 and R53. Survey date: May 8 and 11, 2026 Facility number: 014079 Residential Census: 91 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed May 14, 2026.	R 0000	This Plan of Correction is submitted under regulations applicable to long term care providers.This Plan of Correction is not to be construed as an admission or agreement with the findings and conclusions in the Statement of Deficiencies.The preparation/ submission and/or execution of this Plan does not constitute agreement by the facility that the surveyor’s findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are correctly applied.Submission of this Plan is evidence of compliance.	
R 0027	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(b) (b) Residents have the right to a dignified existence, self-determination, and	R 0027	This Plan of Correction is submitted under regulations applicable to long term care providers. This Plan of Correction is not to be construed as an admission or	06/26/2026

	communication with and access to persons and services inside and outside the facility. Residents have the right to exercise their rights as a resident of the facility and as a citizen or resident of the United States. Based on observation, interview, and record review, the facility failed to protect the resident's right to a dignified existence when a staff member leaned a resident's wheelchair back and wheeled the resident out of the dining room with the two front wheels and the residents feet in the air with other residents and staff watching for 1 of 3 residents reviewed for resident's rights. (Resident B, Resident C) Findings include: During an interview on 5/8/26 at 11:19 a.m., observed Resident B sitting in a manual wheelchair and moving his feet, in a slow and careful motion, to push the wheelchair backward through the bistro area. At that time, Resident B carefully wheeled up to a table and indicated on 4/29/26 at dinner time, Resident B wheeled his chair backward through the dining room. When all of the sudden, Resident B felt his wheelchair stop and lean backward. The Administrator grabbed the back handles of his wheelchair and pushed down so the front wheels and Resident		agreement with the findings and conclusions in the Statement of Deficiencies. The preparation/ submission and/or execution of this Plan does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are correctly applied. Submission of this Plan is evidence of compliance. **R027** Resident B was assessed by paramedics immediately following the alleged incident, resulting in no injuries identified. Resident B was interviewed and assessed by the community's Director of Health and Wellness on the day following the alleged incident with no injuries identified. Resident B was seen by the resident's psych provider on 5/4/2026. Medication adjustments to assist in managing behaviors were made. Resident B was coached by the community's Director of Health and Wellness on 5/6/2026. Coaching included reiteration of proper conduct in the community's common spaces and courtesy for other residents. The community's Director of Health and Wellness conducted	

	B's feet, lifted off the ground. The Administrator wheeled him out of the dining room and into the hallway while he asked to be let down. Resident B felt embarrassed and felt like he was being disciplined. During an interview on 5/8/26 at 11:51 a.m., Qualified Medication Aide (QMA) 1 indicated on 4/29/26 at dinner time, she had been watching the dining room from the hallway window. QMA 1 saw the Administrator grab Resident B's wheelchair from the front arm rest area. The two of them spoke to each other. Then Resident B started to turn away from the Administrator and wheel backward and another resident walked behind him. The Administrator grabbed Resident B's wheelchair again, but this time from the back, and lifted the front wheels in the air. Resident B's hat almost came off. The Administrator wheeled Resident B out of the dining room with the front wheels and his feet in the air. Resident B asked to be let down. QMA 1 did not see Resident B bump into any other residents in the dining room. During an interview on 5/8/26 at 3:50 p.m., QMA 2 indicated on 4/29/26 at dinner time, she was in the dining room when the Administrator got between Resident B's wheelchair and		interviews of other residents who were present for the alleged incident. None of the residents interviewed verbalized concerns or injury related to the alleged incident, including Resident C. On 5/5/2026, the community's Administrator received retraining by the community's Vice President of Operations and the community's People Business Partner to proactive addressing of resident needs, Team Member reactions in situations of varying urgency, appropriate response techniques, and preservation of resident rights and dignity. The community's Administrator received retraining on topics "Abuse: Preventing, Recognizing, and Reporting", and "Knowing the Rights of Residents" through the Relias Learning Management System on 5/25/2026. The community's Director of Health and Wellness, or their designee, shall complete a re-education of current community Team Members to resident rights, dignity, respectful communication, abuse prohibition, and appropriate resident interactions, with emphasis on maintaining residents' dignity during all interventions and	

	another resident who had been walking up to a chair behind Resident B. The Administrator grabbed Resident B's wheelchair from behind, leaned down and said "stop" in a loud voice. Resident B looked like he was trying to tell the Administrator something and then all the sudden, the Administrator leaned Resident B's wheelchair back and rushed him out of the dining room with the front two wheels and Resident B's feet in the air. QMA 2 did not see Resident B bump into any other residents in the dining room. During an interview on 5/8/26 at 4:13 p.m., Resident C indicated on 4/29/26 at dinner time, as she was walking into the dining room, the Administrator wheeled Resident B's wheelchair over her left shoe. Resident B's wheelchair was tilted back with the front wheels and Resident B's feet in the air. The Administrator was pushing Resident B's wheelchair fast. Resident B was asking why the Administrator was taking him out and he was telling the Administrator that he hadn't done anything wrong. The Administrator told Resident B he wasn't going to back up his chair like that. The clinical record for Resident B was reviewed on 5/11/26 at		avoiding actions that may be perceived as punitive, humiliating, or aggressive. Such re-education shall occur by 6/26/2026, and completion of such re-education shall be documented on an Inservice Attendance Log, maintained with the community's training records. Team Members who do not complete re-education by 6/26/2026 shall be removed from the community's schedule until such re-education is completed. New community Team Members shall be trained to Resident Rights and Abuse and Neglect within their initial onboarding training. The community's Director of Health and Wellness, or their designee, shall conduct random observations of resident interactions, including dining room interactions and wheelchair transport practices, a minimum of three times weekly for four weeks, then weekly for four additional weeks to ensure residents are treated with dignity and respect. Identified concerns shall be addressed immediately through counseling and/or additional education.	

	7:50 a.m. The diagnoses included, but were not limited to, diabetes, heart failure, and major depression. A Service Plan Assessment, dated 9/29/25, indicated Resident B had no cognitive impairment. A progress note, dated 4/29/26 at 4:05 p.m., indicated the Administrator pushed Resident B in his wheelchair, out of the dining room, with the wheelchair tilted back and the front wheels, and Resident B's legs, in the air. The clinical record for Resident C was reviewed on 5/11/26 at 8:06 a.m. The diagnoses included, but were not limited to, spina bifida. A Service Plan Assessment, dated 11/7/25, indicated Resident C had no cognitive impairment. On 5/8/26 at 9:21 a.m., the Administrator provided a copy of a facility policy, titled Resident Rights, dated 3/14/22, and indicated this was the current policy used by the facility. A review of the policy indicated all staff shall treat all residents with kindness, respect, and dignity. This citation relates to Intake 469439.			

R 0053	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(w) (w) Residents have the right to be free from verbal abuse. Based on observation, interview, and record review, the facility failed to protect a resident's right to be free from verbal abuse when a staff member yelled at a resident as the resident was being wheeled out of the dining room for 1 of 3 residents reviewed for verbal abuse. (Resident B, Administrator) Findings include: On 5/8/26 at 9:21 a.m., the Administrator provided a copy of a facility reportable incident, dated 4/30/26 at 5:01 p.m. A review of the incident report indicated, staff reported to the Director of Nursing (DON) that the Administrator mishandled Resident B as he was being removed from the dining room. On 5/8/26 at 10:34 a.m., the DON provided a copy of a Qualified Medication Aide (QMA) statement, dated 5/2/26 at 7:21 a.m. A review of the statement indicated Resident B had been trying to tell the Administrator that he was trying to get out and then that was when the Administrator had Resident B's wheelchair tilted	R 0053	This Plan of Correction is submitted under regulations applicable to long term care providers. This Plan of Correction is not to be construed as an admission or agreement with the findings and conclusions in the Statement of Deficiencies. The preparation/ submission and/or execution of this Plan does not constitute agreement by the facility that the surveyor’s findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are correctly applied. Submission of this Plan is evidence of compliance. **R053** Resident B was assessed by paramedics immediately following the alleged incident, resulting in no injuries identified. Resident B was interviewed and assessed by the community’s Director of Health and Wellness on the day following the alleged incident with no injuries identified. Resident B was seen by the resident’s psych provider on 5/4/2026. Medication adjustments to assist in managing behaviors were made. Resident B was coached by the community’s Director of Health and Wellness on 5/6/2026. Coaching included reiteration of proper conduct in	06/26/2026

	back on two wheels and wheeled him out of the dining room and yelled "you are not acting like this in my dining room". During an interview on 5/8/26 at 11:19 a.m., observed Resident B sitting in a manual wheelchair and moving his feet, in a slow and careful motion, to push the wheelchair backward through the bistro area. At that time, Resident B carefully wheeled up to a table and indicated on 4/29/26 at dinner time, Resident B wheeled his chair backward through the dining room. When all of the sudden, Resident B felt his wheelchair stop and lean backward. The Administrator grabbed the back handles of his wheelchair and pushed down so the front wheels and Resident B's feet, lifted off the ground. The Administrator wheeled him out of the dining room and into the hallway while he asked to be let down. The Administrator spoke in a negative tone and Resident B felt embarrassed and felt like he was being disciplined. During an interview on 5/8/26 at 11:51 a.m., Qualified Medication Aide (QMA) 1 indicated on 4/29/26 at dinner time, the Administrator wheeled Resident B out of the dining room, with the front two wheels of his wheelchair up in the air, into the		the community's common spaces and courtesy for other residents. The community's Director of Health and Wellness conducted interviews of other residents who were present for the alleged incident. None of the residents interviewed verbalized concerns or reports of verbal abuse related to the alleged incident. On 5/5/2026, the community's Administrator received retraining by the community's Vice President of Operations and the community's People Business Partner to proactive addressing of resident needs, Team Member reactions in situations of varying urgency, appropriate response techniques, and preservation of resident rights and dignity. The community's Administrator received retraining on topics "Abuse: Preventing, Recognizing, and Reporting", and "Knowing the Rights of Residents" on 5/25/2026 through the Relias Learning Management System. The community's Director of Health and Wellness, or their designee, shall complete a re-education of current community Team Members to abuse prohibition and appropriate resident	

	hallway and yelled at Resident B "don't ever come back in the dining room" and "you aren't going to act like that in my dining room". Resident B was confused and upset. At that time, QMA 1 made the Director of Nursing (DON) aware. During an interview on 5/8/26 at 3:50 p.m., QMA 2 indicated the Administrator leaned Resident B's wheelchair back and pushed him out of the dining room and yelled "you're not acting like this in my dining room". QMA 2 believed the Administrator acted aggressively toward Resident B. The clinical record for Resident B was reviewed on 5/11/26 at 7:50 a.m. The diagnoses included, but were not limited to, diabetes, heart failure, and major depression. A Service Plan Assessment, dated 9/29/25, indicated Resident B had no cognitive impairment. A progress note, dated 4/29/26 at 4:05 p.m., indicated the Administrator pushed Resident B in his wheelchair, out of the dining room, with the wheelchair tilted back and the front wheels, and Resident B's legs, in the air. The Administrator yelled at Resident B that he was not to come back in the dining room. On 5/8/26 at 9:21 a.m., the		interactions, with emphasis on maintaining residents' dignity during all interventions and avoiding actions that may be perceived as punitive, humiliating, or aggressive. Such re-education shall occur by 6/26/2026, and completion of such re-education shall be documented on an Inservice Attendance Log, maintained with the community's training records. Team Members who do not complete re-education by 6/26/2026 shall be removed from the community's schedule until such re-education is completed. New community Team Members shall be trained to Resident Rights and Abuse and Neglect within their initial onboarding training. The community's Director of Health and Wellness, or their designee, shall conduct random interviews with residents and observations of resident interactions a minimum of three times weekly for four weeks, then weekly for four additional weeks to ensure residents remain free from verbal abuse and inappropriate staff interactions. Identified concerns shall be addressed immediately through counseling and/or additional education.	

	Administrator provided a copy of a facility policy, titled Abuse and Neglect Reporting Policy, dated 9/28/23, and indicated this was the current policy used by the facility. A review of the policy indicated the facility strived to provide an abuse free environment. This citation relates to Intake 469439.			

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 SIGNATURERhiannon Study	TITLEExecutive Director	(X6) DATE06/03/2026