STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/29/2025

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 IN00462868 and IN00463661. Complaint IN00463661 - No deficiencies related to the allegations are cited. Complaint IN00462868 - State deficiencies related to the allegations are cited at R0349. Survey date: July 28 and 29, 2025 Facility number: 014079 Residential Census: 79 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed July 31, 2025.	R 0000	**Facility Number:** 014079 **Tag:** R0349 – Clinical Records – Noncompliance **1. Corrective action(s) for residents found to have been affected by the deficient practice:** Resident B: A late entry note was completed, 6/26/2025, in the clinical record documenting the 6/25/2025 elopement event, including assessment findings and follow-up actions. Care plan was updated to reflect exit seeking risk and preventive measures. Resident C & Resident D: All missing MAR documentation was reviewed against physician orders and medication inventory. No missed medications	

			were identified; administrations had occurred but were not documented. Staff who administered medications were counseled on timely and complete documentation. Inservice provide 8/7/2025. **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:** An audit of current resident MARs was/will be completed by the community's director of health and wellness or their designee to identify any missed documentation. Identified omissions shall be addressed with late entries in accordance community policy. Responsible team members were educated on August 7, 2025. Record review for documentation was completed for residents with insulin orders. **3. Measures and/or systemic**	

			changes to ensure the deficient practice does not recur: The community's current nurses and QMA's were re-educated by the Director of Health and Wellness and Executive Director on August 7, 2025 on: Community policy for Electronic Records documentation, Documentation standards for medication administration and resident events, change in condition. Implementation of a double check procedure at the end of each med pass for QMAs/nurses to verify MAR completeness before closing out the med pass. The community Director of Health and Wellness or their designee will review and report on compliance during morning meeting. Progress note shall be completed in the resident record for any reported resident events. The Director of Health and Wellness or Executive Director will review resident record post event for	

			compliance with documentation weekly x4 weeks. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur (Quality Assurance Plan):** The community's Director of Health and Wellness, or their designee, shall audit MARs for residents receiving insulin therapy and/or antibiotics 3x per week for 4 weeks and then weekly for 2 months then monthly for 3 months. The community's Executive Director of their designee shall review incident reports weekly for documentation compliance in the resident's electronic medical record.	

			Findings from audits will be reviewed during the community's weekly Interdiciplinary Team (IDT) Meetings. Noncompliance will result in prompt Team Member reeducation and progressive discipline in the event of repeat noncompliance. **5. Date systemic changes will be completed:** Corrective actions and Team Member education shall be completed by **August 30, 2025**.	
R 0349	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(a)(1-4) (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on interview and record	R 0349	**Facility Number:** 014079 **Tag:** R0349 – Clinical Records – Noncompliance **1. Corrective action(s) for residents found to have been affected by the deficient practice:** Resident B: A late entry note was completed, 6/26/2025, in the clinical record documenting the 6/25/2025 elopement event, including assessment findings and follow-up actions. Care plan was	08/30/2025

review, the facility failed to ensure the resident's clinical records were complete for 3 of 3 residents reviewed for documentation. (Resident B, Resident C, Resident D)

Findings include:

1. During an interview on 7/28/25 at 9:33 a.m., Qualified Medication Aide (QMA) 1 indicated Resident B walked out the door at the end of his hallway a couple weeks ago. In report QMA 1 was told Resident B walked along the sidewalk to the front of the facility where he rang the doorbell and staff brought him back into the facility. Resident B did not have wandering or exit seeking behaviors.

On 7/28/25 at 10:06 a.m., the Administrator provided a copy of an incident report from the state health department survey reporting system, dated 6/25/25 at 12:03 a.m., and indicated this was the facility reported incident when Resident B exited the facility. A review of the incident report indicated Resident B exited the facility, on 6/25/25 at approximately 12:00 a.m., and at 12:06 a.m. Resident B rang the front doorbell to be let back into the facility.

The clinical record for Resident B was reviewed on 7/28/25 at 10:15 a.m. The diagnoses

updated to reflect exit seeking risk and preventive measures.

Resident C & Resident D: All missing MAR documentation was reviewed against physician orders and medication inventory. No missed medications were identified; administrations had occurred but were not documented. Staff who administered medications were counseled on timely and complete documentation. Inservice provide 8/7/2025.

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:

An audit of current resident MARs was/will be completed by the community's director of health and wellness or their designee to identify any missed documentation.

Identified omissions shall be addressed with late entries in accordance community policy.

included, but were not limited to, dementia, non-traumatic intracranial hemorrhage, and major depression.

A Care Evaluation and Service Plan, dated 4/28/25, indicated Resident B was cognitively impaired and did not have wandering or exit seeking behaviors.

The clinical record for Resident B lacked a progress note regarding Resident B exiting the facility.

During an interview on 7/28/25 at 12:08 p.m., QMA 2 indicated she was working the night Resident B exited the facility through the exit door near his apartment. Resident B walked on the sidewalk along the side of the facility and rang the doorbell to come back inside the front door. He was outside the facility for approximately five minutes.

During an interview on 7/28/25 at 12:34 p.m., the Administrator indicated the nurse should have documented a note in Resident B's medical record when he walked out of the facility.

2. During an interview on 7/28/25 at 9:14 a.m., Resident C indicated she used insulin and heard there had been times when there was no staff that was insulin certified in the facility. Resident C was not sure

Responsible team members were educated on August 7, 2025.

Record review for documentation was completed for residents with insulin orders.

3. Measures and/or systemic changes to ensure the deficient practice does not recur:

The community's current nurses and QMA's were re-educated by the Director of Health and Wellness and Executive Director on August 7, 2025 on:

Community policy for Electronic Records documentation, Documentation standards for medication administration and resident events, change in condition.

Implementation of a double check procedure at the end of each med pass for QMAs/nurses to verify MAR completeness before closing out the med pass. The community Director of Health and Wellness or their designee will review and report on

	if she received all of her insulin administrations last week. The clinical record for Resident C was reviewed on 7/28/25 at 10:52 a.m. The diagnoses included, but were not limited to, diabetes, Parkinson's disease, and congestive heart failure. A service plan, dated 3/5/25, indicated Resident C required assistance from staff for medication administration. The Physician's orders indicated: - Fosfomycin (antibiotic) powder, administer 3 grams (gm) dissolved in 4 ounces (oz) of water orally once daily every three days for 9 days for a urinary tract infection, initiated 7/15/25. - Lispro insulin 100 units/milliliter (ml) inject 10 units subcutaneously with lunch for diabetes, initiated 11/10/24, - Lispro insulin 100 units/ml inject 8 units subcutaneously with dinner for diabetes, initiated 11/10/24 The Medication Administration Record (MAR), dated 7/1/25 at 7:00 a.m. through 7/28/25 at 7:00 a.m., indicated: Fosfomycin powder, administer 3 gm dissolved in 4 oz of water orally once daily every three		compliance during morning meeting. Progress note shall be completed in the resident record for any reported resident events. The Director of Health and Wellness or Executive Director will review resident record post event for compliance with documentation weekly x4 weeks. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur (Quality Assurance Plan):** The community's Director of Health and Wellness, or their designee, shall audit MARs for residents receiving insulin therapy and/or antibiotics 3x per week for 4 weeks and then weekly for 2 months then monthly for 3 months.	

	days for 9 days for a urinary tract infection. The MAR lacked completed documentation for 1 of 3 administrations. On 7/15/25 at 7:01 a.m., the MAR was left blank. Lispro insulin 100 units/ml inject 10 units subcutaneously with lunch for diabetes. The MAR lacked completed documentation for 2 of 27 administrations as follows: - On 7/9/25 at 12:00 p.m., left blank. - On 7/20/25 at 12:00 p.m., left blank. Lispro insulin 100 units/ml inject 8 units subcutaneously with dinner for diabetes. The MAR lacked completed documentation for 2 of 27 administrations as follows: - On 7/7/25 at 5:00 p.m., left blank. - On 7/22/25 at 5:00 p.m., left blank. During an interview on 7/28/25 at 12:34 p.m., the Administrator indicated the documentation in Resident C's MAR should have been completed.		The community's Executive Director of their designee shall review incident reports weekly for documentation compliance in the resident's electronic medical record. Findings from audits will be reviewed during the community's weekly Interdiciplinary Team (IDT) Meetings. Noncompliance will result in prompt Team Member reeducation and progressive discipline in the event of repeat noncompliance. **5. Date systemic changes will be completed:** Corrective actions and Team Member education shall be completed by **August 30, 2025**.	

3. During an interview on 7/28/25 at 10:06 a.m., Resident D indicated he used insulin and had received all of his insulin as ordered by the physician.

The clinical record for Resident D was reviewed on 7/28/25 at 11:57 a.m. The diagnoses included, but were not limited to, diabetes, obesity, and major depression.

A Service Plan, dated 1/23/25, indicated Resident D required assistance with medication administration.

The Physician's orders indicated:

- Aspart Flex (insulin) 100 units/ml, check blood sugar three times daily and administer subcutaneously per sliding scale as follows: less than 70 call the physician, 150 to 199 administer 1 unit; 200 to 249 administer 2 units; 250 to 299 administer 3 units; 300 to 349 administer 4 units; 350 to 400 administer 5 units, greater than 400 call the physician, for diabetes, initiated 6/3/25

- Hydralazine (a medication used to treat high blood pressure) 25 milligrams (mg) tablet, give 1 tablet orally every eight hours for anxiety, initiated 5/23/25.

- Symbicort inhaler (a medication used to treat asthma

and chronic obstructive pulmonary disease) 160/45 micrograms (mcg), administer two puffs orally two times daily, initiated 7/1/25.

- Torsemide (diuretic medication) 10 mg tablet, administer one tablet orally once daily for hypertension, initiated on 7/1/25 and discontinued on 7/5/25.

The MAR, dated 7/1/25 at 6:00 a.m. through 7/28/25 at 7:00 a.m. indicated:

Aspart flex 100 units/ml, check blood sugar three times daily and administer subcutaneously per sliding scale.

- On 7/6/25 at 7:01 a.m., left blank.

- On 7/6/25 at 11:01 a.m., left blank.

- On 7/7/25 at 4:01 p.m., left blank.

Hydralazine 25 mg tablet, give 1 tablet orally every eight hours for anxiety. The MAR lacked documentation for 1 of 82 administrations as follows:

- On 7/7/25 at 2:00 p.m., left blank.

Symbicort inhaler 160/45 mcg, administer two puffs orally two times daily for chronic obstructive pulmonary disorder.

The MAR lacked documentation for 2 of 82 administrations as follows:

- On 7/1/25 at 7:01 a.m., left blank.

- On 7/1/25 at 4:01 p.m., left blank.

Torsemide 10 mg tablet, administer one tablet orally once daily for hypertension. The MAR lacked documentation for 1 of 5 administrations as follows:

- On 7/1/25 at 7:01 a.m., left blank

During an interview on 7/28/25 at 12:34 p.m., the Administrator indicated the documentation in Resident D's MAR should have been completed.

On 7/28/25 at 12:56 p.m., the Administrator provided a copy of a facility policy, titled Electronic Records Policy, dated 2/18/23, and indicated this was the current policy used by the facility. A review of the policy indicated the facility should maintain thorough and accurate records.

This citation relates to Complaint IN00462868.

Based on interview and record review, the facility failed to ensure the resident's clinical records were complete for 3 of 3 residents reviewed for

documentation. (Resident B, Resident C, Resident D)

Findings include:

1. During an interview on 7/28/25 at 9:33 a.m., Qualified Medication Aide (QMA) 1 indicated Resident B walked out the door at the end of his hallway a couple weeks ago. In report QMA 1 was told Resident B walked along the sidewalk to the front of the facility where he rang the doorbell and staff brought him back into the facility. Resident B did not have wandering or exit seeking behaviors.

On 7/28/25 at 10:06 a.m., the Administrator provided a copy of an incident report from the state health department survey reporting system, dated 6/25/25 at 12:03 a.m., and indicated this was the facility reported incident when Resident B exited the facility. A review of the incident report indicated Resident B exited the facility, on 6/25/25 at approximately 12:00 a.m., and at 12:06 a.m. Resident B rang the front doorbell to be let back into the facility.

The clinical record for Resident B was reviewed on 7/28/25 at 10:15 a.m. The diagnoses included, but were not limited to, dementia, non-traumatic intracranial hemorrhage, and major depression.

A Care Evaluation and Service Plan, dated 4/28/25, indicated Resident B was cognitively impaired and did not have wandering or exit seeking behaviors.

The clinical record for Resident B lacked a progress note regarding Resident B exiting the facility.

During an interview on 7/28/25 at 12:08 p.m., QMA 2 indicated she was working the night Resident B exited the facility through the exit door near his apartment. Resident B walked on the sidewalk along the side of the facility and rang the doorbell to come back inside the front door. He was outside the facility for approximately five minutes.

During an interview on 7/28/25 at 12:34 p.m., the Administrator indicated the nurse should have documented a note in Resident B's medical record when he walked out of the facility.

2. During an interview on 7/28/25 at 9:14 a.m., Resident C indicated she used insulin and heard there had been times when there was no staff that was insulin certified in the facility. Resident C was not sure if she received all of her insulin administrations last week.

The clinical record for Resident C was reviewed on 7/28/25 at

10:52 a.m. The diagnoses included, but were not limited to, diabetes, Parkinson's disease, and congestive heart failure.

A service plan, dated 3/5/25, indicated Resident C required assistance from staff for medication administration.

The Physician's orders indicated:

- Fosfomycin (antibiotic) powder, administer 3 grams (gm) dissolved in 4 ounces (oz) of water orally once daily every three days for 9 days for a urinary tract infection, initiated 7/15/25.

- Lispro insulin 100 units/milliliter (ml) inject 10 units subcutaneously with lunch for diabetes, initiated 11/10/24,

- Lispro insulin 100 units/ml inject 8 units subcutaneously with dinner for diabetes, initiated 11/10/24

The Medication Administration Record (MAR), dated 7/1/25 at 7:00 a.m. through 7/28/25 at 7:00 a.m., indicated:

Fosfomycin powder, administer 3 gm dissolved in 4 oz of water orally once daily every three days for 9 days for a urinary tract infection. The MAR lacked completed documentation for 1 of 3 administrations. On 7/15/25 at 7:01 a.m., the MAR was left

blank.

Lispro insulin 100 units/ml inject 10 units subcutaneously with lunch for diabetes. The MAR lacked completed documentation for 2 of 27 administrations as follows:

- On 7/9/25 at 12:00 p.m., left blank.

- On 7/20/25 at 12:00 p.m., left blank.

Lispro insulin 100 units/ml inject 8 units subcutaneously with dinner for diabetes. The MAR lacked completed documentation for 2 of 27 administrations as follows:

- On 7/7/25 at 5:00 p.m., left blank.

- On 7/22/25 at 5:00 p.m., left blank.

During an interview on 7/28/25 at 12:34 p.m., the Administrator indicated the documentation in Resident C's MAR should have been completed.

3. During an interview on 7/28/25 at 10:06 a.m., Resident D indicated he used insulin and had received all of his insulin as ordered by the physician.

The clinical record for Resident D was reviewed on 7/28/25 at 11:57 a.m. The diagnoses included, but were not limited to,

diabetes, obesity, and major depression.

A Service Plan, dated 1/23/25, indicated Resident D required assistance with medication administration.

The Physician's orders indicated:

- Aspart Flex (insulin) 100 units/ml, check blood sugar three times daily and administer subcutaneously per sliding scale as follows: less than 70 call the physician, 150 to 199 administer 1 unit; 200 to 249 administer 2 units; 250 to 299 administer 3 units; 300 to 349 administer 4 units; 350 to 400 administer 5 units, greater than 400 call the physician, for diabetes, initiated 6/3/25

- Hydralazine (a medication used to treat high blood pressure) 25 milligrams (mg) tablet, give 1 tablet orally every eight hours for anxiety, initiated 5/23/25.

- Symbicort inhaler (a medication used to treat asthma and chronic obstructive pulmonary disease) 160/45 micrograms (mcg), administer two puffs orally two times daily, initiated 7/1/25.

- Torsemide (diuretic medication) 10 mg tablet, administer one tablet orally once daily for hypertension, initiated

on 7/1/25 and discontinued on 7/5/25.

The MAR, dated 7/1/25 at 6:00 a.m. through 7/28/25 at 7:00 a.m. indicated:

Aspart flex 100 units/ml, check blood sugar three times daily and administer subcutaneously per sliding scale.

- On 7/6/25 at 7:01 a.m., left blank.

- On 7/6/25 at 11:01 a.m., left blank.

- On 7/7/25 at 4:01 p.m., left blank.

Hydralazine 25 mg tablet, give 1 tablet orally every eight hours for anxiety. The MAR lacked documentation for 1 of 82 administrations as follows:

- On 7/7/25 at 2:00 p.m., left blank.

Symbicort inhaler 160/45 mcg, administer two puffs orally two times daily for chronic obstructive pulmonary disorder. The MAR lacked documentation for 2 of 82 administrations as follows:

- On 7/1/25 at 7:01 a.m., left blank.

- On 7/1/25 at 4:01 p.m., left blank.

	Torsemide 10 mg tablet, administer one tablet orally once daily for hypertension. The MAR lacked documentation for 1 of 5 administrations as follows: - On 7/1/25 at 7:01 a.m., left blank During an interview on 7/28/25 at 12:34 p.m., the Administrator indicated the documentation in Resident D's MAR should have been completed. On 7/28/25 at 12:56 p.m., the Administrator provided a copy of a facility policy, titled Electronic Records Policy, dated 2/18/23, and indicated this was the current policy used by the facility. A review of the policy indicated the facility should maintain thorough and accurate records. This citation relates to Complaint IN00462868.			

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