STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/09/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00457119. Complaint IN00457119 - No deficiencies related to the allegations are cited. Survey dates: May 8 and 9, 2025 Facility number: 014079 Residential Census: 77 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed May 13, 2025.	R 0000	Demaree Crossing 05.14.25 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. **R086-Administration and Management-Deficiency** *"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.* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Julia Berry	Executive Director	05/28/2025

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			the alleged deficient practice. CLIA certification was submitted for renewal on 5/09/2025 to labexcellence@cms.hhs.gov and paid through pay.gov-CLIA Laboratory User Fees. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - No residents were affected by the alleged deficient practice. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The ED and DHW will be educated on the Federal and State Regulatory requirements and renewal process for CLIA Certification by the SVP of Health & Wellness. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** ED or their designee will be responsible for monitoring expiration date and submit timely renewal for CLIA Certificate **Date of completion:** June 9, 2025 **R 148- Sanitation and Safety**	

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			Standards- Deficiency *"Facility failed to ensure that potentially hazardous materials were kept secured behind locked doors to prevent resident's access to hazardous materials for 14 of 14 self-mobile and cognitively impaired residents residing on the assisted living unit in the facility* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by the alleged deficient practice. Door to beauty shop was immediately closed and locked. The community's housekeeping staff and beautician will be in-serviced by the community Executive Director on community's policy for Hazardous Substance Classification and Storage. The community beautician was provided a key to the Beauty Shop for access to room. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - No resident was affected by the alleged deficient practice. **3: What measures will be put into place or what systemic changes will be made to**	

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			ensure that the deficient practice does not recur The community's current team members shall be re-educated to the community's Hazardous Substance Classification and Storage Guideline by 6/9/25. An in-service attendance log shall be maintained as evidence of completion of re-education and shall be maintained with the community's training files. New team members shall be trained to the community's Hazardous Substance Classification and Storage Guideline upon hire as part of their pre-service training. The community's Director of Health and Wellness or their designee shall complete monitoring of areas containing hazardous materials to ensure securement at minimum of four days per week for four weeks, and then weekly for four weeks then monthly for six months. The community's Director of Health and Wellness or their designee shall provide summary of findings to the Executive Director weekly and then monthly for review and discussion of any correction action items. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance**	

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			program will be put into place? The Director of Facilities or their designee will be responsible for monitoring compliance of sanitation and safety standards through random monthly checks for unsecured hazardous substance, unlocked cabinets and doors for six months. The random monthly checks results will be reviewed during the monthly safety meeting overseen by the Executive Director. Corrective actions will be implemented based on the findings and discussion during safety meeting. The community through the safety meeting, will review, update and make changes to the DPOC as needed for sustaining substantial compliance for no less than six months. **Date of completion:** June 9, 2025 **R 151- Sanitation & Safety Standards-Noncompliance** *"Facility failed to ensure a pet who resided in the facility had received the rabies vaccination and the annual veterinary examination was completed as required prior to its expiration date for 1 of 4 residents who housed pets in the facility" (Resident 97)* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**	

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			The canine owned by Resident 97 had vaccinations updated on 5/20/25. Record of such vaccination have been updated and shall be maintained by the community's Resident Experience Director or their designee **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** Records of pets currently residing at the community were audited by the community's Director of Health and Wellness on 5/25/25. All in community pet vaccination records shall be monitored and maintained by the community's Resident Experience Director or their designee in the Executive Director's office. Resident Experience Director or their designee will be responsible for notifying and coordinating with resident/responsible party any upcoming or past due pet vaccinations **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The community's Resident Experience Director, Resident	

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			Experience Ambassador and leadership team shall be reeducated by the Executive Director. Current and new residents who have pets residing in the community shall be educated on community's standards and policy for pet annual examination and compliance with vaccination during review of the residency agreement by the Executive Director. The community's Resident Experience Director or their designee shall review and provide Executive Director copy of pet vaccinations for any new pets who resident at the community effective June 9, 2025. Resident Experience Director or their designee shall review pet vaccinations for compliance monthly for at least six months to ensure compliance with community policy. The results of these reviews shall be reported to the Executive Director and discussed during the community's safety meeting. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The community's Executive Director or their designee shall complete random audits of the pet vaccination and examination tracking monthly for six months to	

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			ensure all pet vaccinations and annual examinations are current and up to date. Audit results will be reviewed at the monthly safety meeting overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed. The community through the safety meeting, will review, update and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months **Date of completion:** June 9, 2025 **R 216-** **Evaluation-Noncompliance** *"Facility failed to obtain a baseline admission weight for 1 of 7 residents reviewed for weights" (Resident 39)* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 39 has been discharged from the community on 5/14/25. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - The community's Director of Health and Wellness shall	

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			conduct an audit of electronic health record documentation for current in-house residents to evaluate compliance with documentation of admission weights by June 9, 2025. All inhouse Resident's weights shall be documented within the resident's electronic medical record for any resident(s) identified as missing weights based on the above audit. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The community's Director of Health and Wellness or their designee shall review electronic health record for new move ins to verify compliance and documentation of resident's weight within 72 hours from the date of move-in. - The community's Director of Health and Wellness shall re-educate all Wellness (Care) team members regarding Admission Policy and standard for obtaining and documenting residents' weight upon move in. An in-service attendance log shall be maintained as evidence of completion of re-education, and shall be maintained with the community's training files - The community's Director of Health and Wellness	

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			shall educate new Wellness (Care) team members on community's Admission Policy during the community pre-service training. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The community's Director of Health and Wellness/designee will complete daily monitoring to ensure that new move in resident(s) have an admission weight documented. Results of such monitoring shall be reported to the community's Executive Director at the community's morning meeting following observation for at least the following six months. **Date of completion:** June 9, 2025 **R 217 Evaluation-Deficiency** *"Facility failed to ensure the service plans were signed by the resident or the resident's representative for 7 of 7 residents reviewed for service plans (Resident 25, Resident 39, Resident 48, Resident 85, Resident 90, Resident 103 and Resident 104)* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**	

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			Current service plans for Residents 25, 39, 48, 85, and 90 service plans have been reviewed and signed by resident and/or responsible party. Residents 103 and 104 have been discharged from the community on [ADD DATES OF DISCHARGE] **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - The community's Director of Health and Wellness shall complete an audit of all current resident's service plan to validate signature by resident or responsible party by June 9, 2025. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The community's Director of Health and Wellness will re-educate the Wellness team member on the community's Evaluation policy which includes requirement for review and signature on plan of care. An in-service attendance log shall be maintained as evidence of completion of re-education, and shall be maintained with the community's training files	

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			4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? The community's Director of Health and Wellness or their designee shall complete random weekly audits of at least 2 new resident records weekly to evaluate compliance with signed service plans. The results of weekly monitoring shall be reported to and reviewed with the community's Executive Director **Date of completion:** June 9, 2025 **R 306 Pharmaceutical Services-Noncompliance** *"Facility failed to ensure drug dispositions for all medications, including non-controlled substance medications were accounted for and documented for 2 of 2 closed records reviewed (Resident 103, Resident 104)* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Drug disposition forms have been completed for Residents 103 and 104 on [ADD DATE] **2: How other residents having the potential to be affected by**	

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			the same deficient practice will be identified and what corrective action will be taken. The community's Director of Health and Wellness shall implement the use of Drug disposition form for all residents discharged from the community by June 9, 2025. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** The community's Director of Health and Wellness shall in-service the Wellness Team members on the community's policies for Discarding and Destroying Medication and Discontinuing Medication. An in-service attendance log shall be maintained as evidence of completion and maintained with the community's training files. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The community's Director of Health and Wellness or their designee shall complete random weekly audits of at least 1 discharged resident to ensure Drug Disposition form has been completed and scanned into electronic medical record. The	

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			results of such monitoring shall be reported to and reviewed with the community's Executive Director **Date of completion:** June 9, 2025. **R409- Infection Control-Noncompliance** *"Facility failed to ensure that the annual health assessment statement (a statement by the physician indicating the resident is free of communicable disease) was documented as required for 1 of 7 residents reviewed. (Resident 48)."* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 48 electronic medical record reviewed, and annual health statement updated by the primary physician. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - The community's Director of Health and Wellness or their designee conducted an audit on 05/23/25 of all inhouse resident records for compliance with annual health assessment statement indicating that resident is free of communicable diseases by June 9, 2025.	

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			3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur The Director of Health and Wellness or their designee shall re-educate the Wellness Team on the community's Admission Policy focusing on the annual health assessment statement indicating that resident is free of communicable diseases. An in-service attendance log shall be maintained as evidence of completion of reeducation and maintained with the community's training files. The community's Director of Health and Wellness or their designee shall monitor, manage and coordinate with physicians' residents' annual health assessment including statement indicating resident is free of communicable disease. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The community's Director of Health and Wellness or their designee shall complete daily monitoring to ensure new move-in resident(s) have an annual health statement documented. Results of daily monitoring shall be reported	

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			to the community's Executive Director. The community's Executive Director will randomly review 2 resident records to **Date of completion:** June 9, 2025 **R410-Infection Control-Noncompliance** *"Facility failed to ensure that a first step and second step tuberculin skin test (tool used for screening tuberculosis) was completed upon admission for 2 of 7 residents reviewed (Resident 39 and Resident 90)."* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Residents 39 and 90 two-step tuberculin skin tests have been initiated by the Wellness team. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - The community's Director of Health and Wellness or their designee shall complete an audit of inhouse resident's electronic health records to evaluate compliance with first and second step tuberculin skin test. Tuberculin skin tests will be administered as needed for any	

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			residents identified as missing step 1 or step 2 skin tests by June 9, 2025. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The community's Director of Health and Wellness or their designee shall complete monitoring to ensure that new move in resident(s) receive their first and second tuberculin skin test. The community's Director of Health and Wellness or their designee shall complete daily review of new move in records to ensure compliance with tuberculin skin test for the next 90 days. Results of the daily monitoring will be discussed with Executive Director and corrective actions taken to ensure compliance. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The Executive Director or their designee shall complete weekly random audits of at least 2 resident records weekly for four weeks, then monthly X 6 months to monitor compliance with tuberculin skin testing. **Date of**	

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DEMAREE CROSSING ASSISTED LIVING AND MEMORY CARE	1255 DEMAREE ROAD GREENWOOD, IN 46143

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R 0086 Bldg. 00	410 IAC 16.2-5-1.3(a)(1-2) Administration and Management - Deficiency 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. Finding includes: On 5/9/25 at 10:30 a.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 3/4/24. No subsequent CLIA certification was available. During an interview on 5/9/25 at 10:35 a.m., the Executive Director indicated the CLIA certification's expiration date was in March of 2024 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 5/9/25 at 11:23 a.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.	R 0086	**completion:** June 9, 2025 Demaree Crossing 05.14.25 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. **R086-Administration and Management-Deficiency** *"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.* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	06/09/2025

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			practice? No residents were affected by the alleged deficient practice. CLIA certification was submitted for renewal on 5/09/2025 to labexcellence@cms.hhs.gov and paid through pay.gov-CLIA Laboratory User Fees. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - No residents were affected by the alleged deficient practice. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The ED and DHW will be educated on the Federal and State Regulatory requirements and renewal process for CLIA Certification by the SVP of Health & Wellness. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** ED or their designee will be responsible for monitoring expiration date and submit timely renewal for CLIA Certificate **Date of completion:** June 9,	

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			2025 **R 148- Sanitation and Safety Standards- Deficiency** *"Facility failed to ensure that potentially hazardous materials were kept secured behind locked doors to prevent resident's access to hazardous materials for 14 of 14 self-mobile and cognitively impaired residents residing on the assisted living unit in the facility* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by the alleged deficient practice. Door to beauty shop was immediately closed and locked. The community's housekeeping staff and beautician will be in-serviced by the community Executive Director on community's policy for Hazardous Substance Classification and Storage. The community beautician was provided a key to the Beauty Shop for access to room. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - No resident was affected by the alleged deficient practice. **3: What measures will be put**	

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			into place or what systemic changes will be made to ensure that the deficient practice does not recur The community's current team members shall be re-educated to the community's Hazardous Substance Classification and Storage Guideline by 6/9/25. An in-service attendance log shall be maintained as evidence of completion of re-education and shall be maintained with the community's training files. New team members shall be trained to the community's Hazardous Substance Classification and Storage Guideline upon hire as part of their pre-service training. The community's Director of Health and Wellness or their designee shall complete monitoring of areas containing hazardous materials to ensure securement at minimum of four days per week for four weeks, and then weekly for four weeks then monthly for six months. The community's Director of Health and Wellness or their designee shall provide summary of findings to the Executive Director weekly and then monthly for review and discussion of any correction action items. **4: How the corrective action will be monitored to ensure the**	

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			deficient practice will not recur i.e., what quality assurance program will be put into place? The Director of Facilities or their designee will be responsible for monitoring compliance of sanitation and safety standards through random monthly checks for unsecured hazardous substance, unlocked cabinets and doors for six months. The random monthly checks results will be reviewed during the monthly safety meeting overseen by the Executive Director. Corrective actions will be implemented based on the findings and discussion during safety meeting. The community through the safety meeting, will review, update and make changes to the DPOC as needed for sustaining substantial compliance for no less than six months. **Date of completion:** June 9, 2025 **R 151- Sanitation & Safety Standards-Noncompliance** *"Facility failed to ensure a pet who resided in the facility had received the rabies vaccination and the annual veterinary examination was completed as required prior to its expiration date for 1 of 4 residents who housed pets in the facility" (Resident 97)* **1: What corrective action(s) will be accomplished for those residents found to have been**	

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			affected by the deficient practice? The canine owned by Resident 97 had vaccinations updated on 5/20/25. Record of such vaccination have been updated and shall be maintained by the community's Resident Experience Director or their designee **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** Records of pets currently residing at the community were audited by the community's Director of Health and Wellness on 5/25/25. All in community pet vaccination records shall be monitored and maintained by the community's Resident Experience Director or their designee in the Executive Director's office. Resident Experience Director or their designee will be responsible for notifying and coordinating with resident/responsible party any upcoming or past due pet vaccinations **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur**	

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			The community's Resident Experience Director, Resident Experience Ambassador and leadership team shall be reeducated by the Executive Director. Current and new residents who have pets residing in the community shall be educated on community's standards and policy for pet annual examination and compliance with vaccination during review of the residency agreement by the Executive Director. The community's Resident Experience Director or their designee shall review and provide Executive Director copy of pet vaccinations for any new pets who resident at the community effective June 9, 2025. Resident Experience Director or their designee shall review pet vaccinations for compliance monthly for at least six months to ensure compliance with community policy. The results of these reviews shall be reported to the Executive Director and discussed during the community's safety meeting. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The community's Executive Director or their designee shall complete random audits of the pet	

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			vaccination and examination tracking monthly for six months to ensure all pet vaccinations and annual examinations are current and up to date. Audit results will be reviewed at the monthly safety meeting overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed. The community through the safety meeting, will review, update and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months **Date of completion:** June 9, 2025 **R 216-** **Evaluation-Noncompliance** *"Facility failed to obtain a baseline admission weight for 1 of 7 residents reviewed for weights" (Resident 39)* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 39 has been discharged from the community on 5/14/25. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.**	

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			- The community's Director of Health and Wellness shall conduct an audit of electronic health record documentation for current in-house residents to evaluate compliance with documentation of admission weights by June 9, 2025. All inhouse Resident's weights shall be documented within the resident's electronic medical record for any resident(s) identified as missing weights based on the above audit. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The community's Director of Health and Wellness or their designee shall review electronic health record for new move ins to verify compliance and documentation of resident's weight within 72 hours from the date of move-in. - The community's Director of Health and Wellness shall re-educate all Wellness (Care) team members regarding Admission Policy and standard for obtaining and documenting residents' weight upon move in. An in-service attendance log shall be maintained as evidence of completion of re-education, and shall be maintained with the community's training files	

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			- The community's Director of Health and Wellness shall educate new Wellness (Care) team members on community's Admission Policy during the community pre-service training. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The community's Director of Health and Wellness/designee will complete daily monitoring to ensure that new move in resident(s) have an admission weight documented. Results of such monitoring shall be reported to the community's Executive Director at the community's morning meeting following observation for at least the following six months. **Date of completion:** June 9, 2025 **R 217 Evaluation-Deficiency** *"Facility failed to ensure the service plans were signed by the resident or the resident's representative for 7 of 7 residents reviewed for service plans (Resident 25, Resident 39, Resident 48, Resident 85, Resident 90, Resident 103 and Resident 104)* **1: What corrective action(s) will be accomplished for those residents found to have been**	

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			affected by the deficient practice? Current service plans for Residents 25, 39, 48, 85, and 90 service plans have been reviewed and signed by resident and/or responsible party. Residents 103 and 104 have been discharged from the community on [ADD DATES OF DISCHARGE] **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - The community's Director of Health and Wellness shall complete an audit of all current resident's service plan to validate signature by resident or responsible party by June 9, 2025. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The community's Director of Health and Wellness will re-educate the Wellness team member on the community's Evaluation policy which includes requirement for review and signature on plan of care. An in-service attendance log shall be maintained as evidence of completion of re-education, and shall be maintained with the	

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			community's training files **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The community's Director of Health and Wellness or their designee shall complete random weekly audits of at least 2 new resident records weekly to evaluate compliance with signed service plans. The results of weekly monitoring shall be reported to and reviewed with the community's Executive Director **Date of completion:** June 9, 2025 **R 306 Pharmaceutical Services-Noncompliance** *"Facility failed to ensure drug dispositions for all medications, including non-controlled substance medications were accounted for and documented for 2 of 2 closed records reviewed (Resident 103, Resident 104)* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Drug disposition forms have been completed for Residents 103 and 104 on [ADD DATE]	

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			2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. The community's Director of Health and Wellness shall implement the use of Drug disposition form for all residents discharged from the community by June 9, 2025. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** The community's Director of Health and Wellness shall in-service the Wellness Team members on the community's policies for Discarding and Destroying Medication and Discontinuing Medication. An in-service attendance log shall be maintained as evidence of completion and maintained with the community's training files. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The community's Director of Health and Wellness or their designee shall complete random weekly audits of at least 1 discharged resident to ensure Drug Disposition form has been	

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			completed and scanned into electronic medical record. The results of such monitoring shall be reported to and reviewed with the community's Executive Director **Date of completion:** June 9, 2025. **R409- Infection Control-Noncompliance** *"Facility failed to ensure that the annual health assessment statement (a statement by the physician indicating the resident is free of communicable disease) was documented as required for 1 of 7 residents reviewed. (Resident 48)."* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 48 electronic medical record reviewed, and annual health statement updated by the primary physician. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - The community's Director of Health and Wellness or their designee conducted an audit on 05/23/25 of all inhouse resident records for compliance with annual health assessment statement indicating that resident is free of	

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			communicable diseases by June 9, 2025. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The Director of Health and Wellness or their designee shall re-educate the Wellness Team on the community's Admission Policy focusing on the annual health assessment statement indicating that resident is free of communicable diseases. An in-service attendance log shall be maintained as evidence of completion of reeducation and maintained with the community's training files. The community's Director of Health and Wellness or their designee shall monitor, manage and coordinate with physicians' residents' annual health assessment including statement indicating resident is free of communicable disease. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The community's Director of Health and Wellness or their designee shall complete daily monitoring to ensure new move-in resident(s) have an annual health	

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			statement documented. Results of daily monitoring shall be reported to the community's Executive Director. The community's Executive Director will randomly review 2 resident records to **Date of completion:** June 9, 2025 **R410-Infection Control-Noncompliance** *"Facility failed to ensure that a first step and second step tuberculin skin test (tool used for screening tuberculosis) was completed upon admission for 2 of 7 residents reviewed (Resident 39 and Resident 90)."* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Residents 39 and 90 two-step tuberculin skin tests have been initiated by the Wellness team. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - The community's Director of Health and Wellness or their designee shall complete an audit of inhouse resident's electronic health records to evaluate compliance with first and second step tuberculin skin test.	

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			Tuberculin skin tests will be administered as needed for any residents identified as missing step 1 or step 2 skin tests by June 9, 2025. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The community's Director of Health and Wellness or their designee shall complete monitoring to ensure that new move in resident(s) receive their first and second tuberculin skin test. The community's Director of Health and Wellness or their designee shall complete daily review of new move in records to ensure compliance with tuberculin skin test for the next 90 days. Results of the daily monitoring will be discussed with Executive Director and corrective actions taken to ensure compliance. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The Executive Director or their designee shall complete weekly random audits of at least 2 resident records weekly for four weeks, then monthly X 6 months to monitor compliance with	

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DEMAREE CROSSING ASSISTED LIVING AND MEMORY CARE	1255 DEMAREE ROAD GREENWOOD, IN 46143

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			tuberculin skin testing. **Date of completion:** June 9, 2025	
R 0148 Bldg. 00	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency Based on observation, interview, and record review, the facility failed to ensure that potentially hazardous materials were kept secured behind locked doors to prevent resident's access to hazardous materials for 14 of 14 self-mobile and cognitively impaired residents residing on the assisted living unit in the facility. Findings include: On 5/8/25 from 9:30 a.m. to 9:45 a.m., the beauty shop door located on the assisted living unit was observed to be open and unattended by staff. Inside the beauty shop at that time, the following was observed: - An opened container that was sitting on the vanity shelf that was easily reachable and contained six pairs of 4 - 5 inch sharp scissors. - One 10 oz can of aerosol hair spray sitting on a shelf that was easily reachable. The label indicated "extremely flammable." - A vanity with drawers that were easily opened and inside the drawer was an electric razor. - A shelf on the vanity contained one 32 ounce bottle of creme developer (chemical used to color hair) the label on the bottle indicated "keep out of reach..." - A shelf on the vanity contained 4 tubes	R 0148	Demaree Crossing 05.14.25 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. **R086-Administration and Management-Deficiency** *"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.* **1: What corrective action(s) will be accomplished for those**	06/09/2025

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	measuring 100 ml each of permanent hair color solution. The label indicated "keep out of reach..." During an interview on 5/8/25 at 9:45 a.m., Housekeeper 2 indicated "we unlock the door for the beautician... she does not have a key." During an interview on 5/8/25 at 10:00 a.m., the Beautician indicated "the staff unlock the door for me before I get to work, I don't have a key." During an interview on 5/8/25 at 10:20 a.m., the Executive Director indicated the beauty shop door should have been locked. On 5/9/25 at 8:05 a.m., the Executive Director provided a policy titled Hazardous Substance classification and storage, dated 7/8/24, and indicated it was the current policy being used by the facility. A review of the policy indicated "...chemicals shall be secured behind a secured door or cabinet when not in use by a community Team Member."		**residents found to have been affected by the deficient practice?** No residents were affected by the alleged deficient practice. CLIA certification was submitted for renewal on 5/09/2025 to labexcellence@cms.hhs.gov and paid through pay.gov-CLIA Laboratory User Fees. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - No residents were affected by the alleged deficient practice. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The ED and DHW will be educated on the Federal and State Regulatory requirements and renewal process for CLIA Certification by the SVP of Health & Wellness. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** ED or their designee will be responsible for monitoring expiration date and submit timely	

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			renewal for CLIA Certificate **Date of completion:** June 9, 2025 **R 148- Sanitation and Safety Standards- Deficiency** *"Facility failed to ensure that potentially hazardous materials were kept secured behind locked doors to prevent resident's access to hazardous materials for 14 of 14 self-mobile and cognitively impaired residents residing on the assisted living unit in the facility* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by the alleged deficient practice. Door to beauty shop was immediately closed and locked. The community's housekeeping staff and beautician will be in-serviced by the community Executive Director on community's policy for Hazardous Substance Classification and Storage. The community beautician was provided a key to the Beauty Shop for access to room. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - No resident was affected by the alleged deficient practice.	

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			3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur The community's current team members shall be re-educated to the community's Hazardous Substance Classification and Storage Guideline by 6/9/25. An in-service attendance log shall be maintained as evidence of completion of re-education and shall be maintained with the community's training files. New team members shall be trained to the community's Hazardous Substance Classification and Storage Guideline upon hire as part of their pre-service training. The community's Director of Health and Wellness or their designee shall complete monitoring of areas containing hazardous materials to ensure securement at minimum of four days per week for four weeks, and then weekly for four weeks then monthly for six months. The community's Director of Health and Wellness or their designee shall provide summary of findings to the Executive Director weekly and then monthly for review and discussion of any correction action items.	

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			4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? The Director of Facilities or their designee will be responsible for monitoring compliance of sanitation and safety standards through random monthly checks for unsecured hazardous substance, unlocked cabinets and doors for six months. The random monthly checks results will be reviewed during the monthly safety meeting overseen by the Executive Director. Corrective actions will be implemented based on the findings and discussion during safety meeting. The community through the safety meeting, will review, update and make changes to the DPOC as needed for sustaining substantial compliance for no less than six months. **Date of completion:** June 9, 2025 **R 151- Sanitation & Safety Standards-Noncompliance** *"Facility failed to ensure a pet who resided in the facility had received the rabies vaccination and the annual veterinary examination was completed as required prior to its expiration date for 1 of 4 residents who housed pets in the facility" (Resident 97)* **1: What corrective action(s) will**	

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			be accomplished for those residents found to have been affected by the deficient practice? The canine owned by Resident 97 had vaccinations updated on 5/20/25. Record of such vaccination have been updated and shall be maintained by the community's Resident Experience Director or their designee **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** Records of pets currently residing at the community were audited by the community's Director of Health and Wellness on 5/25/25. All in community pet vaccination records shall be monitored and maintained by the community's Resident Experience Director or their designee in the Executive Director's office. Resident Experience Director or their designee will be responsible for notifying and coordinating with resident/responsible party any upcoming or past due pet vaccinations **3: What measures will be put into place or what systemic changes will be made to**	

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			ensure that the deficient practice does not recur The community's Resident Experience Director, Resident Experience Ambassador and leadership team shall be reeducated by the Executive Director. Current and new residents who have pets residing in the community shall be educated on community's standards and policy for pet annual examination and compliance with vaccination during review of the residency agreement by the Executive Director. The community's Resident Experience Director or their designee shall review and provide Executive Director copy of pet vaccinations for any new pets who resident at the community effective June 9, 2025. Resident Experience Director or their designee shall review pet vaccinations for compliance monthly for at least six months to ensure compliance with community policy. The results of these reviews shall be reported to the Executive Director and discussed during the community's safety meeting. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The community's Executive	

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			Director or their designee shall complete random audits of the pet vaccination and examination tracking monthly for six months to ensure all pet vaccinations and annual examinations are current and up to date. Audit results will be reviewed at the monthly safety meeting overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed. The community through the safety meeting, will review, update and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months **Date of completion:** June 9, 2025 **R 216-** **Evaluation-Noncompliance** *"Facility failed to obtain a baseline admission weight for 1 of 7 residents reviewed for weights" (Resident 39)* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 39 has been discharged from the community on 5/14/25. **2: How other residents having the potential to be affected by the same deficient practice will**	

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			be identified and what corrective action will be taken. - The community's Director of Health and Wellness shall conduct an audit of electronic health record documentation for current in-house residents to evaluate compliance with documentation of admission weights by June 9, 2025. All inhouse Resident's weights shall be documented within the resident's electronic medical record for any resident(s) identified as missing weights based on the above audit. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The community's Director of Health and Wellness or their designee shall review electronic health record for new move ins to verify compliance and documentation of resident's weight within 72 hours from the date of move-in. - The community's Director of Health and Wellness shall re-educate all Wellness (Care) team members regarding Admission Policy and standard for obtaining and documenting residents' weight upon move in. An in-service attendance log shall be maintained as evidence of completion of re-education, and	

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			shall be maintained with the community's training files - The community's Director of Health and Wellness shall educate new Wellness (Care) team members on community's Admission Policy during the community pre-service training. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The community's Director of Health and Wellness/designee will complete daily monitoring to ensure that new move in resident(s) have an admission weight documented. Results of such monitoring shall be reported to the community's Executive Director at the community's morning meeting following observation for at least the following six months. **Date of completion:** June 9, 2025 **R 217 Evaluation-Deficiency** *"Facility failed to ensure the service plans were signed by the resident or the resident's representative for 7 of 7 residents reviewed for service plans (Resident 25, Resident 39, Resident 48, Resident 85, Resident 90, Resident 103 and Resident 104)* **1: What corrective action(s) will**	

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			be accomplished for those residents found to have been affected by the deficient practice? Current service plans for Residents 25, 39, 48, 85, and 90 service plans have been reviewed and signed by resident and/or responsible party. Residents 103 and 104 have been discharged from the community on [ADD DATES OF DISCHARGE] **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - The community's Director of Health and Wellness shall complete an audit of all current resident's service plan to validate signature by resident or responsible party by June 9, 2025. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The community's Director of Health and Wellness will re-educate the Wellness team member on the community's Evaluation policy which includes requirement for review and signature on plan of care. An in-service attendance log shall be maintained as evidence of	

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			completion of re-education, and shall be maintained with the community's training files **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The community's Director of Health and Wellness or their designee shall complete random weekly audits of at least 2 new resident records weekly to evaluate compliance with signed service plans. The results of weekly monitoring shall be reported to and reviewed with the community's Executive Director **Date of completion:** June 9, 2025 **R 306 Pharmaceutical Services-Noncompliance** *"Facility failed to ensure drug dispositions for all medications, including non-controlled substance medications were accounted for and documented for 2 of 2 closed records reviewed (Resident 103, Resident 104)* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Drug disposition forms have been completed for Residents 103	

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			and 104 on [ADD DATE] **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** The community's Director of Health and Wellness shall implement the use of Drug disposition form for all residents discharged from the community by June 9, 2025. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** The community's Director of Health and Wellness shall in-service the Wellness Team members on the community's policies for Discarding and Destroying Medication and Discontinuing Medication. An in-service attendance log shall be maintained as evidence of completion and maintained with the community's training files. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The community's Director of Health and Wellness or their designee shall complete random weekly audits of at least 1	

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			discharged resident to ensure Drug Disposition form has been completed and scanned into electronic medical record. The results of such monitoring shall be reported to and reviewed with the community's Executive Director **Date of completion:** June 9, 2025. **R409- Infection Control-Noncompliance** *"Facility failed to ensure that the annual health assessment statement (a statement by the physician indicating the resident is free of communicable disease) was documented as required for 1 of 7 residents reviewed. (Resident 48)."* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 48 electronic medical record reviewed, and annual health statement updated by the primary physician. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - The community's Director of Health and Wellness or their designee conducted an audit on 05/23/25 of all inhouse resident records for compliance with annual	

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			health assessment statement indicating that resident is free of communicable diseases by June 9, 2025. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The Director of Health and Wellness or their designee shall re-educate the Wellness Team on the community's Admission Policy focusing on the annual health assessment statement indicating that resident is free of communicable diseases. An in-service attendance log shall be maintained as evidence of completion of reeducation and maintained with the community's training files. The community's Director of Health and Wellness or their designee shall monitor, manage and coordinate with physicians' residents' annual health assessment including statement indicating resident is free of communicable disease. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The community's Director of Health and Wellness or their designee shall complete daily	

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			monitoring to ensure new move-in resident(s) have an annual health statement documented. Results of daily monitoring shall be reported to the community's Executive Director. The community's Executive Director will randomly review 2 resident records to **Date of completion:** June 9, 2025 **R410-Infection Control-Noncompliance** *"Facility failed to ensure that a first step and second step tuberculin skin test (tool used for screening tuberculosis) was completed upon admission for 2 of 7 residents reviewed (Resident 39 and Resident 90)."* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Residents 39 and 90 two-step tuberculin skin tests have been initiated by the Wellness team. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - The community's Director of Health and Wellness or their designee shall complete an audit of inhouse resident's electronic health records to evaluate	

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			compliance with first and second step tuberculin skin test. Tuberculin skin tests will be administered as needed for any residents identified as missing step 1 or step 2 skin tests by June 9, 2025. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The community's Director of Health and Wellness or their designee shall complete monitoring to ensure that new move in resident(s) receive their first and second tuberculin skin test. The community's Director of Health and Wellness or their designee shall complete daily review of new move in records to ensure compliance with tuberculin skin test for the next 90 days. Results of the daily monitoring will be discussed with Executive Director and corrective actions taken to ensure compliance. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The Executive Director or their designee shall complete weekly random audits of at least 2 resident records weekly for four	

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			weeks, then monthly X 6 months to monitor compliance with tuberculin skin testing. **Date of completion:** June 9, 2025	
R 0151 Bldg. 00	410 IAC 16.2-5-1.5(h) Sanitation & Safety Standards -Noncompliance Based on interview and record review, the facility failed to ensure a pet who resided in the facility had received the rabies vaccination and the annual veterinary examination was completed as required prior to its expiration date for 1 of 4 residents who housed pets in the facility. (Resident 97) Finding includes: On 5/8/25 at 1:00 p.m., the Executive Director provided a list of residents who housed pets in the facility. A review of the document indicated that Resident 97 had a canine pet who resided with the resident. On 5/9/25 at 9:00 a.m., Resident 97's canine rabies vaccination and annual veterinary examination record was reviewed. The document titled Certificate of Rabies Vaccination, dated 8/8/23, indicated the canine's rabies vaccination was administered and the annual veterinary examination was conducted on 8/8/23. The next rabies vaccination and annual veterinary examination was due was due on 8/7/24. No other documentation was provided. The record lacked a current rabies vaccination certification and the annual veterinary examination of the canine.	R 0151	Demaree Crossing 05.14.25 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. **R086-Administration and Management-Deficiency** *"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.*	06/09/2025

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	During an interview on 5/9/25 at 12:15 p.m., the Executive Director indicated Resident 97's canine rabies vaccination and annual veterinarian examination documentation should have been updated by 8/7/24. On 5/9/25 at 11:35 a.m., the Executive Director provided a copy of the Pet Policy, dated 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..." On 5/9/25 at 3:00 p.m., a review of the Rabies Vaccination Requirements located at 345 IAC 1-5-2 indicated, "...all dogs...3 months of age and older must be vaccinated against rabies..."		**1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by the alleged deficient practice. CLIA certification was submitted for renewal on 5/09/2025 to labexcellence@cms.hhs.gov and paid through pay.gov-CLIA Laboratory User Fees. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - No residents were affected by the alleged deficient practice. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The ED and DHW will be educated on the Federal and State Regulatory requirements and renewal process for CLIA Certification by the SVP of Health & Wellness. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** ED or their designee will be	

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			responsible for monitoring expiration date and submit timely renewal for CLIA Certificate **Date of completion:** June 9, 2025 **R 148- Sanitation and Safety Standards- Deficiency** *"Facility failed to ensure that potentially hazardous materials were kept secured behind locked doors to prevent resident's access to hazardous materials for 14 of 14 self-mobile and cognitively impaired residents residing on the assisted living unit in the facility* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by the alleged deficient practice. Door to beauty shop was immediately closed and locked. The community's housekeeping staff and beautician will be in-serviced by the community Executive Director on community's policy for Hazardous Substance Classification and Storage. The community beautician was provided a key to the Beauty Shop for access to room. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - No resident was	

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			affected by the alleged deficient practice. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The community's current team members shall be re-educated to the community's Hazardous Substance Classification and Storage Guideline by 6/9/25. An in-service attendance log shall be maintained as evidence of completion of re-education and shall be maintained with the community's training files. New team members shall be trained to the community's Hazardous Substance Classification and Storage Guideline upon hire as part of their pre-service training. The community's Director of Health and Wellness or their designee shall complete monitoring of areas containing hazardous materials to ensure securement at minimum of four days per week for four weeks, and then weekly for four weeks then monthly for six months. The community's Director of Health and Wellness or their designee shall provide summary of findings to the Executive Director weekly and then monthly for review and discussion of any	

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			correction action items. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The Director of Facilities or their designee will be responsible for monitoring compliance of sanitation and safety standards through random monthly checks for unsecured hazardous substance, unlocked cabinets and doors for six months. The random monthly checks results will be reviewed during the monthly safety meeting overseen by the Executive Director. Corrective actions will be implemented based on the findings and discussion during safety meeting. The community through the safety meeting, will review, update and make changes to the DPOC as needed for sustaining substantial compliance for no less than six months. **Date of completion:** June 9, 2025 **R 151- Sanitation & Safety Standards-Noncompliance** *"Facility failed to ensure a pet who resided in the facility had received the rabies vaccination and the annual veterinary examination was completed as required prior to its expiration date for 1 of 4 residents who housed pets in the facility"*	

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			(Resident 97) **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The canine owned by Resident 97 had vaccinations updated on 5/20/25. Record of such vaccination have been updated and shall be maintained by the community's Resident Experience Director or their designee **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** Records of pets currently residing at the community were audited by the community's Director of Health and Wellness on 5/25/25. All in community pet vaccination records shall be monitored and maintained by the community's Resident Experience Director or their designee in the Executive Director's office. Resident Experience Director or their designee will be responsible for notifying and coordinating with resident/responsible party any upcoming or past due pet vaccinations **3: What measures will be put**	

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			into place or what systemic changes will be made to ensure that the deficient practice does not recur The community's Resident Experience Director, Resident Experience Ambassador and leadership team shall be reeducated by the Executive Director. Current and new residents who have pets residing in the community shall be educated on community's standards and policy for pet annual examination and compliance with vaccination during review of the residency agreement by the Executive Director. The community's Resident Experience Director or their designee shall review and provide Executive Director copy of pet vaccinations for any new pets who resident at the community effective June 9, 2025. Resident Experience Director or their designee shall review pet vaccinations for compliance monthly for at least six months to ensure compliance with community policy. The results of these reviews shall be reported to the Executive Director and discussed during the community's safety meeting. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance**	

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			program will be put into place? The community's Executive Director or their designee shall complete random audits of the pet vaccination and examination tracking monthly for six months to ensure all pet vaccinations and annual examinations are current and up to date. Audit results will be reviewed at the monthly safety meeting overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed. The community through the safety meeting, will review, update and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months **Date of completion:** June 9, 2025 **R 216-** **Evaluation-Noncompliance** *"Facility failed to obtain a baseline admission weight for 1 of 7 residents reviewed for weights" (Resident 39)* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 39 has been discharged from the community on 5/14/25. **2: How other residents having**	

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			the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. - The community's Director of Health and Wellness shall conduct an audit of electronic health record documentation for current in-house residents to evaluate compliance with documentation of admission weights by June 9, 2025. All inhouse Resident's weights shall be documented within the resident's electronic medical record for any resident(s) identified as missing weights based on the above audit. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The community's Director of Health and Wellness or their designee shall review electronic health record for new move ins to verify compliance and documentation of resident's weight within 72 hours from the date of move-in. - The community's Director of Health and Wellness shall re-educate all Wellness (Care) team members regarding Admission Policy and standard for obtaining and documenting residents' weight upon move in. An in-service attendance log shall	

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			be maintained as evidence of completion of re-education, and shall be maintained with the community's training files - The community's Director of Health and Wellness shall educate new Wellness (Care) team members on community's Admission Policy during the community pre-service training. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The community's Director of Health and Wellness/designee will complete daily monitoring to ensure that new move in resident(s) have an admission weight documented. Results of such monitoring shall be reported to the community's Executive Director at the community's morning meeting following observation for at least the following six months. **Date of completion:** June 9, 2025 **R 217 Evaluation-Deficiency** *"Facility failed to ensure the service plans were signed by the resident or the resident's representative for 7 of 7 residents reviewed for service plans (Resident 25, Resident 39, Resident 48, Resident 85, Resident 90, Resident 103 and*	

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			Resident 104) **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Current service plans for Residents 25, 39, 48, 85, and 90 service plans have been reviewed and signed by resident and/or responsible party. Residents 103 and 104 have been discharged from the community on [ADD DATES OF DISCHARGE] **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - The community's Director of Health and Wellness shall complete an audit of all current resident's service plan to validate signature by resident or responsible party by June 9, 2025. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The community's Director of Health and Wellness will re-educate the Wellness team member on the community's Evaluation policy which includes requirement for review and signature on plan of care. An	

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			in-service attendance log shall be maintained as evidence of completion of re-education, and shall be maintained with the community's training files **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The community's Director of Health and Wellness or their designee shall complete random weekly audits of at least 2 new resident records weekly to evaluate compliance with signed service plans. The results of weekly monitoring shall be reported to and reviewed with the community's Executive Director **Date of completion:** June 9, 2025 **R 306 Pharmaceutical Services-Noncompliance** *"Facility failed to ensure drug dispositions for all medications, including non-controlled substance medications were accounted for and documented for 2 of 2 closed records reviewed (Resident 103, Resident 104)* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**	

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			Drug disposition forms have been completed for Residents 103 and 104 on [ADD DATE] **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** The community's Director of Health and Wellness shall implement the use of Drug disposition form for all residents discharged from the community by June 9, 2025. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** The community's Director of Health and Wellness shall in-service the Wellness Team members on the community's policies for Discarding and Destroying Medication and Discontinuing Medication. An in-service attendance log shall be maintained as evidence of completion and maintained with the community's training files. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The community's Director of Health and Wellness or their	

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			designee shall complete random weekly audits of at least 1 discharged resident to ensure Drug Disposition form has been completed and scanned into electronic medical record. The results of such monitoring shall be reported to and reviewed with the community's Executive Director **Date of completion:** June 9, 2025. **R409- Infection Control-Noncompliance** *"Facility failed to ensure that the annual health assessment statement (a statement by the physician indicating the resident is free of communicable disease) was documented as required for 1 of 7 residents reviewed. (Resident 48)."* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 48 electronic medical record reviewed, and annual health statement updated by the primary physician. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - The community's Director of Health and Wellness or their designee conducted an audit on	

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			05/23/25 of all inhouse resident records for compliance with annual health assessment statement indicating that resident is free of communicable diseases by June 9, 2025. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The Director of Health and Wellness or their designee shall re-educate the Wellness Team on the community's Admission Policy focusing on the annual health assessment statement indicating that resident is free of communicable diseases. An in-service attendance log shall be maintained as evidence of completion of reeducation and maintained with the community's training files. The community's Director of Health and Wellness or their designee shall monitor, manage and coordinate with physicians' residents' annual health assessment including statement indicating resident is free of communicable disease. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The community's Director	

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			of Health and Wellness or their designee shall complete daily monitoring to ensure new move-in resident(s) have an annual health statement documented. Results of daily monitoring shall be reported to the community's Executive Director. The community's Executive Director will randomly review 2 resident records to **Date of completion:** June 9, 2025 **R410-Infection Control-Noncompliance** *"Facility failed to ensure that a first step and second step tuberculin skin test (tool used for screening tuberculosis) was completed upon admission for 2 of 7 residents reviewed (Resident 39 and Resident 90)."* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Residents 39 and 90 two-step tuberculin skin tests have been initiated by the Wellness team. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - The community's Director of Health and Wellness or their designee shall complete an audit	

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			of inhouse resident's electronic health records to evaluate compliance with first and second step tuberculin skin test. Tuberculin skin tests will be administered as needed for any residents identified as missing step 1 or step 2 skin tests by June 9, 2025. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The community's Director of Health and Wellness or their designee shall complete monitoring to ensure that new move in resident(s) receive their first and second tuberculin skin test. The community's Director of Health and Wellness or their designee shall complete daily review of new move in records to ensure compliance with tuberculin skin test for the next 90 days. Results of the daily monitoring will be discussed with Executive Director and corrective actions taken to ensure compliance. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The Executive Director or their designee shall complete	

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			weekly random audits of at least 2 resident records weekly for four weeks, then monthly X 6 months to monitor compliance with tuberculin skin testing. **Date of completion:** June 9, 2025	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance Based on record review and interview, the facility failed to obtain a baseline admission weight for 1 of 7 residents reviewed for weights. (Resident 39) Finding includes: On 5/8/25 at 10:30 a.m., Resident 39's clinical record was reviewed. Resident 39's diagnoses included, but were not limited to, dementia, arthritis, and a history of falls. Resident 39 was admitted to the facility on 10/14/24. Resident 39's clinical record lacked documentation of weight upon admission. During an interview on 5/9/35 at 12:15 p.m., the ED (Executive Director) indicated Resident 39 should have had a weight upon admitting to the facility and "it was missed". On 5/9/25 at 11:15 a.m., the ED provided a copy of the Admissions policy, dated 1/14/22, and indicated it was the current policy in use by the facility. A review of the policy indicated the facility should ensure necessary information for resident care is planned and provided, including	R 0216	Demaree Crossing 05.14.25 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. **R086-Administration and Management-Deficiency** *"Facility failed to ensure a current and valid Clinical Laboratory Improvement Amendments (CLIA) certification (for the purposes of performing laboratory*	06/09/2025

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	height, weight, and vital signs which were to be " ...completed and documented at the time of physical move-in, and monthly thereafter."		*examinations or procedures) was maintained as required.* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by the alleged deficient practice. CLIA certification was submitted for renewal on 5/09/2025 to labexcellence@cms.hhs.gov and paid through pay.gov-CLIA Laboratory User Fees. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - No residents were affected by the alleged deficient practice. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The ED and DHW will be educated on the Federal and State Regulatory requirements and renewal process for CLIA Certification by the SVP of Health & Wellness. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance**	

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			program will be put into place? ED or their designee will be responsible for monitoring expiration date and submit timely renewal for CLIA Certificate **Date of completion:** June 9, 2025 **R 148- Sanitation and Safety Standards- Deficiency** *"Facility failed to ensure that potentially hazardous materials were kept secured behind locked doors to prevent resident's access to hazardous materials for 14 of 14 self-mobile and cognitively impaired residents residing on the assisted living unit in the facility* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by the alleged deficient practice. Door to beauty shop was immediately closed and locked. The community's housekeeping staff and beautician will be in-serviced by the community Executive Director on community's policy for Hazardous Substance Classification and Storage. The community beautician was provided a key to the Beauty Shop for access to room. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what**	

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			corrective action will be taken. - No resident was affected by the alleged deficient practice. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The community's current team members shall be re-educated to the community's Hazardous Substance Classification and Storage Guideline by 6/9/25. An in-service attendance log shall be maintained as evidence of completion of re-education and shall be maintained with the community's training files. New team members shall be trained to the community's Hazardous Substance Classification and Storage Guideline upon hire as part of their pre-service training. The community's Director of Health and Wellness or their designee shall complete monitoring of areas containing hazardous materials to ensure securement at minimum of four days per week for four weeks, and then weekly for four weeks then monthly for six months. The community's Director of Health and Wellness or their designee shall provide summary of findings to the Executive Director	

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			weekly and then monthly for review and discussion of any correction action items. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The Director of Facilities or their designee will be responsible for monitoring compliance of sanitation and safety standards through random monthly checks for unsecured hazardous substance, unlocked cabinets and doors for six months. The random monthly checks results will be reviewed during the monthly safety meeting overseen by the Executive Director. Corrective actions will be implemented based on the findings and discussion during safety meeting. The community through the safety meeting, will review, update and make changes to the DPOC as needed for sustaining substantial compliance for no less than six months. **Date of completion:** June 9, 2025 **R 151- Sanitation & Safety Standards-Noncompliance** *"Facility failed to ensure a pet who resided in the facility had received the rabies vaccination and the annual veterinary examination was completed as required prior to its*	

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			expiration date for 1 of 4 residents who housed pets in the facility" (Resident 97) **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The canine owned by Resident 97 had vaccinations updated on 5/20/25. Record of such vaccination have been updated and shall be maintained by the community's Resident Experience Director or their designee **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** Records of pets currently residing at the community were audited by the community's Director of Health and Wellness on 5/25/25. All in community pet vaccination records shall be monitored and maintained by the community's Resident Experience Director or their designee in the Executive Director's office. Resident Experience Director or their designee will be responsible for notifying and coordinating with resident/responsible party any upcoming or past due pet vaccinations	

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			3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur The community's Resident Experience Director, Resident Experience Ambassador and leadership team shall be reeducated by the Executive Director. Current and new residents who have pets residing in the community shall be educated on community's standards and policy for pet annual examination and compliance with vaccination during review of the residency agreement by the Executive Director. The community's Resident Experience Director or their designee shall review and provide Executive Director copy of pet vaccinations for any new pets who resident at the community effective June 9, 2025. Resident Experience Director or their designee shall review pet vaccinations for compliance monthly for at least six months to ensure compliance with community policy. The results of these reviews shall be reported to the Executive Director and discussed during the community's safety meeting. **4: How the corrective action will be monitored to ensure the**	

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			deficient practice will not recur i.e., what quality assurance program will be put into place? The community's Executive Director or their designee shall complete random audits of the pet vaccination and examination tracking monthly for six months to ensure all pet vaccinations and annual examinations are current and up to date. Audit results will be reviewed at the monthly safety meeting overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed. The community through the safety meeting, will review, update and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months **Date of completion:** June 9, 2025 **R 216-** **Evaluation-Noncompliance** *"Facility failed to obtain a baseline admission weight for 1 of 7 residents reviewed for weights" (Resident 39)* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 39 has been discharged from the community on 5/14/25.	

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			2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. - The community's Director of Health and Wellness shall conduct an audit of electronic health record documentation for current in-house residents to evaluate compliance with documentation of admission weights by June 9, 2025. All inhouse Resident's weights shall be documented within the resident's electronic medical record for any resident(s) identified as missing weights based on the above audit. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The community's Director of Health and Wellness or their designee shall review electronic health record for new move ins to verify compliance and documentation of resident's weight within 72 hours from the date of move-in. - The community's Director of Health and Wellness shall re-educate all Wellness (Care) team members regarding Admission Policy and standard for obtaining and documenting	

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			residents' weight upon move in. An in-service attendance log shall be maintained as evidence of completion of re-education, and shall be maintained with the community's training files - The community's Director of Health and Wellness shall educate new Wellness (Care) team members on community's Admission Policy during the community pre-service training. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The community's Director of Health and Wellness/designee will complete daily monitoring to ensure that new move in resident(s) have an admission weight documented. Results of such monitoring shall be reported to the community's Executive Director at the community's morning meeting following observation for at least the following six months. **Date of completion:** June 9, 2025 **R 217 Evaluation-Deficiency** *"Facility failed to ensure the service plans were signed by the resident or the resident's representative for 7 of 7 residents reviewed for service plans (Resident 25, Resident 39,*	

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			Resident 48, Resident 85, Resident 90, Resident 103 and Resident 104) **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Current service plans for Residents 25, 39, 48, 85, and 90 service plans have been reviewed and signed by resident and/or responsible party. Residents 103 and 104 have been discharged from the community on [ADD DATES OF DISCHARGE] **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - The community's Director of Health and Wellness shall complete an audit of all current resident's service plan to validate signature by resident or responsible party by June 9, 2025. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The community's Director of Health and Wellness will re-educate the Wellness team member on the community's Evaluation policy which includes	

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			requirement for review and signature on plan of care. An in-service attendance log shall be maintained as evidence of completion of re-education, and shall be maintained with the community's training files **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The community's Director of Health and Wellness or their designee shall complete random weekly audits of at least 2 new resident records weekly to evaluate compliance with signed service plans. The results of weekly monitoring shall be reported to and reviewed with the community's Executive Director **Date of completion:** June 9, 2025 **R 306 Pharmaceutical Services-Noncompliance** *"Facility failed to ensure drug dispositions for all medications, including non-controlled substance medications were accounted for and documented for 2 of 2 closed records reviewed (Resident 103, Resident 104)* **1: What corrective action(s) will be accomplished for those residents found to have been**	

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			affected by the deficient practice? Drug disposition forms have been completed for Residents 103 and 104 on [ADD DATE] **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** The community's Director of Health and Wellness shall implement the use of Drug disposition form for all residents discharged from the community by June 9, 2025. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** The community's Director of Health and Wellness shall in-service the Wellness Team members on the community's policies for Discarding and Destroying Medication and Discontinuing Medication. An in-service attendance log shall be maintained as evidence of completion and maintained with the community's training files. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?**	

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			The community's Director of Health and Wellness or their designee shall complete random weekly audits of at least 1 discharged resident to ensure Drug Disposition form has been completed and scanned into electronic medical record. The results of such monitoring shall be reported to and reviewed with the community's Executive Director **Date of completion:** June 9, 2025. **R409- Infection Control-Noncompliance** *"Facility failed to ensure that the annual health assessment statement (a statement by the physician indicating the resident is free of communicable disease) was documented as required for 1 of 7 residents reviewed. (Resident 48)."* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 48 electronic medical record reviewed, and annual health statement updated by the primary physician. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - The community's Director of	

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			Health and Wellness or their designee conducted an audit on 05/23/25 of all inhouse resident records for compliance with annual health assessment statement indicating that resident is free of communicable diseases by June 9, 2025. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The Director of Health and Wellness or their designee shall re-educate the Wellness Team on the community's Admission Policy focusing on the annual health assessment statement indicating that resident is free of communicable diseases. An in-service attendance log shall be maintained as evidence of completion of reeducation and maintained with the community's training files. The community's Director of Health and Wellness or their designee shall monitor, manage and coordinate with physicians' residents' annual health assessment including statement indicating resident is free of communicable disease. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance**	

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DEMAREE CROSSING ASSISTED LIVING AND MEMORY CARE	1255 DEMAREE ROAD GREENWOOD, IN 46143

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			program will be put into place? The community's Director of Health and Wellness or their designee shall complete daily monitoring to ensure new move-in resident(s) have an annual health statement documented. Results of daily monitoring shall be reported to the community's Executive Director. The community's Executive Director will randomly review 2 resident records to **Date of completion:** June 9, 2025 **R410-Infection Control-Noncompliance** *"Facility failed to ensure that a first step and second step tuberculin skin test (tool used for screening tuberculosis) was completed upon admission for 2 of 7 residents reviewed (Resident 39 and Resident 90)."* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Residents 39 and 90 two-step tuberculin skin tests have been initiated by the Wellness team. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - The community's Director of	

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			Health and Wellness or their designee shall complete an audit of inhouse resident's electronic health records to evaluate compliance with first and second step tuberculin skin test. Tuberculin skin tests will be administered as needed for any residents identified as missing step 1 or step 2 skin tests by June 9, 2025. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The community's Director of Health and Wellness or their designee shall complete monitoring to ensure that new move in resident(s) receive their first and second tuberculin skin test. The community's Director of Health and Wellness or their designee shall complete daily review of new move in records to ensure compliance with tuberculin skin test for the next 90 days. Results of the daily monitoring will be discussed with Executive Director and corrective actions taken to ensure compliance. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?**	

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			The Executive Director or their designee shall complete weekly random audits of at least 2 resident records weekly for four weeks, then monthly X 6 months to monitor compliance with tuberculin skin testing. **Date of completion:** June 9, 2025	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency Based on record review and interview, the facility failed to ensure the service plans were signed by the resident or the resident's representative for 7 of 7 residents reviewed for service plans (Resident 25, Resident 39, Resident 48, Resident 85, Resident 90, Resident 103 and Resident 104). Finding includes: 1. On 5/9/25 at 8:30 a.m. Resident 25's clinical record was reviewed. The diagnoses included, but were not limited to, hypertension (high blood pressure), right shoulder pain and orthostatic hypotension (drop in blood pressure with rising from a sitting or lying position). The service plan, revised 8/16/21, lacked a resident or responsible party signature. 2. On 5/9/25 at 8:30 a.m. Resident 39's clinical record was reviewed. The diagnoses included, but were not limited to, history of fall, cystitis (inflammation of the bladder), and hypertension. The service plan, revised 10/14/24, lacked a resident or responsible party signature.	R 0217	Demaree Crossing 05.14.25 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. **R086-Administration and Management-Deficiency** *"Facility failed to ensure a current and valid Clinical Laboratory Improvement Amendments (CLIA)*	06/09/2025

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	3. On 5/9/25 at 8:30 a.m., Resident 48's clinical record was reviewed. The diagnosis included, but was not limited to, generalized anxiety disorder. The service plan, revised 4/28/25, lacked a resident or responsible party signature. 4. On 5/9/25 at 8:30 a.m., Resident 85's clinical record was reviewed. The diagnosis included, but was not limited to, Parkinson's disease (a disorder of the central nervous system that affects movement often including tremors). The service plan, revised 8/8/24, lacked a resident or responsible party signature. 5. On 5/9/25 at 8:30 a.m., Resident 90's clinical record was reviewed. The diagnoses included, but were not limited to, dementia and chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe). The service plan, revised 12/10/24, lacked a resident or responsible party signature. 6. On 5/9/25 at 8:00 a.m., Resident 103's clinical record was reviewed. The diagnoses included, but were not limited to, history of falls, alcohol abuse, and chronic obstructive pulmonary disease. The service plan, revised 7/31/24, lacked a resident or responsible party signature. 7. On 5/9/25 at 8:30 a.m., Resident 104's clinical record was reviewed. The diagnosis included, but was not limited to, wedge compression fracture of second lumbar vertebra. The service plan, revised of 9/24/24, lacked a		*certification (for the purposes of performing laboratory examinations or procedures) was maintained as required.* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by the alleged deficient practice. CLIA certification was submitted for renewal on 5/09/2025 to labexcellence@cms.hhs.gov and paid through pay.gov-CLIA Laboratory User Fees. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - No residents were affected by the alleged deficient practice. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The ED and DHW will be educated on the Federal and State Regulatory requirements and renewal process for CLIA Certification by the SVP of Health & Wellness. **4: How the corrective action will be monitored to ensure the**	

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	resident or responsible party signature. During an interview on 5/9/25 at 9:55 a.m., the Executive Director indicated the service plans should have been signed by a resident or responsible party signature. On 5/9/25 at 10:12 a.m. the Executive Director provided the facility policy, "Guideline Interpretation and Implementation", Last revision date 1/9/25, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "... As required by state, resident and/or the resident's responsible party and the community shall sign the completed service plan within the state-specified period of time. The signed copy of the evaluation shall be maintained in the resident's electronic medical record..."		**deficient practice will not recur i.e., what quality assurance program will be put into place?** ED or their designee will be responsible for monitoring expiration date and submit timely renewal for CLIA Certificate **Date of completion:** June 9, 2025 **R 148- Sanitation and Safety Standards- Deficiency** *"Facility failed to ensure that potentially hazardous materials were kept secured behind locked doors to prevent resident's access to hazardous materials for 14 of 14 self-mobile and cognitively impaired residents residing on the assisted living unit in the facility* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by the alleged deficient practice. Door to beauty shop was immediately closed and locked. The community's housekeeping staff and beautician will be in-serviced by the community Executive Director on community's policy for Hazardous Substance Classification and Storage. The community beautician was provided a key to the Beauty Shop for access to room. **2: How other residents having the potential to be affected by**	

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			the same deficient practice will be identified and what corrective action will be taken. - No resident was affected by the alleged deficient practice. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The community's current team members shall be re-educated to the community's Hazardous Substance Classification and Storage Guideline by 6/9/25. An in-service attendance log shall be maintained as evidence of completion of re-education and shall be maintained with the community's training files. New team members shall be trained to the community's Hazardous Substance Classification and Storage Guideline upon hire as part of their pre-service training. The community's Director of Health and Wellness or their designee shall complete monitoring of areas containing hazardous materials to ensure securement at minimum of four days per week for four weeks, and then weekly for four weeks then monthly for six months. The community's Director of Health and Wellness or their	

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			designee shall provide summary of findings to the Executive Director weekly and then monthly for review and discussion of any correction action items. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The Director of Facilities or their designee will be responsible for monitoring compliance of sanitation and safety standards through random monthly checks for unsecured hazardous substance, unlocked cabinets and doors for six months. The random monthly checks results will be reviewed during the monthly safety meeting overseen by the Executive Director. Corrective actions will be implemented based on the findings and discussion during safety meeting. The community through the safety meeting, will review, update and make changes to the DPOC as needed for sustaining substantial compliance for no less than six months. **Date of completion:** June 9, 2025 **R 151- Sanitation & Safety Standards-Noncompliance** *"Facility failed to ensure a pet who resided in the facility had received the rabies vaccination and the*	

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			annual veterinary examination was completed as required prior to its expiration date for 1 of 4 residents who housed pets in the facility" (Resident 97) **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The canine owned by Resident 97 had vaccinations updated on 5/20/25. Record of such vaccination have been updated and shall be maintained by the community's Resident Experience Director or their designee **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** Records of pets currently residing at the community were audited by the community's Director of Health and Wellness on 5/25/25. All in community pet vaccination records shall be monitored and maintained by the community's Resident Experience Director or their designee in the Executive Director's office. Resident Experience Director or their designee will be responsible for notifying and coordinating with resident/responsible party any	

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			upcoming or past due pet vaccinations **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The community's Resident Experience Director, Resident Experience Ambassador and leadership team shall be reeducated by the Executive Director. Current and new residents who have pets residing in the community shall be educated on community's standards and policy for pet annual examination and compliance with vaccination during review of the residency agreement by the Executive Director. The community's Resident Experience Director or their designee shall review and provide Executive Director copy of pet vaccinations for any new pets who resident at the community effective June 9, 2025. Resident Experience Director or their designee shall review pet vaccinations for compliance monthly for at least six months to ensure compliance with community policy. The results of these reviews shall be reported to the Executive Director and discussed during the community's safety meeting.	

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			4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? The community's Executive Director or their designee shall complete random audits of the pet vaccination and examination tracking monthly for six months to ensure all pet vaccinations and annual examinations are current and up to date. Audit results will be reviewed at the monthly safety meeting overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed. The community through the safety meeting, will review, update and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months **Date of completion:** June 9, 2025 **R 216-** **Evaluation-Noncompliance** *"Facility failed to obtain a baseline admission weight for 1 of 7 residents reviewed for weights" (Resident 39)* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 39 has been	

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			discharged from the community on 5/14/25. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - The community's Director of Health and Wellness shall conduct an audit of electronic health record documentation for current in-house residents to evaluate compliance with documentation of admission weights by June 9, 2025. All inhouse Resident's weights shall be documented within the resident's electronic medical record for any resident(s) identified as missing weights based on the above audit. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The community's Director of Health and Wellness or their designee shall review electronic health record for new move ins to verify compliance and documentation of resident's weight within 72 hours from the date of move-in. - The community's Director of Health and Wellness shall re-educate all Wellness (Care) team members regarding	

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			Admission Policy and standard for obtaining and documenting residents' weight upon move in. An in-service attendance log shall be maintained as evidence of completion of re-education, and shall be maintained with the community's training files - The community's Director of Health and Wellness shall educate new Wellness (Care) team members on community's Admission Policy during the community pre-service training. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The community's Director of Health and Wellness/designee will complete daily monitoring to ensure that new move in resident(s) have an admission weight documented. Results of such monitoring shall be reported to the community's Executive Director at the community's morning meeting following observation for at least the following six months. **Date of completion:** June 9, 2025 **R 217 Evaluation-Deficiency** *"Facility failed to ensure the service plans were signed by the resident or the resident's representative for 7 of 7*	

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			residents reviewed for service plans (Resident 25, Resident 39, Resident 48, Resident 85, Resident 90, Resident 103 and Resident 104) **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Current service plans for Residents 25, 39, 48, 85, and 90 service plans have been reviewed and signed by resident and/or responsible party. Residents 103 and 104 have been discharged from the community on [ADD DATES OF DISCHARGE] **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - The community's Director of Health and Wellness shall complete an audit of all current resident's service plan to validate signature by resident or responsible party by June 9, 2025. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The community's Director of Health and Wellness will re-educate the Wellness team	

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			member on the community's Evaluation policy which includes requirement for review and signature on plan of care. An in-service attendance log shall be maintained as evidence of completion of re-education, and shall be maintained with the community's training files **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The community's Director of Health and Wellness or their designee shall complete random weekly audits of at least 2 new resident records weekly to evaluate compliance with signed service plans. The results of weekly monitoring shall be reported to and reviewed with the community's Executive Director **Date of completion:** June 9, 2025 **R 306 Pharmaceutical Services-Noncompliance** *"Facility failed to ensure drug dispositions for all medications, including non-controlled substance medications were accounted for and documented for 2 of 2 closed records reviewed (Resident 103, Resident 104)* **1: What corrective action(s) will**	

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			be accomplished for those residents found to have been affected by the deficient practice? Drug disposition forms have been completed for Residents 103 and 104 on [ADD DATE] **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** The community's Director of Health and Wellness shall implement the use of Drug disposition form for all residents discharged from the community by June 9, 2025. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** The community's Director of Health and Wellness shall in-service the Wellness Team members on the community's policies for Discarding and Destroying Medication and Discontinuing Medication. An in-service attendance log shall be maintained as evidence of completion and maintained with the community's training files. **4: How the corrective action will be monitored to ensure the deficient practice will not recur**	

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			i.e., what quality assurance program will be put into place? The community's Director of Health and Wellness or their designee shall complete random weekly audits of at least 1 discharged resident to ensure Drug Disposition form has been completed and scanned into electronic medical record. The results of such monitoring shall be reported to and reviewed with the community's Executive Director **Date of completion:** June 9, 2025. **R409- Infection Control-Noncompliance** *"Facility failed to ensure that the annual health assessment statement (a statement by the physician indicating the resident is free of communicable disease) was documented as required for 1 of 7 residents reviewed. (Resident 48)."* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 48 electronic medical record reviewed, and annual health statement updated by the primary physician. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what**	

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			corrective action will be taken. - The community's Director of Health and Wellness or their designee conducted an audit on 05/23/25 of all inhouse resident records for compliance with annual health assessment statement indicating that resident is free of communicable diseases by June 9, 2025. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The Director of Health and Wellness or their designee shall re-educate the Wellness Team on the community's Admission Policy focusing on the annual health assessment statement indicating that resident is free of communicable diseases. An in-service attendance log shall be maintained as evidence of completion of reeducation and maintained with the community's training files. The community's Director of Health and Wellness or their designee shall monitor, manage and coordinate with physicians' residents' annual health assessment including statement indicating resident is free of communicable disease. **4: How the corrective action will be monitored to ensure the**	

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			deficient practice will not recur i.e., what quality assurance program will be put into place? The community's Director of Health and Wellness or their designee shall complete daily monitoring to ensure new move-in resident(s) have an annual health statement documented. Results of daily monitoring shall be reported to the community's Executive Director. The community's Executive Director will randomly review 2 resident records to **Date of completion:** June 9, 2025 **R410-Infection Control-Noncompliance** *"Facility failed to ensure that a first step and second step tuberculin skin test (tool used for screening tuberculosis) was completed upon admission for 2 of 7 residents reviewed (Resident 39 and Resident 90)."* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Residents 39 and 90 two-step tuberculin skin tests have been initiated by the Wellness team. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what**	

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			corrective action will be taken. - The community's Director of Health and Wellness or their designee shall complete an audit of inhouse resident's electronic health records to evaluate compliance with first and second step tuberculin skin test. Tuberculin skin tests will be administered as needed for any residents identified as missing step 1 or step 2 skin tests by June 9, 2025. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The community's Director of Health and Wellness or their designee shall complete monitoring to ensure that new move in resident(s) receive their first and second tuberculin skin test. The community's Director of Health and Wellness or their designee shall complete daily review of new move in records to ensure compliance with tuberculin skin test for the next 90 days. Results of the daily monitoring will be discussed with Executive Director and corrective actions taken to ensure compliance. **4: How the corrective action will be monitored to ensure the deficient practice will not recur**	

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			i.e., what quality assurance program will be put into place? The Executive Director or their designee shall complete weekly random audits of at least 2 resident records weekly for four weeks, then monthly X 6 months to monitor compliance with tuberculin skin testing. **Date of completion:** June 9, 2025	
R 0306 Bldg. 00	410 IAC 16.2-5-6(g)(1-9) Pharmaceutical Services - Noncompliance Based on record review and interview, the facility failed to ensure drug dispositions for all medications, including non-controlled substance medications were accounted for and documented for 2 of 2 closed records reviewed. (Resident 103, Resident 104) Findings include: 1. On 5/8/25 at 11:20 a.m., the clinical record for Resident 103 was reviewed. The diagnoses included, but were not limited to, alcohol abuse, chronic obstructive pulmonary disease (COPD), diabetes, hypertension (HTN), heart failure, and asthma. On 5/9/25 at 12:30 p.m., the Executive Director provided a copy of the physician's order report dated 3/31/25. A review of the medication list included the current medications that Resident 103 had been receiving at the time of his discharge from the facility. The list included, but was not limited to, the following orders:	R 0306	Demaree Crossing 05.14.25 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. **R086-Administration and Management-Deficiency** *"Facility failed to ensure a current*	06/09/2025

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	- Albuterol HFA inhaler 90 micrograms (mcg) 2 puffs by mouth four times a day as needed for asthma. - Jardiance tab 10 milligrams (mg), one tablet daily for heart failure. - Metformin ER 500 mg, one tablet daily for diabetes. - Metoprolol 50 mg, one and a half tablets twice daily for hypertension. - Spiriva Respimat 2.5 mcg, 2 puffs daily for COPD. Resident 103's clinical record lacked an itemized drug disposition record for the above mentioned medications at the time he was discharged to another facility. During an interview on 5/9/25 at 11:20 a.m., the Executive Director indicated Resident 103 was transferred to another facility in March of 2025. 2. On 5/8/25 at 1:00 p.m., the clinical record for Resident 104 was reviewed. The diagnoses included, but were not limited to, dementia, depression, pain, hypertension, constipation, and compression fracture of second lumbar vertebra. On 5/9/25 at 12:30 p.m., the Executive Director provided a copy of the physician's order report dated 4/21/25. A review of the medication list included the current medications that Resident 104 had been receiving prior to the time of his death. The list included, but was not limited to, the following orders: - Furosemide 40 mg, one tablet per day for fluid retention.		*and valid Clinical Laboratory Improvement Amendments (CLIA) certification (for the purposes of performing laboratory examinations or procedures) was maintained as required.* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by the alleged deficient practice. CLIA certification was submitted for renewal on 5/09/2025 to labexcellence@cms.hhs.gov and paid through pay.gov-CLIA Laboratory User Fees. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - No residents were affected by the alleged deficient practice. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The ED and DHW will be educated on the Federal and State Regulatory requirements and renewal process for CLIA Certification by the SVP of Health & Wellness.	

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	- Bisacodyl suppository 10 mg, one suppository rectally daily for constipation. - Haloperidol concentrate 0.5 mg sublingually, two times per day for restlessness or agitation. - Hydrocodone/apap (acetominophen) tablet 10-325 mg, one tablet by mouth every 12 hours for pain. - Lorazepam 0.5 mg tablet every four hours for anxiety or shortness of breath. - Metoprolol 25 mg, one tablet daily for hypertension. - Morphine 5 mg, every three hours as needed for pain or shortness of breath. - Sertraline 25 mg, one tablet every day for depression. Resident 104's clinical record lacked an itemized drug disposition record for the return or destruction of the above medications at the time of his death in the facility. During an interview on 5/9/25 at 11:20 a.m., the Executive Director indicated Resident 104 passed away in the facility. During an interview on 5/9/25 at 12:05 p.m., the Executive Director indicated the facility lacked a drug disposition record for Resident 103's and Resident 104's medication at the time of their discharge from the facility. The facility staff should have completed the required drug disposition records at the time of the Resident's discharge.		**4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** ED or their designee will be responsible for monitoring expiration date and submit timely renewal for CLIA Certificate **Date of completion:** June 9, 2025 **R 148- Sanitation and Safety Standards- Deficiency** *"Facility failed to ensure that potentially hazardous materials were kept secured behind locked doors to prevent resident's access to hazardous materials for 14 of 14 self-mobile and cognitively impaired residents residing on the assisted living unit in the facility* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by the alleged deficient practice. Door to beauty shop was immediately closed and locked. The community's housekeeping staff and beautician will be in-serviced by the community Executive Director on community's policy for Hazardous Substance Classification and Storage. The community beautician was provided a key to the Beauty Shop for access to room.	

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	On 5/9/25 at 11:35 a.m., the Executive Director provided a copy of the Discarding and Destroying Medication policy, dated 12/28/24, and indicated it was the current policy in use by the facility. A review of the document indicated, "...shall be documented within the medication disposition record includes, but is not limited to: resident name, date medication disposed, name and strength of medication, name of the dispensing pharmacy, quantity disposed, method of disposition, reason, and signature of witness...complete medication disposition records shall be kept on file for at least two years...if resident transfers to another community, the nurse shall send all resident medications...transfer documented in resident's medical record..." On 5/9/25 at 12:04 p.m., the Executive Director provided a copy of the Discontinuing Medications policy, dated 7/19/22, and indicated it was the current policy in use by the facility. A review of the document indicated, "...staff shall destroy and discontinued medications or shall return them to the dispensing pharmacy in accordance with community policy..."		**2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - No resident was affected by the alleged deficient practice. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The community's current team members shall be re-educated to the community's Hazardous Substance Classification and Storage Guideline by 6/9/25. An in-service attendance log shall be maintained as evidence of completion of re-education and shall be maintained with the community's training files. New team members shall be trained to the community's Hazardous Substance Classification and Storage Guideline upon hire as part of their pre-service training. The community's Director of Health and Wellness or their designee shall complete monitoring of areas containing hazardous materials to ensure securement at minimum of four days per week for four weeks, and then weekly for four weeks then monthly for six months.	

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			The community's Director of Health and Wellness or their designee shall provide summary of findings to the Executive Director weekly and then monthly for review and discussion of any correction action items. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The Director of Facilities or their designee will be responsible for monitoring compliance of sanitation and safety standards through random monthly checks for unsecured hazardous substance, unlocked cabinets and doors for six months. The random monthly checks results will be reviewed during the monthly safety meeting overseen by the Executive Director. Corrective actions will be implemented based on the findings and discussion during safety meeting. The community through the safety meeting, will review, update and make changes to the DPOC as needed for sustaining substantial compliance for no less than six months. **Date of completion:** June 9, 2025 **R 151- Sanitation & Safety Standards-Noncompliance** *"Facility failed to ensure a pet who*	

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			resided in the facility had received the rabies vaccination and the annual veterinary examination was completed as required prior to its expiration date for 1 of 4 residents who housed pets in the facility" (Resident 97) **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The canine owned by Resident 97 had vaccinations updated on 5/20/25. Record of such vaccination have been updated and shall be maintained by the community's Resident Experience Director or their designee **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** Records of pets currently residing at the community were audited by the community's Director of Health and Wellness on 5/25/25. All in community pet vaccination records shall be monitored and maintained by the community's Resident Experience Director or their designee in the Executive Director's office. Resident Experience Director or their designee will be responsible for notifying and	

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			coordinating with resident/responsible party any upcoming or past due pet vaccinations **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The community's Resident Experience Director, Resident Experience Ambassador and leadership team shall be reeducated by the Executive Director. Current and new residents who have pets residing in the community shall be educated on community's standards and policy for pet annual examination and compliance with vaccination during review of the residency agreement by the Executive Director. The community's Resident Experience Director or their designee shall review and provide Executive Director copy of pet vaccinations for any new pets who resident at the community effective June 9, 2025. Resident Experience Director or their designee shall review pet vaccinations for compliance monthly for at least six months to ensure compliance with community policy. The results of these reviews shall be reported to the Executive Director and discussed during the	

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			community's safety meeting. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The community's Executive Director or their designee shall complete random audits of the pet vaccination and examination tracking monthly for six months to ensure all pet vaccinations and annual examinations are current and up to date. Audit results will be reviewed at the monthly safety meeting overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed. The community through the safety meeting, will review, update and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months **Date of completion:** June 9, 2025 **R 216-** **Evaluation-Noncompliance** *"Facility failed to obtain a baseline admission weight for 1 of 7 residents reviewed for weights" (Resident 39)* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	

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			practice? Resident 39 has been discharged from the community on 5/14/25. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - The community's Director of Health and Wellness shall conduct an audit of electronic health record documentation for current in-house residents to evaluate compliance with documentation of admission weights by June 9, 2025. All inhouse Resident's weights shall be documented within the resident's electronic medical record for any resident(s) identified as missing weights based on the above audit. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The community's Director of Health and Wellness or their designee shall review electronic health record for new move ins to verify compliance and documentation of resident's weight within 72 hours from the date of move-in. - The community's Director of Health and Wellness	

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			shall re-educate all Wellness (Care) team members regarding Admission Policy and standard for obtaining and documenting residents' weight upon move in. An in-service attendance log shall be maintained as evidence of completion of re-education, and shall be maintained with the community's training files - The community's Director of Health and Wellness shall educate new Wellness (Care) team members on community's Admission Policy during the community pre-service training. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The community's Director of Health and Wellness/designee will complete daily monitoring to ensure that new move in resident(s) have an admission weight documented. Results of such monitoring shall be reported to the community's Executive Director at the community's morning meeting following observation for at least the following six months. **Date of completion:** June 9, 2025 **R 217 Evaluation-Deficiency** *"Facility failed to ensure the service plans were signed by the*	

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			resident or the resident's representative for 7 of 7 residents reviewed for service plans (Resident 25, Resident 39, Resident 48, Resident 85, Resident 90, Resident 103 and Resident 104) **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Current service plans for Residents 25, 39, 48, 85, and 90 service plans have been reviewed and signed by resident and/or responsible party. Residents 103 and 104 have been discharged from the community on [ADD DATES OF DISCHARGE] **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - The community's Director of Health and Wellness shall complete an audit of all current resident's service plan to validate signature by resident or responsible party by June 9, 2025. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The community's Director	

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			of Health and Wellness will re-educate the Wellness team member on the community's Evaluation policy which includes requirement for review and signature on plan of care. An in-service attendance log shall be maintained as evidence of completion of re-education, and shall be maintained with the community's training files **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The community's Director of Health and Wellness or their designee shall complete random weekly audits of at least 2 new resident records weekly to evaluate compliance with signed service plans. The results of weekly monitoring shall be reported to and reviewed with the community's Executive Director **Date of completion:** June 9, 2025 **R 306 Pharmaceutical Services-Noncompliance** *"Facility failed to ensure drug dispositions for all medications, including non-controlled substance medications were accounted for and documented for 2 of 2 closed records reviewed (Resident 103, Resident 104)*	

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			1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Drug disposition forms have been completed for Residents 103 and 104 on [ADD DATE] **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** The community's Director of Health and Wellness shall implement the use of Drug disposition form for all residents discharged from the community by June 9, 2025. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** The community's Director of Health and Wellness shall in-service the Wellness Team members on the community's policies for Discarding and Destroying Medication and Discontinuing Medication. An in-service attendance log shall be maintained as evidence of completion and maintained with the community's training files. **4: How the corrective action**	

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			will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? The community's Director of Health and Wellness or their designee shall complete random weekly audits of at least 1 discharged resident to ensure Drug Disposition form has been completed and scanned into electronic medical record. The results of such monitoring shall be reported to and reviewed with the community's Executive Director **Date of completion:** June 9, 2025. **R409- Infection Control-Noncompliance** *"Facility failed to ensure that the annual health assessment statement (a statement by the physician indicating the resident is free of communicable disease) was documented as required for 1 of 7 residents reviewed. (Resident 48)."* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 48 electronic medical record reviewed, and annual health statement updated by the primary physician. **2: How other residents having the potential to be affected by**	

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			the same deficient practice will be identified and what corrective action will be taken. - The community's Director of Health and Wellness or their designee conducted an audit on 05/23/25 of all inhouse resident records for compliance with annual health assessment statement indicating that resident is free of communicable diseases by June 9, 2025. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The Director of Health and Wellness or their designee shall re-educate the Wellness Team on the community's Admission Policy focusing on the annual health assessment statement indicating that resident is free of communicable diseases. An in-service attendance log shall be maintained as evidence of completion of reeducation and maintained with the community's training files. The community's Director of Health and Wellness or their designee shall monitor, manage and coordinate with physicians' residents' annual health assessment including statement indicating resident is free of communicable disease.	

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			4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? The community's Director of Health and Wellness or their designee shall complete daily monitoring to ensure new move-in resident(s) have an annual health statement documented. Results of daily monitoring shall be reported to the community's Executive Director. The community's Executive Director will randomly review 2 resident records to **Date of completion:** June 9, 2025 **R410-Infection Control-Noncompliance** *"Facility failed to ensure that a first step and second step tuberculin skin test (tool used for screening tuberculosis) was completed upon admission for 2 of 7 residents reviewed (Resident 39 and Resident 90)."* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Residents 39 and 90 two-step tuberculin skin tests have been initiated by the Wellness team. **2: How other residents having the potential to be affected by**	

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			the same deficient practice will be identified and what corrective action will be taken. - The community's Director of Health and Wellness or their designee shall complete an audit of inhouse resident's electronic health records to evaluate compliance with first and second step tuberculin skin test. Tuberculin skin tests will be administered as needed for any residents identified as missing step 1 or step 2 skin tests by June 9, 2025. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The community's Director of Health and Wellness or their designee shall complete monitoring to ensure that new move in resident(s) receive their first and second tuberculin skin test. The community's Director of Health and Wellness or their designee shall complete daily review of new move in records to ensure compliance with tuberculin skin test for the next 90 days. Results of the daily monitoring will be discussed with Executive Director and corrective actions taken to ensure compliance. **4: How the corrective action**	

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			will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? The Executive Director or their designee shall complete weekly random audits of at least 2 resident records weekly for four weeks, then monthly X 6 months to monitor compliance with tuberculin skin testing. **Date of completion:** June 9, 2025	
R 0409 Bldg. 00	410 IAC 16.2-5-12(d) Infection Control - Noncompliance Based on record review and interview, the facility failed to ensure that an annual health statement (a statement by the physician indicating the resident is free of communicable disease) was documented as required for 1 of 7 residents reviewed. (Resident 48) Finding includes: On 5/8/25 at 11:10 a.m., the clinical record for Resident 48 was reviewed. The diagnoses included, but were not limited to, generalized anxiety disorder, vascular dementia with other behavioral disturbance, and alcohol dependence with intoxication delirium. Resident 48's clinical record lacked documentation of an annual health statement from the physician. During an interview on 5/9/25 at 12:35 p.m., the ED (Executive Director) indicated the facility was unable to provide the annual health statement	R 0409	Demaree Crossing 05.14.25 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. **R086-Administration and**	06/09/2025

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	from the physician for Resident 48. On 5/9/25 at 11:15 a.m., the ED provided a copy of the Admissions policy, dated 1/14/22, and indicated it was the current policy in use by the facility. A review of the policy indicated that as part of admission procedures for new residents the healthcare provided documentation should " ...include a statement of the resident being free from communicable disease ...".		**Management-Deficiency** *"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.* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by the alleged deficient practice. CLIA certification was submitted for renewal on 5/09/2025 to labexcellence@cms.hhs.gov and paid through pay.gov-CLIA Laboratory User Fees. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - No residents were affected by the alleged deficient practice. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The ED and DHW will be educated on the Federal and State Regulatory requirements and renewal process for CLIA Certification by the SVP of Health	

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			& Wellness. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** ED or their designee will be responsible for monitoring expiration date and submit timely renewal for CLIA Certificate **Date of completion:** June 9, 2025 **R 148- Sanitation and Safety Standards- Deficiency** *"Facility failed to ensure that potentially hazardous materials were kept secured behind locked doors to prevent resident's access to hazardous materials for 14 of 14 self-mobile and cognitively impaired residents residing on the assisted living unit in the facility* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by the alleged deficient practice. Door to beauty shop was immediately closed and locked. The community's housekeeping staff and beautician will be in-serviced by the community Executive Director on community's policy for Hazardous Substance Classification and Storage. The community beautician	

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			was provided a key to the Beauty Shop for access to room. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - No resident was affected by the alleged deficient practice. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The community's current team members shall be re-educated to the community's Hazardous Substance Classification and Storage Guideline by 6/9/25. An in-service attendance log shall be maintained as evidence of completion of re-education and shall be maintained with the community's training files. New team members shall be trained to the community's Hazardous Substance Classification and Storage Guideline upon hire as part of their pre-service training. The community's Director of Health and Wellness or their designee shall complete monitoring of areas containing hazardous materials to ensure securement at minimum of four days per week for four weeks, and	

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			then weekly for four weeks then monthly for six months. The community's Director of Health and Wellness or their designee shall provide summary of findings to the Executive Director weekly and then monthly for review and discussion of any correction action items. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The Director of Facilities or their designee will be responsible for monitoring compliance of sanitation and safety standards through random monthly checks for unsecured hazardous substance, unlocked cabinets and doors for six months. The random monthly checks results will be reviewed during the monthly safety meeting overseen by the Executive Director. Corrective actions will be implemented based on the findings and discussion during safety meeting. The community through the safety meeting, will review, update and make changes to the DPOC as needed for sustaining substantial compliance for no less than six months. **Date of completion:** June 9, 2025 **R 151- Sanitation & Safety**	

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			Standards-Noncompliance *"Facility failed to ensure a pet who resided in the facility had received the rabies vaccination and the annual veterinary examination was completed as required prior to its expiration date for 1 of 4 residents who housed pets in the facility" (Resident 97)* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The canine owned by Resident 97 had vaccinations updated on 5/20/25. Record of such vaccination have been updated and shall be maintained by the community's Resident Experience Director or their designee **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** Records of pets currently residing at the community were audited by the community's Director of Health and Wellness on 5/25/25. All in community pet vaccination records shall be monitored and maintained by the community's Resident Experience Director or their designee in the Executive Director's office. Resident Experience	

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			Director or their designee will be responsible for notifying and coordinating with resident/responsible party any upcoming or past due pet vaccinations **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The community's Resident Experience Director, Resident Experience Ambassador and leadership team shall be reeducated by the Executive Director. Current and new residents who have pets residing in the community shall be educated on community's standards and policy for pet annual examination and compliance with vaccination during review of the residency agreement by the Executive Director. The community's Resident Experience Director or their designee shall review and provide Executive Director copy of pet vaccinations for any new pets who resident at the community effective June 9, 2025. Resident Experience Director or their designee shall review pet vaccinations for compliance monthly for at least six months to ensure compliance with community policy. The results of these reviews shall be	

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			reported to the Executive Director and discussed during the community's safety meeting. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The community's Executive Director or their designee shall complete random audits of the pet vaccination and examination tracking monthly for six months to ensure all pet vaccinations and annual examinations are current and up to date. Audit results will be reviewed at the monthly safety meeting overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed. The community through the safety meeting, will review, update and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months **Date of completion:** June 9, 2025 **R 216-** **Evaluation-Noncompliance** *"Facility failed to obtain a baseline admission weight for 1 of 7 residents reviewed for weights" (Resident 39)* **1: What corrective action(s) will be accomplished for those**	

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			residents found to have been affected by the deficient practice? Resident 39 has been discharged from the community on 5/14/25. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - The community's Director of Health and Wellness shall conduct an audit of electronic health record documentation for current in-house residents to evaluate compliance with documentation of admission weights by June 9, 2025. All inhouse Resident's weights shall be documented within the resident's electronic medical record for any resident(s) identified as missing weights based on the above audit. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The community's Director of Health and Wellness or their designee shall review electronic health record for new move ins to verify compliance and documentation of resident's weight within 72 hours from the date of move-in.	

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			- The community's Director of Health and Wellness shall re-educate all Wellness (Care) team members regarding Admission Policy and standard for obtaining and documenting residents' weight upon move in. An in-service attendance log shall be maintained as evidence of completion of re-education, and shall be maintained with the community's training files - The community's Director of Health and Wellness shall educate new Wellness (Care) team members on community's Admission Policy during the community pre-service training. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The community's Director of Health and Wellness/designee will complete daily monitoring to ensure that new move in resident(s) have an admission weight documented. Results of such monitoring shall be reported to the community's Executive Director at the community's morning meeting following observation for at least the following six months. **Date of completion:** June 9, 2025 **R 217 Evaluation-Deficiency**	

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			"Facility failed to ensure the service plans were signed by the resident or the resident's representative for 7 of 7 residents reviewed for service plans (Resident 25, Resident 39, Resident 48, Resident 85, Resident 90, Resident 103 and Resident 104) **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Current service plans for Residents 25, 39, 48, 85, and 90 service plans have been reviewed and signed by resident and/or responsible party. Residents 103 and 104 have been discharged from the community on [ADD DATES OF DISCHARGE] **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - The community's Director of Health and Wellness shall complete an audit of all current resident's service plan to validate signature by resident or responsible party by June 9, 2025. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient**	

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

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			practice does not recur The community's Director of Health and Wellness will re-educate the Wellness team member on the community's Evaluation policy which includes requirement for review and signature on plan of care. An in-service attendance log shall be maintained as evidence of completion of re-education, and shall be maintained with the community's training files **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The community's Director of Health and Wellness or their designee shall complete random weekly audits of at least 2 new resident records weekly to evaluate compliance with signed service plans. The results of weekly monitoring shall be reported to and reviewed with the community's Executive Director **Date of completion:** June 9, 2025 **R 306 Pharmaceutical Services-Noncompliance** *"Facility failed to ensure drug dispositions for all medications, including non-controlled substance medications were accounted for and documented for*	

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			2 of 2 closed records reviewed (Resident 103, Resident 104) **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Drug disposition forms have been completed for Residents 103 and 104 on [ADD DATE] **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** The community's Director of Health and Wellness shall implement the use of Drug disposition form for all residents discharged from the community by June 9, 2025. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** The community's Director of Health and Wellness shall in-service the Wellness Team members on the community's policies for Discarding and Destroying Medication and Discontinuing Medication. An in-service attendance log shall be maintained as evidence of completion and maintained with the community's training files.	

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			4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? The community's Director of Health and Wellness or their designee shall complete random weekly audits of at least 1 discharged resident to ensure Drug Disposition form has been completed and scanned into electronic medical record. The results of such monitoring shall be reported to and reviewed with the community's Executive Director **Date of completion:** June 9, 2025. **R409- Infection Control-Noncompliance** *"Facility failed to ensure that the annual health assessment statement (a statement by the physician indicating the resident is free of communicable disease) was documented as required for 1 of 7 residents reviewed. (Resident 48)."* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 48 electronic medical record reviewed, and annual health statement updated by the primary physician.	

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			2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. - The community's Director of Health and Wellness or their designee conducted an audit on 05/23/25 of all inhouse resident records for compliance with annual health assessment statement indicating that resident is free of communicable diseases by June 9, 2025. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The Director of Health and Wellness or their designee shall re-educate the Wellness Team on the community's Admission Policy focusing on the annual health assessment statement indicating that resident is free of communicable diseases. An in-service attendance log shall be maintained as evidence of completion of reeducation and maintained with the community's training files. The community's Director of Health and Wellness or their designee shall monitor, manage and coordinate with physicians' residents' annual health assessment including statement indicating resident is free of	

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			communicable disease. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The community's Director of Health and Wellness or their designee shall complete daily monitoring to ensure new move-in resident(s) have an annual health statement documented. Results of daily monitoring shall be reported to the community's Executive Director. The community's Executive Director will randomly review 2 resident records to **Date of completion:** June 9, 2025 **R410-Infection Control-Noncompliance** *"Facility failed to ensure that a first step and second step tuberculin skin test (tool used for screening tuberculosis) was completed upon admission for 2 of 7 residents reviewed (Resident 39 and Resident 90)."* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Residents 39 and 90 two-step tuberculin skin tests have been initiated by the Wellness team.	

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			2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. - The community's Director of Health and Wellness or their designee shall complete an audit of inhouse resident's electronic health records to evaluate compliance with first and second step tuberculin skin test. Tuberculin skin tests will be administered as needed for any residents identified as missing step 1 or step 2 skin tests by June 9, 2025. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The community's Director of Health and Wellness or their designee shall complete monitoring to ensure that new move in resident(s) receive their first and second tuberculin skin test. The community's Director of Health and Wellness or their designee shall complete daily review of new move in records to ensure compliance with tuberculin skin test for the next 90 days. Results of the daily monitoring will be discussed with Executive Director and corrective actions taken to ensure compliance.	

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			4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? The Executive Director or their designee shall complete weekly random audits of at least 2 resident records weekly for four weeks, then monthly X 6 months to monitor compliance with tuberculin skin testing. **Date of completion:** June 9, 2025	
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance Based on interview and record review, the facility failed to ensure a first step and a second step tuberculin skin test (tool used for screening for tuberculosis) was completed upon admission for 2 of 7 resident reviewed. (Resident 39 and Resident 90) Finding includes: 1. On 5/8/25 at 10:30 a.m., Resident 39's clinical record was reviewed. The diagnoses included, but were not limited to, dementia, arthritis, and a history of falls. Resident 39's clinical record lacked documentation of either a first step or a second step of the required two step tuberculin skin test. 2. On 5/8/25 at 11:45 a.m., Resident 90's clinical record was reviewed. The diagnoses included, but	R 0410	Demaree Crossing 05.14.25 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.	06/09/2025

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	were not limited to, dementia, hypertension (high blood pressure), and COPD (chronic obstructive pulmonary disease). Resident 90's clinical record lacked documentation of either a first step or a second step of the required two step tuberculin skin test. During an interview on 5/9/25 at 12:00 p.m., the ED (Executive Director) indicated that documentation could not be found for any tuberculin skin tests for either Resident 39 or Resident 90. During an interview on 5/9/25 at 11:15 a.m., the ED indicated that the facility lacked a specific policy for tuberculin skin tests for tuberculosis prevention, but that the facility followed state guidelines.		**R086-Administration and Management-Deficiency** *"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.* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by the alleged deficient practice. CLIA certification was submitted for renewal on 5/09/2025 to labexcellence@cms.hhs.gov and paid through pay.gov-CLIA Laboratory User Fees. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - No residents were affected by the alleged deficient practice. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The ED and DHW will be educated on the Federal and State Regulatory requirements and	

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			renewal process for CLIA Certification by the SVP of Health & Wellness. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** ED or their designee will be responsible for monitoring expiration date and submit timely renewal for CLIA Certificate **Date of completion:** June 9, 2025 **R 148- Sanitation and Safety Standards- Deficiency** *"Facility failed to ensure that potentially hazardous materials were kept secured behind locked doors to prevent resident's access to hazardous materials for 14 of 14 self-mobile and cognitively impaired residents residing on the assisted living unit in the facility* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by the alleged deficient practice. Door to beauty shop was immediately closed and locked. The community's housekeeping staff and beautician will be in-serviced by the community Executive Director on community's policy for Hazardous Substance Classification and	

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			Storage. The community beautician was provided a key to the Beauty Shop for access to room. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - No resident was affected by the alleged deficient practice. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The community's current team members shall be re-educated to the community's Hazardous Substance Classification and Storage Guideline by 6/9/25. An in-service attendance log shall be maintained as evidence of completion of re-education and shall be maintained with the community's training files. New team members shall be trained to the community's Hazardous Substance Classification and Storage Guideline upon hire as part of their pre-service training. The community's Director of Health and Wellness or their designee shall complete monitoring of areas containing hazardous materials to ensure	

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			securement at minimum of four days per week for four weeks, and then weekly for four weeks then monthly for six months. The community's Director of Health and Wellness or their designee shall provide summary of findings to the Executive Director weekly and then monthly for review and discussion of any correction action items. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The Director of Facilities or their designee will be responsible for monitoring compliance of sanitation and safety standards through random monthly checks for unsecured hazardous substance, unlocked cabinets and doors for six months. The random monthly checks results will be reviewed during the monthly safety meeting overseen by the Executive Director. Corrective actions will be implemented based on the findings and discussion during safety meeting. The community through the safety meeting, will review, update and make changes to the DPOC as needed for sustaining substantial compliance for no less than six months. **Date of completion:** June 9, 2025	

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			R 151- Sanitation & Safety Standards-Noncompliance *"Facility failed to ensure a pet who resided in the facility had received the rabies vaccination and the annual veterinary examination was completed as required prior to its expiration date for 1 of 4 residents who housed pets in the facility" (Resident 97)* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The canine owned by Resident 97 had vaccinations updated on 5/20/25. Record of such vaccination have been updated and shall be maintained by the community's Resident Experience Director or their designee **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** Records of pets currently residing at the community were audited by the community's Director of Health and Wellness on 5/25/25. All in community pet vaccination records shall be monitored and maintained by the community's Resident Experience Director or their designee in the	

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			Executive Director's office. Resident Experience Director or their designee will be responsible for notifying and coordinating with resident/responsible party any upcoming or past due pet vaccinations **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The community's Resident Experience Director, Resident Experience Ambassador and leadership team shall be reeducated by the Executive Director. Current and new residents who have pets residing in the community shall be educated on community's standards and policy for pet annual examination and compliance with vaccination during review of the residency agreement by the Executive Director. The community's Resident Experience Director or their designee shall review and provide Executive Director copy of pet vaccinations for any new pets who resident at the community effective June 9, 2025. Resident Experience Director or their designee shall review pet vaccinations for compliance monthly for at least six months to ensure compliance	

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			with community policy. The results of these reviews shall be reported to the Executive Director and discussed during the community's safety meeting. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The community's Executive Director or their designee shall complete random audits of the pet vaccination and examination tracking monthly for six months to ensure all pet vaccinations and annual examinations are current and up to date. Audit results will be reviewed at the monthly safety meeting overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed. The community through the safety meeting, will review, update and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months **Date of completion:** June 9, 2025 **R 216-** **Evaluation-Noncompliance** *"Facility failed to obtain a baseline admission weight for 1 of 7 residents reviewed for weights" (Resident 39)*	

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			1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident 39 has been discharged from the community on 5/14/25. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - The community's Director of Health and Wellness shall conduct an audit of electronic health record documentation for current in-house residents to evaluate compliance with documentation of admission weights by June 9, 2025. All inhouse Resident's weights shall be documented within the resident's electronic medical record for any resident(s) identified as missing weights based on the above audit. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The community's Director of Health and Wellness or their designee shall review electronic health record for new move ins to verify compliance and documentation of resident's weight	

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			within 72 hours from the date of move-in. - The community's Director of Health and Wellness shall re-educate all Wellness (Care) team members regarding Admission Policy and standard for obtaining and documenting residents' weight upon move in. An in-service attendance log shall be maintained as evidence of completion of re-education, and shall be maintained with the community's training files - The community's Director of Health and Wellness shall educate new Wellness (Care) team members on community's Admission Policy during the community pre-service training. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The community's Director of Health and Wellness/designee will complete daily monitoring to ensure that new move in resident(s) have an admission weight documented. Results of such monitoring shall be reported to the community's Executive Director at the community's morning meeting following observation for at least the following six months. **Date of completion:** June 9,	

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			2025 **R 217 Evaluation-Deficiency** *"Facility failed to ensure the service plans were signed by the resident or the resident's representative for 7 of 7 residents reviewed for service plans (Resident 25, Resident 39, Resident 48, Resident 85, Resident 90, Resident 103 and Resident 104)* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Current service plans for Residents 25, 39, 48, 85, and 90 service plans have been reviewed and signed by resident and/or responsible party. Residents 103 and 104 have been discharged from the community on [ADD DATES OF DISCHARGE] **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - The community's Director of Health and Wellness shall complete an audit of all current resident's service plan to validate signature by resident or responsible party by June 9, 2025. **3: What measures will be put into place or what systemic**	

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			changes will be made to ensure that the deficient practice does not recur The community's Director of Health and Wellness will re-educate the Wellness team member on the community's Evaluation policy which includes requirement for review and signature on plan of care. An in-service attendance log shall be maintained as evidence of completion of re-education, and shall be maintained with the community's training files **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The community's Director of Health and Wellness or their designee shall complete random weekly audits of at least 2 new resident records weekly to evaluate compliance with signed service plans. The results of weekly monitoring shall be reported to and reviewed with the community's Executive Director **Date of completion:** June 9, 2025 **R 306 Pharmaceutical Services-Noncompliance** *"Facility failed to ensure drug dispositions for all medications, including non-controlled*	

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			substance medications were accounted for and documented for 2 of 2 closed records reviewed (Resident 103, Resident 104) **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Drug disposition forms have been completed for Residents 103 and 104 on [ADD DATE] **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** The community's Director of Health and Wellness shall implement the use of Drug disposition form for all residents discharged from the community by June 9, 2025. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** The community's Director of Health and Wellness shall in-service the Wellness Team members on the community's policies for Discarding and Destroying Medication and Discontinuing Medication. An in-service attendance log shall be maintained as evidence of	

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			completion and maintained with the community's training files. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The community's Director of Health and Wellness or their designee shall complete random weekly audits of at least 1 discharged resident to ensure Drug Disposition form has been completed and scanned into electronic medical record. The results of such monitoring shall be reported to and reviewed with the community's Executive Director **Date of completion:** June 9, 2025. **R409- Infection Control-Noncompliance** *"Facility failed to ensure that the annual health assessment statement (a statement by the physician indicating the resident is free of communicable disease) was documented as required for 1 of 7 residents reviewed. (Resident 48)."* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 48 electronic medical record reviewed, and annual health statement updated	

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			by the primary physician. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - The community's Director of Health and Wellness or their designee conducted an audit on 05/23/25 of all inhouse resident records for compliance with annual health assessment statement indicating that resident is free of communicable diseases by June 9, 2025. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The Director of Health and Wellness or their designee shall re-educate the Wellness Team on the community's Admission Policy focusing on the annual health assessment statement indicating that resident is free of communicable diseases. An in-service attendance log shall be maintained as evidence of completion of reeducation and maintained with the community's training files. The community's Director of Health and Wellness or their designee shall monitor, manage and coordinate with physicians' residents' annual health	

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			assessment including statement indicating resident is free of communicable disease. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The community's Director of Health and Wellness or their designee shall complete daily monitoring to ensure new move-in resident(s) have an annual health statement documented. Results of daily monitoring shall be reported to the community's Executive Director. The community's Executive Director will randomly review 2 resident records to **Date of completion:** June 9, 2025 **R410-Infection Control-Noncompliance** *"Facility failed to ensure that a first step and second step tuberculin skin test (tool used for screening tuberculosis) was completed upon admission for 2 of 7 residents reviewed (Resident 39 and Resident 90)."* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Residents 39 and 90 two-step tuberculin skin tests have been initiated by the Wellness	

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			team. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - The community's Director of Health and Wellness or their designee shall complete an audit of inhouse resident's electronic health records to evaluate compliance with first and second step tuberculin skin test. Tuberculin skin tests will be administered as needed for any residents identified as missing step 1 or step 2 skin tests by June 9, 2025. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** The community's Director of Health and Wellness or their designee shall complete monitoring to ensure that new move in resident(s) receive their first and second tuberculin skin test. The community's Director of Health and Wellness or their designee shall complete daily review of new move in records to ensure compliance with tuberculin skin test for the next 90 days. Results of the daily monitoring will be discussed with Executive	

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			Director and corrective actions taken to ensure compliance. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The Executive Director or their designee shall complete weekly random audits of at least 2 resident records weekly for four weeks, then monthly X 6 months to monitor compliance with tuberculin skin testing. **Date of completion:** June 9, 2025	