STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	06/19/2026

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 a State Residential Licensure Survey. This visit included the Investigation of Intake 469606. Intake 469606 - No deficiencies related to the allegations are cited. Survey dates: June 18 and 19, 2026 Facility number: 014079 Residential Census: 91 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed June 22, 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 0086	Administration and Management - Deficiency 410 IAC 16.2-5-1.3(a)(1-2) The licensee:	R 0086	**This Plan of Correction is submitted under regulations applicable to long term care providers. This Plan of Correction is not to be**	08/14/2026

	(1) is responsible for compliance with all applicable laws; and (2) has full authority and responsibility for the: (A) organization; (B) management; (C) operation; and (D) control; of the licensed facility. The delegation of any authority by the licensee does not diminish the responsibilities of the licensee. Based on record review and interview, the facility failed to ensure a current and valid Clinical Laboratory Improvement Amendments (CLIA) certification (for the purposes of performing laboratory examinations or procedures) was maintained as required for 2 of 2 days of the survey. Finding includes: On 6/19/26 at 1:47 p.m., the Executive Director provided a copy of the facility's current CLIA certification document. A review of the document indicated the certification's expiration date was 3/4/26. No subsequent CLIA certification was available.		**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.** **What corrective action will be accomplished for those affected by the deficient practice?** The Executive Director initiated the renewal process with the appropriate regulatory agency and obtained the necessary documentation to restore compliance. **How will the facility identify other residents who may be affected by the same deficient practice?** Any identified concerns will be addressed with the resident's physician and documented accordingly. The community's Executive	

	During an interview on 6/19/26 at 1:47 p.m., the Executive Director indicated the CLIA certification's expiration date was in March of 2026, and it should have been renewed by it's end date. The facility had continued to perform blood glucose testing and other outside vendors had also completed various resident blood draws even though the facility's CLIA certification had expired. During an interview on 6/19/26 at 2:15 p.m., the Executive Director indicated the facility lacked a specific policy for maintaining a current CLIA certification. The facility was to follow all federal and state rules and regulations.		Director has been designated as the primary responsible party for monitoring the CLIA certification expiration date. Required facility licenses, permits, and certifications, including the CLIA certificate, have been added to a regulatory tracking log. Monthly compliance reviews shall be conducted to ensure required certifications remain current. The community's Executive Director shall receive education regarding CLIA requirements and regulatory compliance responsibilities. **How will the corrective action be monitored?** The community's Executive Director, or their designee, shall audit the community's required regulatory at least once monthly for three months and then at least quarterly thereafter. Such audits shall verify that required licenses, certifications, and permits remain current and that renewal applications shall be submitted timely. CLIA Waiver update was submitted on 6/20/2026.	

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 had received the rabies vaccination and the annual veterinary examination for 1 of 3 residents who housed pets in the facility. (Resident 251) Finding includes: On 6/19/26 at 9:10 a.m., the Executive Director provided a list of residents who housed pets in the facility. A review of the document indicated that Resident 251 had a canine pet who resided with the resident. On 6/19/26 at 9:15 a.m., Resident 251's canine rabies vaccination and annual veterinary examination record was reviewed. The document titled Rabies Certificate, dated 5/20/25, indicated the canine's rabies vaccination was administered and the annual veterinary examination was conducted on 5/20/25. The next rabies vaccination and annual veterinary examination was due was due on 5/20/26. No other	R 0151	**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.** **What corrective action will be accomplished for those affected by the deficient practice?** The pet of Resident 251's veterinary examination and rabies vaccination status were verified and updated documentation was requested from the veterinarian. Documentation was placed in the resident's pet record upon receipt. **How will the facility identify other residents who may be**	06/30/2026

	documentation was provided. The records lacked a current rabies vaccination certification and the annual veterinary examination of the canine. During an interview on 6/19/26 at 9:15 a.m., the Executive Director indicated Resident 251's rabies vaccination and annual veterinarian examination documentation should have been updated. On 6/19/26 at 9:15 a.m., the Executive Director provided a copy of the Pet Policy, with a revision date of 3/27/23, and indicated it was the current policy in use by the facility. A review of the document indicated, "...All pets must have annual medical exams and all required vaccinations. Records of these exams and vaccinations must be provided to the community prior to move-in, and upon request thereafter..." On 6/19/26 at 11:18 a.m., a review of the Rabies Vaccination Requirements located at 345 IAC 1-5-2 indicated, "...all dogs and cats...3 months of age and older must be vaccinated against rabies..."		**affected by the same deficient practice?** The Executive Director and/or designee completed an audit of all resident-owned pets residing within the community to verify Current rabies vaccination records are on file. Annual veterinary examination records are on file. Required pet documentation is complete and current. Any missing or expired documentation identified during the audit was immediately addressed with the resident and/or responsible party. **What measures will be put into place to ensure the deficient practice does not recur?** The community has reinforced its Pet Policy requirements with residents, families, and responsible parties. A Pet Compliance Tracking Log has been implemented to monitor all resident-owned pets and record: Annual veterinary examination due dates. Vaccination expiration dates.	

			Documentation receipt dates. The community's Executive Director, or their designee, shall review the tracking system on a monthly basis, to ensure that all records stay updated.	
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 administered by licensed nursing personnel or qualified medication aides. Based on interview and record review, the facility failed to ensure certified personnel administered resident medications for 1 of 10 QMAs reviewed for QMA certification. QMA 3 lacked an active QMA certification to administer resident medications. (QMA 3) Finding includes:	R 0241	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. **What corrective action will be accomplished for those residents found to be affected by the deficient practice?**	06/20/2026

	On 6/18/26 from 8:30 a.m. to 9:00 a.m., Qualified Medication Aide (QMA) 3 was observed administering medications to five residents. On 6/19/26 at 9:00 a.m., the Executive Director provided the facility's employee list for review. On 6/19/26 at 10:00 a.m., QMA 3's employee record was reviewed. QMA 3 was hired on 6/30/25 and was currently employed by the facility as a QMA. On 6/19/26 at 11:16 a.m., the Executive Director provided a copy of QMA 3's State of Indiana Qualified Medication Aide Registry certification. A review of the document indicated QMA 3's certification had expired on 5/10/26. During an interview at that time, the Executive Director indicated QMA 3's certification had expired on 5/10/26. QMA 3 continued to administer medications to the residents even though the QMA certification renewal process had not been completed prior to it's expiration date. QMA 3 should not have worked as a QMA with an expired certification. On 6/19/26 at 1:20 p.m., the Executive Director provided a copy of QMA 3's Medication		Upon identification of the deficient practice, QMA 3 was immediately removed from medication administration duties until proof of a current and active QMA certification was obtained. **How will the facility identify other residents who may be affected by the same deficient practice?** An audit of the community's current licensed nurses and Qualified Medication Aides was completed to verify active and current credentials, certifications, and licensure. No other current community Team Members were identified during this audit who had expired credentials. What measures will be put into place to ensure the deficient practice does not recur? The community's Executive Director, or their designee, shall monitor expiration dates for professional licenses and certifications of Team Members, including QMA certifications. Team Members shall be notified of upcoming expirations and required to provide evidence of renewal prior to the expiration date. Updated documentation shall be maintained within the Team Member's personnel	

	Assistant: Position Description document. A review of the document indicated, "...medication certification as required by state guidelines..." The document was electronically signed by QMA 3 on 6/23/25. On 6/19/26 at 2:15 p.m., the Executive Director provided a copy of the Medication Management policy, dated 8/11/23, and indicated it was the current policy in use by the facility. A review of the document indicated, "...shall provide assistance with administration of medication as required by state...administration of medication by qualified or licensed personnel..."		record. In the event that a Team Member's professional licensure and/ or certification has expired prior to updated documentation being received by the community, such Team Members may not perform duties requiring licensure or certification until updated credentials have been received by the community. **How will the corrective action be monitored?** The community's Executive Director, or their designee, shall conduct monthly audits of the community's licensed and certified staff credentials for three months. Audits shall verify that required licenses and certifications remain current and that renewal documentation is maintained in personnel files. Any identified concerns shall be corrected immediately, and additional monitoring will be implemented as necessary.	

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) DATE07/07/2026