STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	03/06/2025

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 Complaints IN00454855 and IN00454299, which resulted in an unrelated deficiency cited. Complaint IN00454855 - State deficiencies related to the allegations are cited at R245. Complaint IN00454299 - No deficiencies related to the allegations are cited. Unrelated deficiency is cited. Survey date: March 6, 2025 Facility number: 014079 Residential Census: 74 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed March 10, 2025.	R 0000	R0027 Resident rights **Corrective action** Resident H was assessed for injury. Staff member identified filming residents was suspended and terminated on 2/19/25. **Identification of other potentially affected.** The administrator and DHW completed resident interviews for all Memory Care residents 2/7/25 and 2/10/25 **Systemic changes** The administrator or designee reviewed the social media and	

			residents' rights policies and expectations with all staff on 3/20/25 . The administrator or Designee will review the social media, HIPPA, residents' rights and professional conduct policies at monthly-staff meetings for the next 3 months, then quarterly after that. **Quality assurance program** The administrator and all managers will immediately enforce a strict no-phone standard in accordance to the team member handbook while providing resident care. DHW or designee will conduct five random supervisory rounds to ensure adherence to the policy for the next 6 months. DHW or designee will address any deviance from the standard with corrective action.	

			By what date the systemic changes will be completed Systemic changes will be completed after the April 2025 all-staff meeting. R0245 Scope of practice **Corrective action** QMA 3 was educated on the requirements for certification of insulin certification on 3/06/25. The administrator conducted an audit for all QMA's to ensure all insulin certifications are up to date on 3/06/25 **Identification of other potentially affected.**	

			Regional Director of Clinical Services reviewed all insulin-dependent residents who received care from QMA on 3/07/25. No other administration of insulin was noted on the EMAR system. **Systemic changes** DHW or designee will complete re-education on medication and insulin administration to all nursing staff who administer medications 3/20/25 DHW or designee will complete medication administration competency on all QMA's and LPN's by 4/15/25. **Quality assurance program** DHW or HR designee	

			implemented tracking system to monitor certification status and renewal dates. **By what date the systemic changes will be completed** Systematic changes will be completed by April 30 2025.	
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 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 interview and record review, the facility failed to protect the resident's right to a dignified existence for 1 of 4 residents reviewed. A resident was visible in a video posted to social media by a staff member. (Resident H, CNA 2) Finding includes: On 3/6/24 at 12:55 p.m., the	R 0027	**Corrective action** Resident H was assessed for injury. Staff member identified filming residents was suspended and terminated on 2/19/25. **Identification of other potentially affected.** The administrator and DHW completed resident interviews for all Memory Care residents 2/7/25 and 2/10/25 **Systemic changes**	04/30/2025

	clinical record for Resident H was reviewed and indicated the following: Resident H's diagnosis included, but was not limited to, Alzheimer's disease. Resident H resided on the secured memory care unit of the facility. During an interview on 3/6/25 at 12:44 p.m., the Administrator indicated that on 2/7/25 the facility was made aware of an employee (CNA 2) who had posted a video to a social media platform, TikTok, where Resident H was visible with the staff member who was lip-syncing to a song with the resident in the resident's bathroom. CNA 2 was suspended pending the investigation and was terminated from employment from the facility on 2/19/15 for violating facility policies regarding resident rights and dignity which strictly prohibited the use of still photo or video recording involving the residents and the staff members on the premises. On 3/6/25 at 1:30 p.m., the Administrator provided a policy, dated 3/14/22, and titled "Resident Rights" and indicated it was the policy currently in use by the facility. A review of the policy indicated, "Employees shall treat all residents with kindness, respect, and dignity"		The administrator or designee reviewed the social media and residents' rights policies and expectations with all staff on 3/20/25 . The administrator or Designee will review the social media, HIPPA, residents' rights and professional conduct policies at monthly-staff meetings for the next 3 months, then quarterly after that. **Quality assurance program** The administrator and all managers will immediately enforce a strict no-phone standard in accordance to the team member handbook while providing resident care. DHW or designee will conduct five random supervisory rounds to ensure adherence to the policy for the next 6 months. DHW or designee will address any deviance from the standard with corrective action.	

	and residents have the right to a dignified existence. Based on interview and record review, the facility failed to protect the resident's right to a dignified existence for 1 of 4 residents reviewed. A resident was visible in a video posted to social media by a staff member. (Resident H, CNA 2) Finding includes: On 3/6/24 at 12:55 p.m., the clinical record for Resident H was reviewed and indicated the following: Resident H's diagnosis included, but was not limited to, Alzheimer's disease. Resident H resided on the secured memory care unit of the facility. During an interview on 3/6/25 at 12:44 p.m., the Administrator indicated that on 2/7/25 the facility was made aware of an employee (CNA 2) who had posted a video to a social media platform, TikTok, where Resident H was visible with the staff member who was lip-syncing to a song with the resident in the resident's bathroom. CNA 2 was suspended pending the investigation and was terminated from employment from the facility on 2/19/15 for violating facility policies regarding resident rights and dignity which strictly prohibited		**By what date the systemic changes will be completed** Systemic changes will be completed after the April 2025 all-staff meeting.	

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R 0245	Health Services - Offense 410 IAC 16.2-5-4(e)(5) (5) Injectable medications shall be given only by licensed personnel. Based on interview and record review, the facility failed to ensure only qualified personnel administered insulin for 1 of 3 residents reviewed for medication administration. (QMA 3, Resident 3) Finding includes: On 3/6/25 at 9:45 a.m., Resident C's clinical record was reviewed. The diagnosis included, but was not limited to, type 2 diabetes mellitus. The Physician Orders indicated Resident C was prescribed	R 0245	**Corrective action** QMA 3 was educated on the requirements for certification of insulin certification on 3/06/25. The administrator conducted an audit for all QMA's to ensure all insulin certifications are up to date on 3/06/25 **Identification of other potentially affected.**	04/30/2025

	Lantus Solostar (insulin, related to type 2 diabetes mellitus) 20 units subcutaneously one time a day at bedtime, started on 2/23/25 and discontinued on 3/5/25. The March 2025 Medication Administration Record indicated, on 3/4/25, Resident C had received the scheduled 20 units of insulin at bedtime from QMA 10. During an interview on 3/6/25 at 10:40 a.m., QMA 4 indicated only a QMA who was granted insulin administration approved by the "State" was allowed to administer insulin. During an interview on 3/6/25 at 12:42 p.m., the Administrator indicated QMA 10 had QMA 3 administer Resident C's evening insulin on 3/4/25. QMA 10 knew he could not administer insulin, but QMA 3 could. On 3/6/25 at 1:00 p.m., the QMA certifications were reviewed. A review of QMA 3's and QMA 10's certification indicated it was considered in active status with the State of Indiana registry. QMA 3's and QMA 10's certifications did not include the State of Indiana insulin administration approval. During an interview on 3/6/25 at 2:00 p.m., the Administrator indicated QMA 3 was enrolled in nursing school and had		Regional Director of Clinical Services reviewed all insulin-dependent residents who received care from QMA on 3/07/25. No other administration of insulin was noted on the EMAR system. **Systemic changes** DHW or designee will complete re-education on medication and insulin administration to all nursing staff who administer medications 3/20/25 DHW or designee will complete medication administration competency on all QMA’s and LPN’s by 4/15/25.	

	successfully completed a pharmacology course. The Administrator "thought" that once QMA 3 completed the pharmacology course, she was then eligible to administer insulin as a QMA. On 3/6/25 at 3:00 p.m., the Administrator provided a copy of the Medication Management policy, dated 2/16/23, and indicated it was the current policy in use by the facility. A review of the policy indicated, " ...administration of medication by qualified or licensed personnel ..." This citation relates to Complaint IN00454855. Based on interview and record review, the facility failed to ensure only qualified personnel administered insulin for 1 of 3 residents reviewed for medication administration. (QMA 3, Resident 3) Finding includes: On 3/6/25 at 9:45 a.m., Resident C's clinical record was reviewed. The diagnosis included, but was not limited to, type 2 diabetes mellitus. The Physician Orders indicated Resident C was prescribed Lantus Solostar (insulin, related to type 2 diabetes mellitus) 20 units subcutaneously one time a day at bedtime, started on		**Quality assurance program** DHW or HR designee implemented tracking system to monitor certification status and renewal dates. **By what date the systemic changes will be completed** Systematic changes will be completed by April 30 2025.	

2/23/25 and discontinued on 3/5/25.

The March 2025 Medication Administration Record indicated, on 3/4/25, Resident C had received the scheduled 20 units of insulin at bedtime from QMA 10.

During an interview on 3/6/25 at 10:40 a.m., QMA 4 indicated only a QMA who was granted insulin administration approved by the "State" was allowed to administer insulin.

During an interview on 3/6/25 at 12:42 p.m., the Administrator indicated QMA 10 had QMA 3 administer Resident C's evening insulin on 3/4/25. QMA 10 knew he could not administer insulin, but QMA 3 could.

On 3/6/25 at 1:00 p.m., the QMA certifications were reviewed. A review of QMA 3's and QMA 10's certification indicated it was considered in active status with the State of Indiana registry. QMA 3's and QMA 10's certifications did not include the State of Indiana insulin administration approval.

During an interview on 3/6/25 at 2:00 p.m., the Administrator indicated QMA 3 was enrolled in nursing school and had successfully completed a pharmacology course. The Administrator "thought" that once QMA 3 completed the

	pharmacology course, she was then eligible to administer insulin as a QMA. On 3/6/25 at 3:00 p.m., the Administrator provided a copy of the Medication Management policy, dated 2/16/23, and indicated it was the current policy in use by the facility. A review of the policy indicated, " ...administration of medication by qualified or licensed personnel ..." This citation relates to Complaint IN00454855.			

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