PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |   | (X2) MULTIPLE CONSTRUCTION (X3) DATE |                 |         | (X3) DATE  | SURVEY                     |            |
|--|---|--------------------------------------|-----------------|---------|--|----------------------------|------------|
| AND PLAN (   | OF CORRECTION   | IDENTIFICATION NUMBER                | A. BU           | ILDING  | 00   | COMPL                      | ETED       |
|  |   |                                      | B. WI           | B. WING |  |                            | 2025       |
|  |   |                                      |                 | CTREE   | TADDRESS CITY STATE ZID COD  |                            |            |
| NAME OF P  | ROVIDER OR SUPPLIER   |                                      |                 |         | T ADDRESS, CITY, STATE, ZIP COD  DEMAREE ROAD                          |                            |            |
| DEMADE   | E CDOSSING ASS  | SISTED LIVING AND MEMORY CA          | DE              |         | ENWOOD, IN 46143   |                            |            |
| DEIVIAINE  | L Choosing Ass  | MOTED LIVING AND MEMORT CA           |                 | GIVE    |  |                            |            |
| (X4) ID  | SUMMARY S   | STATEMENT OF DEFICIENCIE             |                 | ID      | PROVIDER'S PLAN OF CORRECTION  |                            | (X5)       |
| PREFIX   | (EACH DEFICIEN  | CY MUST BE PRECEDED BY FULL          | PREFIX          |         | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | TE                         | COMPLETION |
| TAG  | REGULATORY OR   | LSC IDENTIFYING INFORMATION          | TAG DEFICIENCY) |         | DEFICIENCY)  |                            | DATE       |
| R 0000   |   |                                      |                 |         |  |                            |            |
| D  |   |                                      |                 |         |  |                            |            |
| Bldg. 00   |   |                                      |                 |         |  |                            |            |
|  | TTT 1 1 1 1 0   | ave Bottle data                      | R 00            | 000     | Demaree Crossing   |                            |            |
|  | This visit was for a State Residential Licensure Survey. This visit included the Investigation of |                                      |                 |         |  | 05.14.25                   |            |
|  |   | _                                    |                 |         |  | This Plan of Correction is |            |
|  | Complaint IN00457   | 119.                                 |                 |         | submitted under regulations  |                            |            |
|  | Complaint INO0457   | 1119 - No deficiencies related to    |                 |         | applicable to long term care   | tion                       |            |
|  | the allegations are c   |                                      |                 |         | providers. This Plan of Correct is not to be construed as an           | uOH                        |            |
|  | the anegations are e  | ned.                                 |                 |         | admission or agreement with t  | ho                         |            |
|  | Survey dates: May   | 8 and 9, 2025                        |                 |         | findings and conclusions in the  |                            |            |
|  | Survey dates. Way 6 and 7, 2025   |                                      |                 |         | Statement of Deficiencies. The   |                            |            |
| Facility number: 014079                              |   | 4079                                 |                 |         | preparation/ submission and/o  |                            |            |
|  |   |                                      |                 |         | execution of this Plan does no   |                            |            |
|  | Residential Census:   | 77                                   |                 |         | constitute agreement by the  | •                          |            |
|  |   |                                      |                 |         | facility that the surveyor's findi                                     | nas                        |            |
|  | These State Residen   | ntial Findings are cited in          |                 |         | or conclusions are accurate, the                                       | _                          |            |
|  | accordance with 410   | 0 IAC 16.2-5.                        |                 |         | the findings constitute a  |                            |            |
|  |   |                                      |                 |         | deficiency, or that the scope a  | nd                         |            |
|  | Quality review com  | pleted May 13, 2025.                 |                 |         | severity regarding any of the  |                            |            |
|  |   |                                      |                 |         | deficiencies are correctly appli                                       | ied.                       |            |
|  |   |                                      |                 |         | Submission of this Plan is   |                            |            |
|  |   |                                      |                 |         | evidence of compliance.  |                            |            |
|  |   |                                      |                 |         |  |                            |            |
|  |   |                                      |                 |         | R086-Administration and  |                            |            |
|  |   |                                      |                 |         | Management-Deficiency  |                            |            |
|  |   |                                      |                 |         | "Facility failed to ensure a curr                                      | rent                       |            |
|  |   |                                      |                 |         | and valid Clinical Laboratory  |                            |            |
|  |   |                                      |                 |         | Improvement Amendments (C  | •                          |            |
|  |   |                                      |                 |         | certification (for the purposes  | OΤ                         |            |
|  |   |                                      |                 |         | performing laboratory  |                            |            |
|  |   |                                      |                 |         | examinations or procedures) v  | vas                        |            |
|  |   |                                      |                 |         | maintained as required.  | azill                      |            |
|  |   |                                      |                 |         | 1: What corrective action(s)   | WIII                       |            |
|  |   |                                      |                 |         | be accomplished for those residents found to have been                 | ,                          |            |
|  |   |                                      |                 |         | affected by the deficient  | •                          |            |
|  |   |                                      |                 |         | practice?  |                            |            |
|  |   |                                      |                 |         | No residents were affecte  | d hv                       |            |
|  |   |                                      |                 |         | ino residents were affecte   | u by                       |            |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Julia Berry Executive Director 05/28/2025

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclodays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 1 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | T OF DEFICIENCIES  OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  | (X2) MULTIPLE A. BUILDING B. WING | 00  | (X3) DATE SURVEY COMPLETED 05/09/2025  |
|--------------------------|----------------------------------|---|-----------------------------------|---|--|
|                          | ROVIDER OR SUPPLIER              | R<br>SISTED LIVING AND MEMORY C   | 1255                              | ET ADDRESS, CITY, STATE, ZIP COD<br>DEMAREE ROAD<br>ENWOOD, IN 46143  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                   | STATEMENT OF DEFICIENCIE<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION | ID<br>PREFIX<br>TAG               | CROSS-REFERENCED TO THE APPROI  | BE COMPLETION DATE   |
|                          |                                  |   |                                   | the alleged deficient practic CLIA certification was submitted for renewal on 5/09/2025 to labexcellence@cms.hhs.go paid through pay.gov-CLIA Laboratory User Fees.  2: How other residents ha the potential to be affected the same deficient practic be identified and what corrective action will be ta - No residents were affe the alleged deficient practic  3: What measures will be into place or what system changes will be made to ensure that the deficient practice does not recur?  The ED and DHW will educated on the Federal ar Regulatory requirements ar renewal process for CLIA Certification by the SVP of & Wellness.  4: How the corrective activ will be monitored to ensure deficient practice will not i.e., what quality assurance program will be put into p  ED or their designee responsible for monitoring expiration date and submit renewal for CLIA Certificate Date of completion: June 2025 R 148- Sanitation and Safe | ving d by e will aken. cted by ee. put ic  be nd State nd Health  on re the recur ee lace? will be timely ene 9, |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 2 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER |                     |  | (X2) MUL<br>A. BUIL<br>B. WING   | DING               | nstruction<br><u>00</u>  | COMPLI  | X3) DATE SURVEY COMPLETED 05/09/2025 |  |
|--|---------------------|--|--|--------------------|--|---|--------------------------------------|--|
|  | ROVIDER OR SUPPLIER | SISTED LIVING AND MEMORY CA  | STREET ADDRESS, CITY, STATE, ZIP COD 1255 DEMAREE ROAD ARE GREENWOOD, IN 46143 |                    |  |   |                                      |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN      | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | PF   | ID<br>REFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  | TE  | (X5)<br>COMPLETION<br>DATE           |  |
| IAU  | REGULATORY UN       | LISC IDENTIFITING INFORMATION  |  | IAU                | Standards- Deficiency "Facility failed to ensure that potentially hazardous material were kept secured behind lock doors to prevent resident's act to hazardous materials for 14 14 self-mobile and cognitively impaired residents residing on assisted living unit in the facilit 1: What corrective action(s) to 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 beautifully be in-serviced by the community Executive Director community's policy for Hazard Substance Classification and Storage.  The community beauticity was provided a key to the Beautiful Shop for access to room.  2: How other residents having the potential to be affected by the same deficient practice where 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 | ked cess of the ty will ted ce. is d. ician on lous ian auty vill en. | DATE                                 |  |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 3 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

| AND PLAN OF CORRECTI               | NCIES<br>ON | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER   | r í  | UILDING             | 00   | COMPL<br>05/09/                               | ETED                       |
|------------------------------------|-------------|---|--|---------------------|--|---|----------------------------|
| NAME OF PROVIDER OR DEMAREE CROSSI |             | SISTED LIVING AND MEMORY C  | STREET ADDRESS, CITY, STATE, ZIP COD 1255 DEMAREE ROAD GREENWOOD, IN 46143 |                     |  |   |                            |
| PREFIX (EACH                       | DEFICIEN    | STATEMENT OF DEFICIENCIE<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  | TE  | (X5)<br>COMPLETION<br>DATE |
|                                    |             |   |  |                     | ensure that the deficient practice does not recur  The community's current team members shall be re-educated to the community Hazardous Substance Classification and Storage Guideline by 6/9/25. An in-sent 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 pre-service training.  The community's Direct 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, then weekly for four weeks the monthly for six months.  The community's Direct of Health and Wellness or their designee shall provide summare findings to the Executive Direct of Health and Wellness or their designee shall provide summare findings to the Executive Direct of Health and Wellness or their designee shall provide summare findings to the Executive Direct of Health and Wellness or their designee shall provide summare findings to the Executive Direct of Health and Wellness or their designee shall provide summare findings to the Executive Direct of Health and Wellness or their designee shall provide summare findings to the Executive Direct 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 rective, what quality assurance | 's vice d all their or ir and en or ir ary of |                            |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 4 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                     |                             | (X2) MULTIPLE CONSTRUCTION |                                |   | (X3) DATE SURVEY |            |
|--|---------------------|-----------------------------|----------------------------|--------------------------------|---|------------------|------------|
| AND PLAN   | OF CORRECTION       | IDENTIFICATION NUMBER       | A. BU                      | JILDING                        | 00  | COMPL            | ETED       |
|  |                     |                             | B. W                       | NG                             |   | 05/09/           | 2025       |
|  |                     |                             |                            | CTREET                         | ADDRESS SITE OF THE SID COD   |                  |            |
| NAME OF P  | ROVIDER OR SUPPLIER | 2                           |                            |                                | ADDRESS, CITY, STATE, ZIP COD   |                  |            |
| DEMADE   | ODOCOINO ACC        | NOTED LIVING AND MEMORY OF  |                            |                                | EMAREE ROAD   |                  |            |
| DEMARE   | E CROSSING ASS      | SISTED LIVING AND MEMORY CA | KE                         | GREEN                          | IWOOD, IN 46143   |                  |            |
| (X4) ID  | SUMMARY             | STATEMENT OF DEFICIENCIE    |                            | ID                             | PROVIDER'S PLAN OF CORRECTION   |                  | (X5)       |
| PREFIX   | (EACH DEFICIEN      | CY MUST BE PRECEDED BY FULL |                            | PREFIX                         | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | TE               | COMPLETION |
| TAG  | REGULATORY OR       | LSC IDENTIFYING INFORMATION |                            | TAG                            | DEFICIENCY)   |                  | DATE       |
|  |                     |                             |                            |                                | program will be put into plac   | e?               |            |
|  |                     |                             |                            |                                | The Director of Facilities  | s or             |            |
|  |                     |                             |                            |                                | their designee will be responsi   | ible             |            |
|  |                     |                             |                            |                                | for monitoring compliance of  |                  |            |
|  |                     |                             |                            |                                | sanitation and safety standard  | s                |            |
|  |                     |                             |                            |                                | through random monthly chec   | ks               |            |
|  |                     |                             |                            |                                | for unsecured hazardous   |                  |            |
|  |                     |                             |                            | substance, unlocked cabinets   | and   |                  |            |
|  |                     |                             |                            |                                | doors for six months. The rand  | dom              |            |
|  |                     |                             |                            |                                | monthly checks results will be  |                  |            |
|  |                     |                             |                            |                                | reviewed during the monthly s   | afety            |            |
|  |                     |                             |                            | meeting overseen by the        |   |                  |            |
|  |                     |                             |                            | Executive Director. Corrective |   |                  |            |
|  |                     |                             |                            |                                | actions will be implemented ba  | ased             |            |
|  |                     |                             |                            |                                | on the findings and discussion  | 1                |            |
|  |                     |                             |                            |                                | during safety meeting.  |                  |            |
|  |                     |                             |                            |                                | The community through   | the              |            |
|  |                     |                             |                            |                                | safety meeting, will review, up   | date             |            |
|  |                     |                             |                            |                                | and make changes to the DP0   | C                |            |
|  |                     |                             |                            |                                | 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 rece  |                  |            |
|  |                     |                             |                            |                                | the rabies vaccination and the  |                  |            |
|  |                     |                             |                            |                                | annual veterinary examination   |                  |            |
|  |                     |                             |                            |                                | completed as required prior to  |                  |            |
|  |                     |                             |                            |                                | expiration date for 1 of 4 resid  |                  |            |
|  |                     |                             |                            |                                | who housed pets in the facility   |                  |            |
|  |                     |                             |                            |                                | (Resident 97)   |                  |            |
|  |                     |                             |                            |                                | 1: What corrective action(s)  | will             |            |
|  |                     |                             |                            |                                | be accomplished for those   |                  |            |
|  |                     |                             |                            |                                | residents found to have beer  | า                |            |
|  |                     |                             |                            |                                | affected by the deficient   |                  |            |
|  |                     |                             |                            |                                | practice?   |                  |            |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 5 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                     | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY |       |                | SURVEY  |          |            |
|--|---------------------|---|-------|----------------|---|----------|------------|
| AND PLAN   | OF CORRECTION       | IDENTIFICATION NUMBER                       | A. BU | ЛLDING         | 00  | COMPL    | ETED       |
|  |                     |   | B. W  | ING            |   | 05/09/   | 2025       |
|  |                     |   |       | CTDEET 4       | ADDRESS CITY STATE ZIR COR  | <u> </u> |            |
| NAME OF P  | ROVIDER OR SUPPLIER | 8   |       |                | ADDRESS, CITY, STATE, ZIP COD   |          |            |
|  |                     | NOTED LIVING AND MEMORY OF                  | DE    |                | EMAREE ROAD   |          |            |
| DEMARE   | E CRUSSING ASS      | SISTED LIVING AND MEMORY CA                 | KE    | GKEEN          | IWOOD, IN 46143   |          |            |
| (X4) ID  | SUMMARY             | STATEMENT OF DEFICIENCIE                    |       | ID             | PROVIDER'S PLAN OF CORRECTION   |          | (X5)       |
| PREFIX   | (EACH DEFICIEN      | CY MUST BE PRECEDED BY FULL                 |       | PREFIX         | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | TE       | COMPLETION |
| TAG  | REGULATORY OR       | R LSC IDENTIFYING INFORMATION               |       | TAG            | DEFICIENCY)   | , L      | DATE       |
|  |                     |   |       |                | The canine owned by   |          |            |
|  |                     |   |       |                | Resident 97 had vaccinations  |          |            |
|  |                     |   |       |                | updated on 5/20/25.   |          |            |
|  |                     |   |       |                | Record of such vaccina  | tion     |            |
|  |                     |   |       |                | have been updated and shall   |          |            |
|  |                     |   |       |                | maintained by the community'  |          |            |
|  |                     |   |       |                | Resident Experience Director  |          |            |
|  |                     |   |       | their designee |   |          |            |
|  |                     |   |       |                |   |          |            |
|  |                     |   |       |                | 2: How other residents havin  | a        |            |
|  |                     |   |       |                | the potential to be affected b  | -        |            |
|  |                     |   |       |                | the same deficient practice v   | -        |            |
|  |                     |   |       |                | be identified and what  |          |            |
|  |                     |   |       |                | corrective action will be take  | n.       |            |
|  |                     |   |       |                | Records of pets current   |          |            |
|  |                     |   |       |                | residing at the community wer   | -        |            |
|  |                     |   |       |                | audited by the community's  |          |            |
|  |                     |   |       |                | Director of Health and Wellnes  | ss       |            |
|  |                     |   |       |                | on 5/25/25.   |          |            |
|  |                     |   |       |                | All in community pet  |          |            |
|  |                     |   |       |                | vaccination records shall be  |          |            |
|  |                     |   |       |                | monitored and maintained by   | the      |            |
|  |                     |   |       |                | community's Resident Experie  |          |            |
|  |                     |   |       |                | Director or their designee in th  |          |            |
|  |                     |   |       |                | 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  | t l      |            |
|  |                     |   |       |                | into place or what systemic   |          |            |
|  |                     |   |       |                | changes will be made to   |          |            |
|  |                     |   |       |                | ensure that the deficient   |          |            |
|  |                     |   |       |                | practice does not recur   |          |            |
|  |                     |   |       |                | The community's Resid   | ent      |            |
|  |                     |   |       |                | Experience Director, Resident   |          |            |
|  |                     |   | ı     |                | , , , , , , , , , , , , , , , , , , ,   |          |            |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 6 of 154

.

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                      |                               | (X2) M | ULTIPLE C                  | ONSTRUCTION   | (X3) DATE SURVEY |            |
|--|----------------------|-------------------------------|--------|----------------------------|---|------------------|------------|
| AND PLAN   | OF CORRECTION        | IDENTIFICATION NUMBER         | A. BU  | JILDING                    | 00  | COMPLETED        |            |
|  |                      |                               | B. W   | ING                        |   | 05/09/2025       |            |
| NAME OF P  |                      |                               | •      | STREET                     | ADDRESS, CITY, STATE, ZIP COD   |                  |            |
| NAME OF P  | PROVIDER OR SUPPLIER | · ·                           |        | 1255 E                     | DEMAREE ROAD  |                  |            |
| DEMARE   | EE CROSSING ASS      | SISTED LIVING AND MEMORY CA   | ARE    | GREE                       | NWOOD, IN 46143   |                  |            |
| (X4) ID  | SUMMARY              | STATEMENT OF DEFICIENCIE      |        | ID                         | PROVIDER'S PLAN OF CORRECTION   |                  | (X5)       |
| PREFIX   | ``                   | ICY MUST BE PRECEDED BY FULL  |        | PREFIX                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | TE               | COMPLETION |
| TAG  | REGULATORY OF        | R LSC IDENTIFYING INFORMATION |        | TAG                        | DEFICIENCY)   |                  | DATE       |
|  |                      |                               |        |                            | Experience Ambassador and   |                  |            |
|  |                      |                               |        |                            | leadership team shall be  |                  |            |
|  |                      |                               |        |                            | reeducated by the Executive Director.   |                  |            |
|  |                      |                               |        |                            | Current and new reside  | nte              |            |
|  |                      |                               |        |                            | who have pets residing in the   | 1110             |            |
|  |                      |                               |        |                            | community shall be educated   | on               |            |
|  |                      |                               |        |                            | community's standards and po  |                  |            |
|  |                      |                               |        |                            | for pet annual examination an   | d                |            |
|  |                      |                               |        |                            | compliance with vaccination during  |                  |            |
|  |                      |                               |        |                            | review of the residency agree   | ment             |            |
|  |                      |                               |        | by the Executive Director. |   |                  |            |
|  |                      |                               |        | The community's Resid      | -   |                  |            |
|  |                      |                               |        |                            | Experience Director or their  |                  |            |
|  |                      |                               |        |                            | designee shall review and pro   |                  |            |
|  |                      |                               |        |                            | Executive Director copy of pet  |                  |            |
|  |                      |                               |        |                            | vaccinations for any new pets resident at the community   | WHO              |            |
|  |                      |                               |        |                            | effective June 9, 2025.   |                  |            |
|  |                      |                               |        |                            | Resident Experience   |                  |            |
|  |                      |                               |        |                            | Director or their designee sha  | II               |            |
|  |                      |                               |        |                            | review pet vaccinations for   |                  |            |
|  |                      |                               |        |                            | compliance monthly for at least   | st               |            |
|  |                      |                               |        |                            | six months to ensure compliar   | nce              |            |
|  |                      |                               |        |                            | with community policy. The  |                  |            |
|  |                      |                               |        |                            | results of these reviews shall  |                  |            |
|  |                      |                               |        |                            | reported to the Executive Dire  | ctor             |            |
|  |                      |                               |        |                            | and discussed during the  |                  |            |
|  |                      |                               |        |                            | community's safety meeting.   |                  |            |
|  |                      |                               |        |                            | 4: How the corrective action  |                  |            |
|  |                      |                               |        |                            | will be monitored to ensure t   | he               |            |
|  |                      |                               |        |                            | deficient practice will not red   | ur               |            |
|  |                      |                               |        |                            | i.e., what quality assurance  |                  |            |
|  |                      |                               |        |                            | program will be put into place  |                  |            |
|  |                      |                               |        |                            | The community's Execu   |                  |            |
|  |                      |                               |        |                            | Director or their designee sha  |                  |            |
|  |                      |                               |        |                            | complete random audits of the   | e pet            |            |
|  |                      |                               |        |                            | vaccination and examination   | c to             |            |
| l l  | Ī                    |                               | ı      |                            | tracking monthly for six month  | ง เ∪             | I          |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 7 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER |                      | IDENTIFICATION NUMBER  | A. BUILDING  B. WING | 00<br>00  | COMPLETED 05/09/2025  |
|--|----------------------|--|----------------------|---|---|
|  | PROVIDER OR SUPPLIER | SISTED LIVING AND MEMORY CA  | 1255 D               | ADDRESS, CITY, STATE, ZIP COD<br>EMAREE ROAD<br>NWOOD, IN 46143   |   |
| (X4) ID<br>PREFIX<br>TAG                     | (EACH DEFICIEN       | STATEMENT OF DEFICIENCIE<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)  | (X5) COMPLETION DATE  |
|  |                      |  |                      | ensure all pet vaccinations an annual examinations are curre and up to date.  Audit results will be reviewed at the monthly safety meeting overseen by the Executive Director. If a threshof 95% is not achieved, an act plan will be developed.  The community through safety meeting, will review, up and make changes to the DPC as needed for sustaining substantial compliance for no than 6 months  Date of completion:  June 2025  R 216- Evaluation-Noncompliance "Facility failed to obtain a base admission weight for 1 of 7 residents reviewed for weights (Resident 39)  1: What corrective action(s) be accomplished for those residents found to have been affected by the deficient practice?  Resident 39 has been discharged from the communit 5/14/25.  2: How other residents having the potential to be affected by the same deficient practice who identified and what corrective action will be taked.  The community's Director Health and Wellness shall | ent  / cold cion  the date DC less  9, will n  ty on  g y vill n. |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 8 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                     |                               | (X2) MULTIPLE CONSTRUCTION |         |   | (X3) DATE SURVEY |            |
|--|---------------------|-------------------------------|----------------------------|---------|---|------------------|------------|
| AND PLAN   | OF CORRECTION       | IDENTIFICATION NUMBER         |                            | JILDING | 00  | COMPLETED        |            |
|  |                     |                               | B. W                       | ING     |   | 05/09/2          | 2025       |
| NAME OF E  | PROVIDER OR SUPPLIE | R                             |                            |         | ADDRESS, CITY, STATE, ZIP COD                                       |                  |            |
|  |                     |                               |                            |         | DEMAREE ROAD  |                  |            |
| DEMARE   | EE CROSSING AS      | SISTED LIVING AND MEMORY C    | ARE                        | GREEN   | NWOOD, IN 46143   |                  |            |
| (X4) ID  | SUMMARY             | STATEMENT OF DEFICIENCIE      |                            | ID      | PROVIDER'S PLAN OF CORRECTION                                       |                  | (X5)       |
| PREFIX   | (EACH DEFICIE       | NCY MUST BE PRECEDED BY FULL  |                            | PREFIX  | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE               | COMPLETION |
| TAG  | REGULATORY O        | R LSC IDENTIFYING INFORMATION | _                          | TAG     | DEFICIENCY)   |                  | DATE       |
|  |                     |                               |                            |         | conduct an audit of electronic                                      |                  |            |
|  |                     |                               |                            |         | health record documentation f                                       | or               |            |
|  |                     |                               |                            |         | 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 resider                                      |                  |            |
|  |                     |                               |                            |         | identified as missing weights                                       | ,                |            |
|  |                     |                               |                            |         | based on the above audit.   |                  |            |
|  |                     |                               |                            |         |   |                  |            |
|  |                     |                               |                            |         | 3: What measures will be pur  | t                |            |
|  |                     |                               |                            |         | into place or what systemic   |                  |            |
|  |                     |                               |                            |         | changes will be made to   |                  |            |
|  |                     |                               |                            |         | ensure that the deficient   |                  |            |
|  |                     |                               |                            |         | practice does not recur The community's Direct                      | or               |            |
|  |                     |                               |                            |         | of Health and Wellness or the                                       |                  |            |
|  |                     |                               |                            |         | designee shall review electror                                      |                  |            |
|  |                     |                               |                            |         | health record for new move in                                       |                  |            |
|  |                     |                               |                            |         | verify compliance and   |                  |            |
|  |                     |                               |                            |         | documentation of resident's w                                       | eight            |            |
|  |                     |                               |                            |         | within 72 hours from the date                                       | of               |            |
|  |                     |                               |                            |         | move-in.  |                  |            |
|  |                     |                               |                            |         | - The community's   |                  |            |
|  |                     |                               |                            |         | Director of Health and Wellnes                                      | ss               |            |
|  |                     |                               |                            |         | shall re-educate all Wellness                                       |                  |            |
|  |                     |                               |                            |         | (Care) team members regardi   | _                |            |
|  |                     |                               |                            |         | Admission Policy and standar obtaining and documenting              | u 101            |            |
|  |                     |                               |                            |         | residents' weight upon move i                                       | n                |            |
|  |                     |                               |                            |         | An in-service attendance log s                                      |                  |            |
|  |                     |                               |                            |         | be maintained as evidence of  |                  |            |
|  |                     |                               |                            |         | completion of re-education, ar                                      |                  |            |
|  |                     |                               |                            |         | shall be maintained with the  |                  |            |
|  |                     |                               |                            |         | community's training files  |                  |            |
|  |                     |                               |                            |         | - The community's   |                  |            |
|  |                     |                               |                            |         | Director of Health and Wellne                                       | ss               |            |

Event ID:  $06WZ11 \qquad {\tt Facility \, ID:} \quad 014079$ Page 9 of 154 State Form If continuation sheet

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | F OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  | (X2) MULTII<br>A. BUILDII<br>B. WING  | PLE CONSTRUCTION NG 00  | (X3) DATE SURVEY  COMPLETED  05/09/2025  |
|--------------------------|---------------------------------|---|---|---|--|
|                          | ROVIDER OR SUPPLIE              | R<br>SISTED LIVING AND MEMORY   | 12  | REET ADDRESS, CITY, STATE, ZIP CO<br>55 DEMAREE ROAD<br>REENWOOD, IN 46143  | D  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                  | STATEMENT OF DEFICIENCIE<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION | ID<br>PREF<br>TA  | PROVIDER'S PLAN OF CORRI<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE AP   | ECTION (X5)  ULD BE PROPRIATE COMPLETION  DATE   |
|                          |                                 |   | shall educate new Wellr (Care) team members of community's Admission during the community programments of training. | n<br>Policy   |  |
|                          |                                 |   |   | 4: How the corrective a will be monitored to endeficient practice will rie., what quality assurprogram will be put into The community's of Health and Wellness/ will complete daily monitoring that new move it resident(s) have an admixed weight documented. Resuch monitoring shall be to the community's Executive for at the community observation for at least following six months.  Date of completion: 2025  R 217 Evaluation-Defice "Facility failed to ensure service plans were significative for 7 of 7 residents reviewed for signals (Resident 25, Resident 48, Resident 18 Resident 48, Resident 18 Resident 490, Resident 18 | ssure the not recur ance o place? Director designee toring to no nission sults of e reported cutive sity's nng the lead by the |
|                          |                                 |   |   | Resident 104) 1: What corrective active accomplished for the residents found to have affected by the deficient practice?  | on(s) will<br>nose<br>e been   |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 10 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER |  |                             | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING |        |  | (X3) DATE SURVEY COMPLETED 05/09/2025 |                      |
|---|--|-----------------------------|--|--------|--|---------------------------------------|----------------------|
|   | PROVIDER OR SUPPLIED                         | SISTED LIVING AND MEMORY C. | ARE  | 1255 D | ADDRESS, CITY, STATE, ZIP COD<br>EMAREE ROAD<br>WOOD, IN 46143 |                                       |                      |
|   | EE CROSSING ASS<br>SUMMARY<br>(EACH DEFICIEN |                             | ARE  |        |  | e DF  g yy vill en. r of elate 2025.  | (X5) COMPLETION DATE |
|   |  |                             |  |        | community's training files                                     |                                       |                      |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 11 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | F OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER                                 | A. B | IULTIPLE CO<br>UILDING<br>'ING | ONSTRUCTION  00   | (X3) DATE \$<br>COMPL!<br>05/09/2 | ETED                       |
|--------------------------|---------------------------------|---|------|--------------------------------|---|-----------------------------------|----------------------------|
|                          | ROVIDER OR SUPPLIEI             | SISTED LIVING AND MEMORY C  | ARE  | 1255 D                         | ADDRESS, CITY, STATE, ZIP COD<br>EMAREE ROAD<br>NWOOD, IN 46143   |                                   |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                  | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION |      | ID<br>PREFIX<br>TAG            | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  4: How the corrective action will be monitored to ensure to  |                                   | (X5)<br>COMPLETION<br>DATE |
|                          |                                 |   |      |                                | deficient practice will not reci.e., what quality assurance program will be put into place. The community's Direct of Health and Wellness or the designee shall complete randoweekly audits of at least 2 new resident records weekly to evaluate compliance with sign service plans. The results of weekly monitoring shall be reported to and reviewed with community's Executive Director Date of completion:  June 9, 2025                                  | e?<br>or<br>r<br>om<br>v<br>ed    |                            |
|                          |                                 |   |      |                                | R 306 Pharmaceutical Services-Noncompliance "Facility failed to ensure drug dispositions for all medications including non-controlled substance medications were accounted for and documente 2 of 2 closed records reviewed (Resident 103, Resident 104)  1: What corrective action(s) be accomplished for those residents found to have been affected by the deficient practice?  Drug disposition forms if been completed for Residents and 104 on [ADD DATE] | d for<br>d<br>will<br>n           |                            |
|                          |                                 |   |      |                                | 2: How other residents having the potential to be affected by   | · .                               |                            |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 12 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | T OF DEFICIENCIES<br>DF CORRECTION    | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER                                       | (X2) MULT<br>A. BUILD<br>B. WING   | DING             | NSTRUCTION  00  | (X3) DATE<br>COMPI<br><b>05/09</b>  | LETED                      |  |
|--------------------------|---------------------------------------|---|--|------------------|---|---|----------------------------|--|
|                          | ROVIDER OR SUPPLIEI<br>E CROSSING ASS | R<br>BISTED LIVING AND MEMORY C   | STREET ADDRESS, CITY, STATE, ZIP COD 1255 DEMAREE ROAD ARE GREENWOOD, IN 46143 |                  |   |   |                            |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                        | STATEMENT OF DEFICIENCIE<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION | PRI  | D<br>EFIX<br>'AG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   |   | (X5)<br>COMPLETION<br>DATE |  |
|                          |                                       |   |  |                  | the same deficient practice be identified and what corrective action will be ta The community's Dire of Health and Wellness sha implement the use of Drug disposition form for all resid discharged from the commu- June 9, 2025.  3: What measures will be p into place or what systemi changes will be made to ensure that the deficient practice does not recur. The community's Dire of Health and Wellness sha in-service the Wellness Tea members on the community policies for Discarding and Destroying Medication and Discontinuing Medication. A in-service attendance log sh maintained as evidence of completion and maintained the community's training file 4: How the corrective actic will be monitored to ensur deficient practice will not a i.e., what quality assuranc program will be put into pl The community's Dire of Health and Wellness or ti designee shall complete rar weekly audits of at least 1 discharged resident to ensur Drug Disposition form has be completed and scanned into electronic medical record. To | ector II ents unity by  out ic ector II am d's  on eethe ector eethe recur ee lace? ector heir ndom  ure peen |                            |  |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 13 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | T OF DEFICIENCIES<br>DF CORRECTION  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER                                    |     | ILDING   | onstruction<br>00   | (X3) DATE S<br>COMPL<br>05/09/                          | ETED                       |  |  |
|--------------------------|-------------------------------------|---|-----|--|---|---|----------------------------|--|--|
|                          | ROVIDER OR SUPPLIE<br>E CROSSING AS | R<br>BISTED LIVING AND MEMORY C   | ARE | STREET ADDRESS, CITY, STATE, ZIP COD 1255 DEMAREE ROAD E GREENWOOD, IN 46143 |   |   |                            |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                      | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION |     | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)  | ATE   | (X5)<br>COMPLETION<br>DATE |  |  |
|                          |                                     |   |     |  | results of such monitoring shate reported to and reviewed with community's Executive Direct Date of completion:  June 9, 2025.  | the   |                            |  |  |
|                          |                                     |   |     |  | R409- Infection Control-Noncompliance "Facility failed to ensure that it annual health assessment statement (a statement by the physician indicating the reside free of communicable disease was documented as required of 7 residents reviewed. (Res. 48)."  1: What corrective action(s) be accomplished for those residents found to have bee affected by the deficient practice?  Resident 48 electronic medical record reviewed, and annual health statement update by the primary physician.  2: How other residents having the potential to be affected to the same deficient practice of the identified and what corrective action will be taked the same deficient practice of the identified and Wellness or their designee conducted an audit 05/23/25 of all inhouse resided records for compliance with a health assessment statement indicating that resident is free | ent is ent is for 1 ident will n ated or on nt nnual of |                            |  |  |
|                          |                                     |   |     |  | communicable diseases by July 9, 2025.  | ·=  |                            |  |  |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 14 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | T OF DEFICIENCIES  OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER                                    | (X2) MULTIPLI<br>A. BUILDING<br>B. WING | E CONSTRUCTION  G 00   | (X3) DATE SURVEY  COMPLETED  05/09/2025   |
|--------------------------|----------------------------------|---|---|--|---|
|                          | ROVIDER OR SUPPLIE               | R<br>SISTED LIVING AND MEMORY   | 125                                     | EET ADDRESS, CITY, STATE, ZIP CO<br>5 DEMAREE ROAD<br>EENWOOD, IN 46143  | OD  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIE                    | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF  | RECTION (X5) OULD BE PPROPRIATE  COMPLETION DATE  |
|                          |                                  |   |   | 3: What measures will into place or what systemanges will be made ensure that the deficie practice does not recurrence and the Director of H. Wellness or their design re-educate the Wellness the community's Admist Policy focusing on the analyth assessment state indicating that resident communicable diseases in-service attendance for maintained as evidence completion of reeducating maintained with the contraining files.  The community's of Health and Wellness designee shall monitor, and coordinate with phyresidents' annual health assessment including sindicating resident is free communicable disease.  4: How the corrective will be monitored to endeficient practice will i.e., what quality assurprogram will be put into the community's of Health and Wellness designee shall complete monitoring to ensure nearesident(s) have an annotatement documented daily monitoring shall be | temic to ent ur lealth and nee shall as Team on sion annual ement is free of as. An og shall be e of ion and munity's a Director or their manage ysicians' n statement ee of action nsure the not recur rance to place? a Director or their e daily ew move-in nual health . Results of |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 15 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | T OF DEFICIENCIES<br>DF CORRECTION    | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER                                    | (X2) MULTI<br>A. BUILD<br>B. WING | IPLE CONSTRUCTION ING <u>00</u>   | (X3) DATE COMPI 05/09   |                            |  |  |  |
|--------------------------|---------------------------------------|---|-----------------------------------|---|---|----------------------------|--|--|--|
|                          | ROVIDER OR SUPPLIEI<br>E CROSSING ASS | R<br>SISTED LIVING AND MEMORY C   | 1:                                | STREET ADDRESS, CITY, STATE, ZIP COD 1255 DEMAREE ROAD GREENWOOD, IN 46143  |   |                            |  |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                        | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | II<br>PRE<br>TA                   | PROVIDERS PLAN OF G (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY  | N SHOULD BE<br>HE APPROPRIATE<br>)  | (X5)<br>COMPLETION<br>DATE |  |  |  |
|                          |                                       |   |                                   | to the community's Edicator.  The community Director.  The community Director will randomly resident records to Date of conduction June 9, 2025  R410-Infection  Control-Noncompliant Facility failed to ensifirst step and second tuberculin skin test (ascreening tuberculos completed upon admonth 7 residents reviewed and Resident 90)."  1: What corrective as be accomplished for residents found to la affected by the definity practice?  Residents 39 at two-step tuberculin is been initiated by the team.  2: How other resident the potential to be at the same deficient point be identified and with corrective action with a corrective action with the same deficient point in the community of inhouse resident's health records to evaluation to the same deficient in the compliance with first step tuberculin skin tests administered as need to same a second to | ty's Executive by review 2  Inpletion:  ance Sure that a d step tool used for sis) was mission for 2 of d (Resident 39  action(s) will or those have been cient  and 90 skin tests have Wellness  Interpretation of so or their blete an audit so electronic aluate and second test. so will be |                            |  |  |  |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 16 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | F OF DEFICIENCIES OF CORRECTION     | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  | (X2) MULTI<br>A. BUILDI<br>B. WING | PLE CONSTRUCTION ING 00  | (X3) DATE SURVEY  COMPLETED  05/09/2025  |
|--------------------------|-------------------------------------|---|------------------------------------|--|--|
|                          | ROVIDER OR SUPPLIE<br>E CROSSING AS | R<br>SISTED LIVING AND MEMORY   | 12                                 | REET ADDRESS, CITY, STATE, ZIP CO<br>255 DEMAREE ROAD<br>REENWOOD, IN 46143  | OD   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIE)                      | STATEMENT OF DEFICIENCIE<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION | II<br>PRE<br>TA                    | PROVIDER'S PLAN OF CORE  | RECTION (X5) IOULD BE PPROPRIATE COMPLETION DATE   |
|                          |                                     |   |                                    | residents identified as r<br>step 1 or step 2 skin tes<br>June 9, 2025.  | -  |
|                          |                                     |   |                                    | 3: What measures will into place or what sys changes will be made ensure that the deficie practice does not recurred.  The community's of Health and Wellness designee shall complet monitoring to ensure the move in resident(s) recurred first and second tuberon test.  The community's of Health and Wellness designee shall complet review of new move in ensure compliance with skin test for the next 90 Results of the daily more be discussed with Executive taken to ensure compliance compliance. | temic to ent ur s Director s or their ee eat new eeive their ulin skin s Director s or their ee daily records to n tuberculin o days. nitoring will cutive actions |
|                          |                                     |   |                                    | 4: How the corrective will be monitored to endeficient practice will i.e., what quality assurprogram will be put in The Executive Ditheir designee shall conweekly random audits or resident records weekly weeks, then monthly X to monitor compliance with tuberculin skin testing.  | nsure the not recur rance to place? irector or mplete of at least 2 y for four 6 months  |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 17 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER |  | A. B   | IULTIPLE CO<br>UILDING<br>'ING  | ONSTRUCTION  00     | (X3) DATE SURVEY  COMPLETED  05/09/2025  |   |  |  |
|--|--|--|---|---------------------|--|---|--|--|
|  | PROVIDER OR SUPPLIER<br>EE CROSSING ASS  | SISTED LIVING AND MEMORY (   | STREET ADDRESS, CITY, STATE, ZIP COD 1255 DEMAREE ROAD CARE GREENWOOD, IN 46143 |                     |  |   |  |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE<br>CY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION   |   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  | (X5) COMPLETION DATE                                      |  |  |
|  |  |  |   |                     | completion: June 9, 2025   |   |  |  |
| R 0086   | 410 IAC 16.2-5-1. Administration and   | 3(a)(1-2)<br>d Management - Deficiency   |   |                     |  |   |  |  |
| Bldg. 00   |  | ,  |   |                     |  |   |  |  |
|  | failed to ensure a cu Laboratory Improve certification (for the laboratory examinal maintained as requi  Finding includes:  On 5/9/25 at 10:30 a provided a copy of certification docum indicated the certificatio | a.m., the Executive Director the facility's current CLIA ent. A review of the document cation's expiration date was nent CLIA certification was do no 5/9/25 at 10:35 a.m., the indicated the CLIA eation date was in March of 2024 deen renewed by it's end date. Intinued to perform blood other outside vendors had ous resident blood draws even a CLIA certification had do not follow all federal eacility was to follow all federal | RO  | 0086                | 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 a findings and conclusions in the Statement of Deficiencies. The preparation/ submission and/dexecution of this Plan does not constitute agreement by the facility that the surveyor's finding or conclusions are accurate, the findings constitute a deficiency, or that the scope as severity regarding any of the deficiencies are correctly apple 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 (Concertification (for the purposes performing laboratory examinations or procedures) amaintained as required.  1: What corrective action(s) the accomplished for those residents found to have been affected by the deficient | the e e e or ot ings hat and ied.  rent CLIA) of was will |  |  |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 18 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | T OF DEFICIENCIES<br>OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER                                    | (X2) MULTIPL<br>A. BUILDING<br>B. WING | E CONSTRUCTION  G 00   | (X3) DATE SURVEY COMPLETED 05/09/2025  |
|--------------------------|------------------------------------|---|--|--|--|
|                          | ROVIDER OR SUPPLIE                 | R<br>SISTED LIVING AND MEMORY (   | 125                                    | EET ADDRESS, CITY, STATE, ZIP COE<br>5 DEMAREE ROAD<br>EENWOOD, IN 46143   | )  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIE)                     | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | ID<br>PREFIX<br>TAG                    | CROSS-REFERENCED TO THE APP  | CTION (X5)  JLD BE COMPLETION DATE   |
|                          |                                    |   |  | practice?  No residents were at the alleged deficient practice CLIA certification was submitted for renewal on 5/09/2025 to labexcellence@cms.hhs.paid through pay.gov-CL Laboratory User Fees.  2: How other residents the potential to be affect the same deficient practice action will be a No residents were at the alleged deficient practice does not recurrate that the deficient practice does not recur | agov and IA  having ted by tice will taken.  ffected by ctice.  be put emic or temperature and state and s |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 19 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | T OF DEFICIENCIES<br>OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  | (X2) MULTIPL<br>A. BUILDING<br>B. WING | E CONSTRUCTION  G 00   | (X3) DATE SURVEY  COMPLETED  05/09/2025  |
|--------------------------|------------------------------------|---|--|--|--|
|                          | ROVIDER OR SUPPLIE                 | R<br>SISTED LIVING AND MEMORY (   | 125                                    | EET ADDRESS, CITY, STATE, ZIP COD<br>5 DEMAREE ROAD<br>EENWOOD, IN 46143   | •  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                     | STATEMENT OF DEFICIENCIE<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION | ID<br>PREFIX<br>TAG                    | CROSS-REFERENCED TO THE APPL   | TION (X5) LD BE ROPRIATE COMPLETION DATE   |
|                          |                                    |   |  | R 148- Sanitation and Sa Standards- Deficiency "Facility failed to ensure to potentially hazardous maderials for the hazardous materials for the hazardous materials for the same deficient practice?  No residents were by the alleged deficient practice?  No residents were by the alleged deficient practice?  No residents were by the alleged deficient practice?  No residents were by the deficient practice?  No residents were by the alleged deficient practice?  No residents were by the community's housekeeping staff and be will be in-serviced by the community Executive Dir community spolicy for Hasubstance Classification Storage.  The community be was provided a key to the Shop for access to room.  2: How other residents If the potential to be affect the same deficient practice identified and what corrective action will be  No resident was affected by the alleged depractice.  3: What measures will be | that terials d locked s's access or 14 of tively ng on the facility n(s) will ose been t affected ractice. op was ocked. eautician ector on azardous and autician e Beauty having ted by tice will  taken. s efficient |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 20 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | F OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  | (X2) MULTIPL<br>A. BUILDING<br>B. WING | E CONSTRUCTION  G  00  | (X3) DATE SURVEY  COMPLETED  05/09/2025   |
|--------------------------|---------------------------------|---|--|--|---|
|                          | ROVIDER OR SUPPLIE              | R<br>SISTED LIVING AND MEMORY (   | 125                                    | EET ADDRESS, CITY, STATE, ZIP CO<br>55 DEMAREE ROAD<br>EENWOOD, IN 46143   | D   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                  | STATEMENT OF DEFICIENCIE<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION | ID<br>PREFIX<br>TAG                    | CROSS-REFERENCED TO THE API  | CCTION (X5) ULD BE PROPRIATE COMPLETION DATE  |
|                          |                                 |   |  | into place or what syste changes will be made to ensure that the deficier practice does not recurrence does not recurrence does not recurrence. The community's team members shall be re-educated to the community and substance. Classification and Storage Guideline by 6/9/25. An attendance log shall be maintained as evidence completion of re-educating shall be maintained with community's training file. New team members be trained to the community and substance. Classification and Storage Guideline upon hire as pre-service training.  The community's of Health and Wellness designee shall complete monitoring of areas conton hazardous materials to esecurement at minimum days per week for four well then weekly for four well monthly for six months.  The community's of Health and Wellness designee shall provide so findings to the Executive weekly and then monthly review and discussion of correction action items.  4: How the corrective a will be monitored to en | current nunity's  ge in-service  of on and the s. ers shall unity's  ge part of their  Director or their etaining ensure of four weeks, and eks then  Director or their summary of e Director y for f any |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 21 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING |     |                     | (X3) DATE SURVEY<br>COMPLETED<br>05/09/2025  |   |                            |
|---|---|--|-----|---------------------|--|---|----------------------------|
|   | PROVIDER OR SUPPLIE                       | R<br>SISTED LIVING AND MEMORY CA                 | ARE | 1255 D              | ADDRESS, CITY, STATE, ZIP COD<br>DEMAREE ROAD<br>NWOOD, IN 46143   |   |                            |
| (X4) ID PREFIX TAG  | (EACH DEFICIENCY MUST BE PRECEDED BY FULL |  |     | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  deficient practice will not rec i.e., what quality assurance  | cur   | (X5)<br>COMPLETION<br>DATE |
|   |   |  |     |                     | rogram will be put into place The Director of Facilities their designee will be response for monitoring compliance of sanitation and safety standard through random monthly check for unsecured hazardous substance, unlocked cabinets doors for six months. The rand monthly checks results will be reviewed during the monthly seeting overseen by the Executive Director. Corrective actions will be implemented be on the findings and discussion during safety meeting.  The community through safety meeting, will review, up and make changes to the DPG as needed for sustaining substantial compliance for no than six months.  Date of completion: June 9, 2025  R 151- Sanitation & Safety Standards-Noncompliance "Facility failed to ensure a pet resided in the facility had received the rabies vaccination and the | s or sible ds cks and dom estable ds cks and dom estable do cks ased on the odate OC less |                            |
|   |   |  |     |                     | annual veterinary examination completed as required prior to expiration date for 1 of 4 residuho housed pets in the facility (Resident 97)  1: What corrective action(s) be accomplished for those residents found to have been  | n was<br>o its<br>dents<br>y"<br>will   |                            |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 22 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | T OF DEFICIENCIES<br>DF CORRECTION    | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER                                    | l í | ILDING   | onstruction 00  | (X3) DATE<br>COMPI<br>05/09  | LETED                      |  |
|--------------------------|---------------------------------------|---|-----|--|---|--|----------------------------|--|
|                          | ROVIDER OR SUPPLIEI<br>E CROSSING ASS | R<br>BISTED LIVING AND MEMORY C   | ARE | STREET ADDRESS, CITY, STATE, ZIP COD 1255 DEMAREE ROAD GREENWOOD, IN 46143 |   |  |                            |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                        | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION |     | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY)   | N<br>BE<br>PRIATE  | (X5)<br>COMPLETION<br>DATE |  |
|                          |                                       |   |     |  | affected by the deficient practice?  The canine owned by Resident 97 had vaccinatio updated on 5/20/25.  Record of such vacci have been updated and shamaintained by the commun Resident Experience Direct their designee  2: How other residents had the potential to be affected the same deficient practic be identified and what corrective action will be taken and the community waudited by the community waudited by the community waudited by the community betwaccination records shall be monitored and maintained by community's Resident Experience Director or their designee was responsible for notifying and coordinating with resident/responsible party aupcoming or past due pet vaccinations  3: What measures will be into place or what system changes will be made to ensure that the deficient | nation all be ity's cor or ving d by e will aken. ently were in ess erience in the vill be d any |                            |  |
|                          |                                       |   |     |  | practice does not recur   |  |                            |  |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 23 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER |                    | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING      |     |              | (X3) DATE SURVEY COMPLETED 05/09/2025  |   |                    |
|---|--------------------|---|-----|--------------|--|---|--------------------|
| NAME OF P   | ROVIDER OR SUPPLIE | R   |     |              | ADDRESS, CITY, STATE, ZIP COD  |   |                    |
| DEMARE  | E CROSSING AS      | SISTED LIVING AND MEMORY CA                           | ARE |              | EMAREE ROAD<br>IWOOD, IN 46143   |   |                    |
| (X4) ID<br>PREFIX   |                    | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL |     | ID<br>PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA  | TE  | (X5)<br>COMPLETION |
| TAG   | REGULATORY O       | R LSC IDENTIFYING INFORMATION                         |     | TAG          | DEFICIENCY)  |   | DATE               |
| TAG   | REGULATORY O       | R LSC IDENTIFYING INFORMATION                         |     | TAG          | The community's Resid Experience Director, Resident Experience Ambassador and leadership team shall be reeducated by the Executive Director.  Current and new reside who have pets residing in the community shall be educated community's standards and post for pet annual examination and compliance with vaccination does not review of the residency agreed by the Executive Director.  The community's Resid Experience Director or their designee shall review and profexecutive Director copy of pet vaccinations for any new pets 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 compliant with community policy. The results of these reviews shall be reported to the Executive Director discussed during the community's safety meeting.  4: How the corrective action will be monitored to ensure to deficient practice will not recise, what quality assurance program will be put into place. | ent t  nts  on olicy d luring ment ent vide t who  Il st nce be cctor | DATE               |
|   |                    |   |     |              | The community's Execu<br>Director or their designee shall<br>complete random audits of the   | II  |                    |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 24 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER |                     | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  00                 |                         |               | (X3) DATE SURVEY   |   |                    |
|---|---------------------|---|-------------------------|---------------|--|---|--------------------|
| AND PLAN  | OF CORRECTION       | IDENTIFICATION NUMBER                                       | A. BUILDING 00  B. WING |               |  | COMPLETED<br>05/09/2025                 |                    |
|   |                     |   | ,,                      |               | CADDRESS CITY STATE ZIB COD  | 1 30,00                                 |                    |
| NAME OF P   | PROVIDER OR SUPPLIE | R   |                         |               | ADDRESS, CITY, STATE, ZIP COD  DEMAREE ROAD  |   |                    |
| DEMARE  | EE CROSSING ASS     | SISTED LIVING AND MEMORY CA                                 | RE                      |               | ENWOOD, IN 46143   |   |                    |
| (X4) ID   |                     | STATEMENT OF DEFICIENCIE                                    |                         | ID            | PROVIDER'S PLAN OF CORRECTION  |   | (X5)               |
| PREFIX<br>TAG   | •                   | NCY MUST BE PRECEDED BY FULL  R LSC IDENTIFYING INFORMATION |                         | PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  | ·ΤΕ                                     | COMPLETION<br>DATE |
| 140   | REGULATORY          | X LSC IDENTIFITING INFORMATION                              |                         | TAU           | vaccination and examination tracking monthly for six month ensure all pet vaccinations an annual examinations are curre and up to date.  Audit results will be reviewed at the monthly safety meeting overseen by the Executive Director. If a thresh of 95% is not achieved, an acreplan will be developed.  The community through safety meeting, will review, up and make changes to the DPC as needed for sustaining substantial compliance for no than 6 months   | os to d ent  y old tion of the odate OC | DAIL               |
|   |                     |   |                         |               | Date of completion: June 2025  R 216- Evaluation-Noncompliance "Facility failed to obtain a base admission weight for 1 of 7 residents reviewed for weights (Resident 39)  1: What corrective action(s) be accomplished for those residents found to have been affected by the deficient practice?  Resident 39 has been discharged from the communi 5/14/25.  2: How other residents having the potential to be affected by the same deficient practice where t | eline s" will n ity on                  |                    |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 25 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | T OF DEFICIENCIES  OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  | (X2) MULTIPLE<br>A. BUILDING<br>B. WING | CONSTRUCTION 00   | (X3) DATE SURVEY COMPLETED 05/09/2025   |
|--------------------------|----------------------------------|---|---|---|---|
|                          | ROVIDER OR SUPPLIE               |   | 1255                                    | ET ADDRESS, CITY, STATE, ZIP COD  |   |
| DEMARE                   | E CROSSING ASS                   | SISTED LIVING AND MEMORY C  | ARE GRE                                 | ENWOOD, IN 46143  |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                   | STATEMENT OF DEFICIENCIE<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOULI<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)   | ON (X5) D BE COMPLETION DATE  |
|                          |                                  |   |   | - The community's Dire Health and Wellness shall conduct an audit of electro health record documentatic current in-house residents evaluate compliance with documentation of admission weights by June 9, 2025.  All inhouse Resident weights shall be document within the resident's electromedical record for any residentified as missing weights based on the above audit.  3: What measures will be into place or what system changes will be made to ensure that the deficient practice does not recur.  The community's Directice and documentation of resident within 72 hours from the damove-in.  The community's Directic of Health and Wellnes (Care) team members regarded and documenting residents' weight upon more An in-service attendance to be maintained as evidence completion of re-education shall be maintained with the community's training files | onic on for to on t's ted onic ident(s) ints  put nic  rector their stronic e ins to d's weight ate of state of state of state of one one of the init |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 26 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                      | (X2) MULTIPLE CONSTRUCTION    |                       |        | (X3) DATE SURVEY  |            |  |
|--|----------------------|-------------------------------|-----------------------|--------|---|------------|--|
| AND PLAN   | OF CORRECTION        | IDENTIFICATION NUMBER         | A. BUILDING <u>00</u> |        |   | COMPLETED  |  |
|  |                      |                               | B. WING               |        |   | 05/09/2025 |  |
|  |                      |                               |                       | CTREET | ADDRESS SITU STATE ZID SOD  |            |  |
| NAME OF P  | PROVIDER OR SUPPLIER | 3                             |                       |        | ADDRESS, CITY, STATE, ZIP COD   |            |  |
| DEMARE   |                      | NOTED LIVING AND MEMORY OF    |                       |        | EMAREE ROAD   |            |  |
| DEMARE   | EE CROSSING ASS      | SISTED LIVING AND MEMORY CA   | KE                    | GREEN  | NWOOD, IN 46143   |            |  |
| (X4) ID  | SUMMARY              | STATEMENT OF DEFICIENCIE      |                       | ID     | DROVIDED'S DI AN OF CODDECTION  | (X5)       |  |
| PREFIX   | (EACH DEFICIEN       | ICY MUST BE PRECEDED BY FULL  |                       | PREFIX | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | COMPLETION |  |
| TAG  | REGULATORY OF        | R LSC IDENTIFYING INFORMATION |                       | TAG    | DEFICIENCY)   | DATE       |  |
|  |                      |                               |                       |        | - The community's   |            |  |
|  |                      |                               |                       |        | Director of Health and Wellnes  | ss         |  |
|  |                      |                               |                       |        | shall educate new Wellness  |            |  |
|  |                      |                               |                       |        | (Care) team members on  |            |  |
|  |                      |                               |                       |        | community's Admission Policy  | ,          |  |
|  |                      |                               |                       |        | during the community pre-serv   |            |  |
|  |                      |                               |                       |        | training.   |            |  |
|  |                      |                               |                       |        |   |            |  |
|  |                      |                               |                       |        | 4: How the corrective action  |            |  |
|  |                      |                               |                       |        | will be monitored to ensure t   | the        |  |
|  |                      |                               |                       |        | deficient practice will not red   |            |  |
|  |                      |                               |                       |        | i.e., what quality assurance  |            |  |
|  |                      |                               |                       |        | program will be put into place  | e?         |  |
|  |                      |                               |                       |        | The community's Direct  |            |  |
|  |                      |                               |                       |        | of Health and Wellness/design   |            |  |
|  |                      |                               |                       |        | will complete daily monitoring  |            |  |
|  |                      |                               |                       |        | ensure that new move in   |            |  |
|  |                      |                               |                       |        | resident(s) have an admission   | 1          |  |
|  |                      |                               |                       |        | weight documented. Results of   |            |  |
|  |                      |                               |                       |        | such monitoring shall be report   |            |  |
|  |                      |                               |                       |        | 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 an  | d          |  |
|  |                      |                               |                       |        | Resident 104)   |            |  |
|  |                      |                               |                       |        | 1: What corrective action(s)  | will       |  |
|  |                      |                               |                       |        | be accomplished for those   |            |  |
|  |                      |                               |                       |        | residents found to have been  | n          |  |
| 1  | Ī                    |                               | 1                     |        | Ī   | I          |  |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 27 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | OF CORRECTION        | IDENTIFICATION NUMBER  | A. BUILDING  B. WING  | 00  | COMPLETED 05/09/2025  |  |  |
|--------------------------|----------------------|--|---|---|---|--|--|
|                          | PROVIDER OR SUPPLIER | SISTED LIVING AND MEMORY CA  | STREET ADDRESS, CITY, STATE, ZIP COD  1255 DEMAREE ROAD  CARE GREENWOOD, IN 46143 |   |   |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN       | STATEMENT OF DEFICIENCIE<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)   | (X5) COMPLETION DATE  |  |  |
|                          |                      |  |   | affected by the deficient practice?  Current service plans for Residents 25, 39, 48, 85, and service plans have been revier 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 of the same deficient of the community's Director of Health and Wellness shall complete an audit of all current resident's service plan to valid signature by resident or responsible party by June 9, 2.  3: What measures will be pure 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 include requirement for review and signature on plan of care. An in-service attendance log shall maintained as evidence of completion of re-education, and shall be maintained with the | ewed  ewed  ne DF  ng  y  will  en.  or of  nt  date  2025.  t  tor  n  des |  |  |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 28 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER |                     | (X2) MULTIPLE (<br>A. BUILDING<br>B. WING  | construction<br>00  | (X3) DATE SURVEY COMPLETED 05/09/2025   |                                    |
|---|---------------------|--|---------------------|---|------------------------------------|
|   | ROVIDER OR SUPPLIER | SISTED LIVING AND MEMORY CA  | 1255                | FADDRESS, CITY, STATE, ZIP COD<br>DEMAREE ROAD<br>ENWOOD, IN 46143  |                                    |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN      | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  community's training files   | (X5) COMPLETION DATE               |
|   |                     |  |                     | 4: How the corrective action will be monitored to ensure to deficient practice will not redie., what quality assurance program will be put into place. The community's Direct of Health and Wellness or the designee shall complete randoweekly audits of at least 2 new resident records weekly to evaluate compliance with sign service plans. The results of weekly monitoring shall be reported to and reviewed with community's Executive Direct Date of completion:  June 9, 2025 | the cur  ee? dor ir om v  aed  the |
|   |                     |  |                     | R 306 Pharmaceutical Services-Noncompliance "Facility failed to ensure drug dispositions for all medication including non-controlled substance medications were accounted for and documente 2 of 2 closed records reviewer (Resident 103, Resident 104)  1: What corrective action(s) be accomplished for those residents found to have been affected by the deficient practice?  Drug disposition forms been completed for Residents and 104 on [ADD DATE]                             | will n                             |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 29 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                     | (X2) MULTIPLE CONSTRUCTION    |                       |       | NSTRUCTION | (X3) DATE SURVEY  |      |            |
|--|---------------------|-------------------------------|-----------------------|-------|------------|---|------|------------|
| AND PLAN   | OF CORRECTION       | IDENTIFICATION NUMBER         | A. BUILDING <u>00</u> |       |            | COMPI   | ETED |            |
|  |                     |                               | B. WING 05/09/2025    |       |            |   |      |            |
|  |                     |                               |                       |       |            |   |      | -          |
| NAME OF I  | PROVIDER OR SUPPLIE | R                             |                       |       |            | DDRESS, CITY, STATE, ZIP COD  |      |            |
|  |                     |                               |                       |       |            | EMAREE ROAD   |      |            |
| DEMARE   | EE CROSSING AS      | SISTED LIVING AND MEMORY CA   | ARE                   | GR    | EEN        | WOOD, IN 46143  |      |            |
| (X4) ID  | SUMMARY             | STATEMENT OF DEFICIENCIE      |                       | ID    |            | DROWIDERS BY AN OF CORRECTION   |      | (X5)       |
| PREFIX   | (EACH DEFICIEN      | NCY MUST BE PRECEDED BY FULL  |                       | PREFI | X          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | TE   | COMPLETION |
| TAG  | REGULATORY O        | R LSC IDENTIFYING INFORMATION |                       | TAG   | j          | DEFICIENCY)   | 16   | DATE       |
|  |                     |                               |                       |       |            | 2: How other residents havin  | a    |            |
|  |                     |                               |                       |       |            | the potential to be affected b  | •    |            |
|  |                     |                               |                       |       |            | the same deficient practice v   | -    |            |
|  |                     |                               |                       |       |            | be identified and what  |      |            |
|  |                     |                               |                       |       |            | corrective action will be take  | n.   |            |
|  |                     |                               |                       |       |            | The community's Direct  | or   |            |
|  |                     |                               |                       |       |            | of Health and Wellness shall  |      |            |
|  |                     |                               |                       |       |            | implement the use of Drug   |      |            |
|  |                     |                               |                       |       |            | disposition form for all residen  | ts   |            |
|  |                     |                               |                       |       |            | discharged from the community   |      |            |
|  |                     |                               |                       |       |            | June 9, 2025.   | , ,  |            |
|  |                     |                               |                       |       |            | ·   |      |            |
|  |                     |                               |                       |       |            | 3: What measures will be put  | t    |            |
|  |                     |                               |                       |       |            | into place or what systemic   |      |            |
|  |                     |                               |                       |       |            | changes will be made to   |      |            |
|  |                     |                               |                       |       |            | ensure that the deficient   |      |            |
|  |                     |                               |                       |       |            | practice does not recur.  |      |            |
|  |                     |                               |                       |       |            | The community's Direct  | or   |            |
|  |                     |                               |                       |       |            | 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 shal  | l be |            |
|  |                     |                               |                       |       |            | maintained as evidence of   |      |            |
|  |                     |                               |                       |       |            | completion and maintained with  | th   |            |
|  |                     |                               |                       |       |            | the community's training files.   |      |            |
|  |                     |                               |                       |       |            |   |      |            |
|  |                     |                               |                       |       |            | 4: How the corrective action  |      |            |
|  |                     |                               |                       |       |            | will be monitored to ensure t   | -    |            |
|  |                     |                               |                       |       |            | deficient practice will not rec   | ur   |            |
|  |                     |                               |                       |       |            | i.e., what quality assurance  |      |            |
|  |                     |                               |                       |       |            | program will be put into plac   |      |            |
|  |                     |                               |                       |       |            | The community's Direct  |      |            |
|  |                     |                               |                       |       |            | of Health and Wellness or their   |      |            |
|  |                     |                               |                       |       |            | designee shall complete rando   | om   |            |
|  |                     |                               |                       |       |            | weekly audits of at least 1   |      |            |
|  |                     |                               |                       |       |            | discharged resident to ensure   |      |            |
|  |                     |                               | 1                     |       |            | Drug Disposition form has bee   | en   |            |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 30 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | T OF DEFICIENCIES<br>DF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  | (X2) MULTIPL<br>A. BUILDING<br>B. WING  | E CONSTRUCTION  G <u>00</u>  | (X3) DATE SURVEY COMPLETED 05/09/2025  |  |  |
|--------------------------|------------------------------------|---|---|--|--|--|--|
|                          | ROVIDER OR SUPPLIEI                | R<br>BISTED LIVING AND MEMORY C   | STREET ADDRESS, CITY, STATE, ZIP COD 1255 DEMAREE ROAD CARE GREENWOOD, IN 46143 |  |  |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                     | STATEMENT OF DEFICIENCIE<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION | ID<br>PREFIX<br>TAG   | CROSS-REFERENCED TO THE API  | CCTION (X5) UILD BE PROPRIATE COMPLETION DATE  |  |  |
|                          |                                    |   |   | completed and scanned electronic medical recorresults of such monitorir reported to and reviewed community's Executive I Date of completion June 9, 2025.  | d. The<br>ng shall be<br>d with the<br>Director  |  |  |
|                          |                                    |   |   | R409- Infection Control-Noncomplianc "Facility failed to ensure annual health assessme statement (a statement physician indicating the free of communicable di was documented as req of 7 residents reviewed. 48)." 1: What corrective active be accomplished for th residents found to have affected by the deficier practice?  Resident 48 elect medical record reviewed annual health statement   | that the ent by the resident is isease) ruired for 1 (Resident  con(s) will rose e been nt  ronic d, and t updated |  |  |
|                          |                                    |   |   | 2: How other residents the potential to be affect the same deficient practice action will be a corrective action w | having cted by ctice will  e taken. Director of their audit on resident with annual ement                          |  |  |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 31 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | T OF DEFICIENCIES  OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER   | (X2) MULTIPL<br>A. BUILDING<br>B. WING | E CONSTRUCTION  G 00   | (X3) DATE SURVEY  COMPLETED  05/09/2025   |
|--------------------------|----------------------------------|--|--|--|---|
|                          | ROVIDER OR SUPPLIE               | R<br>SISTED LIVING AND MEMORY (  | 125                                    | EET ADDRESS, CITY, STATE, ZIP CO<br>5 DEMAREE ROAD<br>EENWOOD, IN 46143  | DD .  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIE                    | Y STATEMENT OF DEFICIENCIE<br>NCY MUST BE PRECEDED BY FULL<br>OF LSC IDENTIFYING INFORMATION | ID<br>PREFIX<br>TAG                    | CROSS-REFERENCED TO THE AP   | ECTION (X5) DULD BE COMPLETION PROPRIATE DATE   |
|                          |                                  |  |  | communicable diseases 9, 2025.   | s by June   |
|                          |                                  |  |  | 3: What measures will into place or what syst changes will be made to ensure that the deficient practice does not reculate the Director of Howellness or their design re-educate the Wellness the community's Admission Policy focusing on the analth assessment state indicating that resident incommunicable diseases in-service attendance to maintained as evidence completion of reeducation maintained with the community files.  The community's of Health and Wellness designee shall monitor, and coordinate with phy residents' annual health assessment including stindicating resident is free communicable disease.  4: How the corrective as | temic to nt r ealth and nee shall s Team on sion unnual ement s free of s. An ng shall be of on and nmunity's  Director or their manage esicians' tatement e of |
|                          |                                  |  |  | will be monitored to endeficient practice will ri.e., what quality assurprogram will be put into The community's of Health and Wellness designee shall complete monitoring to ensure ne resident(s) have an ann  | not recur<br>ance<br>o place?<br>Director<br>or their<br>e daily<br>w move-in   |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 32 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                | F OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER     | (X2) MULTIPLE ( A. BUILDING B. WING | OO OO   | (X3) DATE SURVEY COMPLETED 05/09/2025 |
|----------------|---------------------------------|---|-------------------------------------|---|---------------------------------------|
|                | ROVIDER OR SUPPLIE              | RISTED LIVING AND MEMORY C                              | 1255                                | T ADDRESS, CITY, STATE, ZIP COD  DEMAREE ROAD  ENIMOOD, IN 46143  |                                       |
| (X4) ID PREFIX | SUMMARY                         | STATEMENT OF DEFICIENCIE  STATEMENT OF PRECEDED BY FULL | ID PREFIX                           | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE   | (X5) COMPLETION                       |
| TAG            |                                 | R LSC IDENTIFYING INFORMATION                           | TAG                                 | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  statement documented. Result | ts of                                 |
|                |                                 |   |                                     | daily monitoring shall be report to the community's Executive Director.                                       | ted                                   |
|                |                                 |   |                                     | The community's Execu<br>Director will randomly review 2<br>resident records to                               |                                       |
|                |                                 |   |                                     | Date of completion:<br>June 9, 2025   |                                       |
|                |                                 |   |                                     | R410-Infection Control-Noncompliance "Facility failed to ensure that a  | ,                                     |
|                |                                 |   |                                     | first step and second step<br>tuberculin skin test (tool used   |                                       |
|                |                                 |   |                                     | screening tuberculosis) was<br>completed upon admission for<br>7 residents reviewed (Resider                  |                                       |
|                |                                 |   |                                     | <ul><li>and Resident 90)."</li><li>1: What corrective action(s) be accomplished for those</li></ul>           | will                                  |
|                |                                 |   |                                     | residents found to have been affected by the deficient  | 1                                     |
|                |                                 |   |                                     | practice? Residents 39 and 90 two-step tuberculin skin tests  | have                                  |
|                |                                 |   |                                     | been initiated by the Wellness team.  |                                       |
|                |                                 |   |                                     | 2: How other residents havin the potential to be affected b   | ·                                     |
|                |                                 |   |                                     | the same deficient practice v be identified and what corrective action will be take                           |                                       |
|                |                                 |   |                                     | - The community's Directo<br>Health and Wellness or their   | r of                                  |
|                |                                 |   |                                     | designee shall complete an au<br>of inhouse resident's electroni<br>health records to evaluate                |                                       |
|                |                                 |   |                                     | compliance with first and seco  | ond                                   |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 33 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

| A BLLIDING OF PROVIDER OR SUPPLIER  DEMAREE CROSSING ASSISTED LIVING AND MEMORY CARE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY PULL TAG OF PROVIDER OR SUPPLIER OR PRICE OF THE PROVIDER OF THE PROVIDER OF THE PROVIDER OR SUMMARY STATEMENT OF DEFICIENCY OF THE PROVIDER OF THE PROVIDER OR SUMMARY STATEMENT OF DEFICIENCY OR SUMMARY STATEMENT OF DEFICE OR SUMMARY STATEMENT OF DEFICIENCY OR SUMMARY STATEMENT OF DEFICE OR SUMMARY STATEMENT OF DEFICIENCY STATEMENT OF DEFICIENCY OR SUMMARY STATEMENT OF DEFICIENCY STATEMENT OF DEFICIENCY STATEMENT OF DEFICIENCY STATEMENT OF DEF | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                      | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY |                    |          |                                   | SURVEY |      |
|--|--|----------------------|---|--------------------|----------|-----------------------------------|--------|------|
| NAME OF PROVIDER OR SUPPLIER  DEMAREE CROSSING ASSISTED LIVING AND MEMORY CARE  (M) ID PREFIX (BACH DEFICIENCY MUST BE PRECEDED BY FULL TAG)  TAG REGULATORY OR ISC IDENTIFYING INFORMATION  REGULATORY OR ISC IDENTIFYING INFORMATION  TO supplies the supplies of the suppli | AND PLAN   | OF CORRECTION        | IDENTIFICATION NUMBER                       |                    |          |                                   |        | ETED |
| DEMAREE CROSSING ASSISTED LIVING AND MEMORY CARE  IXA SUMMARY STATEMENT OF DEFICIENCE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  TAG  IDENTIFY TAG  IDEN |  |                      |   | B. WING 05/09/2025 |          |                                   |        | 2025 |
| DEMAREE CROSSING ASSISTED LIVING AND MEMORY CARE  IXA SUMMARY STATEMENT OF DEFICIENCE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  TAG  IDENTIFY TAG  IDEN |  |                      |   |                    | STREET A | ADDRESS CITY STATE ZIP COD        |        |      |
| DEMAREE CROSSING ASSISTED LIVING AND MEMORY CARE   GREENWOOD, IN 46143   | NAME OF P  | PROVIDER OR SUPPLIER |   |                    |          |                                   |        |      |
| SUMMARY STATEMENT OF DEFICIENCIE   PREFIX   CACH DEFICIENCY MINST BE PRECIDED BY PULL   TAG   REGULATORY OR LSC IDENTIFYING INFORMATION   TAG   REGULATORY OR LSC IDENTIFYING INFORMATION      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.   | DEMARE   | F CROSSING ASS       | SISTED LIVING AND MEMORY CA                 | RF                 |          |                                   |        |      |
| PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG CONSERVENCE CONTROL OF THE PROPRESS AND CONTROL OF THE P |  |                      |   | . \_               |          |                                   |        |      |
| TAG REGULATORY OR LSC IDENTIFYING INFORMATION  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 motioning 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   |  |                      |   |                    |          | PROVIDER'S PLAN OF CORRECTION     |        |      |
| 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   |  | ·                    |   |                    |          | CROSS-REFERENCED TO THE APPROPRIA | TE     |      |
| 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 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 qualify 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   | TAG  | REGULATORY OR        | LSC IDENTIFYING INFORMATION                 |                    | TAG      |                                   |        | DATE |
| residents identified as missing siep 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 of 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 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  |  |                      |   |                    |          |                                   |        |      |
| 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 one 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   |  |                      |   |                    |          |                                   |        |      |
| 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 actions 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   |  |                      |   |                    |          | _                                 |        |      |
| 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  |  |                      |   |                    |          | 1                                 |        |      |
| 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  |  |                      |   |                    |          | June 9, 2025.                     |        |      |
| 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  |  |                      |   |                    |          | 3: What measures will be put      | t l    |      |
| 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  |  |                      |   |                    |          | -                                 |        |      |
| 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 \$6\$ months   |  |                      |   |                    |          |                                   |        |      |
| 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  |  |                      |   |                    |          | _                                 |        |      |
| 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   |  |                      |   |                    |          | practice does not recur           |        |      |
| 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  |  |                      |   |                    |          |                                   |        |      |
| 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   |  |                      |   |                    |          |                                   | ir     |      |
| 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   |  |                      |   |                    |          |                                   |        |      |
| 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  |  |                      |   |                    |          | _                                 |        |      |
| 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  |  |                      |   |                    |          | , ,                               |        |      |
| 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   |  |                      |   |                    |          |                                   | n      |      |
| 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 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  |  |                      |   |                    |          |                                   |        |      |
| 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  |  |                      |   |                    |          |                                   |        |      |
| 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  |  |                      |   |                    |          |                                   | ı İ    |      |
| 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   |  |                      |   |                    |          |                                   | s to   |      |
| 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   |  |                      |   |                    |          |                                   |        |      |
| 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  |  |                      |   |                    |          |                                   |        |      |
| 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  |  |                      |   |                    |          |                                   | will   |      |
| 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   |  |                      |   |                    |          | ,                                 |        |      |
| 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   |  |                      |   |                    |          |                                   | ,      |      |
| 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   |  |                      |   |                    |          | taken to ensure compliance.       |        |      |
| 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   |  |                      |   |                    |          |                                   |        |      |
| 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  |  |                      |   |                    |          |                                   | .      |      |
| 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  |  |                      |   |                    |          |                                   |        |      |
| 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  |  |                      |   |                    |          | -                                 | ur     |      |
| 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   |  |                      |   |                    |          |                                   |        |      |
| their designee shall complete weekly random audits of at least 2 resident records weekly for four weeks, then monthly X 6 months   |  |                      |   |                    |          | 1                                 |        |      |
| weekly random audits of at least 2 resident records weekly for four weeks, then monthly X 6 months   |  |                      |   |                    |          | = =                               | OI     |      |
| resident records weekly for four weeks, then monthly X 6 months  |  |                      |   |                    |          |                                   | set 2  |      |
| weeks, then monthly X 6 months   |  |                      |   |                    |          | _                                 |        |      |
|  |  |                      |   |                    |          | -                                 |        |      |
|  |  |                      |   |                    |          |                                   |        |      |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 34 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES X1 |  | X1) PROVIDER/SUPPLIER/CLIA        | (X2) MULTIPLE CONSTRUCTION   |        |   | (X3) DATE SURVEY                   |            |
|------------------------------|--|-----------------------------------|------------------------------|--------|---|------------------------------------|------------|
| AND PLAN                     | OF CORRECTION                                  | IDENTIFICATION NUMBER             | A. BUILDING <u>00</u> COMPLE |        |   | PLETED                             |            |
|                              |  |                                   | B. WI                        | NG     |   |                                    | 9/2025     |
|                              |  |                                   |                              | _      |   |                                    |            |
| NAME OF F                    | PROVIDER OR SUPPLIER                           | 8                                 |                              |        | T ADDRESS, CITY, STATE, ZIP COD                                 |                                    |            |
|                              |  |                                   |                              |        | DEMAREE ROAD  |                                    |            |
| DEMARE                       | EE CROSSING ASS                                | SISTED LIVING AND MEMORY C        | ARE                          | GRE    | ENWOOD, IN 46143  |                                    |            |
| (X4) ID                      | SUMMARY  | STATEMENT OF DEFICIENCIE          |                              | ID     | PROVIDER'S PLAN OF CORRECT                                      | ION                                | (X5)       |
| PREFIX                       | (EACH DEFICIEN                                 | ICY MUST BE PRECEDED BY FULL      |                              | PREFIX | (EACH CORRECTIVE ACTION SHOULI<br>CROSS-REFERENCED TO THE APPRO | D BE                               | COMPLETION |
| TAG                          | REGULATORY OF                                  | R LSC IDENTIFYING INFORMATION     |                              | TAG    | DEFICIENCY)   | FRIATE                             | DATE       |
|                              |  |                                   |                              |        | tuberculin skin testing.  |                                    |            |
|                              |  |                                   |                              |        | Date of   |                                    |            |
|                              |  |                                   |                              |        | completion: June 9, 202   | 5                                  |            |
|                              |  |                                   |                              |        | · ·   |                                    |            |
| R 0148                       | 410 IAC 16.2-5-1.                              | 5(e)(1-4)                         |                              |        |   |                                    |            |
|                              | Sanitation and Sa                              | fety Standards - Deficiency       |                              |        |   |                                    |            |
| Bldg. 00                     |  | •                                 |                              |        |   |                                    |            |
|                              | Based on observation                           | on, interview, and record         | R 0                          | 148    | Demaree Crossing  |                                    | 06/09/2025 |
|                              | review, the facility                           | failed to ensure that potentially |                              |        | 05.14.25  |                                    |            |
|                              | hazardous materials                            | s were kept secured behind        |                              |        | This Plan of Correction is                                      |                                    |            |
|                              | locked doors to pre-                           | vent resident's access to         |                              |        | submitted under regulation                                      |                                    |            |
|                              | hazardous materials                            | s for 14 of 14 self-mobile and    |                              |        | applicable to long term car                                     | applicable to long term care       |            |
|                              | cognitively impaired residents residing on the |                                   |                              |        | providers. This Plan of Co                                      | providers. This Plan of Correction |            |
|                              | assisted living unit                           | in the facility.                  |                              |        | is not to be construed as a                                     |                                    |            |
|                              |  |                                   |                              |        | admission or agreement w  | ith the                            |            |
|                              | Findings include:                              |                                   |                              |        | findings and conclusions in                                     | n the                              |            |
|                              |  |                                   |                              |        | Statement of Deficiencies.                                      | The                                |            |
|                              | On 5/8/25 from 9:3                             | 0 a.m. to 9:45 a.m., the beauty   |                              |        | preparation/ submission a                                       | nd/or                              |            |
|                              | shop door located o                            | n the assisted living unit was    |                              |        | execution of this Plan does                                     | s not                              |            |
|                              | observed to be oper                            | n and unattended by staff.        |                              |        | constitute agreement by th                                      | ıe                                 |            |
|                              | Inside the beauty sh                           | nop at that time, the following   |                              |        | facility that the surveyor's                                    | findings                           |            |
|                              | was observed:                                  |                                   |                              |        | or conclusions are accurat                                      | e, that                            |            |
|                              |  |                                   |                              |        | the findings constitute a                                       |                                    |            |
|                              | - An opened contain                            | ner that was sitting on the       |                              |        | deficiency, or that the scor                                    | e and                              |            |
|                              | vanity shelf that wa                           | s easily reachable and            |                              |        | severity regarding any of t                                     | he                                 |            |
|                              | contained six pairs                            | of 4 - 5 inch sharp scissors.     |                              |        | deficiencies are correctly a                                    | applied.                           |            |
|                              |  |                                   |                              |        | Submission of this Plan is                                      |                                    |            |
|                              |  | aerosol hair spray sitting on a   |                              |        | evidence of compliance.   |                                    |            |
|                              | shelf that was easily                          | y reachable. The label            |                              |        |   |                                    |            |
|                              | indicated "extremel                            | y flammable."                     |                              |        | R086-Administration and   |                                    |            |
|                              |  |                                   |                              |        | Management-Deficiency   |                                    |            |
|                              |  | wers that were easily opened      |                              |        | "Facility failed to ensure a                                    | current                            |            |
|                              | and inside the draw                            | er was an electric razor.         |                              |        | and valid Clinical Laborato                                     | iry                                |            |
|                              |  |                                   |                              |        | Improvement Amendment   | s (CLIA)                           |            |
|                              |  | nity contained one 32 ounce       |                              |        | certification (for the purpos                                   | ses of                             |            |
|                              |  | eloper (chemical used to color    |                              |        | performing laboratory   |                                    |            |
|                              | hair) the label on th                          | e bottle indicated "keep out of   |                              |        | examinations or procedure                                       | es) was                            |            |
|                              | reach"   |                                   |                              |        | maintained as required.   |                                    |            |
|                              |  |                                   |                              |        | 1: What corrective action                                       | (s) will                           |            |
|                              | - A shelf on the vanity contained 4 tubes      |                                   | 1                            |        | be accomplished for thos  | <b>S</b> e                         |            |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 35 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |  | (X2) MULTIPLE CONSTRUCTION (X3) DATE |                                 |  | (X3) DATE  | SURVEY   |            |
|--|--|--------------------------------------|---------------------------------|--|--|----------|------------|
| AND PLAN   | OF CORRECTION  | IDENTIFICATION NUMBER                | A. BUILDING <u>00</u> COMPLETED |  |  | ETED     |            |
|  |  |                                      | B. W                            | ING                                      |  | 05/09/   | 2025       |
|  |  | 1                                    |                                 | STREET                                   | ADDRESS, CITY, STATE, ZIP COD  | <u> </u> |            |
| NAME OF P  | PROVIDER OR SUPPLIEF   | R                                    |                                 |  |  |          |            |
| DEMVDE   | E CDOSSING ASS   | SISTED LIVING AND MEMORY CA          | DE                              | 1255 DEMAREE ROAD RE GREENWOOD, IN 46143 |  |          |            |
| DEMAKE   | E OKOSSING ASS   | SISTED LIVING AND MEMORY CA          | \ITC                            | GKEEN                                    | NVVOOD, IN 40143   |          |            |
| (X4) ID  | SUMMARY  | STATEMENT OF DEFICIENCIE             |                                 | ID                                       | PROVIDER'S PLAN OF CORRECTION  |          | (X5)       |
| PREFIX   | (EACH DEFICIEN   | NCY MUST BE PRECEDED BY FULL         |                                 | PREFIX                                   | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA         | TE.      | COMPLETION |
| TAG  | REGULATORY OF  | R LSC IDENTIFYING INFORMATION        |                                 | TAG                                      | DEFICIENCY)  |          | DATE       |
|  | measuring 100 ml each of permanent hair color  |                                      |                                 |  | residents found to have been   | n        |            |
|  | solution. The label indicated "keep out of   |                                      |                                 |  | affected by the deficient  |          |            |
|  | reach"   |                                      |                                 |  | practice?  |          |            |
|  |  |                                      |                                 |  | No residents were affecte  | d by     |            |
|  | _  | v on 5/8/25 at 9:45 a.m.,            |                                 |  | the alleged deficient practice.  |          |            |
|  | Housekeeper 2 indicated "we unlock the door for  |                                      |                                 |  | CLIA certification was   |          |            |
|  | the beautician she   | e does not have a key."              |                                 |  | submitted for renewal on   |          |            |
|  |  |                                      |                                 |  | 5/09/2025 to   |          |            |
|  | During an interview on 5/8/25 at 10:00 a.m., the   |                                      |                                 |  | labexcellence@cms.hhs.gov  | and      |            |
|  |  | d "the staff unlock the door for     |                                 |  | paid through pay.gov-CLIA  |          |            |
|  | me before I get to v   | vork, I don't have a key."           |                                 |  | Laboratory User Fees.  |          |            |
|  | Dania - an intansian   |                                      |                                 |  | 0. 11  |          |            |
|  | During an interview on 5/8/25 at 10:20 a.m., the Executive Director indicated the beauty shop door |                                      |                                 |  | 2: How other residents havin   |          |            |
|  | should have been lo  |                                      |                                 |  | the potential to be affected by  | -        |            |
|  | should have been it  | ocked.                               |                                 |  | the same deficient practice v  | VIII     |            |
|  | On 5/0/25 at 8:05 a  | .m., the Executive Director          |                                 |  | be identified and what   |          |            |
|  |  | itled Hazardous Substance            |                                 |  | corrective action will be take   |          |            |
|  |  | torage, dated 7/8/24, and            |                                 |  | <ul> <li>No residents were affected the alleged deficient practice.</li> </ul> | ed by    |            |
|  |  | current policy being used by         |                                 |  | line alleged delicient practice.   |          |            |
|  |  | ew of the policy indicated           |                                 |  | 3: What measures will be pu  |          |            |
|  | -  | be secured behind a secured          |                                 |  | into place or what systemic  | •        |            |
|  |  | en not in use by a community         |                                 |  | changes will be made to  |          |            |
|  | Team Member."  | on not in use by a community         |                                 |  | ensure that the deficient  |          |            |
|  | 1 00000 1/100000   |                                      |                                 |  | 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 He   | alth     |            |
|  |  |                                      |                                 |  | & Wellness.  |          |            |
|  |  |                                      |                                 |  |  |          |            |
|  |  |                                      |                                 |  | 4: How the corrective action   |          |            |
|  |  |                                      |                                 |  | will be monitored to ensure t  | the      |            |
|  |  |                                      |                                 |  | deficient practice will not red  | cur      |            |
|  |  |                                      |                                 |  | i.e., what quality assurance   |          |            |
|  |  |                                      |                                 |  | program will be put into place   |          |            |
|  |  |                                      |                                 |  | ED or their designee wi  | ll be    |            |
|  |  |                                      |                                 |  | responsible for monitoring   |          |            |
|  |  |                                      |                                 |  | expiration date and submit tim   | nely     |            |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 36 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | T OF DEFICIENCIES<br>OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  | (X2) MULTIF<br>A. BUILDII<br>B. WING | PLE CONSTRUCTION NG 00   | (X3) DATE SURVEY  COMPLETED  05/09/2025   |
|--------------------------|------------------------------------|---|--------------------------------------|--|---|
|                          | ROVIDER OR SUPPLIE                 | R<br>SISTED LIVING AND MEMORY   | 12                                   | REET ADDRESS, CITY, STATE, ZIP CO<br>55 DEMAREE ROAD<br>REENWOOD, IN 46143   | OD  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                     | STATEMENT OF DEFICIENCIE<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION | ID<br>PREF<br>TA                     | FIX (EACH CORRECTIVE ACTION SHORT)  CROSS-REFERENCED TO THE A  | RECTION (X5) IOULD BE PPROPRIATE COMPLETION DATE  |
|                          |                                    |   |                                      | renewal for CLIA Certification Date of completion: 2025 R 148- Sanitation and Standards- Deficiency "Facility failed to ensure potentially hazardous in were kept secured behadoors to prevent reside to hazardous materials 14 self-mobile and cog impaired residents residents found to have assisted living unit in the 1: What corrective act be accomplished for the residents found to have affected by the deficient practice?  No residents well by the alleged deficient Door to beauty so immediately closed and The community's housekeeping staff and will be in-serviced by the community Executive Exe | Safety  de that materials ind locked ent's access for 14 of mitively ding on the me facility mion(s) will hose we been ent  The affected de practice. hop was delocked. Self beautician me Director on Hazardous on and  Deautician the Beauty m. Se having metted by metted by metted by metted by metted by metted by metted taken. Mas |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 37 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|               | IT OF DEFICIENCIES   | X1) PROVIDER/SUPPLIER/CLIA                               | ì í   |                | ONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED                                     |                 |
|---------------|----------------------|--|-------|----------------|---|---|-----------------|
| AND PLAN      | OF CORRECTION        | IDENTIFICATION NUMBER                                    | B. WI | JILDING<br>ING | 00  | 05/09/  |                 |
|               |                      |  |       |                | ADDRESS SITE STATE SID COD  | 00/00/  |                 |
| NAME OF P     | PROVIDER OR SUPPLIER |  |       |                | ADDRESS, CITY, STATE, ZIP COD<br>EMAREE ROAD  |   |                 |
| DEMARE        | EE CROSSING ASS      | SISTED LIVING AND MEMORY CA                              | RE    |                | NWOOD, IN 46143   |   |                 |
| (X4) ID       | SUMMARY              | STATEMENT OF DEFICIENCIE                                 |       | ID             | PROVIDER'S PLAN OF CORRECTION   |   | (X5)            |
|               | •                    |  |       |                | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA  | .TE   |                 |
| PREFIX<br>TAG | (EACH DEFICIEN       | CY MUST BE PRECEDED BY FULL RESC IDENTIFYING INFORMATION |       | PREFIX TAG     | 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 currer team members shall be re-educated to the community Hazardous Substance Classification and Storage Guideline by 6/9/25. An in-ser 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 maintained to the community's Hazardous Substance Classification and Storage Guideline by 6/9/25. An in-ser attendance log 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 pre-service training.  The community's Direct 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, then weekly for four weeks the monthly for six months.  The community's Direct of Health and Wellness or their designee shall provide summate findings to the Executive Direct weekly and then monthly for six monthly | t  nt  s vice  d all  their  or  ir  and  en  or  ir  and  en  or | COMPLETION DATE |
|               |                      |  |       |                | The community's Direct of Health and Wellness or thei designee shall provide summa findings to the Executive Direct   | ir<br>ary of  |                 |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 38 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | T OF DEFICIENCIES<br>OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  | (X2) MULTIPLI<br>A. BUILDING<br>B. WING | E CONSTRUCTION  G 00   | (X3) DATE<br>COMPI<br>05/09  |                            |
|--------------------------|------------------------------------|---|---|--|--|----------------------------|
|                          | ROVIDER OR SUPPLIE                 | R<br>SISTED LIVING AND MEMORY (   | 125                                     | EET ADDRESS, CITY, STATE, ZIP CO<br>5 DEMAREE ROAD<br>EENWOOD, IN 46143  | D  |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIE                      | STATEMENT OF DEFICIENCIE<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)  | ECTION<br>ULD BE<br>PROPRIATE  | (X5)<br>COMPLETION<br>DATE |
|                          |                                    |   |   | 4: How the corrective a will be monitored to endeficient practice will nie., what quality assura program will be put into The Director of Fatheir designee will be resfor monitoring compliant sanitation and safety stathrough random monthly for unsecured hazardous substance, unlocked caldoors for six months. The monthly checks results were viewed during the more meeting overseen by the Executive Director. Corrections will be implement on the findings and discuturing safety meeting.  The community the safety meeting, will revise and make changes to the as needed for sustaining substantial compliance of than six months.  Date of complete June 9, 2025  R 151- Sanitation & Safe Standards-Noncomplia "Facility failed to ensure resided in the facility had the rabies vaccination and annual veterinary examination date for 1 of 4 who housed pets in the interpretation date for 1 of 4 who housed pets in the interpretation date for 1 of 4 who housed pets in the interpretation date for 1 of 4 who housed pets in the interpretation date for 1 of 4 who housed pets in the interpretation date for 1 of 4 who housed pets in the interpretation date for 1 of 4 who housed pets in the interpretation date for 1 of 4 who housed pets in the interpretation date for 1 of 4 who housed pets in the interpretation date for 1 of 4 who housed pets in the interpretation date for 1 of 4 who housed pets in the interpretation date for 1 of 4 who housed pets in the interpretation date for 1 of 4 who housed pets in the interpretation date for 1 of 4 who housed pets in the interpretation date for 2 of 4 who housed pets in the interpretation date for 2 of 4 who housed pets in the interpretation date for 2 of 4 who housed pets in the interpretation date for 2 of 4 who housed pets in the interpretation date for 3 of 4 who housed pets in the interpretation date for 3 of 4 who housed pets in the interpretation date for 3 of 4 who housed pets in the interpretation date for 3 of 4 who housed pets in the interpretation date for 3 of 4 who housed pets in the inter | sure the not recur ance oplace? acilities or sponsible ce of andards or checks is poinets and he random will be nothly safety elective and the ew, update elew, update element elew, update elew, update element el |                            |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 39 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | T OF DEFICIENCIES<br>OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  | (X2) MULTIPLE A. BUILDING B. WING | OO OO  | (X3) DATE SURVEY COMPLETED 05/09/2025  |
|--------------------------|------------------------------------|---|-----------------------------------|--|--|
|                          | ROVIDER OR SUPPLIE                 | R<br>SISTED LIVING AND MEMORY   | 1255                              | ET ADDRESS, CITY, STATE, ZIP COD<br>DEMAREE ROAD<br>ENWOOD, IN 46143   |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIE                      | STATEMENT OF DEFICIENCIE<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION | ID<br>PREFIX<br>TAG               | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B: CROSS-REFERENCED TO THE APPROPE DEFICIENCY)  | (X5) E COMPLETION DATE   |
|                          |                                    |   |                                   | be accomplished for those residents found to have be affected by the deficient practice?  The canine owned by Resident 97 had vaccination updated on 5/20/25.  Record of such vaccin have been updated and sha maintained by the communit Resident Experience Director their designee  2: How other residents have the potential to be affected the same deficient practice be identified and what corrective action will be talked Records of pets current residing at the community we audited by the community we audited by the community we audited by the community bet vaccination records shall be monitored and maintained be community's Resident Expendirector or their designee in Executive Director's office.  Resident Experience Director or their designee with responsible for notifying and coordinating with resident/responsible party and upcoming or past due pet vaccinations  3: What measures will be pinto place or what systemic | en  Is Is Ination II be Cy's For or  Ing by Ewill Is Intly Ere Eess  If the II be II be Iny  Intly Inter II be II be II be II be II be II be |
|                          |                                    |   |                                   | changes will be made to  |  |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 40 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2 |                     |                               | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY |                              |   |               |            |
|---|---------------------|-------------------------------|---|------------------------------|---|---------------|------------|
| AND PLAN  | OF CORRECTION       | IDENTIFICATION NUMBER         | A. B  | JILDING                      | 00  | COMPLI        | ETED       |
|   |                     |                               | B. W  | ING                          |   | 05/09/2       | 2025       |
|   |                     |                               | _   | STREET                       | ADDRESS, CITY, STATE, ZIP COD   |               |            |
| NAME OF F   | PROVIDER OR SUPPLIE | R                             |   | 1                            | DEMAREE ROAD  |               |            |
| DEMARE  | EE CROSSING ASS     | SISTED LIVING AND MEMORY C    | ARE   |                              | NWOOD, IN 46143   |               |            |
| (X4) ID   | SUMMARY             | STATEMENT OF DEFICIENCIE      |   | ID                           | PROVIDER'S PLAN OF CORRECTION   |               | (X5)       |
| PREFIX  | (EACH DEFICIEN      | ICY MUST BE PRECEDED BY FULL  |   | PREFIX                       | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE            | COMPLETION |
| TAG   | REGULATORY O        | R LSC IDENTIFYING INFORMATION |   | TAG                          | DEFICIENCY)   |               | DATE       |
|   |                     |                               |   |                              | ensure that the deficient   |               |            |
|   |                     |                               |   |                              | practice does not recur   |               |            |
|   |                     |                               |   |                              | The community's Resid   |               |            |
|   |                     |                               |   |                              | Experience Director, Resident   |               |            |
|   |                     |                               |   |                              | Experience Ambassador and   |               |            |
|   |                     |                               |   |                              | leadership team shall be  |               |            |
|   |                     |                               |   |                              | reeducated by the Executive   |               |            |
|   |                     |                               |   |                              | Director.   |               |            |
|   |                     |                               |   |                              | Current and new reside  | nts           |            |
|   |                     |                               |   |                              | who have pets residing in the   |               |            |
|   |                     |                               |   |                              | community shall be educated   |               |            |
|   |                     |                               |   |                              | community's standards and po  | -             |            |
|   |                     |                               |   |                              | for pet annual examination an   |               |            |
|   |                     |                               |   |                              | compliance with vaccination d   | -             |            |
|   |                     |                               |   |                              | review of the residency agree   | ment          |            |
|   |                     |                               |   |                              | by the Executive Director.  |               |            |
|   |                     |                               |   |                              | The community's Resid   | ent           |            |
|   |                     |                               |   |                              | Experience Director or their  |               |            |
|   |                     |                               |   |                              | designee shall review and pro   |               |            |
|   |                     |                               |   |                              | Executive Director copy of pet  |               |            |
|   |                     |                               |   |                              | vaccinations for any new pets   | wno           |            |
|   |                     |                               |   |                              | resident at the community   |               |            |
|   |                     |                               |   |                              | effective June 9, 2025.   |               |            |
|   |                     |                               |   |                              | Resident Experience Director or their designee sha  | .             |            |
|   |                     |                               |   |                              | review pet vaccinations for   | "             |            |
|   |                     |                               |   |                              | compliance monthly for at least   | <sub>st</sub> |            |
|   |                     |                               |   |                              | six months to ensure complian   |               |            |
|   |                     |                               |   |                              | with community policy. The  |               |            |
|   |                     |                               |   |                              | results of these reviews shall  | he            |            |
|   |                     |                               |   |                              | reported to the Executive Dire  |               |            |
|   |                     |                               |   |                              | and discussed during the  |               |            |
|   |                     |                               |   |                              | community's safety meeting.   |               |            |
|   |                     |                               |   |                              | 22g 5 salety mosting.   |               |            |
|   |                     |                               |   |                              | 4: How the corrective action  |               |            |
|   |                     |                               |   |                              | will be monitored to ensure t   |               |            |
|   |                     |                               |   |                              | deficient practice will not red   | ur            |            |
|   |                     |                               |   | i.e., what quality assurance |   |               |            |
|   |                     |                               |   |                              | program will be put into place  | e?            |            |
| 1   | Ī                   |                               |   |                              | The community's Execu   | ıtive         |            |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 41 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

| F OF DEFICIENCIES OF CORRECTION             | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER | A. B | IULTIPLE CO<br>UILDING<br>'ING | ONSTRUCTION  00  |   | ESURVEY<br>LETED<br>0/2025 |
|---|---|------|--------------------------------|--|---|----------------------------|
| ROVIDER OR SUPPLIE                          | SISTED LIVING AND MEMORY C                          | ARE  | 1255 D                         | ADDRESS, CITY, STATE, ZIP COD<br>EMAREE ROAD<br>NWOOD, IN 46143  |   |                            |
| E CROSSING ASS<br>SUMMARY<br>(EACH DEFICIEN |   | ARE  |                                |  | III e pet as to d ent old tion a the odate DC less 9, eline s" will | (X5) COMPLETION DATE       |
|   |   |      |                                | Resident 39 has been discharged from the communi 5/14/25.  2: How other residents having the potential to be affected by the same deficient practice with the same deficient practice. | ng<br>Dy  |                            |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 42 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

| STATEMEN  | NT OF DEFICIENCIES  | X1) PROVIDER/SUPPLIER/CLIA    | X2) MULTIPLE CONSTRUCTION (X3) DATE S |         |  | SURVEY |            |
|-----------|---------------------|-------------------------------|---------------------------------------|---------|--|--------|------------|
| AND PLAN  | OF CORRECTION       | IDENTIFICATION NUMBER         | A. BU                                 | JILDING | 00   | COMPL  | ETED       |
|           |                     |                               | B. W                                  | ING _   |  | 05/09/ | 2025       |
|           |                     |                               |                                       | STREET  | ADDRESS, CITY, STATE, ZIP COD  |        |            |
| NAME OF I | PROVIDER OR SUPPLIE | R.                            |                                       |         | DEMAREE ROAD   |        |            |
| DEMARE    | EE CROSSING AS      | SISTED LIVING AND MEMORY CA   | ARE                                   | GREE    | NWOOD, IN 46143  |        |            |
| (X4) ID   | SUMMARY             | STATEMENT OF DEFICIENCIE      |                                       | ID      | PROVIDER'S PLAN OF CORRECTION  |        | (X5)       |
| PREFIX    | (EACH DEFICIE)      | NCY MUST BE PRECEDED BY FULL  |                                       | PREFIX  | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | TE     | COMPLETION |
| TAG       | REGULATORY O        | R LSC IDENTIFYING INFORMATION | _                                     | TAG     | DEFICIENCY)  |        | DATE       |
|           |                     |                               |                                       |         | be identified and what   |        |            |
|           |                     |                               |                                       |         | corrective action will be take   |        |            |
|           |                     |                               |                                       |         | - The community's Directo  | r of   |            |
|           |                     |                               |                                       |         | Health and Wellness shall  |        |            |
|           |                     |                               |                                       |         | conduct an audit of electronic   |        |            |
|           |                     |                               |                                       |         | health record documentation f current in-house residents to            | UI     |            |
|           |                     |                               |                                       |         | 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 resider   |        |            |
|           |                     |                               |                                       |         | identified as missing weights  | ` '    |            |
|           |                     |                               |                                       |         | based on the above audit.  |        |            |
|           |                     |                               |                                       |         | 3: What measures will be put   | t      |            |
|           |                     |                               |                                       |         | into place or what systemic  |        |            |
|           |                     |                               |                                       |         | changes will be made to  |        |            |
|           |                     |                               |                                       |         | ensure that the deficient  |        |            |
|           |                     |                               |                                       |         | practice does not recur  |        |            |
|           |                     |                               |                                       |         | The community's Direct   |        |            |
|           |                     |                               |                                       |         | of Health and Wellness or their  |        |            |
|           |                     |                               |                                       |         | designee shall review electron health record for new move in:          |        |            |
|           |                     |                               |                                       |         | verify compliance and  | ธ เ∪   |            |
|           |                     |                               |                                       |         | documentation of resident's w  | eiaht  |            |
|           |                     |                               |                                       |         | within 72 hours from the date  | -      |            |
|           |                     |                               |                                       |         | move-in.   |        |            |
|           |                     |                               |                                       |         | - The community's  |        |            |
|           |                     |                               |                                       |         | Director of Health and Wellnes   | ss     |            |
|           |                     |                               |                                       |         | shall re-educate all Wellness  |        |            |
|           |                     |                               |                                       |         | (Care) team members regardi  | ng     |            |
|           |                     |                               |                                       |         | Admission Policy and standard  | _      |            |
|           |                     |                               |                                       |         | obtaining and documenting  |        |            |
|           |                     |                               |                                       |         | residents' weight upon move i  | n.     |            |
|           |                     |                               |                                       |         | An in-service attendance log s   |        |            |
|           |                     |                               |                                       |         | be maintained as evidence of   |        |            |
|           |                     |                               |                                       |         | completion of re-education, ar   | ıd     |            |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 43 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|           | T OF DEFICIENCIES<br>OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING |        |   | (X3) DATE SURVEY  COMPLETED  05/09/2025 |            |
|-----------|------------------------------------|--|--|--------|---|---|------------|
| NAME OF P | ROVIDER OR SUPPLIEI                | R  |  | 1      | ADDRESS, CITY, STATE, ZIP COD   |   |            |
| DEMARE    | E CROSSING ASS                     | SISTED LIVING AND MEMORY CA                      | ARE  |        | EMAREE ROAD<br>IWOOD, IN 46143  |   |            |
| (X4) ID   | SUMMARY                            | STATEMENT OF DEFICIENCIE                         |  | ID     | PROVIDERIC DI AN OF CORRECTION  |   | (X5)       |
| PREFIX    | (EACH DEFICIEN                     | NCY MUST BE PRECEDED BY FULL                     |  | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE                                      | COMPLETION |
| TAG       | REGULATORY OF                      | R LSC IDENTIFYING INFORMATION                    |  | TAG    | DEFICIENCY)   |   | DATE       |
|           |                                    |  |  |        | shall be maintained with the community's training files   |   |            |
|           |                                    |  |  |        | - The community's   |   |            |
|           |                                    |  |  |        | Director of Health and Wellnes  | ss                                      |            |
|           |                                    |  |  |        | shall educate new Wellness  |   |            |
|           |                                    |  |  |        | (Care) team members on  |   |            |
|           |                                    |  |  |        | community's Admission Policy  |   |            |
|           |                                    |  |  |        | during the community pre-serv   | /ice                                    |            |
|           |                                    |  |  |        | training.   |   |            |
|           |                                    |  |  |        | 4: How the corrective action  |   |            |
|           |                                    |  |  |        | will be monitored to ensure t   | :he                                     |            |
|           |                                    |  |  |        | deficient practice will not red   | ur                                      |            |
|           |                                    |  |  |        | i.e., what quality assurance  |   |            |
|           |                                    |  |  |        | program will be put into place  |   |            |
|           |                                    |  |  |        | The community's Direct of Health and Wellness/design  |   |            |
|           |                                    |  |  |        | will complete daily monitoring  |   |            |
|           |                                    |  |  |        | ensure that new move in   |   |            |
|           |                                    |  |  |        | resident(s) have an admission   | ı                                       |            |
|           |                                    |  |  |        | weight documented. Results of   |   |            |
|           |                                    |  |  |        | such monitoring shall be report   | rted                                    |            |
|           |                                    |  |  |        | 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 an  | d                                       |            |
|           |                                    |  |  |        | Resident 104) 1: What corrective action(s)  | will                                    |            |
|           |                                    |  | 1  |        | ı   ı.  vviial corrective action(S) '   | VVIII                                   |            |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 44 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | T OF DEFICIENCIES<br>DF CORRECTION    | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  | (X2) MUL'<br>A. BUILI<br>B. WING | DING               | NSTRUCTION  00   | (X3) DATE<br>COMPL<br>05/09/  | ETED                       |
|--------------------------|---------------------------------------|---|----------------------------------|--------------------|--|---|----------------------------|
|                          | ROVIDER OR SUPPLIEI<br>E CROSSING ASS | R<br>BISTED LIVING AND MEMORY C   |                                  | 1255 DE            | DDRESS, CITY, STATE, ZIP COD<br>EMAREE ROAD<br>WOOD, IN 46143  |   |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                        | STATEMENT OF DEFICIENCIE<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION | PR                               | ID<br>REFIX<br>FAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY)   | N<br>BE<br>RIATE  | (X5)<br>COMPLETION<br>DATE |
|                          |                                       |   |                                  |                    | be accomplished for those residents found to have be affected by the deficient practice?  Current service plans Residents 25, 39, 48, 85, and service plans have been revalued and signed by resident and/oresponsible party.  Residents 103 and 10 have been discharged from community on [ADD DATES DISCHARGE]  2: How other residents have the potential to be affected the same deficient practice be identified and what corrective action will be tall to the community's Direct Health and Wellness shall complete an audit of all curresident's service plan to vasignature by resident or responsible party by June 9  3: What measures will be printo place or what systemic changes will be made to ensure that the deficient practice does not recure.  The community's Direct of Health and Wellness will re-educate the Wellness teamember on the community's Evaluation policy which inclured in the community's Evaluation policy which includes the will be provided in the community's Evaluation policy which includes the community in the communi | for and 90 viewed for 04 the 6 OF ving 1 by e will extor of ent lidate 1, 2025. Out c |                            |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 45 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | T OF DEFICIENCIES  OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER                                    |      | ILDING              | onstruction 00   | (X3) DATE<br>COMPI<br>05/09                      | LETED                      |
|--------------------------|----------------------------------|---|------|---------------------|--|--|----------------------------|
|                          | ROVIDER OR SUPPLIER              | R<br>BISTED LIVING AND MEMORY C   | CARE | 1255 DI             | ADDRESS, CITY, STATE, ZIP COD<br>EMAREE ROAD<br>IWOOD, IN 46143  |  |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                   | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | I    | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPI<br>DEFICIENCY)  | E<br>RIATE                                       | (X5)<br>COMPLETION<br>DATE |
|                          |                                  |   |      |                     | completion of re-education,<br>shall be maintained with the<br>community's training files  |  |                            |
|                          |                                  |   |      |                     | 4: How the corrective action will be monitored to ensure deficient practice will not rive., what quality assurance program will be put into plate of Health and Wellness or the designee shall complete rank weekly audits of at least 2 noresident records weekly to evaluate compliance with significant plans. The results of weekly monitoring shall be reported to and reviewed with community's Executive Direct Date of completion June 9, 2025 | e the ecur ector neir edom ew gned f th the ctor |                            |
|                          |                                  |   |      |                     | R 306 Pharmaceutical Services-Noncompliance "Facility failed to ensure dru dispositions for all medicatio including non-controlled substance medications were accounted for and documen 2 of 2 closed records review (Resident 103, Resident 104  1: What corrective action(s be accomplished for those residents found to have be affected by the deficient practice?  Drug disposition forms been completed for Resident                             | eted for<br>ved<br>4)<br>s) will<br>een          |                            |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 46 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | T OF DEFICIENCIES<br>OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  | (X2) MULTIP<br>A. BUILDIN<br>B. WING | ig <u>00</u>   | (X3) DATE SURVEY  COMPLETED  05/09/2025   |
|--------------------------|------------------------------------|---|--------------------------------------|--|---|
|                          | ROVIDER OR SUPPLIE                 | R<br>SISTED LIVING AND MEMORY   | 125                                  | EET ADDRESS, CITY, STATE, ZIP C<br>55 DEMAREE ROAD<br>EENWOOD, IN 46143  | OD  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIE)                     | STATEMENT OF DEFICIENCIE<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION | ID<br>PREF                           | CROSS-REFERENCED TO THE A  | RECTION (X5) HOULD BE COMPLETION APPROPRIATE DATE   |
|                          |                                    |   |                                      | and 104 on [ADD DAT  2: How other resident the potential to be aff the same deficient probe identified and what corrective action will.  The community's of Health and Wellness implement the use of Edisposition form for all discharged from the conjune 9, 2025.  3: What measures will into place or what system changes will be made ensure that the deficie practice does not reconfict the Wellness in-service the Wellness in-service the Wellness members on the community's of Health and Wellness in-service attendance of the community in the community is training the community's training in the community in the community's training in the community in th | s having ected by actice will t be taken. s Director s shall Drug residents bommunity by  I be put stemic to ent ur. s Director s shall s Team hunity's and and on. An og shall be e of ined with |
|                          |                                    |   |                                      | 4: How the corrective will be monitored to e deficient practice will i.e., what quality assu program will be put in The community's of Health and Wellness designee shall comple weekly audits of at least   | nsure the not recur irance ito place? s Director s or their te random   |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 47 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | T OF DEFICIENCIES  OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  | (X2) MUL'<br>A. BUIL!<br>B. WING | DING              | NSTRUCTION 00  | COMP  | E SURVEY<br>PLETED<br>9/2025 |
|--------------------------|----------------------------------|---|----------------------------------|-------------------|--|---|------------------------------|
|                          | ROVIDER OR SUPPLIE               | R<br>SISTED LIVING AND MEMORY (   |                                  | 1255 DE           | DDRESS, CITY, STATE, ZIP COD<br>EMAREE ROAD<br>WOOD, IN 46143  |   |                              |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIE)                   | STATEMENT OF DEFICIENCIE<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION | PR                               | ID<br>EFIX<br>ΓAG | PROVIDER'S PLAN OF CORRECTIC<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROI<br>DEFICIENCY)  | )N<br>BE<br>PRIATE  | (X5)<br>COMPLETION<br>DATE   |
|                          |                                  |   |                                  |                   | discharged resident to ensure Drug Disposition form has be completed and scanned intelectronic medical record. To results of such monitoring sereported to and reviewed we community's Executive Director Date of completion:  June 9, 2025.   | been<br>to<br>The<br>shall be<br>vith the                     |                              |
|                          |                                  |   |                                  |                   | R409- Infection Control-Noncompliance "Facility failed to ensure the annual health assessment statement (a statement by a physician indicating the residue of communicable diseased was documented as require of 7 residents reviewed. (R48)."  1: What corrective action(   | the<br>sident is<br>ase)<br>ed for 1<br>esident               |                              |
|                          |                                  |   |                                  |                   | be accomplished for those residents found to have be affected by the deficient practice?  Resident 48 electron medical record reviewed, a annual health statement up by the primary physician.   | e<br>een<br>ic<br>nd  |                              |
|                          |                                  |   |                                  |                   | 2: How other residents hat the potential to be affected the same deficient practice be identified and what corrective action will be targonic to the community's Directive and Wellness or the designee conducted an audio 5/23/25 of all inhouse residences with the correction of the co | d by<br>ee will<br>aken.<br>actor of<br>eir<br>dit on<br>dent |                              |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 48 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                   | TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00  B. WING |  |     | (X3) DATE SURVEY  COMPLETED  05/09/2025 |   |  |                            |
|-------------------|--|--|-----|---|---|--|----------------------------|
|                   | ROVIDER OR SUPPLIER  | SISTED LIVING AND MEMORY CA  | \RE | 1255 DE                                 | ADDRESS, CITY, STATE, ZIP COD<br>EMAREE ROAD<br>IWOOD, IN 46143   |  |                            |
| (X4) ID<br>PREFIX | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION |     | ID<br>PREFIX                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)  | TE   | (X5)<br>COMPLETION<br>DATE |
| TAG               | REGULATORY OR  | LSC IDENTIFYING INFORMATION  |     | TAG                                     | health assessment statement indicating that resident is free communicable diseases by Ju 9, 2025.   |  | DATE                       |
|                   |  |  |     |   | 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 at Wellness or their designee share-educate the Wellness Team the community's Admission Policy focusing on the annual health assessment statement indicating that resident is free communicable diseases. An in-service attendance log shall maintained as evidence of completion of reeducation and maintained with the communit training files.  The community's Direct of Health and Wellness or their designee shall monitor, managand coordinate with physicians residents' annual health assessment including statemes indicating resident is free of communicable disease.  4: How the corrective action will be monitored to ensure the deficient practice will not recite, what quality assurance program will be put into place.  The community's Direct of Health and Wellness or their designee shall complete daily | ond all on on of I be I y's or ir ges' ent er. |                            |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 49 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER |                    | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  |     |                     | (X3) DATE SURVEY COMPLETED 05/09/2025  |   |                            |
|---|--------------------|---|-----|---------------------|--|---|----------------------------|
|   | ROVIDER OR SUPPLIE | R<br>SISTED LIVING AND MEMORY CA  | ARE | 1255 D              | ADDRESS, CITY, STATE, ZIP COD<br>EMAREE ROAD<br>IWOOD, IN 46143  |   |                            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN     | STATEMENT OF DEFICIENCIE<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION |     | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)   | TE  | (X5)<br>COMPLETION<br>DATE |
|   |                    |   |     |                     | monitoring to ensure new move resident(s) have an annual he statement documented. Result daily monitoring shall be report 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 screening tuberculosis) was completed upon admission for 7 residents reviewed (Resider and Resident 90)."  1: What corrective action(s) be accomplished for those residents found to have been affected by the deficient practice?  Residents 39 and 90 two-step tuberculin skin tests been initiated by the Wellness team.  2: How other residents having the potential to be affected by the deficient practice where initiated and what corrective action will be taken.  - The community's Director Health and Wellness or their designee shall complete an autof inhouse resident's electronic health records to evaluate | alth Its of Its |                            |
| ı .   |                    |   | 1   |                     | incaitii iecolus to evaluate   |   | 1                          |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 50 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | T OF DEFICIENCIES  OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER                                    | (X2) MULTIPL<br>A. BUILDING<br>B. WING | E CONSTRUCTION  G 00   | (X3) DATE SURVEY COMPLETED 05/09/2025                        |
|--------------------------|----------------------------------|---|--|--|--|
|                          | ROVIDER OR SUPPLIE               | R<br>SISTED LIVING AND MEMORY   | 125                                    | EET ADDRESS, CITY, STATE, ZIP COI<br>5 DEMAREE ROAD<br>EENWOOD, IN 46143   | D  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIE                    | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | ID<br>PREFIX<br>TAG                    | CROSS-REFERENCED TO THE APP  | CTION (X5) ULD BE PROPRIATE COMPLETION DATE                  |
|                          |                                  |   |  | compliance with first and step tuberculin skin test. Tuberculin skin tests will administered as needed residents identified as m step 1 or step 2 skin test June 9, 2025.                            | be<br>for any<br>issing                                      |
|                          |                                  |   |  | 3: What measures will be into place or what system changes will be made to ensure that the deficient practice does not recurrent The community's I of Health and Wellness of                         | emic o nt . Director   |
|                          |                                  |   |  | designee shall complete monitoring to ensure tha move in resident(s) receifirst and second tubercul test.  The community's I   | t new<br>ive their<br>lin skin                               |
|                          |                                  |   |  | of Health and Wellness of designee shall complete review of new move in reensure compliance with skin test for the next 90 of Results of the daily monible discussed with Executive and corrective a | or their daily ecords to tuberculin days. itoring will utive |
|                          |                                  |   |  | 4: How the corrective as will be monitored to end deficient practice will note, what quality assura  | nce. ction sure the ot recur ance                            |
|                          |                                  |   |  | program will be put into The Executive Dire their designee shall com weekly random audits of resident records weekly   | ector or<br>plete<br>f at least 2                            |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 51 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER |                                      | ì í                              | UILDING | onstruction<br>00 | (X3) DATE SURVEY  COMPLETED  05/09/2025   |        |            |
|---|--------------------------------------|----------------------------------|---------|-------------------|---|--------|------------|
| NAME OF I   | PROVIDER OR SUPPLIER                 |                                  | -       |                   | ADDRESS, CITY, STATE, ZIP COD<br>EMAREE ROAD  | -      |            |
| DEMARE  | EE CROSSING ASS                      | SISTED LIVING AND MEMORY O       | ARE     |                   | NWOOD, IN 46143   |        |            |
| (X4) ID   |                                      | STATEMENT OF DEFICIENCIE         |         | ID                | PROVIDER'S PLAN OF CORRECTION   |        | (X5)       |
| PREFIX  | `                                    | CY MUST BE PRECEDED BY FULL      |         | PREFIX            | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | ATE    | COMPLETION |
| TAG   | REGULATORY OR                        | R LSC IDENTIFYING INFORMATION    |         | TAG               | weeks, then monthly X 6 mon   | ths    | DATE       |
|   |                                      |                                  |         |                   | to monitor compliance with tuberculin skin testing.                                   |        |            |
|   |                                      |                                  |         |                   | Date of completion: June 9, 2025  |        |            |
| D 0454  | 44040040054                          | =4.                              |         |                   |   |        |            |
| R 0151  | 410 IAC 16.2-5-1. Sanitation & Safet | • •                              |         |                   |   |        |            |
| Bldg. 00  | -Noncompliance                       | y Standards                      |         |                   |   |        |            |
| J   |                                      |                                  | R 0     | 151               | Demaree Crossing  |        | 06/09/2025 |
|   |                                      | and record review, the facility  |         |                   | 05.14.25  |        |            |
|   |                                      | et who resided in the facility   |         |                   | This Plan of Correction is  |        |            |
|   |                                      | pies vaccination and the         |         |                   | submitted under regulations   |        |            |
|   |                                      | xamination was completed as      |         |                   | applicable to long term care  |        |            |
|   |                                      | expiration date for 1 of 4       |         |                   | providers. This Plan of Correct   | tion   |            |
|   |                                      | ed pets in the facility.         |         |                   | is not to be construed as an  |        |            |
|   | (Resident 97)                        |                                  |         |                   | admission or agreement with   |        |            |
|   | Finding includes                     |                                  |         |                   | findings and conclusions in th  |        |            |
|   | Finding includes:                    |                                  |         |                   | Statement of Deficiencies. The  |        |            |
|   | On 5/8/25 at 1:00 n                  | .m., the Executive Director      |         |                   | preparation/ submission and/o execution of this Plan does no                          |        |            |
|   | _                                    | sidents who housed pets in       |         |                   | constitute agreement by the   | 7.     |            |
|   | 1 ~                                  | ew of the document indicated     |         |                   | facility that the surveyor's find   | inge   |            |
|   |                                      | d a canine pet who resided       |         |                   | or conclusions are accurate, t  | -      |            |
|   | with the resident.                   | a a canno per who resided        |         |                   | the findings constitute a   | i i di |            |
|   |                                      |                                  |         |                   | deficiency, or that the scope a   | and    |            |
|   | On 5/9/25 at 9:00 a.                 | .m., Resident 97's canine rabies |         |                   | severity regarding any of the   |        |            |
|   |                                      | nual veterinary examination      |         |                   | deficiencies are correctly appl   | ied.   |            |
|   | record was reviewed                  | d. The document titled           |         |                   | Submission of this Plan is  |        |            |
|   | Certificate of Rabie                 | s Vaccination, dated 8/8/23,     |         |                   | evidence of compliance.   |        |            |
|   | indicated the canine                 | e's rabies vaccination was       |         |                   | ·   |        |            |
|   | administered and th                  | e annual veterinary              |         |                   | R086-Administration and   |        |            |
|   | examination was co                   | onducted on 8/8/23. The next     |         |                   | Management-Deficiency   |        |            |
|   | rabies vaccination a                 | and annual veterinary            |         |                   | "Facility failed to ensure a cur  | rent   |            |
|   | examination was du                   | ne was due on 8/7/24. No other   |         |                   | and valid Clinical Laboratory   |        |            |
|   | documentation was                    | provided.                        |         |                   | Improvement Amendments (C   | CLIA)  |            |
|   |                                      |                                  |         |                   | certification (for the purposes   | of     |            |
|   |                                      | current rabies vaccination       |         |                   | performing laboratory   |        |            |
|   |                                      | e annual veterinary examination  |         |                   | examinations or procedures)   | was    |            |
|   | of the canine.                       |                                  |         |                   | maintained as required.   |        |            |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 52 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

| NAME OF PROVIDER OR SUPPLIER  DEMAREE CROSSING ASSISTED LIVING AND MEMORY CARE  CX4] ID  PREFIX  (EACH DEFICENCY MUST BE PRECEDED BY FULL REGULATION OF INCOMPLETION OF INCOMP |        | NT OF DEFICIENCIES  OF CORRECTION  | IDENTIFICATION NUMBER   | А. В | BUILDING WING | 00   | COMPI<br>05/09  | LETED      |
|--|--------|--|---|------|---------------|--|---|------------|
| PREFIX TAG REGULATORY OR LISC IDENTIFYING INFORMATION  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 87/24.  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 dogs3 months of age and older must be vaccinated against rabies"  2: How other residents having the potential to be affected by the alleged deficient practice.  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 same deficient practice.  2: How other residents having the potential to be 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.  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.  |        |  |   | CARE | 1255 D        | EMAREE ROAD  |   |            |
| 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 open 3.m onths of age and older must be vaccinated against rabies"  2: How other residents having the potential to be aeffected by the alleged deficient practice.  2: How other residents having the potential to be aeffected by the alleged deficient practice will be identified and what corrective action will be taken.  No residents were affected by the alleged medicient practice.  2: How other residents having the potential to be aeffected 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.  | PREFIX | (EACH DEFICIEN   | ICY MUST BE PRECEDED BY FULL  |      | PREFIX        | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRI  | ATE   | COMPLETION |
| 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  |        | Executive Director rabies vaccination a examination docum updated by 8/7/24.  On 5/9/25 at 11:35 provided a copy of and indicated it was the facility. A review "all pets must have required vaccination on 5/9/25 at 3:00 p Vaccination Required 1-5-2 indicated, " | and annual veterinarian mentation should have been a.m., the Executive Director the Pet Policy, dated 3/27/23, as the current policy in use by the document indicated, we annual medical exams and all ms"  I.m., a review of the Rabies rements located at 345 IAC all dogs3 months of age and |      |               | be accomplished for those residents found to have bee affected by the deficient practice?  No residents were affected the alleged deficient practice. CLIA certification was submitted for renewal on 5/09/2025 to labexcellence@cms.hhs.gov paid through pay.gov-CLIA Laboratory User Fees.  2: How other residents havi the potential to be affected the same deficient practice be identified and what corrective action will be tak.  No residents were affect the alleged deficient practice.  3: What measures will be purinto 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 Regulatory requirements and renewal process for CLIA Certification by the SVP of How Wellness.  4: How the corrective action will be monitored to ensure deficient practice will not reie., what quality assurance program will be put into pla | n ed by and ng by will en. ed by tt State ealth the cur ce? |            |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 53 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | F OF DEFICIENCIES OF CORRECTION       | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  | (X2) MULTIPL<br>A. BUILDIN<br>B. WING | LE CONSTRUCTION  G  00   | COM  | e survey<br>pleted<br>9/2025 |
|--------------------------|---------------------------------------|---|---------------------------------------|--|--|------------------------------|
|                          | ROVIDER OR SUPPLIEI<br>E CROSSING ASS | R<br>SISTED LIVING AND MEMORY (   | 125                                   | EET ADDRESS, CITY, STATE, ZIP<br>55 DEMAREE ROAD<br>EENWOOD, IN 46143  | COD  |                              |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                        | STATEMENT OF DEFICIENCIE<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION | ID<br>PREFI<br>TAG                    | CROSS-REFERENCED TO THE  | RRECTION<br>SHOULD BE<br>APPROPRIATE   | (X5)<br>COMPLETION<br>DATE   |
|                          |                                       |   |                                       | responsible for monitor expiration date and surenewal for CLIA Cert Date of completion: 2025 R 148- Sanitation and Standards- Deficience "Facility failed to ensure potentially hazardous were kept secured be doors to prevent reside to hazardous material 14 self-mobile and compaired residents residents found to has assisted living unit in a 1: What corrective actions be accomplished for residents found to has affected by the deficit practice?  No residents we by the alleged deficient Door to beauty immediately closed are will be in-serviced by community housekeeping staff are will be in-serviced by community Executive community's policy for Substance Classificated Storage.  The community was provided a key to Shop for access to roce 2: How other resident the potential to be aff the same deficient probe identified and what corrective action will - No resident | d Safety  Ey  Ire that  materials  whind locked  dent's access  Is for 14 of  ignitively  siding on the  the facility  ction(s) will  those  ave been  ient  ere affected  int practice.  shop was  ind locked.  "'s  ind beautician  the  Director on  ir Hazardous  tion and  beautician  the Beauty  om.  its having  ffected by  ractice will  at  I be taken. |                              |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 54 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | T OF DEFICIENCIES<br>OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  | (X2) MULT<br>A. BUILI<br>B. WING | DING              | nstruction 00  | (X3) DATE<br>COMPL<br>05/09/   | ETED                       |
|--------------------------|------------------------------------|---|----------------------------------|-------------------|--|--|----------------------------|
|                          | ROVIDER OR SUPPLIEI                | SISTED LIVING AND MEMORY C  | 1                                | 1255 DE           | DDRESS, CITY, STATE, ZIP COD<br>EMAREE ROAD<br>WOOD, IN 46143  | _  |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                     | STATEMENT OF DEFICIENCIE<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION | PR                               | ID<br>EFIX<br>FAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPR<br>DEFICIENCY)   | IATE   | (X5)<br>COMPLETION<br>DATE |
|                          |                                    |   |                                  |                   | affected by the alleged defici practice.   | ent  |                            |
|                          |                                    |   |                                  |                   | 3: What measures will be printo place or what systemic changes will be made to ensure that the deficient practice does not recur  The community's curreteam members shall be re-educated to the communith Hazardous Substance Classification and Storage Guideline by 6/9/25. An in-seattendance log shall be maintained as evidence of completion of re-education a shall be maintained with the community's training files.  New team members show that the community's training files.  New team members show that the community's training files.  New team members show that the community's Direct character of the designed shall complete monitoring of areas containing hazardous materials to ensure securement at minimum of for days per week for four weeks then weekly for four weeks then weekly for four weeks then weekly for four weeks the community's Direct of Health and Wellness or the designee shall provide summer findings to the Executive Direct of the community of the community's Direct of Health and Wellness or the designee shall provide summer findings to the Executive Direct of the community | ent  cy's  ervice  nd  nall  s  of their  ctor  eir  ng  re  our  s, and  nen  ctor  eir  ary of |                            |
|                          |                                    |   |                                  |                   | weekly and then monthly for review and discussion of any   | ,  |                            |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 55 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | T OF DEFICIENCIES<br>OF CORRECTION    | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER                                 | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING |                     | (X3) DATE SURVEY COMPLETED 05/09/2025  |  |                            |
|--------------------------|---------------------------------------|--|--|---------------------|--|--|----------------------------|
|                          | ROVIDER OR SUPPLIER<br>E CROSSING ASS | SISTED LIVING AND MEMORY CA  | ARE  | 1255 DE             | ADDRESS, CITY, STATE, ZIP COD<br>EMAREE ROAD<br>IWOOD, IN 46143  |  |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                        | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERNCED TO THE APPROPRIA DEFICIENCY)   | TE   | (X5)<br>COMPLETION<br>DATE |
| IAG                      | REGULATORY OR                         | A LISC IDENTIFYING INFORMATION   |  | IAU                 | 4: How the corrective action will be monitored to ensure to deficient practice will not recise., what quality assurance program will be put into place. The Director of Facilities their designee will be respons for monitoring compliance of sanitation and safety standard through random monthly check for unsecured hazardous substance, unlocked cabinets doors for six months. The rand monthly checks results will be reviewed during the monthly smeeting overseen by the Executive Director. Corrective actions will be implemented be on the findings and discussion during safety meeting.  The community through safety meeting, will review, up and make changes to the DPC as needed for sustaining substantial compliance for no than six months.  Date of completion: June 9, 2025  R 151- Sanitation & Safety Standards-Noncompliance "Facility failed to ensure a pet resided in the facility had recet the rabies vaccination and the annual veterinary examination completed as required prior to expiration date for 1 of 4 reside | eur  ee? s or ible ds ks and dom afety ased the date DC dess who ived ived ived ives dents | DATE                       |
|                          |                                       |  |  |                     | who housed pets in the facility  | <i>/</i>   |                            |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 56 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | T OF DEFICIENCIES  DF CORRECTION      | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER                                 | (X2) MULTI<br>A. BUILDI<br>B. WING | PLE CONSTRUCTION ING 00   | (X3) DATE SURVEY  COMPLETED  05/09/2025     |
|--------------------------|---------------------------------------|---|------------------------------------|---|---|
|                          | ROVIDER OR SUPPLIEI<br>E CROSSING ASS | R<br>SISTED LIVING AND MEMORY C   | 12                                 | REET ADDRESS, CITY, STATE, ZIP CO<br>255 DEMAREE ROAD<br>REENWOOD, IN 46143   | D   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                        | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | ID<br>PREI<br>TA                   | FIX  PROVIDER'S PLAN OF CORRE  (EACH CORRECTIVE ACTION SHO  CROSS-REFERENCED TO THE APP   | CTION (X5) ULD BE COMPLETION PROPRIATE DATE |
|                          |                                       |   |                                    | 1: What corrective actions be accomplished for the residents found to have affected by the deficient practice?  The canine owned Resident 97 had vaccinate updated on 5/20/25.  Record of such vaccinate updated and maintained by the commod Resident Experience Directive action will be affect the same deficient practice of the although the community practice of the action of the action and maintained community's Resident Experient Director or their designed Executive Director's office action actions actions actions actions. | been been been been been been been been     |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 57 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | T OF DEFICIENCIES<br>OF CORRECTION    |   |     | (X3) DATE SURVEY COMPLETED 05/09/2025 |   |   |
|--------------------------|---------------------------------------|---|-----|---------------------------------------|---|---|
|                          | ROVIDER OR SUPPLIEI<br>E CROSSING ASS | R<br>BISTED LIVING AND MEMORY C   | ARE | 1255 D                                | ADDRESS, CITY, STATE, ZIP COD<br>DEMAREE ROAD<br>NWOOD, IN 46143  |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                        | STATEMENT OF DEFICIENCIE<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION |     | ID<br>PREFIX<br>TAG                   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)   | (X5) COMPLETION DATE  |
|                          |                                       |   |     |                                       | 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 resident who have pets residing in the community shall be educated community's standards and perfor pet annual examination and compliance with vaccination dereview of the residency agreement by the Executive Director.  The community's Residency agreement by the Executive Director or their designee shall review and professed to the Executive Director copy of pet vaccinations for any new pets 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 to deficient practice will not recommunity policy and the corrective action will be monitored to ensure to deficient practice will not recommunity practice. | ent  ints  on blicy d uring ment ent vide who  l st nce be ctor |
|                          |                                       |   |     |                                       | i.e., what quality assurance  |   |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 58 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | ENT OF DEFICIENCIES  N OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  | (X2) MULTIP<br>A. BUILDIN<br>B. WING | PLE CONSTRUCTION  NG 00  | (X3) DATE SURVEY COMPLETED 05/09/2025   |  |  |  |
|--------------------------|--------------------------------------|---|--------------------------------------|--|---|--|--|--|
|                          | F PROVIDER OR SUPPLIE                | R<br>SISTED LIVING AND MEMORY C   | 12                                   | STREET ADDRESS, CITY, STATE, ZIP COD 1255 DEMAREE ROAD GREENWOOD, IN 46143   |   |  |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                       | STATEMENT OF DEFICIENCIE<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION | ID<br>PREF<br>TA                     | CROSS-REFERENCED TO THE APPL   | TION (X5)  JLD BE COMPLETION ROPRIATE DATE  |  |  |  |
|                          |                                      |   |                                      | program will be put into The community's E Director or their designed complete random audits a vaccination and examinal tracking monthly for six mensure all pet vaccination annual examinations are and up to date.  Audit results will be reviewed at the monthly smeeting overseen by the Executive Director. If a thof 95% is not achieved, a plan will be developed.  The community thr safety meeting, will review and make changes to the as needed for sustaining substantial compliance for than 6 months  Date of completion: 2025  R 216- Evaluation-Noncomplian "Facility failed to obtain a admission weight for 1 of residents reviewed for we (Resident 39)  1: What corrective action be accomplished for the residents found to have affected by the deficient practice?  Resident 39 has be discharged from the com 5/14/25.  2: How other residents I | executive e shall of the pet tition nonths to ns and current e safety nreshold an action rough the w, update e DPOC or no less June 9,  nce n baseline f 7 eights" en(s) will ose n been t en |  |  |  |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 59 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | OF CORRECTION        | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER                                 | A. BUILDING B. WING | 00  | COMPLETED 05/09/2025  |
|--------------------------|----------------------|--|---------------------|---|---|
|                          | PROVIDER OR SUPPLIER | ISTED LIVING AND MEMORY CA   | 1255                | ET ADDRESS, CITY, STATE, ZIP COD<br>DEMAREE ROAD<br>ENWOOD, IN 46143  |   |
| (X4) ID<br>PREFIX<br>TAG | SUMMARY S            | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION   | (X5) COMPLETION DATE  |
|                          |                      |  |                     | the potential to be affected the same deficient practice be identified and what corrective action will be take.  The community's Direct. Health and Wellness shall conduct an audit of electronic health record documentation 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 electroni medical record for any reside identified as missing weights based on the above audit.  3: What measures will be purinto place or what systemic changes will be made to ensure that the deficient practice does not recur.  The community's Direct of Health and Wellness or the designee shall review electron health record for new move in verify compliance and documentation of resident's within 72 hours from the date move-in.  The community's Direct of Health and Wellness (Care) team members regard Admission Policy and standarobtaining and documenting residents' weight upon move An in-service attendance log | en. or of c for  c nt(s)  tt  ttor eir nic ns to veight of ess ing rd for in. |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 60 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | T OF DEFICIENCIES  OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER                                    | ľ í | LDING               | nstruction<br>00   | (X3) DATE<br>COMPI<br><b>05/09</b>  | LETED                      |
|--------------------------|----------------------------------|---|-----|---------------------|--|---|----------------------------|
|                          | ROVIDER OR SUPPLIE               | R<br>BISTED LIVING AND MEMORY C   | ARE | 1255 DI             | ADDRESS, CITY, STATE, ZIP COD<br>EMAREE ROAD<br>IWOOD, IN 46143  |   |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                   | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | I   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPI<br>DEFICIENCY)  | r<br>E<br>RIATE   | (X5)<br>COMPLETION<br>DATE |
|                          |                                  |   |     |                     | be maintained as evidence of completion of re-education, shall be maintained with the community's training files  The community's Director of Health and Wellness (Care) team members on community's Admission Polit during the community pre-set training.  4: How the corrective action will be monitored to ensure deficient practice will not rive., what quality assurance program will be put into plate of Health and Wellness/desi will complete daily monitoring ensure that new move in resident(s) have an admission weight documented. Results such monitoring shall be reput 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 2025  R 217 Evaluation-Deficience "Facility failed to ensure the service plans were signed by resident or the resident's representative for 7 of 7 residents reviewed for service plans (Resident 25, Resident 85, Resident 48, Resident 85, Resident 90, Resident 103 and 1 | ess  cy ervice  n e the ecur e ace? ctor gnee g to on s of orted e e 9, y the |                            |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 61 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

| NT OF DEFICIENCIES<br>OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER | A. B | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING |  |  | (X3) DATE SURVEY<br>COMPLETED<br>05/09/2025 |  |
|-------------------------------------|---|------|--|--|--|---|--|
| PROVIDER OR SUPPLIE                 | R<br>SISTED LIVING AND MEMORY C                     | ARE  | 12   | EET ADDRESS, CITY, STATE, ZIP COD<br>55 DEMAREE ROAD<br>REENWOOD, IN 46143   |  |   |  |
| SUMMARY<br>(EACH DEFICIE)           |   | ARE  | 12   | PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDERS OF THE APP | (s) will  e eeen  s for and 90 eviewed d/or  04 n the S OF  aving d by ce will  ector of | (X5) COMPLETION DATE                        |  |
|                                     |   |      |  | responsible party by June  3: What measures will be into place or what systen changes will be made to ensure that the deficient practice does not recur  The community's Di of Health and Wellness wi re-educate the Wellness to member on the community Evaluation policy which increquirement for review and signature on plan of care.  | put<br>nic<br>rector<br>l<br>sam<br>''s  |   |  |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 62 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | T OF DEFICIENCIES<br>DF CORRECTION    | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  | (X2) MULTIPI<br>A. BUILDIN<br>B. WING | LE CONSTRUCTION  G  00  | (X3) DATE (<br>COMPL<br>05/09/  | ETED                       |
|--------------------------|---------------------------------------|---|---------------------------------------|---|---|----------------------------|
|                          | ROVIDER OR SUPPLIEI<br>E CROSSING ASS | R<br>BISTED LIVING AND MEMORY C   | 125                                   | EET ADDRESS, CITY, STATE, ZIP COI<br>55 DEMAREE ROAD<br>EENWOOD, IN 46143   | )   |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                        | STATEMENT OF DEFICIENCIE<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION | ID<br>PREFI<br>TAG                    | CROSS-REFERENCED TO THE APP<br>DEFICIENCY)  | ULD BE<br>PROPRIATE   | (X5)<br>COMPLETION<br>DATE |
|                          |                                       |   |                                       | in-service attendance log<br>maintained as evidence<br>completion of re-education<br>shall be maintained with<br>community's training files   | of<br>on, and<br>the  |                            |
|                          |                                       |   |                                       | 4: How the corrective as will be monitored to enside deficient practice will not i.e., what quality assurate program will be put into The community's form of Health and Wellness of designee shall complete weekly audits of at least resident records weekly evaluate compliance with service plans. The result weekly monitoring shall be reported to and reviewed community's Executive Executive Executive Date of complete June 9, 2025 | sure the ot recur ince o place? Director or their random 2 new to a signed as of oe d with the Director |                            |
|                          |                                       |   |                                       | R 306 Pharmaceutical Services-Noncompliand "Facility failed to ensure dispositions for all medic including non-controlled substance medications v accounted for and docur 2 of 2 closed records rev (Resident 103, Resident  1: What corrective actic be accomplished for the residents found to have affected by the deficien practice?  | drug rations, were mented for viewed 104) on(s) will ose  |                            |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 63 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | T OF DEFICIENCIES<br>OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER                                 | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING |                     |  | (X3) DATE SURVEY COMPLETED 05/09/2025 |                            |
|--------------------------|------------------------------------|---|--|---------------------|--|---------------------------------------|----------------------------|
| NAME OF P                | ROVIDER OR SUPPLIE                 | R   |  |                     | ADDRESS, CITY, STATE, ZIP COD<br>EMAREE ROAD   |                                       |                            |
| DEMARE                   | E CROSSING AS                      | SISTED LIVING AND MEMORY CA   | ARE  |                     | WOOD, IN 46143   |                                       |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                     | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)   | ίΤΕ.                                  | (X5)<br>COMPLETION<br>DATE |
|                          |                                    |   |  |                     | Drug disposition forms been completed for Residents and 104 on [ADD DATE]  |                                       |                            |
|                          |                                    |   |  |                     | 2: How other residents having the potential to be affected by the same deficient practice where identified and what corrective action will be taken and the community's Direct of Health and Wellness shall implement the use of Drug disposition form for all resident discharged from the community June 9, 2025.  3: What measures will be purint into place or what systemic changes will be made to ensure that the deficient practice does not recur.  The community's Direct 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 maintained as evidence of completion and maintained withe community's training files.  4: How the corrective action will be monitored to ensure deficient practice will not recipe, what quality assurance | will en. tor tts tty by t tt          |                            |
|                          |                                    |   |  |                     | The community's Direct of Health and Wellness or the   | tor                                   |                            |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 64 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | OF CORRECTION                         | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER                                      | A. BUILDING 00  B. WING |                     |  | COMPLETED<br>05/09/2025              |                            |
|--------------------------|---------------------------------------|--|-------------------------|---------------------|--|--------------------------------------|----------------------------|
|                          | ROVIDER OR SUPPLIER<br>E CROSSING ASS | SISTED LIVING AND MEMORY C   | ARE                     | 1255 D              | ADDRESS, CITY, STATE, ZIP COD<br>EMAREE ROAD<br>NWOOD, IN 46143  |                                      |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                        | STATEMENT OF DEFICIENCIE<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION |                         | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  | TE                                   | (X5)<br>COMPLETION<br>DATE |
|                          |                                       |  |                         |                     | designee shall complete rando weekly audits of at least 1 discharged resident to ensure Drug Disposition form has bee completed and scanned into electronic medical record. The results of such monitoring sha reported to and reviewed with community's Executive Director Date of completion:  June 9, 2025.  R409- Infection  | en<br>e<br>II be<br>the              |                            |
|                          |                                       |  |                         |                     | Control-Noncompliance "Facility failed to ensure that the annual health assessment statement (a statement by the physician indicating the reside free of communicable disease was documented as required to f 7 residents reviewed. (Residual)."  1: What corrective action(s) to be accomplished for those residents found to have been   | ent is<br>)<br>for 1<br>dent<br>will |                            |
|                          |                                       |  |                         |                     | affected by the deficient practice? Resident 48 electronic medical record reviewed, and annual health statement update by the primary physician.  2: How other residents having the potential to be affected by the same deficient practice where identified and what corrective action will be take. The community's Director Health and Wellness or their designee conducted an audit of | g<br>y<br>vill<br>n.<br>r of         |                            |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 65 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | T OF DEFICIENCIES<br>OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER                                       | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  |        | (X3) DATE SURVEY COMPLETED 05/09/2025   |  |
|--------------------------|------------------------------------|---|---|--------|---|--|
|                          | ROVIDER OR SUPPLIE                 | R<br>SISTED LIVING AND MEMORY C   | ARE   | 1255 D | ADDRESS, CITY, STATE, ZIP COD<br>DEMAREE ROAD<br>NWOOD, IN 46143  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                     | STATEMENT OF DEFICIENCIE<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION | ID PROVIDER'S PLAN OF CORRECTIC  PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)  OF (OR OF A Minimum) |        |   | (X5) COMPLETION DATE                       |
|                          |                                    |   |   |        | 05/23/25 of all inhouse resider records for compliance with an health assessment statement indicating that resident is free communicable diseases by Ju 9, 2025.  | nnual<br>of                                |
|                          |                                    |   |   |        | 3: What measures will be purinto place or what systemic changes will be made to ensure that the deficient practice does not recur  The Director of Health a Wellness or their designee shore-educate the Wellness Team the community's Admission Policy focusing on the annual health assessment statement indicating that resident is free communicable diseases. An in-service attendance log shall maintained as evidence of completion of reeducation and maintained with the communit training files.  The community's Direct of Health and Wellness or the designee shall monitor, managand coordinate with physician residents' annual health assessment including statemer indicating resident is free of communicable disease. | and all n on  of ll be d ty's tor ir ge s' |
|                          |                                    |   |   |        | 4: How the corrective action will be monitored to ensure to deficient practice will not reci.e., what quality assurance program will be put into place.  The community's Direct   | the<br>cur<br>ce?                          |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 66 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | IT OF DEFICIENCIES<br>OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER                                     | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING | ONSTRUCTION  00  | (X3) DATE SURVEY COMPLETED 05/09/2025  |
|--------------------------|-------------------------------------|---|--|--|--|
|                          | ROVIDER OR SUPPLIER                 |   | 1255 D                                     | ADDRESS, CITY, STATE, ZIP COD  |  |
| DEMARE                   | E CROSSING ASS                      | SISTED LIVING AND MEMORY CA   | ARE GREEN                                  | NWOOD, IN 46143  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                      | STATEMENT OF DEFICIENCIE<br>CY MUST BE PRECEDED BY FULL<br>LISC IDENTIFYING INFORMATION | ID<br>PREFIX<br>TAG                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY)  | (X5) COMPLETION DATE   |
|                          |                                     |   |  | of Health and Wellness or the designee shall complete daily monitoring to ensure new moresident(s) have an annual he statement documented. Result daily monitoring shall be reported to the community's Executive Director.  The community's Executive Director will randomly review resident records to  Date of completion: June 9, 2025  R410-Infection  Control-Noncompliance  "Facility failed to ensure that first step and second step tuberculin skin test (tool used screening tuberculosis) was completed upon admission for 7 residents reviewed (Reside and Resident 90)."  1: What corrective action(s) be accomplished for those residents found to have been affected by the deficient practice?  Residents 39 and 90 two-step tuberculin skin tests been initiated by the Wellness team.  2: How other residents having the potential to be affected the same deficient practice be identified and what corrective action will be taktorically and Wellness or their designee shall complete an action of the community's Direct Health and Wellness or their designee shall complete an action of the community of the complete and th | eir ve-in ealth ults of orted  utive 2  a  for or 2 of ont 39  will en  have s  ng by will en. or of |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 67 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

| STATEMEN  | T OF DEFICIENCIES   | X1) PROVIDER/SUPPLIER/CLIA    | (X2) M | ULTIP  | LE CO | NSTRUCTION   | (X3) DATE | SURVEY     |
|-----------|---------------------|-------------------------------|--------|--------|-------|--|-----------|------------|
| AND PLAN  | OF CORRECTION       | IDENTIFICATION NUMBER         | A. BU  | JILDIN | NG    | 00   | COMPL     | ETED       |
|           |                     |                               | B. W   | ING    |       |  | 05/09/    | 2025       |
|           |                     |                               |        | _      |       |  |           |            |
| NAME OF P | PROVIDER OR SUPPLIE | R                             |        |        |       | ADDRESS, CITY, STATE, ZIP COD  |           |            |
|           |                     |                               |        |        |       | EMAREE ROAD  |           |            |
| DEMARE    | E CROSSING AS       | SISTED LIVING AND MEMORY CA   | RE     | GF     | KEEN  | IWOOD, IN 46143  |           |            |
| (X4) ID   | SUMMARY             | STATEMENT OF DEFICIENCIE      |        | ID     |       | PROVIDER'S PLAN OF CORRECTION  |           | (X5)       |
| PREFIX    | (EACH DEFICIEN      | NCY MUST BE PRECEDED BY FULL  | PREFIX |        | IX    | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | TE        | COMPLETION |
| TAG       | REGULATORY O        | R LSC IDENTIFYING INFORMATION |        | TAG    | G     | DEFICIENCY)  | 16        | DATE       |
|           |                     |                               |        |        |       | of inhouse resident's electroni  | С         |            |
|           |                     |                               |        |        |       | health records to evaluate   |           |            |
|           |                     |                               |        |        |       | compliance with first and seco   | ond       |            |
|           |                     |                               |        |        |       | step tuberculin skin test.   |           |            |
|           |                     |                               |        |        |       | Tuberculin skin tests will be  |           |            |
|           |                     |                               |        |        |       | administered as needed for ar  | าง        |            |
|           |                     |                               |        |        |       | residents identified as missing  | •         |            |
|           |                     |                               |        |        |       | step 1 or step 2 skin tests by   |           |            |
|           |                     |                               |        |        |       | June 9, 2025.  |           |            |
|           |                     |                               |        |        |       |  |           |            |
|           |                     |                               |        |        |       | 3: What measures will be put   | t         |            |
|           |                     |                               |        |        |       | into place or what systemic  |           |            |
|           |                     |                               |        |        |       | changes will be made to  |           |            |
|           |                     |                               |        |        |       | ensure that the deficient  |           |            |
|           |                     |                               |        |        |       | practice does not recur  |           |            |
|           |                     |                               |        |        |       | The community's Direct   | or        |            |
|           |                     |                               |        |        |       | of Health and Wellness or thei   | ir        |            |
|           |                     |                               |        |        |       | designee shall complete  |           |            |
|           |                     |                               |        |        |       | monitoring to ensure that new  |           |            |
|           |                     |                               |        |        |       | move in resident(s) receive the  | eir       |            |
|           |                     |                               |        |        |       | first and second tuberculin ski  | n         |            |
|           |                     |                               |        |        |       | test.  | ļ         |            |
|           |                     |                               |        |        |       | The community's Direct   | .or       |            |
|           |                     |                               |        |        |       | of Health and Wellness or thei   | ir        |            |
|           |                     |                               |        |        |       | designee shall complete daily  | ļ         |            |
|           |                     |                               |        |        |       | review of new move in records  | s to      |            |
|           |                     |                               |        |        |       | ensure compliance with tubero  | culin     |            |
|           |                     |                               |        |        |       | skin test for the next 90 days.  | ļ         |            |
|           |                     |                               |        |        |       | Results of the daily monitoring  | ı will    |            |
|           |                     |                               |        |        |       | be discussed with Executive  | ļ         |            |
|           |                     |                               |        |        |       | Director and corrective actions  | 3         |            |
|           |                     |                               |        |        |       | taken to ensure compliance.  |           |            |
|           |                     |                               |        |        |       |  |           |            |
|           |                     |                               |        |        |       | 4: How the corrective action   |           |            |
|           |                     |                               |        |        |       | will be monitored to ensure t  |           |            |
|           |                     |                               |        |        |       | deficient practice will not rec  | ur        |            |
|           |                     |                               |        |        |       | i.e., what quality assurance   | ļ         |            |
|           |                     |                               |        |        |       | program will be put into plac  |           |            |
|           |                     |                               |        |        |       | The Executive Director   | or        |            |
|           |                     |                               |        |        |       | their designee shall complete  |           |            |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 68 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | NT OF DEFICIENCIES<br>OF CORRECTION  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER   | A (X2) MULTIPLE CON A. BUILDING B. WING |                     | ONSTRUCTION  00   | COMP                       | x3) date survey<br>COMPLETED<br>05/09/2025 |  |
|--------------------------|--|---|---|---------------------|---|----------------------------|--|--|
|                          | PROVIDER OR SUPPLIER   | SISTED LIVING AND MEMORY C  | ARE                                     | 1255 D              | ADDRESS, CITY, STATE, ZIP COD<br>EMAREE ROAD<br>NWOOD, IN 46143   |                            |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE<br>CY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION  |   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)   | ATE                        | (X5)<br>COMPLETION<br>DATE                 |  |
|                          |  |   |   |                     | weekly random audits of at le resident records weekly for for weeks, then monthly X 6 mor to monitor compliance with tuberculin skin testing.  Date of completion: June 9, 2025   | our                        |  |  |
| R 0216                   | 410 IAC 16.2-5-2(<br>Evaluation - Nonc   |   |   |                     |   |                            |  |  |
| Bldg. 00                 | Based on record reversal failed to obtain a base of 7 residents review Finding includes:  On 5/8/25 at 10:30 record was reviewed included, but were narthritis, and a histor Resident 39 was add 10/14/24.  Resident 39's clinic of weight upon adm During an interview (Executive Director) | view and interview, the facility iseline admission weight for 1 wed for weights. (Resident 39)  a.m., Resident 39's clinical d. Resident 39's diagnoses not limited to, dementia, bry of falls.  mitted to the facility on  al record lacked documentation ission.  or on 5/9/35 at 12:15 p.m., the ED by indicated Resident 39 should upon admitting to the facility | R 0                                     | 216                 | 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 findings and conclusions in the Statement of Deficiencies. The preparation of this Plan does not constitute agreement by the facility that the surveyor's find or conclusions are accurate, the findings constitute a deficiency, or that the scope as severity regarding any of the deficiencies are correctly app Submission of this Plan is evidence of compliance.  R086-Administration and | the ne ne or ot tings that | 06/09/2025                                 |  |
|                          | the Admissions poli<br>indicated it was the<br>facility. A review o<br>facility should ensu  | a.m., the ED provided a copy of icy, dated 1/14/22, and current policy in use by the f the policy indicated the re necessary information for and provided, including  |   |                     | Management-Deficiency "Facility failed to ensure a cui and valid Clinical Laboratory Improvement Amendments (Coertification (for the purposes performing laboratory   | CLIA)                      |  |  |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 69 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | OF CORRECTION                   | IDENTIFICATION NUMBER  | A. BUILDING <u>00</u> B. WING |                    |  | COMPLETED<br>05/09/2025            |                            |
|--------------------------|---------------------------------|--|-------------------------------|--------------------|--|------------------------------------|----------------------------|
|                          | PROVIDER OR SUPPLIER            | SISTED LIVING AND MEMORY CA  |                               | 1255 DE            | DDRESS, CITY, STATE, ZIP COD<br>EMAREE ROAD<br>WOOD, IN 46143  |                                    |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN<br>REGULATORY OR | STATEMENT OF DEFICIENCIE<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION | PF                            | ID<br>REFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA'<br>DEFICIENCY)  | TE                                 | (X5)<br>COMPLETION<br>DATE |
|                          | completed and do                | vital signs which were to be " cumented at the time of nd monthly thereafter."         |                               |                    | examinations or procedures) of maintained as required.  1: What corrective action(s) or be accomplished for those residents found to have been affected by the deficient practice?  No residents were affected the alleged deficient practice.  CLIA certification was submitted for renewal on 5/09/2025 to labexcellence@cms.hhs.gov apaid through pay.gov-CLIA Laboratory User Fees.  2: How other residents having the potential to be affected by the same deficient practice where identified and what corrective action will be take.  No residents were affected 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 Segulatory requirements and renewal process for CLIA Certification by the SVP of Heat & Wellness.  4: How the corrective action will be monitored to ensure the deficient practice will not recipie, what quality assurance in the second | will  d by  and  g y vill  n. d by |                            |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 70 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | T OF DEFICIENCIES<br>OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER                                 | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING |                     |  | (X3) DATE SURVEY COMPLETED 05/09/2025   |                            |
|--------------------------|------------------------------------|---|--|---------------------|--|---|----------------------------|
|                          | ROVIDER OR SUPPLIEI                | R<br>BISTED LIVING AND MEMORY C   | ARE  | 1255 D              | ADDRESS, CITY, STATE, ZIP COD<br>DEMAREE ROAD<br>NWOOD, IN 46143   |   |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                     | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)   | ATE   | (X5)<br>COMPLETION<br>DATE |
|                          |                                    |   |  |                     | program will be put into place ED or their designee will responsible for monitoring expiration date and submit time renewal for CLIA Certificate Date of completion: June 2025 R 148- Sanitation and Safety Standards- Deficiency "Facility failed to ensure that potentially hazardous material were kept secured behind lock doors to prevent resident's act to hazardous materials for 14 14 self-mobile and cognitively impaired residents residing or assisted living unit in the facilit 1: What corrective action(s) be accomplished for those residents found to have been affected by the deficient practice?  No residents were affected by the alleged deficient practice proof to beauty shop was immediately closed and locked. The community's housekeeping staff and beaut will be in-serviced by the community Executive Director community Executive Director community's policy for Hazard Substance Classification and Storage.  The community beautic was provided a key to the Beauth Shop for access to room.  2: How other residents having the potential to be affected by the same deficient practice was deficient practice of the same deficient practice | Il be nely 9, Is ked cess of the ty will n cted ce. as d. ician dous ian auty |                            |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 71 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | T OF DEFICIENCIES<br>OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER                                    | (X2) MULTIF<br>A. BUILDII<br>B. WING | PLE CONSTRUCTION  NG  00  | (X3) DATE SURVEY COMPLETED 05/09/2025  |
|--------------------------|------------------------------------|---|--------------------------------------|---|--|
|                          | ROVIDER OR SUPPLIEI                | R<br>BISTED LIVING AND MEMORY C   | 12                                   | REET ADDRESS, CITY, STATE, ZIP COE<br>55 DEMAREE ROAD<br>REENWOOD, IN 46143   | )  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                     | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | ID<br>PREF<br>TA                     | PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APP   | CTION (X5)  ILD BE COMPLETION  ROPRIATE DATE   |
|                          |                                    |   |                                      | - No resident wa<br>affected by the alleged d<br>practice.  | s  |
|                          |                                    |   |                                      | 3: What measures will be into place or what systes changes will be made to ensure that the deficien practice does not recur.  The community's of team members shall be re-educated to the community and suited line by 6/9/25. An invalidation and Storage Guideline does not re-educated shall be maintained with community's training files.  New team members to be trained to the community and substance. Classification and Storage Guideline upon hire as proposed for the storage Guideline upon hire as proposed for the service training.  The community's for feet and the securement at minimum days per week for four week then weekly for four week monthly for six months.  The community's for feet and Wellness of the signess shall provide six designes shall provide six designes shall provide six designes shall provide six designess shall | emic  t  current  cur |
|                          |                                    |   |                                      | findings to the Executive   | -  |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 72 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | T OF DEFICIENCIES<br>OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  | (X2) MULTIPL<br>A. BUILDING<br>B. WING | E CONSTRUCTION  G <u>00</u>  | (X3) DATE SURVEY  COMPLETED  05/09/2025  |
|--------------------------|------------------------------------|---|--|--|--|
|                          | ROVIDER OR SUPPLIE                 | R<br>SISTED LIVING AND MEMORY   | 125                                    | EET ADDRESS, CITY, STATE, ZIP C<br>5 DEMAREE ROAD<br>EENWOOD, IN 46143   | OD   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIE)                     | STATEMENT OF DEFICIENCIE<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION | ID<br>PREFIX<br>TAG                    | CROSS-REFERENCED TO THE A  | RECTION (X5) HOULD BE COMPLETION DATE  |
|                          |                                    |   |  | weekly and then month<br>review and discussion<br>correction action items  | of any   |
|                          |                                    |   |  | 4: How the corrective will be monitored to e deficient practice will i.e., what quality assu program will be put in The Director of F their designee will be refor monitoring compliar sanitation and safety st through random month for unsecured hazardo substance, unlocked cadoors for six months. T monthly checks results reviewed during the momeeting overseen by the Executive Director. Con actions will be implemed on the findings and disiduring safety meeting.  The community is safety meeting, will reveal and make changes to the as needed for sustaining substantial compliance than six months.  Date of computer of Ferrita and Parket of Computer of Co | nsure the not recur rance to place? Facilities or esponsible noe of tandards ly checks us abinets and the random will be onthly safety ne rective ented based cussion through the people for no less letion: |
|                          |                                    |   |  | R 151- Sanitation & Sa<br>Standards-Noncompli<br>"Facility failed to ensur<br>resided in the facility ha<br>the rabies vaccination<br>annual veterinary exan<br>completed as required  | iance e a pet who ad received and the nination was   |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 73 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | T OF DEFICIENCIES<br>OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER                                 | A. B | IULTIPLE CO<br>UILDING<br>'ING | ONSTRUCTION  00   | (X3) DATE<br>COMPI<br>05/09                                     | LETED                      |
|--------------------------|------------------------------------|---|------|--------------------------------|---|---|----------------------------|
|                          | ROVIDER OR SUPPLIE                 | R<br>SISTED LIVING AND MEMORY C   | ARE  | 1255 D                         | ADDRESS, CITY, STATE, ZIP COD<br>EMAREE ROAD<br>NWOOD, IN 46143   |   |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                     | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION |      | ID<br>PREFIX<br>TAG            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY)   | ATE   | (X5)<br>COMPLETION<br>DATE |
| TAG                      | REGULATORY O                       | R LSC IDENTIFYING INFORMATION   |      | TAG                            | expiration date for 1 of 4 resident 97)  1: What corrective action(s) 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 vaccinations updated on 5/20/25.  Record of such vaccinations updated on 5/20/25.  Record of such vaccinations updated and shall maintained by the community Resident Experience Director their designee  2: How other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken a Records of pets current residing at the community we audited by the community we audited by the community we audited by the community bet vaccination records shall be monitored and maintained by community's Resident Experience Director or their designee in the Executive Director's office.  Resident Experience Director or their designee will responsible for notifying and coordinating with resident/responsible party and upcoming or past due pet vaccinations | will  an  ation be 's or  ng by will en. tly re ess the ence he | DATE                       |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 74 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | OF CORRECTION                         | IDENTIFICATION NUMBER  |      | JILDING             | 00  | 1   | LETED<br>1/2025            |
|--------------------------|---------------------------------------|--|------|---------------------|---|---|----------------------------|
|                          | ROVIDER OR SUPPLIER<br>E CROSSING ASS | SISTED LIVING AND MEMORY C   | CARE | 1255 D              | ADDRESS, CITY, STATE, ZIP COD<br>EMAREE ROAD<br>IWOOD, IN 46143   |   |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                        | STATEMENT OF DEFICIENCIE<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION |      | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)   | ATE   | (X5)<br>COMPLETION<br>DATE |
|                          |                                       |  |      |                     | 3: What measures will be puinto 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 resident who have pets residing in the community shall be educated community's standards and property for pet annual examination and compliance with vaccination or review of the residency agree by the Executive Director.  The community's Resident Experience Director or their designee shall review and proper vaccinations for any new pets resident at the community effective June 9, 2025.  Resident Experience Director or their designee shall review pet vaccinations for compliance monthly for at leas six months to ensure compliant with community policy. The results of these reviews shall reported to the Executive Director and discussed during the community's safety meeting. | ent t ents on olicy d luring ment ent ovide t who |                            |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 75 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

| STATEMEN  | T OF DEFICIENCIES   | X1) PROVIDER/SUPPLIER/CLIA  | (X2) MULTIF |          | NSTRUCTION   | (X3) DATE SURVEY |       |
|-----------|---------------------|-----------------------------|-------------|----------|--|------------------|-------|
| AND PLAN  | OF CORRECTION       | IDENTIFICATION NUMBER       | A. BU       | JILDING  | 00   | COMPLETED        |       |
|           |                     |                             | B. WI       | ING      |  | 05/09/2025       |       |
|           |                     |                             |             | CTDEET : | ADDRESS SITE OF SOR  |                  |       |
| NAME OF P | ROVIDER OR SUPPLIER | 1                           |             |          | ADDRESS, CITY, STATE, ZIP COD  |                  |       |
|           |                     | NOTED LIVING AND MEMORY OF  | DE          |          | EMAREE ROAD  |                  |       |
| DEMARE    | E CRUSSING ASS      | SISTED LIVING AND MEMORY CA | KE          | GKEEN    | IWOOD, IN 46143  |                  |       |
| (X4) ID   | SUMMARY             | STATEMENT OF DEFICIENCIE    |             | ID       | PROVIDER'S PLAN OF CORRECTION  | (X               | (5)   |
| PREFIX    | (EACH DEFICIEN      | CY MUST BE PRECEDED BY FULL |             | PREFIX   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA' | COMPL            | ETION |
| TAG       | REGULATORY OR       | LSC IDENTIFYING INFORMATION |             | TAG      | DEFICIENCY)  | DAT              | ГЕ    |
|           |                     |                             |             |          | deficient practice will not rec  | ur               |       |
|           |                     |                             |             |          | i.e., what quality assurance   |                  |       |
|           |                     |                             |             |          | program will be put into plac  | e?               |       |
|           |                     |                             |             |          | The community's Execu  |                  |       |
|           |                     |                             |             |          | Director or their designee shal  |                  |       |
|           |                     |                             |             |          | complete random audits of the  |                  |       |
|           |                     |                             |             |          | vaccination and examination  |                  |       |
|           |                     |                             |             |          | tracking monthly for six month   | s to             |       |
|           |                     |                             |             |          | ensure all pet vaccinations and  |                  |       |
|           |                     |                             |             |          | annual examinations are curre  |                  |       |
|           |                     |                             |             |          | and up to date.  |                  |       |
|           |                     |                             |             |          | Audit results will be  |                  |       |
|           |                     |                             |             |          | reviewed at the monthly safety   | ,                |       |
|           |                     |                             |             |          | meeting overseen by the  |                  |       |
|           |                     |                             |             |          | Executive Director. If a thresho   | old              |       |
|           |                     |                             |             |          | of 95% is not achieved, an act   | ion              |       |
|           |                     |                             |             |          | plan will be developed.  |                  |       |
|           |                     |                             |             |          | The community through  | the              |       |
|           |                     |                             |             |          | safety meeting, will review, up  | date             |       |
|           |                     |                             |             |          | and make changes to the DPC  | C                |       |
|           |                     |                             |             |          | as needed for sustaining   |                  |       |
|           |                     |                             |             |          | substantial compliance for no  | ess              |       |
|           |                     |                             |             |          | than 6 months  |                  |       |
|           |                     |                             |             |          | Date of completion: June   | €,               |       |
|           |                     |                             |             |          | 2025   |                  |       |
|           |                     |                             |             |          |  |                  |       |
|           |                     |                             |             |          | R 216-   |                  |       |
|           |                     |                             |             |          | Evaluation-Noncompliance   |                  |       |
|           |                     |                             |             |          | "Facility failed to obtain a base  | line             |       |
|           |                     |                             |             |          | admission weight for 1 of 7  |                  |       |
|           |                     |                             |             |          | residents reviewed for weights   | "                |       |
|           |                     |                             |             |          | (Resident 39)  |                  |       |
|           |                     |                             |             |          | 1: What corrective action(s)   | vill             |       |
|           |                     |                             |             |          | be accomplished for those  |                  |       |
|           |                     |                             |             |          | residents found to have beer   | 1                |       |
|           |                     |                             |             |          | affected by the deficient  |                  |       |
|           |                     |                             |             |          | practice?  |                  |       |
|           |                     |                             |             |          | Resident 39 has been   |                  |       |
|           |                     |                             |             |          | discharged from the communit   | y on             |       |
|           |                     |                             |             |          | 5/14/25.   |                  |       |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 76 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | T OF DEFICIENCIES<br>DF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER                                    |      | ILDING              | ONSTRUCTION  00  | (X3) DATE<br>COMPI<br>05/09   |                            |
|--------------------------|------------------------------------|---|------|---------------------|--|---|----------------------------|
|                          | ROVIDER OR SUPPLIE                 | R<br>SISTED LIVING AND MEMORY (   | CARE | 1255 D              | ADDRESS, CITY, STATE, ZIP COD<br>EMAREE ROAD<br>IWOOD, IN 46143  | -   |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                     | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION |      | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIC<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROI<br>DEFICIENCY)  | ON<br>BE<br>PRIATE  | (X5)<br>COMPLETION<br>DATE |
|                          |                                    |   |      |                     | 2: How other residents hat the potential to be affected the same deficient practice be identified and what corrective action will be tare. The community's Dire Health and Wellness shall conduct an audit of electron health record documentation current in-house residents evaluate compliance with documentation of admission weights by June 9, 2025.  All inhouse Resident weights shall be documented within the resident's electron medical record for any residing dentified as missing weights based on the above audit.  3: What measures will be into place or what system changes will be made to ensure that the deficient practice does not recur.  The community's Directive decident practice does not recur.  The community's Directive decident practice does not recur.  The community's Directive election of Health and Wellness or the designee shall review election health record for new move verify compliance and documentation of resident's within 72 hours from the damove-in.  The community's Director of Health and Well shall re-educate all Wellness (Care) team members regard Admission Policy and stand obtaining and documenting | d by e will aken. ctor of nic on for to n 's ed onic dent(s) ts  put ic ector heir ronic e ins to s weight tte of ness ss irding dard for |                            |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 77 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | T OF DEFICIENCIES  OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER   | (X2) MUI<br>A. BUII<br>B. WIN | LDING               | nstruction 00  | (X3) DATE S<br>COMPL<br>05/09/                             | ETED                       |
|--------------------------|----------------------------------|---|-------------------------------|---------------------|--|--|----------------------------|
|                          | ROVIDER OR SUPPLIER              | R<br>SISTED LIVING AND MEMORY C   | ARE                           | 1255 DE             | ADDRESS, CITY, STATE, ZIP COD<br>EMAREE ROAD<br>WOOD, IN 46143   |  |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                   | STATEMENT OF DEFICIENCIE<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION | P                             | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)  |  | (X5)<br>COMPLETION<br>DATE |
|                          |                                  |   |                               |                     | residents' weight upon move An in-service attendance log be maintained as evidence of completion of re-education, a shall be maintained with the community's training files  The community's Director of Health and Wellness (Care) team members on community's Admission Polic during the community pre-ser training.  4: How the corrective action will be monitored to ensure deficient practice will not rei.e., what quality assurance program will be put into plan. The community's Directof Health and Wellness/desig will complete daily monitoring ensure that new move in resident(s) have an admission weight documented. Results 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 2025  R 217 Evaluation-Deficiency "Facility failed to ensure the service plans were signed by resident or the resident's representative for 7 of 7 residents reviewed for service plans (Resident 25, Resident). | shall ind ind iss y vice the cur ce? tor nee to n of inted |                            |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 78 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | OF CORRECTION        | IDENTIFICATION NUMBER  | A. BUILDING B. WING | 00   | COMPLETED<br>05/09/2025                       |
|--------------------------|----------------------|--|---------------------|--|---|
|                          | PROVIDER OR SUPPLIER | SISTED LIVING AND MEMORY CA  | 1255 D              | ADDRESS, CITY, STATE, ZIP COD<br>EMAREE ROAD<br>NWOOD, IN 46143  |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN       | STATEMENT OF DEFICIENCIE<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  | (X5) COMPLETION DATE                          |
|                          |                      |  |                     | Resident 48, Resident 85, Resident 90, Resident 103 and Resident 104)  1: What corrective action(s) be accomplished for those residents found to have been affected by the deficient practice?  Current service plans for Residents 25, 39, 48, 85, and service plans have been revie 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 be the same deficient practice of be identified and what corrective action will be taked The community's Director Health and Wellness shall complete an audit of all current resident's service plan to valid signature by resident or responsible party by June 9, 20  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 include | will  or 90 ewed  eDF  or of ot date 2025.  t |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 79 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | IT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER                              | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING | onstruction<br>00   | (X3) DATE SURVEY COMPLETED 05/09/2025 |
|--------------------------|----------------------------------|--|--|---|---------------------------------------|
|                          | PROVIDER OR SUPPLIER             | SISTED LIVING AND MEMORY CA  | 1255 D                                     | ADDRESS, CITY, STATE, ZIP COD<br>EMAREE ROAD<br>NWOOD, IN 46143   |                                       |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                   | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | ID<br>PREFIX<br>TAG                        | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  requirement for review and   | (X5) COMPLETION DATE                  |
|                          |                                  |  |  | signature on plan of care. An in-service attendance log sha maintained as evidence of completion of re-education, at shall be maintained with the community's training files  |                                       |
|                          |                                  |  |  | 4: How the corrective action will be monitored to ensure a deficient practice will not reci.e., what quality assurance program will be put into place.  The community's Directions  | the<br>cur<br>ce?                     |
|                          |                                  |  |  | of Health and Wellness or the designee shall complete rand weekly audits of at least 2 new resident records weekly to evaluate compliance with sign   | ir<br>om<br>v                         |
|                          |                                  |  |  | service plans. The results of weekly monitoring shall be reported to and reviewed with community's Executive Direct Date of completion: June 9, 2025  |                                       |
|                          |                                  |  |  | R 306 Pharmaceutical Services-Noncompliance "Facility failed to ensure drug dispositions for all medication including non-controlled substance medications were accounted for and documente 2 of 2 closed records reviewe | ed for                                |
|                          |                                  |  |  | (Resident 103, Resident 104)  1: What corrective action(s) be accomplished for those residents found to have been   | will                                  |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 80 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | IT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER                                       |     | UILDING             | ONSTRUCTION  00   | (X3) DATE<br>COMPL<br><b>05/09</b> / | ETED                       |
|--------------------------|----------------------------------|---|-----|---------------------|---|--------------------------------------|----------------------------|
|                          | PROVIDER OR SUPPLIEF             | R<br>SISTED LIVING AND MEMORY CA  | ARE | 1255 D              | ADDRESS, CITY, STATE, ZIP COD<br>EMAREE ROAD<br>NWOOD, IN 46143   |                                      |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                   | STATEMENT OF DEFICIENCIE<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION |     | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)  | TE                                   | (X5)<br>COMPLETION<br>DATE |
|                          |                                  |   |     |                     | CROSS-REFERENCED TO THE APPROPRIA   | nave 103  g y vill  n. or  ts ty by  |                            |
|                          |                                  |   |     |                     | the community's training files.  4: How the corrective action will be monitored to ensure t deficient practice will not reci.e., what quality assurance program will be put into place. | cur                                  |                            |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 81 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | OF CORRECTION        | IDENTIFICATION NUMBER  | A. BUILDING  B. WING | 00   | COMPLETED 05/09/2025                     |
|--------------------------|----------------------|--|----------------------|--|--|
|                          | PROVIDER OR SUPPLIER | SISTED LIVING AND MEMORY CA  | 1255 D               | ADDRESS, CITY, STATE, ZIP COD<br>EMAREE ROAD<br>NWOOD, IN 46143  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN       | STATEMENT OF DEFICIENCIE<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  | DATE                                     |
|                          |                      |  |                      | The community's Direct of Health and Wellness or their designee shall complete randoweekly 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 share reported to and reviewed with 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 free of communicable disease was documented as required to for residents reviewed. (Resident)."  1: What corrective action(s) to be accomplished for those residents found to have been affected by the deficient practice?  Resident 48 electronic medical record reviewed, and annual health statement update by the primary physician.  2: How other residents having the potential to be affected by the same deficient practice where identified and what corrective action will be taked.  The community's Directors of the same deficient practice where identified and what corrective action will be taked. | en e |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 82 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | T OF DEFICIENCIES  OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER                                    | (X2) MULTIPLE<br>A. BUILDING<br>B. WING | E CONSTRUCTION  00  | (X3) DATE SURVEY COMPLETED 05/09/2025 |
|--------------------------|----------------------------------|---|---|---|---------------------------------------|
|                          | ROVIDER OR SUPPLIE               | R<br>BISTED LIVING AND MEMORY C   | 1255                                    | ET ADDRESS, CITY, STATE, ZIP COD<br>5 DEMAREE ROAD<br>EENWOOD, IN 46143   |                                       |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                   | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | ID<br>PREFIX<br>TAG                     | Health and Wellness or their  | DATE                                  |
|                          |                                  |   |   | designee conducted an audi 05/23/25 of all inhouse resid records for compliance with a health assessment statemen indicating that resident is free communicable diseases by 9, 2025.  | ent<br>annual<br>it<br>e of           |
|                          |                                  |   |   | 3: What measures will be printo place or what systemic changes will be made to ensure that the deficient practice does not recur  The Director of Health Wellness or their designee   | and<br>hall                           |
|                          |                                  |   |   | re-educate the Wellness Tea<br>the community's Admission<br>Policy focusing on the annua<br>health assessment statemen<br>indicating that resident is free<br>communicable diseases. An<br>in-service attendance log sha<br>maintained as evidence of | al<br>ut<br>e of                      |
|                          |                                  |   |   | completion of reeducation ar maintained with the commun training files.  The community's Direct of Health and Wellness or the designee shall monitor, man-  | uity's<br>ctor<br>eir                 |
|                          |                                  |   |   | and coordinate with physicia residents' annual health assessment including statem indicating resident is free of communicable disease.  |                                       |
|                          |                                  |   |   | 4: How the corrective action will be monitored to ensure deficient practice will not relie.   | the<br>ecur                           |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 83 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

| STATEMEN  | T OF DEFICIENCIES   | X1) PROVIDER/SUPPLIER/CLIA    | (X2) MULTIPLE CONSTRUCTION (X3) DAT   |                     |  | (X3) DATE  | SURVEY |
|-----------|---------------------|-------------------------------|---|---------------------|--|------------|--------|
| AND PLAN  | OF CORRECTION       | IDENTIFICATION NUMBER         | A. BU   | JILDING             | 00   | COMPLETED  |        |
|           |                     |                               | B. W  | ING                 |  | 05/09/     | 2025   |
|           |                     |                               |   | CTREET              | ADDRESS SITY STATE ZID COD                   |            |        |
| NAME OF P | ROVIDER OR SUPPLIER | 2                             |   |                     | ADDRESS, CITY, STATE, ZIP COD                |            |        |
| DEMARE    | E CDOSSING ASS      | SISTED LIVING AND MEMORY CA   | DE  |                     | EMAREE ROAD                                  |            |        |
| DEMARE    | E CRUSSING ASS      | SISTED LIVING AND MEMORY CA   | NKE.  | GREEN               | NWOOD, IN 46143                              |            |        |
| (X4) ID   | SUMMARY             | STATEMENT OF DEFICIENCIE      |   | ID                  | PROVIDER'S PLAN OF CORRECTION                |            | (X5)   |
| PREFIX    | (EACH DEFICIEN      | CY MUST BE PRECEDED BY FULL   | PROVIDERS PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE |                     | TE   | COMPLETION |        |
| TAG       | REGULATORY OF       | R LSC IDENTIFYING INFORMATION |   | TAG                 | DEFICIENCY)                                  |            | DATE   |
|           |                     |                               |   |                     | program will be put into place               | e?         |        |
|           |                     |                               |   |                     | The community's Direct                       | or         |        |
|           |                     |                               |   |                     | of Health and Wellness or the                | ir         |        |
|           |                     |                               |   |                     | designee shall complete daily                |            |        |
|           |                     |                               |   |                     | monitoring to ensure new mov                 | /e-in      |        |
|           |                     |                               |   |                     | resident(s) have an annual he                | alth       |        |
|           |                     |                               |   |                     | statement documented. Resul                  | ts of      |        |
|           |                     |                               |   |                     | daily monitoring shall be repor              | ted        |        |
|           |                     |                               |   |                     | to the community's Executive                 |            |        |
|           |                     |                               |   |                     | Director.                                    |            |        |
|           |                     |                               |   |                     | The community's Execu                        | ıtive      |        |
|           |                     |                               |   |                     | Director will randomly review 2              | 2          |        |
|           |                     |                               |   |                     | resident records to                          |            |        |
|           |                     |                               |   | Date of completion: |  |            |        |
|           |                     |                               |   | June 9, 2025        |  |            |        |
|           |                     |                               |   |                     | R410-Infection                               |            |        |
|           |                     |                               |   |                     | Control-Noncompliance                        |            |        |
|           |                     |                               |   |                     | "Facility failed to ensure that a            | ı          |        |
|           |                     |                               |   |                     | first step and second step                   |            |        |
|           |                     |                               |   |                     | tuberculin skin test (tool used              | for        |        |
|           |                     |                               |   |                     | screening tuberculosis) was                  |            |        |
|           |                     |                               |   |                     | completed upon admission for                 |            |        |
|           |                     |                               |   |                     | 7 residents reviewed (Resider                | nt 39      |        |
|           |                     |                               |   |                     | and Resident 90)."                           |            |        |
|           |                     |                               |   |                     | 1: What corrective action(s)                 | will       |        |
|           |                     |                               |   |                     | be accomplished for those                    |            |        |
|           |                     |                               |   |                     | residents found to have been                 | า          |        |
|           |                     |                               |   |                     | affected by the deficient                    |            |        |
|           |                     |                               |   |                     | practice?                                    |            |        |
|           |                     |                               |   |                     | Residents 39 and 90                          |            |        |
|           |                     |                               |   |                     | two-step tuberculin skin tests               |            |        |
|           |                     |                               |   |                     | been initiated by the Wellness               |            |        |
|           |                     |                               | 1   |                     | team.  |            |        |
|           |                     |                               |   |                     |  |            |        |
|           |                     |                               |   |                     | 2: How other residents havin                 | _          |        |
|           |                     |                               |   |                     | the potential to be affected b               | _          |        |
|           |                     |                               |   |                     | the same deficient practice v                | vill       |        |
|           |                     |                               |   |                     | be identified and what                       |            |        |
|           |                     |                               |   |                     | corrective action will be take               |            |        |
|           |                     |                               |   |                     | <ul> <li>The community's Director</li> </ul> | r of       |        |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 84 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

| T OF DEFICIENCIES OF CORRECTION               | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULT<br>A. BUILI<br>B. WING | DING   | nstruction<br>00   | (X3) DATE SU<br>COMPLE<br>05/09/2            |                      |
|---|--|----------------------------------|--------|--|--|----------------------|
| ROVIDER OR SUPPLIER                           | SISTED LIVING AND MEMORY CA                      | 1                                | 255 DE | DDRESS, CITY, STATE, ZIP COD<br>EMAREE ROAD<br>WOOD, IN 46143  |  |                      |
| E CROSSING ASS<br>SUMMARY S<br>(EACH DEFICIEN |  | RE 1                             | 255 DE | PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)  Health and Wellness or their designee shall complete an au of inhouse resident's electronic health records to evaluate compliance with first and seconstep tuberculin skin tests.  Tuberculin skin tests will be administered as needed for an 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 Direct of Health and Wellness or their designee shall complete monitoring to ensure that new move in resident(s) receive the first and second tuberculin skin test.  The community's Direct community | or<br>r<br>eir<br>n                          | (X5) COMPLETION DATE |
|   |  |                                  |        | of Health and Wellness or thei designee shall complete daily review of new move in records ensure compliance with tubero skin test for the next 90 days. Results of the daily monitoring 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 recoile, what quality assurance program will be put into place.   | r<br>s to<br>culin<br>will<br>s<br>he<br>cur |                      |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 85 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | NT OF DEFICIENCIES OF CORRECTION   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER   | r í  | UILDING             | ONSTRUCTION 00  | (X3) DATE<br>COMPI<br>05/09            | LETED                      |
|--------------------------|--|--|------|---------------------|---|--|----------------------------|
|                          | PROVIDER OR SUPPLIER   | SISTED LIVING AND MEMORY (   | CARE | 1255 D              | ADDRESS, CITY, STATE, ZIP COD<br>EMAREE ROAD<br>NWOOD, IN 46143   |  | _                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION   |      | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY)   |  | (X5)<br>COMPLETION<br>DATE |
|                          |  |  |      |                     | The Executive Director their designee shall complete weekly random audits of at le resident records weekly for fo weeks, then monthly X 6 mor to monitor compliance with tuberculin skin testing.  Date of completion: June 9, 2025   | e<br>east 2<br>our                     |                            |
| R 0217<br>Bldg. 00       | 410 IAC 16.2-5-2(<br>Evaluation - Defic  |  |      |                     |   |  |                            |
|                          | failed to ensure the the resident or the r of 7 residents review 25, Resident 39, Re Resident 90, Reside Finding includes:  1. On 5/9/25 at 8:30 record was reviewe were not limited to, pressure), right show hypotension (drop in from a sitting or lying The service plan, represident or responsion 2. On 5/9/25 at 8:30 record was reviewe were not limited to, (inflammation of the service plan). | evised 8/16/21, lacked a ble party signature.  D. a.m. Resident 39's clinical d. The diagnoses included, but history of fall, cystitis e bladder), and hypertension. | RO   | 217                 | Demaree Crossing 05.14.25 This Plan of Correction is submitted under regulations applicable to long term care providers. This Plan of Corre is not to be construed as an admission or agreement with findings and conclusions in the Statement of Deficiencies. The preparation of this Plan does not constitute agreement by the facility that the surveyor's find or conclusions are accurate, the findings constitute a deficiency, or that the scope severity regarding any of the deficiencies are correctly approximately submission of this Plan is evidence of compliance.  R086-Administration and Management-Deficiency "Facility failed to ensure a cut and valid Clinical Laboratory Improvement Amendments (in | the ne ne dor ot dings that and blied. | 06/09/2025                 |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 86 of 154

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |  | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY |  |          | (X3) DATE SURVEY  |            |
|--|--|---|--|----------|---|------------|
| AND PLAN   | OF CORRECTION                                      | IDENTIFICATION NUMBER                       | A. BUILDING <u>00</u> COMPLETED                |          |   | COMPLETED  |
|  |  |   | B. W   | ING      |   | 05/09/2025 |
|  |  |   | <u>.                                      </u> | STREET A | ADDRESS, CITY, STATE, ZIP COD   | 1          |
| NAME OF P  | ROVIDER OR SUPPLIER                                | 8   |  |          | EMAREE ROAD   |            |
| DEMARE   | E CROSSING ASS                                     | SISTED LIVING AND MEMORY CA                 | ARE  |          | NWOOD, IN 46143   |            |
| (X4) ID  | SUMMARY  | STATEMENT OF DEFICIENCIE                    |  | ID       | PROVIDER'S PLAN OF CORRECTION   | (X5)       |
| PREFIX   | (EACH DEFICIEN                                     | ICY MUST BE PRECEDED BY FULL                |  | PREFIX   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | COMPLETION |
| TAG  |  | R LSC IDENTIFYING INFORMATION               |  | TAG      | DEFICIENCY)   | DATE       |
|  |  | a.m., Resident 48's clinical                |  |          | certification (for the purposes   | of         |
|  |  | d. The diagnosis included, but              |  |          | performing laboratory   |            |
|  | was not limited to,                                | generalized anxiety disorder.               |  |          | examinations or procedures)   | was        |
|  |  |   |  |          | maintained as required.   |            |
|  | _  | evised 4/28/25, lacked a                    |  |          | 1: What corrective action(s)  | will       |
|  | resident or responsi                               | ble party signature.                        |  |          | be accomplished for those   |            |
|  |  |   |  |          | residents found to have been  | n          |
|  |  | a.m., Resident 85's clinical                |  |          | affected by the deficient   |            |
|  |  | d. The diagnosis included, but              |  |          | practice?   |            |
|  |  | Parkinson's disease (a disorder             |  |          | No residents were affecte   | ed by      |
|  |  | us system that affects                      |  |          | the alleged deficient practice.   |            |
|  | movement often inc                                 | cluding tremors).                           |  |          | CLIA certification was  |            |
|  |  |   |  |          | submitted for renewal on  |            |
|  | •  | evised 8/8/24, lacked a resident            |  |          | 5/09/2025 to  |            |
|  | or responsible party                               | signature.                                  |  |          | labexcellence@cms.hhs.gov   | and        |
|  |  |   |  |          | paid through pay.gov-CLIA   |            |
|  |  | a.m., Resident 90's clinical                |  |          | Laboratory User Fees.   |            |
|  |  | d. The diagnoses included, but              |  |          |   |            |
|  |  | dementia and chronic                        |  |          | 2: How other residents havir  | _          |
|  | _  | ary disease (a group of lung                |  |          | the potential to be affected by   | ру         |
|  |  | airflow and make it difficult to            |  |          | the same deficient practice v   | vill       |
|  | breathe).  |   |  |          | be identified and what  |            |
|  |  |   |  |          | corrective action will be take  |            |
|  |  | evised 12/10/24, lacked a                   | - No residents were affected by                |          |   | ed by      |
|  | resident or responsi                               | ble party signature.                        |  |          | the alleged deficient practice.   |            |
|  | 6. On 5/9/25 at 8:00                               | a.m., Resident 103's clinical               |  |          | 3: What measures will be pu   | t          |
|  |  | d. The diagnoses included, but              |  |          | into place or what systemic   |            |
|  |  | history of falls, alcohol abuse,            |  |          | changes will be made to   |            |
|  |  | tive pulmonary disease.                     |  |          | ensure that the deficient   |            |
|  |  |   |  |          | practice does not recur?  |            |
|  | The service plan, re                               | evised 7/31/24, lacked a                    |  |          | The ED and DHW will be  |            |
|  | resident or responsi                               |   |  |          | educated on the Federal and   | State      |
|  | •  |   |  |          | Regulatory requirements and   |            |
|  | 7. On 5/9/25 at 8:30 a.m., Resident 104's clinical |   |  |          | renewal process for CLIA  |            |
|  |  | d. The diagnosis included, but              |  |          | Certification by the SVP of He  | alth       |
|  |  | wedge compression fracture of               |  |          | & Wellness.   |            |
|  | second lumbar verte                                |   |  |          |   |            |
|  |  |   |  |          | 4: How the corrective action  |            |
|  | The service plan, revised of 9/24/24, lacked a     |   |  |          | will be monitored to ensure t   |            |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 87 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | NT OF DEFICIENCIES OF CORRECTION  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER  | A. B | MULTIPLE CO<br>FUILDING<br>VING | ONSTRUCTION  00  | COME   | E SURVEY<br>PLETED<br>9/2025 |
|--------------------------|---|--|------|---------------------------------|--|--|------------------------------|
|                          | PROVIDER OR SUPPLIEI  | R<br>BISTED LIVING AND MEMORY (  | CARE | 1255 D                          | ADDRESS, CITY, STATE, ZIP COD<br>EMAREE ROAD<br>IWOOD, IN 46143  | •  | _                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION                    |      | ID<br>PREFIX<br>TAG             | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPI<br>DEFICIENCY)   | TION<br>LD BE<br>ROPRIATE  | (X5)<br>COMPLETION<br>DATE   |
|                          | During an interview Executive Director should have been so responsible party si On 5/9/25 at 10:12 provided the facility Interpretation and I date 1/9/25, and incurrently being use the policy indicated resident and/or the and the community service plan within time. The signed co | ble party signature.  y on 5/9/25 at 9:55 a.m., the indicated the service plans igned by a resident or |      |                                 | deficient practice will not i.e., what quality assural program will be put into ED or their designer responsible for monitoring expiration date and submirenewal for CLIA Certification Date of completion: 2025 R 148- Sanitation and Sastandards- Deficiency "Facility failed to ensure to potentially hazardous mawere kept secured behind doors to prevent resident to hazardous materials for 14 self-mobile and cognitimpaired residents residing assisted living unit in the 1: What corrective actions be accomplished for the residents found to have affected by the deficient practice?  No residents were by the alleged deficient poor to beauty shousekeeping staff and be will be in-serviced by the community's housekeeping staff and be will be in-serviced by the community Executive Directon Community Executive Directon Storage.  The community bewas provided a key to the Shop for access to room. 2: How other residents in the potential to be affective. | place? ee will be g iit timely ate June 9, afety that terials d locked 's access or 14 of fively ng on the facility n(s) will bee  affected ractice. by was bocked. eautician ector on azardous and autician e Beauty naving |                              |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 88 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|               | T OF DEFICIENCIES<br>OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER        | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING |               |   | (X3) DATE SURVEY COMPLETED 05/09/2025                    |                    |
|---------------|------------------------------------|--|--|---------------|---|--|--------------------|
| NAME OF P     | ROVIDER OR SUPPLIE                 | R  |  |               | ADDRESS, CITY, STATE, ZIP COD   |  |                    |
| DEMARE        | E CROSSING AS                      | SISTED LIVING AND MEMORY CA                                | ARE  |               | EMAREE ROAD<br>NWOOD, IN 46143  |  |                    |
| (X4) ID       |                                    | STATEMENT OF DEFICIENCIE                                   |  | ID            | PROVIDER'S PLAN OF CORRECTION   |  | (X5)               |
| PREFIX<br>TAG | `                                  | NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION |  | PREFIX<br>TAG | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)   | TE   | COMPLETION<br>DATE |
| TAG           | `                                  | R LSC IDENTIFYING INFORMATION                              |  | TAG           | the same deficient practice of be identified and what corrective action will be taken - No resident was affected by the alleged deficient practice.  3: What measures will be purinto 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. Hazardous Substance Classification and Storage Guideline by 6/9/25. An in-sent 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 shibe trained to the community's Hazardous Substance Classification and Storage Guideline upon hire as part of pre-service training.  The community's Direct of Health and Wellness or the designee shall complete monitoring of areas containing hazardous materials to ensure securement at minimum of for days per week for four weeks the monthly for six months.  The community's Direct of the community's Direct of the state of the securement at minimum of for days per week for four weeks the monthly for six months. | vill en. nt  t  t  t  their  or  ir  and  en  or  or  or | DATE               |
| 1             |                                    |  | 1  |               | of Health and Wellness or the   | II   | I                  |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 89 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                     | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY |                       |          |  |            |            |
|--|---------------------|---|-----------------------|----------|--|------------|------------|
| AND PLAN   | OF CORRECTION       | IDENTIFICATION NUMBER                       | A. BUILDING <u>00</u> |          |  | COMPLETED  |            |
|  |                     |   | B. WI                 | NG       |  | 05/09/2025 |            |
|  |                     |   |                       | CTDEET 4 | DDDESC CITY STATE ZIR COD  |            |            |
| NAME OF P  | ROVIDER OR SUPPLIER | L.  |                       |          | ADDRESS, CITY, STATE, ZIP COD  |            |            |
|  |                     | PICTED I IVINO AND MEMORY OF                | DE                    |          | EMAREE ROAD  |            |            |
| DEMAKE   | E UKUSSING ASS      | SISTED LIVING AND MEMORY CA                 | KE                    | GKEEN    | IWOOD, IN 46143  |            |            |
| (X4) ID  | SUMMARY             | STATEMENT OF DEFICIENCIE                    |                       | ID       | PROVIDER'S PLAN OF CORRECTION  |            | (X5)       |
| PREFIX   | (EACH DEFICIEN      | CY MUST BE PRECEDED BY FULL                 |                       | PREFIX   | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | TE         | COMPLETION |
| TAG  | REGULATORY OR       | LSC IDENTIFYING INFORMATION                 |                       | TAG      | DEFICIENCY)  |            | DATE       |
|  |                     |   |                       |          | designee shall provide summa   | ary of     |            |
|  |                     |   |                       |          | findings to the Executive Direct                                       | ctor       |            |
|  |                     |   |                       |          | weekly and then monthly for  |            |            |
|  |                     |   |                       |          | review and discussion of any   |            |            |
|  |                     |   |                       |          | correction action items.   |            |            |
|  |                     |   |                       |          |  |            |            |
|  |                     |   |                       |          | 4: How the corrective action   |            |            |
|  |                     |   |                       |          | will be monitored to ensure t  |            |            |
|  |                     |   |                       |          | deficient practice will not rec  | ur         |            |
|  |                     |   |                       |          | i.e., what quality assurance   | _          |            |
|  |                     |   |                       |          | program will be put into plac  |            |            |
|  |                     |   |                       |          | The Director of Facilities   |            |            |
|  |                     |   |                       |          | their designee will be responsi  | bie        |            |
|  |                     |   |                       |          | for monitoring compliance of   | 1_         |            |
|  |                     |   |                       |          | sanitation and safety standard   |            |            |
|  |                     |   |                       |          | through random monthly chec  | KS         |            |
|  |                     |   |                       |          | for unsecured hazardous  | and        |            |
|  |                     |   |                       |          | substance, unlocked cabinets doors for six months. The rand            |            |            |
|  |                     |   |                       |          |  |            |            |
|  |                     |   |                       |          | monthly checks results will be<br>reviewed during the monthly s        |            |            |
|  |                     |   |                       |          | meeting overseen by the  | alety      |            |
|  |                     |   |                       |          | Executive Director. Corrective   |            |            |
|  |                     |   |                       |          | actions will be implemented ba   |            |            |
|  |                     |   |                       |          | on the findings and discussion   |            |            |
|  |                     |   |                       |          | during safety meeting.   | 1          |            |
|  |                     |   |                       |          | The community through  | the        |            |
|  |                     |   |                       |          | safety meeting, will review, up  |            |            |
|  |                     |   |                       |          | and make changes to the DPC  |            |            |
|  |                     |   |                       |          | 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                                       |            |            |
|  |                     |   |                       |          | resided in the facility had rece                                       | ived       |            |
|  |                     |   |                       |          | the rabies vaccination and the   |            |            |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 90 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | T OF DEFICIENCIES<br>OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  | (X2) MULTIPLE<br>A. BUILDING<br>B. WING | e construction  00   | (X3) DATE SURVEY  COMPLETED  05/09/2025   |
|--------------------------|------------------------------------|---|---|--|---|
|                          | ROVIDER OR SUPPLIE                 | R<br>SISTED LIVING AND MEMORY (   | 1255                                    | ET ADDRESS, CITY, STATE, ZIP CO<br>5 DEMAREE ROAD<br>ENWOOD, IN 46143  | D   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIE                      | STATEMENT OF DEFICIENCIE<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP   | CCTION (X5) ULD BE PROPRIATE COMPLETION DATE  |
|                          |                                    |   |   | annual veterinary examicompleted as required pexpiration date for 1 of 4 who housed pets in the (Resident 97)  1: What corrective actions be accomplished for the residents found to have affected by the deficient practice?  The canine owned Resident 97 had vaccinate updated on 5/20/25.  Record of such vaccinate updated and maintained by the common Resident Experience Director designee  2: How other residents the potential to be affect the same deficient practice action will be Records of pets or residing at the communicated by the communicat | prior to its it residents facility"  con(s) will cose the been that  d by facination shall be facility's facitor or  contracted by cotice will the taken. |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 91 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

| NT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER   | (X2) MULT<br>A. BUILD<br>B. WING |        | nstruction<br><u>00</u>                   | (X3) DATE<br>COMPL<br>05/09/  | LETED                |
|----------------------------------|--|----------------------------------|--------|---|---|----------------------|
| PROVIDER OR SUPPLIE              |  | 1                                | 255 DE | DDRESS, CITY, STATE, ZIP COD  EMAREE ROAD |   |                      |
| SUMMARY<br>(EACH DEFICIEN        | SISTED LIVING AND MEMORY CONTROL STATEMENT OF DEFICIENCIE NOY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | CARE 1                           | 255 DE |   | dent at  dent at  ents a don policy and during ement dent ovide et s who  all ast ance be | (X5) COMPLETION DATE |
|                                  |  |                                  |        | community's safety meeting.               |   |                      |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 92 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | F OF DEFICIENCIES  OF CORRECTION      | X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER A. BUILDING 00 B. WING |     |                     | (X3) DATE SURVEY COMPLETED 05/09/2025   |   |                            |
|--------------------------|---------------------------------------|--|-----|---------------------|---|---|----------------------------|
|                          | ROVIDER OR SUPPLIEI<br>E CROSSING ASS | R<br>BISTED LIVING AND MEMORY C  | ARE | 1255 D              | ADDRESS, CITY, STATE, ZIP COD<br>DEMAREE ROAD<br>NWOOD, IN 46143  |   |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                        | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION                |     | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)  | .TE   | (X5)<br>COMPLETION<br>DATE |
|                          |                                       |  |     |                     | 4: How the corrective action will be monitored to ensure to deficient practice will not recise, what quality assurance program will be put into place. The community's Exect Director or their designee shat complete random audits of the vaccination and examination tracking monthly for six month ensure all pet vaccinations are currecand up to date.  Audit results will be reviewed at the monthly safety meeting overseen by the Executive Director. If a thresh of 95% is not achieved, an acreplan will be developed.  The community through safety meeting, will review, up and make changes to the DPC as needed for sustaining substantial compliance for nothan 6 months  Date of completion: June 2025  R 216- Evaluation-Noncompliance "Facility failed to obtain a base admission weight for 1 of 7 residents reviewed for weights (Resident 39)  1: What corrective action(s) be accomplished for those residents found to have been affected by the deficient practice?  Resident 39 has been | the cur  ce? utive II e pet es to d ent  old tion the date DC less 9, eline s" will |                            |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 93 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

| STREET ADDRESS, CITY, STATE, ZIP COD   |                            |
|--|----------------------------|
| DEMAREE CROSSING ASSISTED LIVING AND MEMORY CARE  1255 DEMAREE ROAD  GREENWOOD, IN 46143   |                            |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDERS PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY)  | (X5)<br>COMPLETION<br>DATE |
| 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 shall re-educate all Wellness shall re-educate all Wellness (Care) team members regarding |                            |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 94 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

| STATEMEN  | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRU |                               | E CONSTRUCTION        | (X3) DATE SURVEY |  |            |        |
|-----------|--|-------------------------------|-----------------------|------------------|--|------------|--------|
| AND PLAN  | OF CORRECTION  | IDENTIFICATION NUMBER         | a. building <u>00</u> |                  |  | COMPLETED  |        |
|           |  |                               | B. W                  | ING              |  | 05/09/2025 |        |
|           |  | <b>!</b>                      |                       | STRE             | ET ADDRESS, CITY, STATE, ZIP COD                           |            |        |
| NAME OF F | PROVIDER OR SUPPLIEF   | ₹                             |                       |                  | 5 DEMAREE ROAD   |            |        |
| DEMARE    | EE CROSSING ASS  | SISTED LIVING AND MEMORY C    | ARE                   | GRE              | EENWOOD, IN 46143  |            |        |
| (X4) ID   | SUMMARY  | STATEMENT OF DEFICIENCIE      |                       | ID               | PROVIDER'S PLAN OF CORRECTION                              | (          | X5)    |
| PREFIX    | (EACH DEFICIEN   | ICY MUST BE PRECEDED BY FULL  |                       | PREFIX           | CROSS-REFERENCED TO THE APPROPRI                           | COMP:      | LETION |
| TAG       | REGULATORY OF  | R LSC IDENTIFYING INFORMATION |                       | TAG              | DEFICIENCY)  |            | TE     |
|           |  |                               |                       |                  | Admission Policy and standa                                | d for      |        |
|           |  |                               |                       |                  | obtaining and documenting                                  |            |        |
|           |  |                               |                       |                  | residents' weight upon move                                |            |        |
|           |  |                               |                       |                  | An in-service attendance log                               |            |        |
|           |  |                               |                       |                  | be maintained as evidence of                               |            |        |
|           |  |                               |                       |                  | completion of re-education, a shall be maintained with the | IU         |        |
|           |  |                               |                       |                  | community's training files                                 |            |        |
|           |  |                               |                       |                  | - The community's  |            |        |
|           |  |                               |                       |                  | Director of Health and Wellne                              | ss         |        |
|           |  |                               |                       |                  | shall educate new Wellness                                 |            |        |
|           |  |                               |                       |                  | (Care) team members on                                     |            |        |
|           |  |                               |                       |                  | community's Admission Polic                                | ,          |        |
|           |  |                               |                       |                  | during the community pre-sei                               |            |        |
|           |  |                               |                       |                  | training.  |            |        |
|           |  |                               |                       |                  | 4: How the corrective action                               |            |        |
|           |  |                               |                       |                  | will be monitored to ensure                                |            |        |
|           |  |                               |                       |                  | deficient practice will not re                             | cur        |        |
|           |  |                               |                       |                  | i.e., what quality assurance                               |            |        |
|           |  |                               |                       |                  | program will be put into pla                               |            |        |
|           |  |                               |                       |                  | The community's Direct                                     |            |        |
|           |  |                               |                       |                  | of Health and Wellness/desig                               |            |        |
|           |  |                               |                       |                  | will complete daily monitoring ensure that new move in     | ιυ         |        |
|           |  |                               |                       |                  | resident(s) have an admissio                               | ,          |        |
|           |  |                               |                       |                  | weight documented. Results                                 |            |        |
|           |  |                               |                       |                  | such monitoring shall be repo                              |            |        |
|           |  |                               |                       |                  | 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                             | the        |        |
|           |  |                               |                       |                  | service plans were signed by resident or the resident's    | uie        |        |
|           |  |                               |                       |                  | representative for 7 of 7                                  |            |        |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 95 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | T OF DEFICIENCIES  OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  | (X2) MULTIP<br>A. BUILDIN<br>B. WING | le construction<br>ig <u>00</u>   | (X3) DATE SURVEY COMPLETED 05/09/2025   |
|--------------------------|----------------------------------|---|--------------------------------------|---|---|
|                          | ROVIDER OR SUPPLIE               | R<br>BISTED LIVING AND MEMORY C   | 125                                  | EET ADDRESS, CITY, STATE, ZIP COI<br>55 DEMAREE ROAD<br>EENWOOD, IN 46143   |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                   | STATEMENT OF DEFICIENCIE<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION | ID<br>PREFI<br>TAC                   | CROSS-REFERENCED TO THE APP   | CTION (X5)  JLD BE COMPLETION PROPRIATE DATE  |
|                          |                                  |   |                                      | residents reviewed for se plans (Resident 25, Res. Resident 48, Resident 8 Resident 104)  1: What corrective actions be accomplished for the residents found to have affected by the deficient practice?  Current service plans have been and signed by resident a responsible party.  Residents 25, 39, 48, 85 service plans have been discharged from community on [ADD DAT DISCHARGE]  2: How other residents the potential to be affect the same deficient practice and what corrective action will be a more than the deficient practice and will be resident's service plan to signature by resident or responsible party by Junual 3: What measures will be into place or what systems changes will be made to ensure that the deficient practice does not recurred the community's of Health and Wellness of the educate the Wellness re-educate the Wellness re-educate the Wellness | ident 39, 5, 03 and on(s) will ose been t ans for , and 90 reviewed and/or d 104 om the FES OF  having sted by tice will e taken. irector of all current o validate e 9, 2025.  oe put emic o ot t  Director will |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 96 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | T OF DEFICIENCIES<br>OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER                              | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING | ONSTRUCTION  00  | (X3) DATE SURVEY COMPLETED 05/09/2025  |
|--------------------------|------------------------------------|--|--|--|--|
|                          | ROVIDER OR SUPPLIER                | SISTED LIVING AND MEMORY CA  | 1255 D                                     | ADDRESS, CITY, STATE, ZIP COD<br>EMAREE ROAD<br>NWOOD, IN 46143  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                     | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | ID<br>PREFIX<br>TAG                        | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  | (X5) COMPLETION DATE   |
|                          |                                    |  |  | member on the community's Evaluation policy which included requirement for review and signature on plan of care. An in-service attendance log shall 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 reduce, what quality assurance program will be put into place. The community's Direct of Health and Wellness or the designee shall complete randoweekly audits of at least 2 new resident records weekly to evaluate compliance with sign service plans. The results of weekly monitoring shall be reported to and reviewed with 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 2 of 2 closed records reviewed (Resident 103, Resident 104)  1: What corrective action(s) | I be  I be  I he  

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 97 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | T OF DEFICIENCIES  OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  | (X2) MULTII<br>A. BUILDII<br>B. WING  | PLE CONSTRUCTION NG 00   | (X3) DATE SURVEY COMPLETED 05/09/2025   |  |  |
|--------------------------|----------------------------------|---|---|--|---|--|--|
|                          | ROVIDER OR SUPPLIEI              | R<br>SISTED LIVING AND MEMORY C   | STREET ADDRESS, CITY, STATE, ZIP COD 1255 DEMAREE ROAD Y CARE GREENWOOD, IN 46143 |  |   |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                   | STATEMENT OF DEFICIENCIE<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION | ID<br>PREF<br>TA  | PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD ACTION OF CORRECTIVE ACTION OF CORRECTIVE ACTION OF CORRECTIVE ACTION SHOULD ACTION OF CORRECTIVE  | TION (X5) LD BE ROPRIATE COMPLETION DATE  |  |  |
|                          |                                  |   |   | be accomplished for the residents found to have affected by the deficient practice?  Drug disposition for been completed for Resident 104 on [ADD DATE]  2: How other residents if the potential to be affect the same deficient practice identified and what corrective action will be The community's Definition of Health and Wellness implement the use of Drug disposition form for all residischarged from the community of June 9, 2025.  3: What measures will be into place or what syste changes will be made to ensure that the deficient practice does not recur.  The community's Definition of Health and Wellness in service the Wellness Tempolicies for Discarding and Destroying Medication and Discontinuing Medication in service attendance log maintained as evidence of completion and maintained the community's training the community's training the monitored to ensure deficient practice will not the community of the communit | rms have dents 103  having ted by tice will  taken. Director hall g sidents munity by  e put mic o t  Director hall feam hity's had |  |  |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 98 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION |                      |                               | CONSTRUCTION | (X3) DATE SURVEY |  |            |     |
|---|----------------------|-------------------------------|--------------|------------------|--|------------|-----|
| AND PLAN  | OF CORRECTION        | IDENTIFICATION NUMBER         | A. BU        | JILDING          | 00   | COMPLETED  |     |
|   |                      |                               | B. W         | ING _            |  | 05/09/2025 |     |
|   |                      |                               |              | STREET           | ADDRESS, CITY, STATE, ZIP COD  |            |     |
| NAME OF F   | PROVIDER OR SUPPLIEF | t .                           |              |                  | DEMAREE ROAD   |            |     |
| DEMARE  | E CROSSING ASS       | SISTED LIVING AND MEMORY C    | ARE          | GREE             | NWOOD, IN 46143  |            |     |
| (X4) ID   | SUMMARY              | STATEMENT OF DEFICIENCIE      |              | ID               | PROVIDER'S PLAN OF CORRECTION  | (X5)       |     |
| PREFIX  | •                    | CY MUST BE PRECEDED BY FULL   |              | PREFIX           | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA |            | ION |
| TAG   | REGULATORY OF        | R LSC IDENTIFYING INFORMATION |              | TAG              | DEFICIENCY)  | DATE       |     |
|   |                      |                               |              |                  | i.e., what quality assurance   | -2         |     |
|   |                      |                               |              |                  | program will be put into place   |            |     |
|   |                      |                               |              |                  | The community's Direct of Health and Wellness or the                   |            |     |
|   |                      |                               |              |                  | designee shall complete rando  |            |     |
|   |                      |                               |              |                  | weekly audits of at least 1  | ,,,,,      |     |
|   |                      |                               |              |                  | discharged resident to ensure  |            |     |
|   |                      |                               |              |                  | Drug Disposition form has bee  | n          |     |
|   |                      |                               |              |                  | completed and scanned into   |            |     |
|   |                      |                               |              |                  | electronic medical record. The   |            |     |
|   |                      |                               |              |                  | results of such monitoring sha   | ll be      |     |
|   |                      |                               |              |                  | reported to and reviewed with  | the        |     |
|   |                      |                               |              |                  | community's Executive Direct   | or         |     |
|   |                      |                               |              |                  | Date of completion:  |            |     |
|   |                      |                               |              |                  | June 9, 2025.  |            |     |
|   |                      |                               |              |                  | R409- Infection  |            |     |
|   |                      |                               |              |                  | Control-Noncompliance  |            |     |
|   |                      |                               |              |                  | "Facility failed to ensure that the                                    | ne         |     |
|   |                      |                               |              |                  | annual health assessment   |            |     |
|   |                      |                               |              |                  | statement (a statement by the  |            |     |
|   |                      |                               |              |                  | physician indicating the reside  |            |     |
|   |                      |                               |              |                  | free of communicable disease was documented as required                |            |     |
|   |                      |                               |              |                  | of 7 residents reviewed. (Resi   |            |     |
|   |                      |                               |              |                  | 48)."  |            |     |
|   |                      |                               |              |                  | 1: What corrective action(s)   | will       |     |
|   |                      |                               |              |                  | be accomplished for those  |            |     |
|   |                      |                               |              |                  | residents found to have been   | n          |     |
|   |                      |                               |              |                  | affected by the deficient  |            |     |
|   |                      |                               |              |                  | practice?  |            |     |
|   |                      |                               |              |                  | Resident 48 electronic   |            |     |
|   |                      |                               |              |                  | medical record reviewed, and   |            |     |
|   |                      |                               |              |                  | annual health statement upda   | ted        |     |
|   |                      |                               |              |                  | by the primary physician.  |            |     |
|   |                      |                               |              |                  | 2: How other residents havin   | -          |     |
|   |                      |                               |              |                  | the potential to be affected b   | - I        |     |
|   |                      |                               |              |                  | the same deficient practice v  | /ill       |     |
|   |                      |                               |              |                  | be identified and what   |            |     |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 99 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

| STATEMEN  | T OF DEFICIENCIES   | X1) PROVIDER/SUPPLIER/CLIA    | (X2) MULTIPLE CONSTRUCTION (X3) DATE SUR |         |   | SURVEY |            |
|-----------|---------------------|-------------------------------|--|---------|---|--------|------------|
| AND PLAN  | OF CORRECTION       | IDENTIFICATION NUMBER         | A. BU                                    | JILDING | 00  | COMPL  | .ETED      |
|           |                     |                               | B. W                                     | ING     |   | 05/09/ | /2025      |
|           |                     |                               |  | CTREET  | ADDRESS OF A STATE SID COD  |        |            |
| NAME OF P | ROVIDER OR SUPPLIER | 2                             |  |         | ADDRESS, CITY, STATE, ZIP COD<br>EMAREE ROAD  |        |            |
| DEMADE    | E CDOSSING ASS      | SISTED LIVING AND MEMORY CA   | DE                                       |         |   |        |            |
| DEMARE    | E CRUSSING ASS      | SISTED LIVING AND MEMORY CA   | NKE.                                     | GREEN   | IWOOD, IN 46143   |        |            |
| (X4) ID   | SUMMARY             | STATEMENT OF DEFICIENCIE      |  | ID      | PROVIDER'S PLAN OF CORRECTION   |        | (X5)       |
| PREFIX    | (EACH DEFICIEN      | CY MUST BE PRECEDED BY FULL   |  | PREFIX  | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE     | COMPLETION |
| TAG       | REGULATORY OR       | R LSC IDENTIFYING INFORMATION |  | TAG     | DEFICIENCY)   |        | DATE       |
|           |                     |                               |  |         | corrective action will be take  | n.     |            |
|           |                     |                               |  |         | - The community's Directo   | r of   |            |
|           |                     |                               |  |         | Health and Wellness or their  |        |            |
|           |                     |                               |  |         | designee conducted an audit of  | on     |            |
|           |                     |                               |  |         | 05/23/25 of all inhouse resider   | nt     |            |
|           |                     |                               |  |         | records for compliance with ar  | nnual  |            |
|           |                     |                               |  |         | health assessment statement   |        |            |
|           |                     |                               |  |         | indicating that resident is free  | of     |            |
|           |                     |                               |  |         | communicable diseases by Ju   | ne     |            |
|           |                     |                               |  |         | 9, 2025.  |        |            |
|           |                     |                               |  |         |   |        |            |
|           |                     |                               |  |         | 3: What measures will be put  | t      |            |
|           |                     |                               |  |         | into place or what systemic   |        |            |
|           |                     |                               |  |         | changes will be made to   |        |            |
|           |                     |                               |  |         | ensure that the deficient   |        |            |
|           |                     |                               |  |         | practice does not recur   |        |            |
|           |                     |                               |  |         | The Director of Health a  |        |            |
|           |                     |                               |  |         | Wellness or their designee sha  |        |            |
|           |                     |                               |  |         | re-educate the Wellness Tean  | n 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 shal  | l be   |            |
|           |                     |                               |  |         | maintained as evidence of   |        |            |
|           |                     |                               |  |         | completion of reeducation and   |        |            |
|           |                     |                               |  |         | maintained with the communit  | y s    |            |
|           |                     |                               |  |         | training files.   |        |            |
|           |                     |                               |  |         | The community's Direct of Health and Wellness or the  |        |            |
|           |                     |                               |  |         |   |        |            |
|           |                     |                               |  |         | designee shall monitor, manag   | -      |            |
|           |                     |                               |  |         | and coordinate with physicians residents' annual health   | 5      |            |
|           |                     |                               |  |         |   | nt     |            |
|           |                     |                               |  |         | assessment including stateme  | :1 IL  |            |
|           |                     |                               |  |         | indicating resident is free of communicable disease.  |        |            |
|           |                     |                               |  |         | Communicable disease.   |        |            |
|           |                     |                               |  |         | 4: How the corrective action  |        |            |
|           |                     |                               |  |         | will be monitored to ensure t   | ho     |            |
|           |                     |                               | 1  |         | i wiii be iiioiiitorea to eiisare t   | 116    | I          |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 100 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | T OF DEFICIENCIES<br>DF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER                                       |     | JILDING             | onstruction 00  | COMP   | E SURVEY<br>LETED<br>0/2025 |
|--------------------------|------------------------------------|--|-----|---------------------|---|--|-----------------------------|
|                          | ROVIDER OR SUPPLIER                | SISTED LIVING AND MEMORY C   | ARE | 1255 DI             | ADDRESS, CITY, STATE, ZIP COD<br>EMAREE ROAD<br>IWOOD, IN 46143   |  |                             |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                     | STATEMENT OF DEFICIENCIE<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION |     | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY)  | D BE<br>OPRIATE  | (X5)<br>COMPLETION<br>DATE  |
|                          |                                    |  |     |                     | deficient practice will not i.e., what quality assurant program will be put into The community's Doof Health and Wellness or designee shall complete of monitoring to ensure new resident(s) have an annual statement documented. Redaily monitoring shall be not to the community's Execut Director.  The community's Execut Director will randomly reviresident records to  Date of completion Control-Noncompliance "Facility failed to ensure the first step and second step tuberculin skin test (tool unscreening tuberculosis) will completed upon admission 7 residents reviewed (Resident 90)."  1: What corrective action be accomplished for those accomplished for those affected by the deficient practice?  Residents 39 and 9 two-step tuberculin skin test been initiated by the Welln team.  2: How other residents he the potential to be affected to the same deficient practice identified and what | place? irector their laily move-in al health esults of eported tive  xecutive ew 2  on:  nat a  sed for as n for 2 of sident 39  n(s) will se been  0 ests have ness |                             |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 101 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | OF CORRECTION        | IDENTIFICATION NUMBER  | A. BUILDING  B. WING  | 00   | COMPLETED<br>05/09/2025                     |  |  |
|--------------------------|----------------------|--|---|--|---|--|--|
|                          | PROVIDER OR SUPPLIER | SISTED LIVING AND MEMORY CA  | STREET ADDRESS, CITY, STATE, ZIP COD  1255 DEMAREE ROAD  CARE GREENWOOD, IN 46143 |  |   |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN       | STATEMENT OF DEFICIENCIE<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  | (X5) COMPLETION DATE                        |  |  |
|                          |                      |  |   | corrective action will be taked.  The community's Director Health and Wellness or their designee shall complete an and of inhouse resident's electronic health records to evaluate compliance with first and second step tuberculin skin tests.  Tuberculin skin tests will be administered as needed for an residents identified as missing step 1 or step 2 skin tests by June 9, 2025.  3: What measures will be purinto 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 the designee shall complete monitoring to ensure that new move in resident(s) receive the first and second tuberculin skintest.  The community's Director of Health and Wellness or the designee shall complete daily review of new move in record ensure compliance with tubertor skin test for the next 90 days. Results of the daily monitoring be discussed with Executive Director and corrective actions taken to ensure compliance.  4: How the corrective action will be monitored to ensure deficient practice will not recorded. | t dit c c c c c c c c c c c c c c c c c c c |  |  |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 102 of 154

|                          | IT OF DEFICIENCIES OF CORRECTION   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER  | r í | UILDING             | onstruction 00  | (X3) DATE<br>COMPL<br>05/09/   | ETED                       |
|--------------------------|--|--|-----|---------------------|---|--------------------------------|----------------------------|
|                          | PROVIDER OR SUPPLIER   | SISTED LIVING AND MEMORY C   | ARE | 1255 D              | ADDRESS, CITY, STATE, ZIP COD<br>EMAREE ROAD<br>IWOOD, IN 46143   |                                |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION   |     | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY)   | ATE                            | (X5)<br>COMPLETION<br>DATE |
|                          |  |  |     |                     | i.e., what quality assurance program will be put into place. The Executive Director their designee shall complete weekly random audits of at le resident records weekly for for weeks, then monthly X 6 monto monitor compliance with tuberculin skin testing.  Date of completion: June 9, 2025  | or<br>ast 2<br>our             |                            |
| R 0306<br>Bldg. 00       | 410 IAC 16.2-5-6(<br>Pharmaceutical S  | g)(1-9)<br>ervices - Noncompliance   |     |                     |   |                                |                            |
|                          | failed to ensure drumedications, included medications were as for 2 of 2 closed reconstructions.  1. On 5/8/25 at 11:2 Resident 103 was reincluded, but were a chronic obstructive diabetes, hypertensia asthma.  On 5/9/25 at 12:30 provided a copy of dated 3/31/25. A reincluded the current 103 had been received. | g dispositions for all ing non-controlled substance ecounted for and documented cords reviewed. (Resident 103, 20 a.m., the clinical record for eviewed. The diagnoses not limited to, alcohol abuse, pulmonary disease (COPD), fon (HTN), heart failure, and p.m., the Executive Director the physician's order report eview of the medication list at medications that Resident ring at the time of his discharge he list included, but was not wing orders: | R 0 | 306                 | 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 findings and conclusions in the Statement of Deficiencies. The preparation of this Plan does not constitute agreement by the facility that the surveyor's find or conclusions are accurate, the findings constitute a deficiency, or that the scope as severity regarding any of the deficiencies are correctly app Submission of this Plan is evidence of compliance.  R086-Administration and Management-Deficiency "Facility failed to ensure a curi | the e e or ot lings that lied. | 06/09/2025                 |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 103 of 154

|   | IT OF DEFICIENCIES OF CORRECTION              | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER          | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING |   |   | (X3) DATE SURVEY COMPLETED 05/09/2025 |                    |
|---|---|--|--|---|---|---------------------------------------|--------------------|
|   | PROVIDER OR SUPPLIER                          | R<br>SISTED LIVING AND MEMORY C                              | ARE  | 1255 D  | ADDRESS, CITY, STATE, ZIP COD<br>EMAREE ROAD<br>NWOOD, IN 46143                                   |                                       |                    |
| (X4) ID<br>PREFIX   |   | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL        |  | ID<br>PREFIX  | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA |                                       | (X5)<br>COMPLETION |
| TAG   | `   | R LSC IDENTIFYING INFORMATION                                |  | TAG   | CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)  | TE                                    | DATE               |
|   |   | haler 90 micrograms (mcg) 2                                  |  |   | and valid Clinical Laboratory   |                                       |                    |
|   | puffs by mouth four times a day as needed for |  |  |   | Improvement Amendments (C   | -                                     |                    |
|   | asthma.                                       |  |  |   | certification (for the purposes   | of                                    |                    |
| Idi   |   |  |  | performing laboratory                                 |   |                                       |                    |
| - Jardiance tab 10 milligrams (mg), one tablet daily for heart failure. |   |  |  | examinations or procedures) t                         | was   |                                       |                    |
| for heart famure.   |   |  |  | maintained as required.  1: What corrective action(s) | azill   |                                       |                    |
|   | - Metformin ER 500 mg, one tablet daily for   |  |  |   | be accomplished for those   | vv 111                                |                    |
| diabetes.   |   |  |  | residents found to have been                          | า   |                                       |                    |
| diabotosi   |   |  |  | affected by the deficient                             |   |                                       |                    |
| - Metoprolol 50 mg, one and a half tablets twice                        |   |  |  |   | practice?   |                                       |                    |
| daily for hypertension.   |   |  |  | No residents were affecte                             | d by  |                                       |                    |
|   | the alleged deficient practice.               |  |  |   |   |                                       |                    |
| - Spiriva Respimat 2.5 mcg, 2 puffs daily for COPD.                     |   |  |  | CLIA certification was                                |   |                                       |                    |
|   |   |  |  |   | submitted for renewal on  |                                       |                    |
|   |   | ical record lacked an itemized                               |  |   | 5/09/2025 to  |                                       |                    |
|   |   | cord for the above mentioned                                 |  |   | labexcellence@cms.hhs.gov and   |                                       |                    |
|   | another facility.                             | time he was discharged to                                    |  |   | paid through pay.gov-CLIA<br>Laboratory User Fees.  |                                       |                    |
|   |   | v on 5/9/25 at 11:20 a.m., the                               |  |   | 2: How other residents havin  | ıg                                    |                    |
|   | Executive Director                            | indicated Resident 103 was                                   |  |   | the potential to be affected b  | У                                     |                    |
|   | transferred to anoth                          | ner facility in March of 2025.                               |  |   | the same deficient practice v   | vill                                  |                    |
|   |   |  |  |   | be identified and what  |                                       |                    |
|   |   | 0 p.m., the clinical record for                              |  |   | corrective action will be take  |                                       |                    |
|   |   | eviewed. The diagnoses                                       |  |   | - No residents were affected  | d by                                  |                    |
|   |   | not limited to, dementia,                                    |  |   | the alleged deficient practice.   |                                       |                    |
|   |   | ypertension, constipation, and re of second lumbar vertebra. |  |   | 2. M/bet messures will be now   |                                       |                    |
|   | compression fractu                            | re of second fumbar vertebra.                                |  |   | 3: What measures will be puinto place or what systemic  | L                                     |                    |
|   | On 5/9/25 at 12:30                            | p.m., the Executive Director                                 |  |   | changes will be made to   |                                       |                    |
|   |   | the physician's order report                                 |  |   | ensure that the deficient   |                                       |                    |
|   |   | eview of the medication list                                 |  |   | practice does not recur?  |                                       |                    |
|   | included the curren                           | t medications that Resident                                  |  |   | The ED and DHW will be  |                                       |                    |
|   | 104 had been receiv                           | ving prior to the time of his                                |  |   | educated on the Federal and   | State                                 |                    |
|   | death. The list incl                          | uded, but was not limited to,                                |  |   | Regulatory requirements and   |                                       |                    |
|   | the following order                           | s:   |  |   | renewal process for CLIA  |                                       |                    |
|   |   |  |  |   | Certification by the SVP of He  | alth                                  |                    |
|   | - Furosemide 40 mg                            | g, one tablet per day for fluid                              |  |   | & Wellness.   |                                       |                    |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 104 of 154

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |   | X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY |                                    |                                 |   | SURVEY |            |
|--|---|--|------------------------------------|---------------------------------|---|--------|------------|
| AND PLAN   | OF CORRECTION                                   | IDENTIFICATION NUMBER                      | A. BUILDING <u>00</u> COMPLETED    |                                 |   | ETED   |            |
|  |   |  | B. WI                              | NG                              |   | 05/09/ | 2025       |
|  |   |  |                                    | CTREET                          | ADDRESS, CITY, STATE, ZIP COD   |        |            |
| NAME OF F  | PROVIDER OR SUPPLIER                            | 2  |                                    | 1                               |   |        |            |
| DEMADE   |   | SISTED LIVING AND MEMORY CA                | DE                                 |                                 | EMAREE ROAD   |        |            |
| DEWARE   | E CRUSSING ASS                                  | SISTED LIVING AND MEMORY CA                | NKE.                               | GREEN                           | NWOOD, IN 46143   |        |            |
| (X4) ID  | SUMMARY   | STATEMENT OF DEFICIENCIE                   |                                    | ID                              | PROVIDER'S PLAN OF CORRECTION   |        | (X5)       |
| PREFIX   | (EACH DEFICIEN                                  | CY MUST BE PRECEDED BY FULL                | PREFIX  (EACH CORRECTION SHOULD BI |                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | TE     | COMPLETION |
| TAG  | REGULATORY OF                                   | R LSC IDENTIFYING INFORMATION              |                                    | TAG                             | DEFICIENCY)   | . –    | DATE       |
|  |   |  |                                    |                                 | 4: How the corrective action  |        |            |
|  | - Bisacodyl suppository 10 mg, one suppository  |  |                                    |                                 | will be monitored to ensure t   | he     |            |
| rectally daily for constipation.                     |   |  |                                    | deficient practice will not rec | ur  |        |            |
|  |   |  |                                    |                                 | i.e., what quality assurance  |        |            |
|  | - Haloperidol conce                             | entrate 0.5 mg sublingually, two           |                                    |                                 | program will be put into plac   | e?     |            |
|  | times per day for re                            | stlessness or agitation.                   |                                    |                                 | ED or their designee wil  | l be   |            |
|  |   |  |                                    |                                 | responsible for monitoring  |        |            |
|  | - Hydrocodone/apa                               | p (acetominophen) tablet                   |                                    |                                 | expiration date and submit tim  | ely    |            |
|  | 10-325 mg, one tab                              | let by mouth every 12 hours for            |                                    |                                 | renewal for CLIA Certificate  | -      |            |
|  | pain.   |  |                                    |                                 | Date of completion: June  | 9,     |            |
|  | •   |  |                                    |                                 | 2025  |        |            |
| - Lorazepam 0.5 mg tablet every four hours for       |   |  |                                    | R 148- Sanitation and Safety    |   |        |            |
| anxiety or shortness of breath.                      |   |  | Standards- Deficiency              |                                 |   |        |            |
|  |   |  |                                    | "Facility failed to ensure that |   |        |            |
|  | - Metoprolol 25 mg                              | , one tablet daily for                     |                                    |                                 | potentially hazardous material  | s      |            |
|  | hypertension.                                   |  |                                    |                                 | were kept secured behind lock   | red    |            |
|  |   |  |                                    |                                 | doors to prevent resident's acc   | cess   |            |
|  | - Morphine 5 mg, e                              | very three hours as needed for             |                                    |                                 | to hazardous materials for 14   | of     |            |
|  | pain or shortness of                            | breath.                                    |                                    |                                 | 14 self-mobile and cognitively  |        |            |
|  |   |  | impaired residents residing on the |                                 |   |        |            |
|  | - Sertraline 25 mg,                             | one tablet every day for                   |                                    |                                 | assisted living unit in the facilit   | ty     |            |
|  | depression.                                     |  |                                    |                                 | 1: What corrective action(s) will   |        |            |
|  |   |  |                                    |                                 | be accomplished for those   |        |            |
|  | Resident 104's clini                            | cal record lacked an itemized              |                                    |                                 | residents found to have beer  | 1      |            |
|  |   | cord for the return or                     |                                    |                                 | affected by the deficient   |        |            |
|  | destruction of the al                           | bove medications at the time               |                                    |                                 | practice?   |        |            |
|  | of his death in the f                           | acility.                                   |                                    |                                 | No residents were affec   | ted    |            |
|  |   |  |                                    |                                 | by the alleged deficient practic  | e.     |            |
|  | During an interview                             | on 5/9/25 at 11:20 a.m., the               |                                    |                                 | Door to beauty shop wa  | s      |            |
|  | Executive Director                              | indicated Resident 104 passed              |                                    |                                 | immediately closed and locked   | d.     |            |
|  | away in the facility.                           |  |                                    |                                 | The community's   |        |            |
|  |   |  |                                    |                                 | housekeeping staff and beauti   | cian   |            |
|  | -   | v on 5/9/25 at 12:05 p.m., the             |                                    |                                 | will be in-serviced by the  |        |            |
|  |   | indicated the facility lacked a            |                                    |                                 | community Executive Director  | on     |            |
|  | drug disposition rec                            | cord for Resident 103's and                |                                    |                                 | community's policy for Hazard   | ous    |            |
|  | Resident 104's medication at the time of their  |  |                                    |                                 | Substance Classification and  |        |            |
|  | discharge from the facility. The facility staff |  |                                    |                                 | Storage.  |        |            |
|  | should have completed the required drug         |  |                                    |                                 | The community beautici  | an     |            |
|  | disposition records                             | at the time of the Resident's              |                                    |                                 | was provided a key to the Bea   | uty    |            |
|  | discharge.                                      |  |                                    |                                 | Shop for access to room.  |        |            |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 105 of 154

|                          | T OF DEFICIENCIES<br>OF CORRECTION   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING |   | (X3) DATE SURVEY  COMPLETED  05/09/2025     |  |
|--------------------------|--|---|--|---|---|--|
| DEMARE                   |  | SISTED LIVING AND MEMORY CA   | 1255 DI<br>RE GREEN                              | ADDRESS, CITY, STATE, ZIP COD<br>EMAREE ROAD<br>IWOOD, IN 46143   |   |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION  | ID<br>PREFIX<br>TAG                              | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)  | DATE  |  |
|                          | provided a copy of Medication policy, was the current poli review of the docum documented within record includes, but name, date medicatistrength of medicatistrength of medicatipharmacy, quantity disposition, reason, witnesscomplete a shall be kept on file resident transfers to nurse shall send all documented in resident transfers | medication disposition records for at least two yearsif another community, the resident medicationstransfer dent's medical record"  p.m., the Executive Director the Discontinuing dated 7/19/22, and indicated it cy in use by the facility. A ment indicated, "staff shall inued medications or shall ispensing pharmacy in |  | 2: How other residents having the potential to be affected by the same deficient practice of be identified and what corrective action will be taken affected by the alleged deficient practice.  3: What measures will be purinto 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 Hazardous Substance Classification and Storage Guideline by 6/9/25. An in-sent 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 pre-service training.  The community's Direct of Health and Wellness or the designee shall complete monitoring of areas containing hazardous materials to ensure securement at minimum of for days per week for four weeks the monthly for six months. | y vill on.  nt  t  t  t  their  or  ir  and |  |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 106 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | T OF DEFICIENCIES<br>DF CORRECTION    | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER                                       | (X2) MULT<br>A. BUILD<br>B. WING | DING             | nstruction<br><u>00</u>   | (X3) DATE<br>COMPL<br>05/09/   | ETED                       |
|--------------------------|---------------------------------------|---|----------------------------------|------------------|---|--|----------------------------|
|                          | ROVIDER OR SUPPLIER<br>E CROSSING ASS | R<br>BISTED LIVING AND MEMORY C   | 1                                | 255 DE           | DDRESS, CITY, STATE, ZIP COD<br>EMAREE ROAD<br>WOOD, IN 46143   |  |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                        | STATEMENT OF DEFICIENCIE<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION | PRE                              | D<br>EFIX<br>'AG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)  |  | (X5)<br>COMPLETION<br>DATE |
|                          |                                       |   |                                  |                  | The community's Direct of Health and Wellness or the designee shall provide summindings to the Executive Direct weekly and then monthly for review and discussion of any correction action items.  4: How the corrective action will be monitored to ensure deficient practice will not refice, what quality assurance program will be put into plath the Director of Facilities their designee will be responsion monitoring compliance of sanitation and safety standarthrough random monthly chefor unsecured hazardous substance, unlocked cabinets doors for six months. The random monthly checks results will be reviewed during the monthly meeting overseen by the Executive Director. Corrective actions will be implemented to on the findings and discussion during safety meeting.  The community throug safety meeting, will review, unand make changes to the DP as needed for sustaining substantial compliance for not than six months.  Date of completion:  June 9, 2025  R 151- Sanitation & Safety Standards-Noncompliance | eir eary of ector  the cur es or sible ds cks s and adom e safety e poased n the poased n the poased n the poased n the poased n |                            |
|                          |                                       |   | 1                                |                  | "Facility failed to ensure a pe   | LVVIIO   |                            |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 107 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | T OF DEFICIENCIES<br>OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER                                    | (X2) MULTIPLE<br>A. BUILDING<br>B. WING | e construction  00   | (X3) DATE SURVEY  COMPLETED  05/09/2025   |
|--------------------------|------------------------------------|---|---|--|---|
|                          | ROVIDER OR SUPPLIE                 | R<br>SISTED LIVING AND MEMORY   | 1255                                    | ET ADDRESS, CITY, STATE, ZIP CO<br>5 DEMAREE ROAD<br>EENWOOD, IN 46143   | DD .  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIE)                     | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | ID<br>PREFIX<br>TAG                     | PROVIDERS PLAN OF CORR<br>(EACH CORRECTIVE ACTION SHE<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY)   | ECTION JULD BE PROPRIATE  COMPLETION DATE   |
|                          |                                    |   |   | resided in the facility hat the rabies vaccination at annual veterinary examicompleted as required pexpiration date for 1 of a who housed pets in the (Resident 97)  1: What corrective active active accomplished for the residents found to have affected by the deficient practice?  The canine owner Resident 97 had vaccing updated on 5/20/25.  Record of such vaccing updated and maintained by the common Resident Experience Ditheir designee  2: How other residents the potential to be affected and what corrective action will be residing at the communication and the communication of Health and V on 5/25/25.  All in community practice and maintain community's Resident Experience Director or their designed Executive Director's office Resident Experience Director or their designed responsible for notifying responsible for n | and the ination was prior to its of residents facility"  on(s) will nose e been not to the domination shall be nunity's rector or to the facility were gity's vellness pet to the domination be ed by the experience ere in the coe. Ince the will be |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 108 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING                                |                    |  | (X3) DATE SURVEY COMPLETED 05/09/2025       |                            |
|--------------------------|---|--|---|--------------------|--|---|----------------------------|
|                          | ROVIDER OR SUPPLIER   | SISTED LIVING AND MEMORY CA  | STREET ADDRESS, CITY, STATE, ZIP COD 1255 DEMAREE ROAD CARE GREENWOOD, IN 46143 |                    |  |   |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIE<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION | PF  | ID<br>REFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  | TE  | (X5)<br>COMPLETION<br>DATE |
|                          |   |  |   |                    | coordinating with<br>resident/responsible party any<br>upcoming or past due pet<br>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 reside who have pets residing in the community shall be educated community's standards and post for pet annual examination and compliance with vaccination deview of the residency agreed by the Executive Director.  The community's Reside Experience Director or their designee shall review and profexecutive Director copy of pet vaccinations for any new pets 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 compliar with community policy. The results of these reviews shall the reported to the Executive Director Director Director or their designee shall reported to the Executive Director and discussed during the | ent ints on olicy d uring ment ent vide who |                            |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 109 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

| AND PLAN OF (            |                   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER                                    | (X2) MULTIPI<br>A. BUILDIN<br>B. WING | LE CONSTRUCTION  G  00   | (X3) DATE SURVEY COMPLETED 05/09/2025                                 |  |  |  |  |
|--------------------------|-------------------|--|---------------------------------------|--|---|--|--|--|--|
|                          | VIDER OR SUPPLIER | SISTED LIVING AND MEMORY C   | 125                                   | STREET ADDRESS, CITY, STATE, ZIP COD  1255 DEMAREE ROAD  RE GREENWOOD, IN 46143  |   |  |  |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN    | STATEMENT OF DEFICIENCIE<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION | ID<br>PREFI<br>TAC                    | CROSS-REFERENCED TO THE APPR<br>DEFICIENCY)  | LD BE COMPLETION DATE   |  |  |  |  |
|                          |                   |  |                                       | 4: How the corrective ac will be monitored to ensideficient practice will not i.e., what quality assurate program will be put into.  The community's EDirector or their designeer complete random audits of vaccination and examinate tracking monthly for six mensure all pet vaccination annual examinations are and up to date.  Audit results will be reviewed at the monthly semeeting overseen by the Executive Director. If a the of 95% is not achieved, a plan will be developed.  The community threst safety meeting, will reviewed and make changes to the as needed for sustaining substantial compliance for than 6 months | ing.  Ition Fure the ot recur Ince Ince Ince Ince Ince Ince Ince Ince |  |  |  |  |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 110 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

| AND PLAN OF C            |                   | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER                                |   | ILDING | 00   | COMPL<br>05/09/                  | ETED                       |
|--------------------------|-------------------|---|---|--------|--|----------------------------------|----------------------------|
|                          | VIDER OR SUPPLIER | ISTED LIVING AND MEMORY C   | STREET ADDRESS, CITY, STATE, ZIP COD 1255 DEMAREE ROAD GREENWOOD, IN 46143  |        |  |                                  |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)  TAG DEFICIENCY) |        |  | TE                               | (X5)<br>COMPLETION<br>DATE |
|                          |                   |   |   |        | practice? Resident 39 has been discharged from the communit 5/14/25.   | ty on                            |                            |
|                          |                   |   |   |        | 2: How other residents havin the potential to be affected by the same deficient practice whe identified and what corrective action will be take - The community's Director 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 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 electron health record for new move insidentified and documentation of resident's working the process of the designee shall review electron health record for new move insidentified and wellness or the documentation of resident's working the process of the designee shall review electron health record for new move insidentified and wellness or the documentation of resident's working the process of the designee and documentation of resident's working the process of the designee of the process | y vill n. r of or it(s) eight of |                            |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 111 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER |                                     | A. B  | IULTIPLE CO<br>UILDING<br>/ING | onstruction<br><u>00</u> | (X3) DATE SURVEY COMPLETED 05/09/2025  |  |                            |
|---|-------------------------------------|---|--------------------------------|--------------------------|--|--|----------------------------|
|   | ROVIDER OR SUPPLIE<br>E CROSSING AS | R<br>SISTED LIVING AND MEMORY C   | ARE                            | 1255 D                   | ADDRESS, CITY, STATE, ZIP COD<br>DEMAREE ROAD<br>NWOOD, IN 46143   |  |                            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN                      | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION |                                | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)   | ATE  | (X5)<br>COMPLETION<br>DATE |
|   |                                     |   |                                |                          | shall re-educate all Wellness (Care) team members regard Admission Policy and standar obtaining and documenting residents' weight upon move An in-service attendance log be maintained as evidence of completion of re-education, a shall be maintained with the community's training files  The community's  The community's  Director of Health and Wellness (Care) team members on community's Admission Polic during the community pre-ser training.  4: How the corrective action will be monitored to ensure deficient practice will not rei.e., what quality assurance program will be put into plath and Wellness/design will complete daily monitoring ensure that new move in resident(s) have an admission weight documented. Results 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 2025  R 217 Evaluation-Deficiency "Facility failed to ensure the service plans were signed by | rd for in. shall f nd ess  y vice the cur ce? ttor nee i to n of orted |                            |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 112 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER |                     |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING |              |   | (X3) DATE SURVEY COMPLETED 05/09/2025        |                    |
|---|---------------------|--|--|--------------|---|--|--------------------|
| NAME OF P   | PROVIDER OR SUPPLIE | R  |  |              | ADDRESS, CITY, STATE, ZIP COD   |  |                    |
| DEMARE  | E CROSSING AS       | SISTED LIVING AND MEMORY C                               | ARE  |              | EMAREE ROAD<br>NWOOD, IN 46143  |  |                    |
| (X4) ID<br>PREFIX   | (EACH DEFICIEN      | STATEMENT OF DEFICIENCIE<br>NCY MUST BE PRECEDED BY FULL |  | ID<br>PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA   | ATE  | (X5)<br>COMPLETION |
| TAG   | REGULATORY O        | R LSC IDENTIFYING INFORMATION                            |  | TAG          | resident or the resident's representative for 7 of 7 residents reviewed for service plans (Resident 25, Resident Resident 48, Resident 103 and Resident 104)  1: What corrective action(s) be accomplished for those residents found to have been affected by the deficient practice?  Current service plans for Residents 25, 39, 48, 85, and service plans have been revie 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 patential to be affected by the deficient practice where identified and what corrective action will be takendary.  The community's Director of the complete an audit of all current resident's service plan to valid signature by resident or responsible party by June 9, 20.  3: What measures will be pure into place or what systemic changes will be made to ensure that the deficient practice does not recurrective does not recurrective community's Director of the community | e 39, ad will n or 90 ewed or of otate 2025. | DATE               |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 113 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER |                    |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING |                     |  | (X3) DATE SURVEY COMPLETED 05/09/2025                      |  |
|---|--------------------|---|--|---------------------|--|--|--|
| NAME OF P   | ROVIDER OR SUPPLIE | R   |  |                     | ADDRESS, CITY, STATE, ZIP COD  |  |  |
| DEMARE  | E CROSSING AS      | SISTED LIVING AND MEMORY CA   | ARE  |                     | EMAREE ROAD<br>IWOOD, IN 46143   |  |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN     | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  | (X5) COMPLETION DATE                                       |  |
|   |                    |   |  |                     | of Health and Wellness will re-educate the Wellness team member on the community's Evaluation policy which includ requirement for review and signature on plan of care. An in-service attendance log shal maintained as evidence of completion of re-education, ar shall be maintained with the community's training files  4: How the corrective action will be monitored to ensure the deficient practice will not recite, what quality assurance program will be put into place. The community's Direct of Health and Wellness or their designee shall complete randoweekly audits of at least 2 new resident records weekly to evaluate compliance with sign service plans. The results of weekly monitoring shall be reported to and reviewed with community's Executive Director Date of completion:  June 9, 2025 | es I be ad the cur ee? or ir or ir or ir or ir the the the |  |
|   |                    |   |  |                     | R 306 Pharmaceutical Services-Noncompliance "Facility failed to ensure drug dispositions for all medications including non-controlled substance medications were accounted for and documente 2 of 2 closed records reviewed (Resident 103, Resident 104)   | d for  |  |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 114 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | T OF DEFICIENCIES  OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER                                    | (X2) MUL<br>A. BUIL<br>B. WING  | DING | nstruction  00   | (X3) DATE<br>COMPL<br>05/09/                                  | ETED                       |  |
|--------------------------|----------------------------------|---|---|------|--|---|----------------------------|--|
|                          | ROVIDER OR SUPPLIE               | R<br>BISTED LIVING AND MEMORY C   | STREET ADDRESS, CITY, STATE, ZIP COD 1255 DEMAREE ROAD CARE GREENWOOD, IN 46143   |      |  |   |                            |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                   | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) |      |  |   | (X5)<br>COMPLETION<br>DATE |  |
|                          |                                  |   |   |      | 1: What corrective action(s) be accomplished for those residents found to have been affected by the deficient practice?  Drug disposition forms been completed for Resident and 104 on [ADD DATE]  2: How other residents have the potential to be affected the same deficient practice be identified and what corrective action will be take. The community's Direct of Health and Wellness shall implement the use of Drug disposition form for all resided discharged from the community. June 9, 2025.  3: What measures will be purint to place or what systemic changes will be made to ensure that the deficient practice does not recur.  The community's Direct of Health and Wellness shall in-service the Wellness Team members on the community's policies for Discarding and Destroying Medication and Discontinuing Medication. Ar in-service attendance log shamaintained as evidence of completion and maintained with community's training files. | ing by will ten. ctor ents hity by ut ctor n s all be with s. |                            |  |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 115 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | IT OF DEFICIENCIES<br>OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER                              | (X2) MULTIPLE C A. BUILDING B. WING | onstruction<br><u>00</u>  | (X3) DATE SURVEY COMPLETED 05/09/2025              |  |
|--------------------------|-------------------------------------|--|-------------------------------------|---|--|--|
|                          | ROVIDER OR SUPPLIER                 | ISTED LIVING AND MEMORY CA   | 1255 E                              | ADDRESS, CITY, STATE, ZIP COD<br>DEMAREE ROAD<br>NWOOD, IN 46143  |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                      | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | ID<br>PREFIX<br>TAG                 | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)   | DATE   |  |
|                          |                                     |  |                                     | will be monitored to ensure to deficient practice will not recise, what quality assurance program will be put into place. The community's Direct of Health and Wellness or the designee shall complete randoweekly 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 share reported to and reviewed with community's Executive Direct Date of completion:  June 9, 2025.  R409- Infection  Control-Noncompliance  "Facility failed to ensure that to annual health assessment statement (a statement by the physician indicating the reside free of communicable disease was documented as required of 7 residents reviewed. (Residents found to have been affected by the deficient practice?  Resident 48 electronic medical record reviewed, and annual health statement updat by the primary physician.  2: How other residents having the potential to be affected by the deficient practice? | ee? or ir om en en en ent is e) for 1 ident will n |  |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 116 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | T OF DEFICIENCIES  OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER                                 | (X2) MULTI<br>A. BUILDI<br>B. WING | PLE CONSTRUCTION  NG 00  | COMP   | E SURVEY<br>PLETED<br>9/2025 |  |  |  |
|--------------------------|----------------------------------|---|------------------------------------|--|--|------------------------------|--|--|--|
|                          | ROVIDER OR SUPPLIER              | R<br>BISTED LIVING AND MEMORY C   | 12                                 | STREET ADDRESS, CITY, STATE, ZIP COD 1255 DEMAREE ROAD RE GREENWOOD, IN 46143  |  |                              |  |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                   | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | ID<br>PREI<br>TA                   | FIX (EACH CORRECTIV<br>CROSS-REFERENCE<br>G DEFI   | LAN OF CORRECTION TE ACTION SHOULD BE ED TO THE APPROPRIATE ICIENCY)   | (X5)<br>COMPLETION<br>DATE   |  |  |  |
|                          |                                  |   |                                    | be identified a corrective acti The commodified and We designee condition of the alth assessment indicating that is communicable 9, 2025.  3: What measure into place or with the community of the alth assessment indicating that is community of the community of the community of the community of the alth assessment indicating that is communicable in-service attention and completion of the community of the community of the communicable in-service attention of the communicable in-service attention of the communicatine of the communication of the communic | ion will be taken. Inunity's Director of ellness or their ucted an audit on inhouse resident inpliance with annual ment statement resident is free of diseases by June  ures will be put what systemic be made to be deficient into trecur into the annual ment statement in the community's indicate of interesident is free of indicates. An indicate log shall be evidence of interesident in the community's indicate in the community's indicate in the community's indicate in the louding statement in the louding statement in the statement in the statement in the louding statement in the louding statement in the statement in the louding st |                              |  |  |  |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 117 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | T OF DEFICIENCIES<br>OF CORRECTION  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER                                    | ì í | ILDING                      | ONSTRUCTION  00   | (X3) DATE SURVEY COMPLETED 05/09/2025  |
|--------------------------|-------------------------------------|---|-----|-----------------------------|---|--|
|                          | ROVIDER OR SUPPLIE<br>E CROSSING AS | R<br>BISTED LIVING AND MEMORY C   | ARE | STREET A<br>1255 D<br>GREEN |   |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                      | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION |     | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY)   | 5.112  |
|                          |                                     |   |     |                             | 4: How the corrective action will be monitored to ensure deficient practice will not reite., what quality assurance program will be put into plate. The community's Direct of Health and Wellness or the designee shall complete daily monitoring to ensure new more resident(s) have an annual he statement documented. Resudaily monitoring shall be repot to the community's Executive Director.  The community's Executive Director will randomly review 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 screening tuberculosis) was completed upon admission for residents reviewed (Reside and Resident 90)."  1: What corrective action(s) be accomplished for those residents found to have bee affected by the deficient practice?  Residents 39 and 90 two-step tuberculin skin tests been initiated by the Wellness team.  2: How other residents having the potential to be affected by the deficient practice? | the cur  ce? ctor eir / ve-in ealth ults of orted  utive 2  a  I for or 2 of out 39  will en  have s |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 118 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | OF CORRECTION                         | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER                                 |   | UILDING             | 00   | COMPL<br>05/09/                                | ETED                       |
|--------------------------|---------------------------------------|--|---|---------------------|--|--|----------------------------|
|                          | ROVIDER OR SUPPLIER<br>E CROSSING ASS | ISTED LIVING AND MEMORY C  | STREET ADDRESS, CITY, STATE, ZIP COD 1255 DEMAREE ROAD CARE GREENWOOD, IN 46143 |                     |  |  |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                        | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION |   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)   |  | (X5)<br>COMPLETION<br>DATE |
|                          |                                       |  |   |                     | the same deficient practice was identified and what corrective action will be take.  The community's Directo Health and Wellness or their designee shall complete an au of inhouse resident's electronic health records to evaluate compliance with first and seconstep tuberculin skin test.  Tuberculin skin tests will be administered as needed for an 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 Direct of Health and Wellness or their designee shall complete monitoring to ensure that new move in resident(s) receive the first and second tuberculin skin test.  The community's Direct of Health and Wellness or their designee shall complete daily review of new move in records ensure compliance with tubercy skin test for the next 90 days. Results of the daily monitoring be discussed with Executive Director and corrective actions taken to ensure compliance. | n. r of dit c nd ny  eir n or r sto culin will |                            |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 119 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER |  | r í  | UILDING | ONSTRUCTION  00     | (X3) DATE<br>COMPI<br>05/09  | LETED                      |                            |
|--|--|--|---------|---------------------|--|----------------------------|----------------------------|
|  | ROVIDER OR SUPPLIER  | SISTED LIVING AND MEMORY C   | CARE    | 1255 D              | ADDRESS, CITY, STATE, ZIP COD<br>EMAREE ROAD<br>NWOOD, IN 46143  |                            |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION   |         | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY)  | IATE                       | (X5)<br>COMPLETION<br>DATE |
| R 0409   | 410 IAC 16.2-5-12  | • •  |         |                     | will be monitored to ensure deficient practice will not re i.e., what quality assurance program will be put into pla  The Executive Director their designee shall complete weekly random audits of at le resident records weekly for for weeks, then monthly X 6 mon to monitor compliance with tuberculin skin testing.  Date of completion: June 9, 2025   | ce? or east 2              |                            |
| Bldg. 00   | Infection Control -  | • •  |         |                     |  |                            |                            |
|  | failed to ensure that statement by the ph is free of communic as required for 1 of (Resident 48)  Finding includes:  On 5/8/25 at 11:10 and Resident 48 was revincluded, but were an anxiety disorder, variety dis | riew and interview, the facility an annual health statement (a sysician indicating the resident reable disease) was documented residents reviewed.  Tresidents reviewed.  a.m., the clinical record for reiewed. The diagnoses not limited to, generalized scular dementia with other nee, and alcohol dependence elirium.  al record lacked documentation statement from the physician.  To on 5/9/25 at 12:35 p.m., the ED indicated the facility was an annual health statement | R 0     | 409                 | Demaree Crossing 05.14.25 This Plan of Correction is submitted under regulations applicable to long term care providers. This Plan of Corre is not to be construed as an admission or agreement with findings and conclusions in the Statement of Deficiencies. The preparation of this Plan does not constitute agreement by the facility that the surveyor's find or conclusions are accurate, the findings constitute a deficiency, or that the scope severity regarding any of the deficiencies are correctly approximates.  R086-Administration and | the ne or or ot dings that | 06/09/2025                 |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 120 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER |  |   | JILDING | 00                  | COMPL<br>05/09/   | ETED  |                            |
|--|--|---|---------|---------------------|---|---|----------------------------|
|  | PROVIDER OR SUPPLIER   | SISTED LIVING AND MEMORY CA   | ARE     | 1255 DI             | ADDRESS, CITY, STATE, ZIP COD<br>EMAREE ROAD<br>IWOOD, IN 46143   |   |                            |
| (X4) ID<br>PREFIX<br>TAG                     | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION  |         | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)  | TE  | (X5)<br>COMPLETION<br>DATE |
|  | the Admissions poli<br>indicated it was the<br>facility. A review of<br>part of admission pr<br>the healthcare provi | a.m., the ED provided a copy of cy, dated 1/14/22, and current policy in use by the f the policy indicated that as rocedures for new residents ded documentation should " at of the resident being free |         |                     | Management-Deficiency "Facility failed to ensure a currand valid Clinical Laboratory Improvement Amendments (Coertification (for the purposes performing laboratory examinations or procedures) imaintained as required.  1: What corrective action(s) is be accomplished for those residents found to have been affected by the deficient practice?  No residents were affected the alleged deficient practice. CLIA certification was submitted for renewal on 5/09/2025 to labexcellence@cms.hhs.gov apaid through pay.gov-CLIA Laboratory User Fees.  2: How other residents having the potential to be affected by the same deficient practice is identified and what corrective action will be take.  No residents were affected 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 Segulatory requirements and renewal process for CLIA Certification by the SVP of He | eLIA) of was will d by and g y will n. d by |                            |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 121 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                      | (X2) MULTIPLE CONSTRUCTION (X3) DATE SU |   |         |   | SURVEY     |            |
|--|----------------------|---|---|---------|---|------------|------------|
| AND PLAN   | OF CORRECTION        | IDENTIFICATION NUMBER                   | A. BU   | JILDING | 00  | COMPLETED  |            |
|  |                      |   | B. W  | ING     |   | 05/09/2025 |            |
|  |                      |   |   | STREET  | ADDRESS, CITY, STATE, ZIP COD   | <u> </u>   |            |
| NAME OF P  | PROVIDER OR SUPPLIEF | 8                                       |   |         | EMAREE ROAD   |            |            |
| DEMARE   | E CROSSING ASS       | SISTED LIVING AND MEMORY C              | ARE   |         | NWOOD, IN 46143   |            |            |
| 77.0 770   |                      |   | 1   |         | ,<br>T  |            |            |
| (X4) ID  |                      | STATEMENT OF DEFICIENCIE                | ID PROVIDER'S PLAN OF CORRECTION SHOULD BE ACTION SHOULD |         | PROVIDER'S PLAN OF CORRECTION   |            | (X5)       |
| PREFIX   | ``                   | ICY MUST BE PRECEDED BY FULL            | PREFIX  |         | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | TE         | COMPLETION |
| TAG  | REGULATORY OF        | R LSC IDENTIFYING INFORMATION           | +   | TAG     |   |            | DATE       |
|  |                      |   |   |         | & Wellness.   |            |            |
|  |                      |   |   |         | 4: How the corrective action  |            |            |
|  |                      |   |   |         | will be monitored to ensure t   | ho         |            |
|  |                      |   |   |         | deficient practice will not rec   |            |            |
|  |                      |   |   |         | i.e., what quality assurance  | ,u.        |            |
|  |                      |   |   |         | program will be put into place  | e?         |            |
|  |                      |   |   |         | ED or their designee wil  |            |            |
|  |                      |   |   |         | responsible for monitoring  |            |            |
|  |                      |   |   |         | expiration date and submit tim  | ely        |            |
|  |                      |   |   |         | renewal for CLIA Certificate  |            |            |
|  |                      |   |   |         | Date of completion: June  | 9,         |            |
|  |                      |   |   |         | 2025  |            |            |
|  |                      |   |   |         | R 148- Sanitation and Safety  |            |            |
|  |                      |   |   |         | Standards- Deficiency   |            |            |
|  |                      |   |   |         | "Facility failed to ensure that   |            |            |
|  |                      |   |   |         | potentially hazardous material  |            |            |
|  |                      |   |   |         | were kept secured behind lock   |            |            |
|  |                      |   |   |         | doors to prevent resident's ac  |            |            |
|  |                      |   |   |         | to hazardous materials for 14 14 self-mobile and cognitively                          |            |            |
|  |                      |   |   |         | impaired residents residing on  |            |            |
|  |                      |   |   |         | assisted living unit in the facility  |            |            |
|  |                      |   |   |         | 1: What corrective action(s)  | -          |            |
|  |                      |   |   |         | be accomplished for those   |            |            |
|  |                      |   |   |         | residents found to have been  | ո          |            |
|  |                      |   |   |         | affected by the deficient   |            |            |
|  |                      |   |   |         | practice?   |            |            |
|  |                      |   |   |         | No residents were affect  | ted        |            |
|  |                      |   |   |         | by the alleged deficient praction   |            |            |
|  |                      |   |   |         | Door to beauty shop wa  |            |            |
|  |                      |   |   |         | immediately closed and locked   | d.         |            |
|  |                      |   |   |         | The community's   |            |            |
|  |                      |   |   |         | housekeeping staff and beaut  | cıan       |            |
|  |                      |   |   |         | will be in-serviced by the  | an         |            |
|  |                      |   |   |         | community Executive Director  |            |            |
|  |                      |   |   |         | community's policy for Hazard Substance Classification and                            | ous        |            |
|  |                      |   |   |         |   |            |            |
|  |                      |   |   |         | Storage.  The community beautic   | ian        |            |
| 1  | i e                  |   | 1   |         | I The community beaution  | ull        | 1          |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 122 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER |                     | A. BUILDING <u>00</u> COMPLET |     |                         | (X3) DATE SURVEY COMPLETED 05/09/2025                                  |            |
|---|---------------------|-------------------------------|-----|-------------------------|--|------------|
| NAME OF P   | ROVIDER OR SUPPLIER | <del></del>                   |     | 1                       | ADDRESS, CITY, STATE, ZIP COD  |            |
| DEMARE  | E CROSSING ASS      | SISTED LIVING AND MEMORY CA   | ARE |                         | EMAREE ROAD<br>IWOOD, IN 46143   |            |
| (X4) ID   | SUMMARY             | STATEMENT OF DEFICIENCIE      |     | ID                      | PROVIDER'S PLAN OF CORRECTION  | (X5)       |
| PREFIX  | (EACH DEFICIEN      | CY MUST BE PRECEDED BY FULL   |     | PREFIX                  | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | COMPLETION |
| TAG   | REGULATORY OR       | LSC IDENTIFYING INFORMATION   |     | TAG                     | DEFICIENCY)  | DATE       |
|   |                     |                               |     |                         | was provided a key to the Bea  | auty       |
|   |                     |                               |     |                         | Shop for access to room.   |            |
|   |                     |                               |     |                         | 2: How other residents having the potential to be affected by          | <u> </u>   |
|   |                     |                               |     |                         | the same deficient practice v  | - I        |
|   |                     |                               |     |                         | be identified and what   |            |
|   |                     |                               |     |                         | corrective action will be take   | en.        |
|   |                     |                               |     |                         | - No resident was  |            |
|   |                     |                               |     |                         | affected by the alleged deficie  | nt         |
|   |                     |                               |     |                         | practice.  |            |
|   |                     |                               |     |                         | 3: What measures will be pu  | t l        |
|   |                     |                               |     |                         | into place or what systemic  |            |
|   |                     |                               |     | changes will be made to |  |            |
|   |                     |                               |     |                         | ensure that the deficient  |            |
|   |                     |                               |     |                         | practice does not recur  |            |
|   |                     |                               |     |                         | The community's currer   | nt         |
|   |                     |                               |     |                         | team members shall be  |            |
|   |                     |                               |     |                         | re-educated to the community   | 's         |
|   |                     |                               |     |                         | Hazardous Substance  |            |
|   |                     |                               |     |                         | Classification and Storage   |            |
|   |                     |                               |     |                         | Guideline by 6/9/25. An in-ser   | vice       |
|   |                     |                               |     |                         | attendance log shall be  |            |
|   |                     |                               |     |                         | maintained as evidence of completion of re-education an                | d          |
|   |                     |                               |     |                         | shall be maintained with the   | ч          |
|   |                     |                               |     |                         | community's training files.  |            |
|   |                     |                               |     |                         | New team members sha   | all        |
|   |                     |                               |     |                         | be trained to the community's  |            |
|   |                     |                               |     |                         | Hazardous Substance  |            |
|   |                     |                               | 1   |                         | Classification and Storage   |            |
|   |                     |                               |     |                         | Guideline upon hire as part of   | their      |
|   |                     |                               |     |                         | pre-service training.  |            |
|   |                     |                               |     |                         | The community's Direct   |            |
|   |                     |                               |     |                         | of Health and Wellness or the  | ir         |
|   |                     |                               |     |                         | designee shall complete  |            |
|   |                     |                               |     |                         | monitoring of areas containing   |            |
|   |                     |                               |     |                         | hazardous materials to ensure  |            |
|   |                     |                               |     |                         | securement at minimum of fou   |            |
|   |                     |                               | 1   |                         | days per week for four weeks,  | and I      |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 123 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

| STATEMEN  | T OF DEFICIENCIES    | X1) PROVIDER/SUPPLIER/CLIA    | (X2) MULTIPLE CONSTRUCTION (X3)                                     |       |   | (X3) DATE | (3) DATE SURVEY |  |
|-----------|----------------------|-------------------------------|---|-------|---|-----------|-----------------|--|
| AND PLAN  | OF CORRECTION        | IDENTIFICATION NUMBER         | A. BUILDING <u>00</u> COMPLE  |       |   | ETED      |                 |  |
|           |                      |                               | B. W  | ING   |   | 05/09/    | 2025            |  |
|           |                      |                               |   | CERET | ADDRESS OF A STATE OF COD   |           |                 |  |
| NAME OF P | PROVIDER OR SUPPLIEF | 8                             |   |       | ADDRESS, CITY, STATE, ZIP COD   |           |                 |  |
| DEMADE    |                      | NOTED LIVING AND MEMORY OF    | DE .  |       | EMAREE ROAD   |           |                 |  |
| DEMARE    | EE CROSSING ASS      | SISTED LIVING AND MEMORY CA   | KE  | GREEN | IWOOD, IN 46143   |           |                 |  |
| (X4) ID   | SUMMARY              | STATEMENT OF DEFICIENCIE      |   | ID    | DDOVIDED'S DI AN OE CODDECTION  |           | (X5)            |  |
| PREFIX    | (EACH DEFICIEN       | CY MUST BE PRECEDED BY FULL   | PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO |       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | TE        | COMPLETION      |  |
| TAG       | REGULATORY OF        | R LSC IDENTIFYING INFORMATION |   | TAG   | DEFICIENCY)   | , L       | DATE            |  |
|           |                      |                               |   |       | then weekly for four weeks the  | en        |                 |  |
|           |                      |                               |   |       | monthly for six months.   |           |                 |  |
|           |                      |                               |   |       | The community's Direct  | or        |                 |  |
|           |                      |                               |   |       | of Health and Wellness or thei  |           |                 |  |
|           |                      |                               |   |       | designee shall provide summa  |           |                 |  |
|           |                      |                               |   |       | findings to the Executive Direct  | -         |                 |  |
|           |                      |                               |   |       | weekly and then monthly for   |           |                 |  |
|           |                      |                               |   |       | review and discussion of any  |           |                 |  |
|           |                      |                               |   |       | correction action items.  |           |                 |  |
| ļ         |                      |                               |   |       |   |           |                 |  |
|           |                      |                               |   |       | 4: How the corrective action  |           |                 |  |
|           |                      |                               |   |       | will be monitored to ensure t   | he        |                 |  |
|           |                      |                               |   |       | deficient practice will not rec   |           |                 |  |
|           |                      |                               |   |       | i.e., what quality assurance  |           |                 |  |
|           |                      |                               |   |       | program will be put into plac   | e?        |                 |  |
|           |                      |                               |   |       | The Director of Facilities  |           |                 |  |
|           |                      |                               |   |       | their designee will be respons  |           |                 |  |
|           |                      |                               |   |       | for monitoring compliance of  |           |                 |  |
|           |                      |                               |   |       | sanitation and safety standard  | s         |                 |  |
|           |                      |                               |   |       | through random monthly chec   |           |                 |  |
|           |                      |                               |   |       | for unsecured hazardous   |           |                 |  |
|           |                      |                               |   |       | substance, unlocked cabinets  | and       |                 |  |
|           |                      |                               |   |       | doors for six months. The rand  |           |                 |  |
|           |                      |                               |   |       | monthly checks results will be  |           |                 |  |
|           |                      |                               |   |       | reviewed during the monthly s   | afetv     |                 |  |
|           |                      |                               |   |       | meeting overseen by the   |           |                 |  |
|           |                      |                               |   |       | Executive Director. Corrective  |           |                 |  |
|           |                      |                               |   |       | actions will be implemented ba  |           |                 |  |
|           |                      |                               |   |       | on the findings and discussion  |           |                 |  |
|           |                      |                               |   |       | during safety meeting.  |           |                 |  |
|           |                      |                               |   |       | The community through   | the       |                 |  |
|           |                      |                               |   |       | safety meeting, will review, up   |           |                 |  |
|           |                      |                               |   |       | and make changes to the DPC   |           |                 |  |
|           |                      |                               |   |       | as needed for sustaining  |           |                 |  |
|           |                      |                               |   |       | substantial compliance for no   | less      |                 |  |
|           |                      |                               |   |       | than six months.  | .500      |                 |  |
|           |                      |                               |   |       | Date of completion:   |           |                 |  |
|           |                      |                               |   |       | June 9, 2025  |           |                 |  |
|           |                      |                               |   |       | 04.10 0, 2020   |           |                 |  |
|           |                      |                               |   |       | R 151- Sanitation & Safety  |           |                 |  |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 124 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | F OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER                                    | (X2) MULTIPI<br>A. BUILDIN<br>B. WING   | le construction<br>ig <u>00</u>   | (X3) DATE SURVEY  COMPLETED  05/09/2025  |  |  |
|--------------------------|---------------------------------|---|---|---|--|--|--|
|                          | ROVIDER OR SUPPLIE              | R<br>SISTED LIVING AND MEMORY   | STREET ADDRESS, CITY, STATE, ZIP COD  1255 DEMAREE ROAD  CARE GREENWOOD, IN 46143 |   |  |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                  | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | ID<br>PREFI<br>TAC  | CROSS-REFERENCED TO THE A   | RECTION (X5) OULD BE PPROPRIATE COMPLETION DATE  |  |  |
|                          |                                 |   |   | Standards-Noncompli "Facility failed to ensure resided in the facility ha the rabies vaccination a annual veterinary exam completed as required expiration date for 1 of who housed pets in the (Resident 97) 1: What corrective act be accomplished for ti residents found to hav affected by the deficie practice?  The canine owne Resident 97 had vaccin updated on 5/20/25. Record of such v have been updated and maintained by the commaintained and what corrective action will be Records of pets or residing at the community audited by the community vaccination records sha monitored and maintain community's Resident I Director or their design Executive Director's off Resident Experience | e a pet who ad received and the aination was prior to its 4 residents a facility"  ion(s) will hose we been ant  ed by nations  raccination d shall be munity's irector or  s having acted by actice will actice w |  |  |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 125 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | T OF DEFICIENCIES<br>OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  | (X2) MULTIPLI<br>A. BUILDING<br>B. WING  | E CONSTRUCTION  G 00  | (X3) DATE SURVEY COMPLETED 05/09/2025  |
|--------------------------|------------------------------------|---|--|---|--|
|                          | ROVIDER OR SUPPLIE                 | R<br>SISTED LIVING AND MEMORY (   | 125  | EET ADDRESS, CITY, STATE, ZIP COD<br>5 DEMAREE ROAD<br>EENWOOD, IN 46143  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIE                      | STATEMENT OF DEFICIENCIE<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL)<br>CROSS-REFERENCED TO THE APPRODEFICIENCY)   | ION (X5) D BE COMPLETION DPRIATE DATE  |
|                          |                                    |   | Director or their designee responsible for notifying at coordinating with resident/responsible party upcoming or past due pet vaccinations | nd  |  |
|                          |                                    |   |  | 3: What measures will be into place or what system changes will be made to ensure that the deficient practice does not recur  The community's Re Experience Director, Reside Experience Ambassador a leadership team shall be reeducated by the Execution Director.  Current and new residency and the system of the residency and for pet annual examination compliance with vaccination review of the residency agony the Executive Director.  The community's Re Experience Director or the designee shall review and Executive Director copy of | esident dent and ve sidents the ted on id policy n and on during preement esident ir provide |
|                          |                                    |   |  | vaccinations for any new president at the community effective June 9, 2025.  Resident Experience Director or their designee review pet vaccinations for compliance monthly for at six months to ensure compute with community policy. The results of these reviews sharpers.  | e shall r least pliance e  |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 126 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | T OF DEFICIENCIES<br>DF CORRECTION    | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER                                    | (X2) MULT<br>A. BUILI<br>B. WING | DING  | nstruction<br><u>00</u>   | (X3) DATE :<br>COMPL<br>05/09/  | ETED                       |  |  |
|--------------------------|---------------------------------------|--|----------------------------------|---|---|---|----------------------------|--|--|
|                          | ROVIDER OR SUPPLIER<br>E CROSSING ASS | SISTED LIVING AND MEMORY C   | 1                                | STREET ADDRESS, CITY, STATE, ZIP COD  1255 DEMAREE ROAD  RE GREENWOOD, IN 46143 |   |   |                            |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                        | STATEMENT OF DEFICIENCIE<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION | PRI                              | D<br>EFIX<br>'AG  | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)  |   | (X5)<br>COMPLETION<br>DATE |  |  |
|                          |                                       |  |                                  |   | reported to the Executive Dire<br>and discussed during the<br>community's safety meeting.   | ector   |                            |  |  |
|                          |                                       |  |                                  |   | 4: How the corrective action will be monitored to ensure deficient practice will not rei.e., what quality assurance program will be put into place. The community's Executive Director or their designee shat complete random audits of the vaccination and examination tracking monthly for six month ensure all pet vaccinations are currently and up to date.  Audit results will be reviewed at the monthly safet meeting overseen by the Executive Director. If a thresh of 95% is not achieved, an accipant will be developed.  The community through safety meeting, will review, up and make changes to the DP as needed for sustaining | the cur  ce? utive util e pet  ns to nd ent  y  nold tion  n the odate OC |                            |  |  |
|                          |                                       |  |                                  |   | substantial compliance for no<br>than 6 months <b>Date of completion:</b> June 2025   |   |                            |  |  |
|                          |                                       |  |                                  |   | R 216- Evaluation-Noncompliance "Facility failed to obtain a bas admission weight for 1 of 7 residents reviewed for weight (Resident 39) 1: What corrective action(s) be accomplished for those   | s"  |                            |  |  |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 127 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | OF CORRECTION        | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER                                 | A. BUILDING  B. WING  | 00   | COMPLETED 05/09/2025  |  |  |  |
|--------------------------|----------------------|--|---|--|---|--|--|--|
|                          | PROVIDER OR SUPPLIER | ISTED LIVING AND MEMORY CA   | STREET ADDRESS, CITY, STATE, ZIP COD  1255 DEMAREE ROAD  CARE GREENWOOD, IN 46143 |  |   |  |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN       | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)   | (X5) COMPLETION DATE  |  |  |  |
|                          |                      |  |   | residents found to have been affected by the deficient practice?  Resident 39 has been discharged from the community 5/14/25.  2: How other residents having the potential to be affected by the same deficient practice of the identified and what corrective action will be taken and wellness shall conduct an audit of electronic health record documentation of 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 resider identified as missing weights based on the above audit.  3: What measures will be purinto place or what systemic changes will be made to ensure that the deficient practice does not recur  The community's Direct of Health and Wellness or the designee shall review electror health record for new move in verify compliance and documentation of resident's weightin 72 hours from the date move-in. | ty on  ng  ny  vill  en.  or of  for  t  cor  ir  nic  s to  reight |  |  |  |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 128 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER |  |   |     | ILDING   | ONSTRUCTION  00   | COMP   | (X3) DATE SURVEY COMPLETED 05/09/2025 |  |
|---|--|---|-----|--|---|--|---------------------------------------|--|
|   | ROVIDER OR SUPPLIER<br>E CROSSING ASSI | STED LIVING AND MEMORY C  | ARE | STREET ADDRESS, CITY, STATE, ZIP COD  1255 DEMAREE ROAD  GREENWOOD, IN 46143 |   |  |                                       |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC                        | FATEMENT OF DEFICIENCIE  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION |     | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY)   | N<br>BE<br>PRIATE  | (X5)<br>COMPLETION<br>DATE            |  |
|   |  |   |     |  | - The community's Director of Health and Welli shall re-educate all Wellnes (Care) team members rega Admission Policy and stand obtaining and documenting residents' weight upon mov An in-service attendance lobe maintained as evidence completion of re-education, shall be maintained with the community's training files - The community's Director of Health and Wellishall educate new Wellness (Care) team members on community's Admission Polduring the community pre-straining.  4: How the corrective action will be monitored to ensure deficient practice will not i.e., what quality assurance program will be put into | rding lard for le in. g shall of and e le in. g shall of an e shall of a le in. g shall of a le in |                                       |  |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 129 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | T OF DEFICIENCIES  OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER                                    | (X2) MUL<br>A. BUIL<br>B. WING | DING   | nstruction <u>00</u>   |   | ESURVEY<br>LETED<br>0/2025 |  |  |
|--------------------------|----------------------------------|---|--------------------------------|--|--|---|----------------------------|--|--|
|                          | ROVIDER OR SUPPLIE               | R<br>SISTED LIVING AND MEMORY C   |                                | STREET ADDRESS, CITY, STATE, ZIP COD  1255 DEMAREE ROAD  GREENWOOD, IN 46143 |  |   |                            |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                   | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | PF                             | ID<br>REFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTIC<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROI<br>DEFICIENCY)  | ON<br>BE<br>PRIATE  | (X5)<br>COMPLETION<br>DATE |  |  |
|                          |                                  |   |                                |  | "Facility failed to ensure the service plans were signed a resident or the resident's representative for 7 of 7 residents reviewed for service plans (Resident 25, Resident 85, Resident 48, Resident 103) Resident 104)  1: What corrective action(be accomplished for those residents found to have be affected by the deficient practice?  Current service plans Residents 25, 39, 48, 85, as service plans have been reand signed by resident and responsible party.  Residents 103 and 1 have been discharged from community on [ADD DATE: DISCHARGE]  2: How other residents has the potential to be affected the same deficient practice be identified and what corrective action will be table to the same deficient or responsible party by June 9 signature by resident or responsible party by June 9 signature that the deficient censure that the deficient | by the  ice nt 39, and s) will een s for nd 90 viewed /or 04 a the S OF  ving d by e will aken. ctor of rent alidate 9, 2025. put |                            |  |  |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 130 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER |                     | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING                                 |     |   | (X3) DATE SURVEY COMPLETED 05/09/2025   |                               |                            |
|---|---------------------|--|-----|---|---|-------------------------------|----------------------------|
|   | ROVIDER OR SUPPLIER | SISTED LIVING AND MEMORY CA  | \RE | STREET ADDRESS, CITY, STATE, ZIP COD  1255 DEMAREE ROAD  RE GREENWOOD, IN 46143 |   |                               |                            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN      | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | 1   | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  practice does not recur  | TE                            | (X5)<br>COMPLETION<br>DATE |
|   |                     |  |     |   | The community's Direct of Health and Wellness will re-educate the Wellness team member on the community's Evaluation policy which includ requirement for review and signature on plan of care. An in-service attendance log shall maintained as evidence of completion of re-education, ar shall be maintained with the community's training files  4: How the corrective action will be monitored to ensure the deficient practice will not recise, what quality assurance | es<br>I be<br>nd<br><b>he</b> |                            |
|   |                     |  |     |   | program will be put into place The community's Direct of Health and Wellness or their designee shall complete randoweekly audits of at least 2 new resident records weekly to evaluate compliance with sign service plans. The results of weekly monitoring shall be reported to and reviewed with community's Executive Director Date of completion:  June 9, 2025   | or<br>r<br>om<br>v<br>ed      |                            |
|   |                     |  |     |   | R 306 Pharmaceutical<br>Services-Noncompliance<br>"Facility failed to ensure drug<br>dispositions for all medications<br>including non-controlled<br>substance medications were<br>accounted for and documente  |                               |                            |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 131 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|               | F OF DEFICIENCIES  OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER        |  | UILDING       | ONSTRUCTION  00  | (X3) DATE SURVEY COMPLETED 05/09/2025 |                    |  |
|---------------|----------------------------------|--|--|---------------|--|---------------------------------------|--------------------|--|
| NAME OF PI    | ROVIDER OR SUPPLIEF              | ·<br>{   | STREET ADDRESS, CITY, STATE, ZIP COD 1255 DEMAREE ROAD |               |  |                                       |                    |  |
| DEMARE        | E CROSSING ASS                   | SISTED LIVING AND MEMORY CA                                | ARE  |               |  |                                       |                    |  |
| (X4) ID       |                                  | STATEMENT OF DEFICIENCIE                                   |  | ID            | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  |                                       | (X5)               |  |
| PREFIX<br>TAG | •                                | ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION |  | PREFIX<br>TAG |  |                                       | COMPLETION<br>DATE |  |
|               |                                  |  |  |               | 2 of 2 closed records reviewe<br>(Resident 103, Resident 104)  |                                       |                    |  |
|               |                                  |  |  |               | 1: What corrective action(s) be accomplished for those residents found to have been affected by the deficient practice? Drug disposition forms been completed for Residents and 104 on [ADD DATE]                              | n<br>have<br>s 103                    |                    |  |
|               |                                  |  |  |               | 2: How other residents having the potential to be affected to the same deficient practice with the same deficient practice.  | ру                                    |                    |  |
|               |                                  |  |  |               | be identified and what corrective action will be take.  The community's Direct of Health and Wellness shall implement the use of Drug disposition form for all residen discharged from the communidune 9, 2025.                | en.<br>tor                            |                    |  |
|               |                                  |  |  |               | 3: What measures will be pu into place or what systemic changes will be made to ensure that the deficient practice does not recur.   |                                       |                    |  |
|               |                                  |  |  |               | The community's Direct 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 |                                       |                    |  |
|               |                                  |  |  |               | maintained as evidence of completion and maintained wi the community's training files.   |                                       |                    |  |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 132 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | IT OF DEFICIENCIES<br>OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER                              | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING | ONSTRUCTION  00   | (X3) DATE SURVEY COMPLETED 05/09/2025   |
|--------------------------|-------------------------------------|--|--|---|---|
|                          | ROVIDER OR SUPPLIER                 | SISTED LIVING AND MEMORY CA  | 1255 D                                     | ADDRESS, CITY, STATE, ZIP COD<br>DEMAREE ROAD<br>NWOOD, IN 46143  |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                      | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | ID<br>PREFIX<br>TAG                        | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)   | (X5) COMPLETION DATE  |
|                          |                                     |  |  | 4: How the corrective action will be monitored to ensure a deficient practice will not reci.e., what quality assurance program will be put into place. The community's Direct of Health and Wellness or the designee shall complete randoweekly 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 share reported to and reviewed with community's Executive Direct Date of completion:  June 9, 2025.  R409- Infection  Control-Noncompliance "Facility failed to ensure that to annual health assessment statement (a statement by the physician indicating the resident free of communicable disease was documented as required of 7 residents reviewed. (Residents)."  1: What corrective action(s) be accomplished for those residents found to have been affected by the deficient practice?  Resident 48 electronic medical record reviewed, and annual health statement updat by the primary physician. | er corrier com  en com  en com  en com  the corr  the corr  for 1 dent  will  n |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 133 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | T OF DEFICIENCIES<br>OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER                                    | (X2) MULTI<br>A. BUILDI<br>B. WING | PLE CONSTRUCTION ING 00                                | (X3) DATE SURVEY COMPLETED 05/09/2025   |
|--------------------------|------------------------------------|---|------------------------------------|--|---|
| NAME OF P                | ROVIDER OR SUPPLIEI                | R   |                                    | REET ADDRESS, CITY, STATE, ZIP COD<br>255 DEMAREE ROAD |   |
| DEMARE                   | E CROSSING ASS                     | SISTED LIVING AND MEMORY C  |                                    | REENWOOD, IN 46143                                     |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                     | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | II<br>PRE<br>TA                    | PROVIDER'S PLAN OF CORREC                              | TION (X5) LD BE ROPRIATE COMPLETION DATE  |
| TAG                      | REGULATORY OI                      | R LSC IDENTIFYING INFORMATION   | TA                                 |  | naving ted by ice will  taken. rector of neir udit on esident ith annual nent free of by June  e put mic  t alth and le shall Team on on nual nent free of An shall be of n and nunity's  Director or their nanage icians' tement |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 134 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                           | F OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER   | A. B | MULTIPLE CO<br>BUILDING<br>VING | ONSTRUCTION  00   | (X3) DATE<br>COMPI<br><b>05/09</b>              | LETED                |
|---------------------------|---------------------------------|---|------|---------------------------------|---|---|----------------------|
|                           | ROVIDER OR SUPPLIED             | R<br>BISTED LIVING AND MEMORY C   | ARE  | 1255 D                          | ADDRESS, CITY, STATE, ZIP COD<br>EMAREE ROAD<br>IWOOD, IN 46143   |   |                      |
| DEMARE (X4) ID PREFIX TAG | SUMMARY<br>(EACH DEFICIEN       | SISTED LIVING AND MEMORY C. STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | ARE  | ID PREFIX TAG                   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  Communicable disease.  4: How the corrective action will be monitored to ensure to deficient practice will not red i.e., what quality assurance program will be put into place The community's Direct of Health and Wellness or the designee shall complete daily monitoring to ensure new move resident(s) have an annual he statement documented. Result daily monitoring shall be report to the community's Executive Director. The community's Executive | the cur  ee?  or  ir  /e-in  alth  tts of  tted | (X5) COMPLETION DATE |
|                           |                                 |   |      |                                 | 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 screening tuberculosis) was completed upon admission for 7 residents reviewed (Resider and Resident 90)."  1: What corrective action(s) be accomplished for those residents found to have been affected by the deficient practice?  Residents 39 and 90 two-step tuberculin skin tests been initiated by the Wellness team.                         | for<br>2 of<br>at 39<br>will<br>1               |                      |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 135 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | T OF DEFICIENCIES<br>DF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER                                       | (X2) MULT<br>A. BUILI<br>B. WING |  | C   | DATE SURVEY OMPLETED 5/09/2025 |
|--------------------------|------------------------------------|---|----------------------------------|--|---|--------------------------------|
|                          | ROVIDER OR SUPPLIER                | SISTED LIVING AND MEMORY C  | 1                                | TREET ADDRESS, CITY, 3<br>255 DEMAREE ROA<br>GREENWOOD, IN 46  | AD  |                                |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                     | STATEMENT OF DEFICIENCIE<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION | PR                               | D PROVIDEI EFIX (EACH CORREC CROSS-REFERE  | R'S PLAN OF CORRECTION<br>CTIVE ACTION SHOULD BE<br>INCED TO THE APPROPRIATE<br>DEFICIENCY)   | (X5)<br>COMPLETION<br>DATE     |
|                          |                                    |   |                                  | the potential the same de be identified corrective are a large of the alth and a designee should be identified to the alth record compliance step tubercul Tuberculin substantial step 1 or step and a large of the alth and esignee should be introplated of the alth and designee should be introplated to the step 1 or s | mmunity's Director of Wellness or their lall complete an audit esident's electronic ds to evaluate with first and second lin skin test. Skin tests will be d as needed for any entified as missing ep 2 skin tests by 5.  asures will be put or what systemic li be made to the deficient es not recur ommunity's Director dd Wellness or their |                                |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 136 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | NT OF DEFICIENCIES OF CORRECTION   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  |      | LDING               | nstruction<br><u>00</u>   |  | SURVEY<br>LETED<br>1/2025  |
|--------------------------|--|---|------|---------------------|---|--|----------------------------|
|                          | PROVIDER OR SUPPLIEI   | SISTED LIVING AND MEMORY (  | CARE | 1255 DE             | DDRESS, CITY, STATE, ZIP COD<br>EMAREE ROAD<br>WOOD, IN 46143   |  |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION   | I    | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)  | ON<br>BE<br>PRIATE   | (X5)<br>COMPLETION<br>DATE |
| R 0410<br>Bldg. 00       | failed to ensure a fit tuberculin skin test tuberculosis) was c of 7 resident review 90)  Finding includes:  1. On 5/8/25 at 10:: record was reviewed were not limited to history of falls.  Resident 39's clinic of either a first step required two step to 2. On 5/8/25 at 11:- | and record review, the facility rst step and a second step (tool used for screening for completed upon admission for 2 yed. (Resident 39 and Resident 30 a.m., Resident 39's clinical d. The diagnoses included, but dementia, arthritis, and a second step of the aberculin skin test. | R 04 | 10                  | 4: How the corrective activill be monitored to ensure deficient practice will not i.e., what quality assurance program will be put into put their designee shall complete weekly random audits of attresident records weekly for weeks, then monthly X 6 m to monitor compliance with tuberculin skin testing.  Date of  Completion: June 9, 2025  Demaree Crossing 05.14.25  This Plan of Correction is submitted under regulation applicable to long term care providers. This Plan of Corris not to be construed as attachment of Deficiencies. preparation/ submission and execution of this Plan does constitute agreement by the facility that the surveyor's for conclusions are accurate the findings constitute a deficiency, or that the scop severity regarding any of the deficiencies are correctly a Submission of this Plan is | re the recur ce blace? tor or ete i least 2 four nonths  s e rection n ith the n the The nd/or s not e indings e, that he and he | 06/09/2025                 |
|                          | record was reviewe   | d. The diagnoses included, but  |      |                     | evidence of compliance.   |  |                            |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 137 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | OF CORRECTION   | IDENTIFICATION NUMBER  | A. BUILD<br>B. WING |                 | 00  | COMPL<br>05/09/                             | ETED                       |
|--------------------------|---|--|---------------------|-----------------|---|---|----------------------------|
|                          | PROVIDER OR SUPPLIER  | SISTED LIVING AND MEMORY CA  | 1:                  | 255 DE          | DDRESS, CITY, STATE, ZIP COD<br>EMAREE ROAD<br>WOOD, IN 46143   |   |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN<br>REGULATORY OR<br>were not limited to,<br>blood pressure), and   | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION dementia, hypertension (high I COPD (chronic obstructive  |                     | O<br>EFIX<br>AG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  R086-Administration and Management-Deficiency  | TE  | (X5)<br>COMPLETION<br>DATE |
|                          | pulmonary disease).  Resident 90's clinica of either a first step required two step tu  During an interview (Executive Director could not be found for either Resident 3  During an interview indicated that the fa for tuberculin skin t | al record lacked documentation or a second step of the berculin skin test.  Ton 5/9/25 at 12:00 p.m., the ED indicated that documentation for any tuberculin skin tests by or Resident 90.  Ton 5/9/25 at 11:15 a.m., the ED cility lacked a specific policy |                     |                 | Management-Deficiency "Facility failed to ensure a currand valid Clinical Laboratory Improvement Amendments (Coertification (for the purposes performing laboratory examinations or procedures) of maintained as required.  1: What corrective action(s) of the accomplished for those residents found to have been affected by the deficient practice?  No residents were affected the alleged deficient practice. CLIA certification was submitted for renewal on 5/09/2025 to labexcellence@cms.hhs.gov apaid through pay.gov-CLIA Laboratory User Fees.  2: How other residents having the potential to be affected by the same deficient practice who identified and what corrective action will be take - No residents were affected 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 a Regulatory requirements and requirements | cLIA) of was will d by and g y vill n. d by |                            |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 138 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | OF CORRECTION        | IDENTIFICATION NUMBER  | A. BUILDING  B. WING | 00   | COMPLETED<br>05/09/2025          |
|--------------------------|----------------------|--|----------------------|--|----------------------------------|
|                          | PROVIDER OR SUPPLIER |  | 1255 D               | ADDRESS, CITY, STATE, ZIP COD<br>DEMAREE ROAD  |                                  |
| DEMARE                   | E CROSSING ASS       | SISTED LIVING AND MEMORY CA  | RE GREEN             | NWOOD, IN 46143  |                                  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN       | STATEMENT OF DEFICIENCIE<br>CY MUST BE PRECEDED BY FULL<br>. LSC IDENTIFYING INFORMATION | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  | (X5) COMPLETION DATE             |
|                          |                      |  |                      | renewal process for CLIA Certification by the SVP of He & Wellness.  | alth                             |
|                          |                      |  |                      | 4: How the corrective action will be monitored to ensure to deficient practice will not redice, what quality assurance program will be put into place ED or their designee will responsible for monitoring expiration date and submit time renewal for CLIA Certificate Date of completion: June 2025 R 148- Sanitation and Safety Standards- Deficiency "Facility failed to ensure that potentially hazardous material were kept secured behind local | cur  ee? Il be eely  9,          |
|                          |                      |  |                      | doors to prevent resident's ac to hazardous materials for 14 14 self-mobile and cognitively impaired residents residing on assisted living unit in the facili 1: What corrective action(s) be accomplished for those residents found to have been  | of<br>the<br>ty<br>will          |
|                          |                      |  |                      | affected by the deficient practice?  No residents were affect by the alleged deficient practice. Door to beauty shop we immediately closed and locked. The community's housekeeping staff and beaut will be in-serviced by the community Executive Director community's policy for Hazard Substance Classification and   | eted<br>ce.<br>as<br>d.<br>ician |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 139 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | T OF DEFICIENCIES<br>OF CORRECTION  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER                                 | A. B | IULTIPLE CO<br>UILDING<br>/ING | onstruction<br><u>00</u>  | (X3) DATE<br>COMPI<br><b>05/09</b> |                            |
|--------------------------|-------------------------------------|---|------|--------------------------------|---|------------------------------------|----------------------------|
|                          | ROVIDER OR SUPPLIE<br>E CROSSING AS | R<br>SISTED LIVING AND MEMORY C   | ARE  | 1255 D                         | ADDRESS, CITY, STATE, ZIP COD<br>DEMAREE ROAD<br>NWOOD, IN 46143  |                                    |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                      | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION |      | ID<br>PREFIX<br>TAG            | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)   | ATE                                | (X5)<br>COMPLETION<br>DATE |
| IAU                      | REGULATORI O                        | A LOC IDENTIFICING INFORMATION  |      | IAU                            | Storage.  The community beautic was provided a key to the Beautic Shop for access to room.  2: How other residents having the potential to be affected by the same deficient practice of be identified and what corrective action will be taken and the same deficient was affected by the alleged deficient practice.  3: What measures will be purinto 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. Hazardous Substance Classification and Storage Guideline by 6/9/25. An in-sent 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 pre-service training.  The community's Direct of Health and Wellness or the designee shall complete monitoring of areas containing hazardous materials to ensure | ng y will en. ent t t tt tc d all  | DAIL                       |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 140 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|            | OF DEFICIENCIES F CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPI<br>A. BUILDIN<br>B. WING | E CONSTRUCTION  G 00  | (X3) DATE SURVEY COMPLETED 05/09/2025 |
|------------|------------------------------|--|---------------------------------------|---|---------------------------------------|
| NAME OF PR | OVIDER OR SUPPLIEI           | R  |                                       | EET ADDRESS, CITY, STATE, ZIP COD   |                                       |
| DEMARE     | E CROSSING ASS               | SISTED LIVING AND MEMORY C                       |                                       | 5 DEMAREE ROAD<br>EENWOOD, IN 46143   |                                       |
| (X4) ID    |                              | STATEMENT OF DEFICIENCIE                         | ID                                    | 1   | . (X5)                                |
| PREFIX     |                              | NCY MUST BE PRECEDED BY FULL                     | PREFI                                 | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B                      |                                       |
| TAG        |                              | R LSC IDENTIFYING INFORMATION                    | TAG                                   | X (EACH CORRECTIVE ACTION SHOULD E<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | DATE                                  |
|            |                              |  |                                       | securement at minimum of t  |                                       |
|            |                              |  |                                       | days per week for four week   |                                       |
|            |                              |  |                                       | then weekly for four weeks t  | inen                                  |
|            |                              |  |                                       | monthly for six months.  The community's Dire                                       | ector                                 |
|            |                              |  |                                       | of Health and Wellness or th  |                                       |
|            |                              |  |                                       | designee shall provide sum  |                                       |
|            |                              |  |                                       | findings to the Executive Dir   | rector                                |
|            |                              |  |                                       | weekly and then monthly for   |                                       |
|            |                              |  |                                       | review and discussion of an   | у                                     |
|            |                              |  |                                       | correction action items.  |                                       |
|            |                              |  |                                       | 4: How the corrective action  | on l                                  |
|            |                              |  |                                       | will be monitored to ensure   |                                       |
|            |                              |  |                                       | deficient practice will not r   |                                       |
|            |                              |  |                                       | i.e., what quality assurance  | e                                     |
|            |                              |  |                                       | program will be put into pl   |                                       |
|            |                              |  |                                       | The Director of Facilit   |                                       |
|            |                              |  |                                       | their designee will be respon   |                                       |
|            |                              |  |                                       | for monitoring compliance o<br>sanitation and safety standa                         |                                       |
|            |                              |  |                                       | through random monthly ch   |                                       |
|            |                              |  |                                       | for unsecured hazardous   |                                       |
|            |                              |  |                                       | substance, unlocked cabine  | ts and                                |
|            |                              |  |                                       | doors for six months. The ra  |                                       |
|            |                              |  |                                       | monthly checks results will I   |                                       |
|            |                              |  |                                       | reviewed during the monthly   | / sarety                              |
|            |                              |  |                                       | meeting overseen by the<br>Executive Director. Correcti                             | ve                                    |
|            |                              |  |                                       | actions will be implemented   |                                       |
|            |                              |  |                                       | on the findings and discussi  |                                       |
|            |                              |  |                                       | during safety meeting.  |                                       |
|            |                              |  |                                       | The community throu   | -                                     |
|            |                              |  |                                       | safety meeting, will review,  | · ·                                   |
|            |                              |  |                                       | and make changes to the D   | POC                                   |
|            |                              |  |                                       | as needed for sustaining<br>substantial compliance for n                            | no less                               |
|            |                              |  |                                       | than six months.  | IU IU33                               |
|            |                              |  |                                       | Date of completion  | ո։                                    |
|            |                              |  |                                       | June 9, 2025  |                                       |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 141 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | T OF DEFICIENCIES<br>OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER                                    | (X2) MULTIPLI<br>A. BUILDING<br>B. WING | E CONSTRUCTION  G 00  | (X3) DATE SURVEY COMPLETED 05/09/2025  |
|--------------------------|------------------------------------|---|---|---|--|
|                          | ROVIDER OR SUPPLIE                 | R<br>SISTED LIVING AND MEMORY   | 1255                                    | ET ADDRESS, CITY, STATE, ZIP COD<br>5 DEMAREE ROAD<br>EENWOOD, IN 46143   | •  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIE                      | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPER DEFICIENCY)   | TION (X5) LD BE COMPLETION ROPRIATE DATE   |
|                          |                                    |   |   | R 151- Sanitation & Safe Standards-Noncomplian "Facility failed to ensure a resided in the facility had the rabies vaccination an annual veterinary examin completed as required preexpiration date for 1 of 4 who housed pets in the facility had the rabies vaccination date for 1 of 4 who housed pets in the facility had the resident 97 of 1: What corrective actions be accomplished for the residents found to have affected by the deficient practice?  The canine owned Resident 97 had vaccinate updated on 5/20/25.  Record of such vaccinate updated and significant experience Directly their designee  2: How other residents in the potential to be affect the same deficient practice identified and what corrective action will be Records of pets curesiding at the community audited by the community audited by the community pet vaccination records shall monitored and maintained community's Resident Expirector or their designee | a pet who received d the nation was ior to its residents acility"  n(s) will ose been t by tions ccination shall be unity's ector or  naving ted by tice will  taken. urrently y were y's ellness et be d by the cperience |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 142 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | OF CORRECTION                         | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER                                | A. BUILI<br>B. WING | DING             | 00   | COMPL<br>05/09/ | ETED                       |
|--------------------------|---------------------------------------|--|---------------------|------------------|--|-----------------|----------------------------|
|                          | ROVIDER OR SUPPLIER<br>E CROSSING ASS | ISTED LIVING AND MEMORY C  | 1                   | 255 DE           | ADDRESS, CITY, STATE, ZIP COD<br>EMAREE ROAD<br>WOOD, IN 46143   |                 |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                        | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | PR                  | D<br>EFIX<br>'AG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)   | TE              | (X5)<br>COMPLETION<br>DATE |
|                          |                                       |  |                     |                  | 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 Reside Experience Director, Resident   |                 |                            |
|                          |                                       |  |                     |                  | Experience Ambassador and leadership team shall be reeducated by the Executive Director.  Current and new resider  | nte             |                            |
|                          |                                       |  |                     |                  | who have pets residing in the community shall be educated community's standards and pofor pet annual examination and   | on<br>olicy     |                            |
|                          |                                       |  |                     |                  | compliance with vaccination do<br>review of the residency agreer<br>by the Executive Director.  The community's Reside   | uring<br>ment   |                            |
|                          |                                       |  |                     |                  | Experience Director or their designee shall review and prove Executive Director copy of pet vaccinations for any new pets resident at the community  |                 |                            |
|                          |                                       |  |                     |                  | effective June 9, 2025.  Resident Experience Director or their designee shal review pet vaccinations for compliance monthly for at leas six months to ensure complian  | st              |                            |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 143 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | F OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER                                    | (X2) MULTIP<br>A. BUILDIN<br>B. WING | le construction<br>ig <u>00</u>  | (X3) DATE SURVEY  COMPLETED  05/09/2025  |
|--------------------------|---------------------------------|---|--------------------------------------|--|--|
|                          | ROVIDER OR SUPPLIE              | R<br>SISTED LIVING AND MEMORY   | 125                                  | EET ADDRESS, CITY, STATE, ZIP CO<br>55 DEMAREE ROAD<br>EENWOOD, IN 46143   | D  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIE                   | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | ID<br>PREF                           | CROSS-REFERENCED TO THE AP   | ECTION JULD BE PROPRIATE  COMPLETION DATE  |
|                          |                                 |   |                                      | with community policy. results of these reviews reported to the Executiv and discussed during the community's safety meeting.  | shall be<br>re Director<br>e   |
|                          |                                 |   |                                      | 4: How the corrective a will be monitored to en deficient practice will ri.e., what quality assurprogram will be put int.  The community's Director or their designer complete random audits vaccination and examinations and examinations and examinations are all pet vaccination annual examinations are and up to date.  Audit results will be reviewed at the monthly meeting overseen by the Executive Director. If a tof 95% is not achieved, plan will be developed.  The community the safety meeting, will reviewed and make changes to the as needed for sustaining substantial compliance in the community of the community of the safety meeting overseen by the safety meeting, will reviewed and make changes to the safety meeting overseen by the safety meeting will reviewed and make changes to the safety meeting overseen by the safety meeting will reviewed and make changes to the safety meeting overseen by the safety meeting will reviewed and make changes to the safety meeting overseen by the safety meeting will reviewed and make changes to the safety meeting overseen by the safety meeting the sa | essure the not recur ance o place? Executive see shall soft the pet ation months to ons and securrent one safety see threshold an action ancugh the sew, update see DPOC see |
|                          |                                 |   |                                      | than 6 months  Date of completion: 2025  R 216- Evaluation-Noncomplia "Facility failed to obtain admission weight for 1 or residents reviewed for weight (Resident 39)   | June 9,  ance a baseline of 7  |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 144 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | T OF DEFICIENCIES<br>DF CORRECTION    | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER                                    | (X2) MULTI<br>A. BUILDI<br>B. WING | PLE CONSTRUCTION ING 00   | (X3) DATE SURVEY COMPLETED 05/09/2025  |
|--------------------------|---------------------------------------|---|------------------------------------|---|--|
|                          | ROVIDER OR SUPPLIEI<br>E CROSSING ASS | R<br>BISTED LIVING AND MEMORY C   | 12                                 | REET ADDRESS, CITY, STATE, ZIP COI<br>255 DEMAREE ROAD<br>REENWOOD, IN 46143  | )  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                        | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | IC<br>PRE<br>TA                    | FIX (EACH CORRECTIVE ACTION SHOW) CROSS-REFERENCED TO THE APP AG DEFICIENCY)  | ULD BE COMPLETION DATE   |
| IAU                      | REGULATORY OF                         | A LOC IDENTIFITING INPURMATION  |                                    | 1: What corrective actions be accomplished for the residents found to have affected by the deficient practice?  Resident 39 has be discharged from the complished form the compliance of the same deficient practice action will be the same deficient practice documents are conduct an audit of elect health record documents current in-house resident evaluate compliance with documentation of admission weights by June 9, 2025. All inhouse Resides weights shall be documentation within the resident's elect medical record for any residentified as missing weights based on the above audit as: What measures will be into place or what systems changes will be made to the ensure that the deficient practice does not recurrent that the deficient practice | en (s) will ose esteen to teen en munity on thaving eted by etice will estaten. eirector of eall erronic estion for ent's ented etronic esident(s) epits eit.  Director or their ectronic externic ectronic extens to enter enter ectronic extens to enter enter ectronic extens to enter extens enter extens extens enter extens ex |
| i l                      |                                       |   | I                                  | documentation of resider  | nisweigni  |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 145 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | OF CORRECTION        | IDENTIFICATION NUMBER  | A. BUILDING B. WING | 00   | COMPLETED 05/09/2025   |
|--------------------------|----------------------|--|---------------------|--|--|
|                          | PROVIDER OR SUPPLIER | SISTED LIVING AND MEMORY CA  | 1255 D              | ADDRESS, CITY, STATE, ZIP COD<br>DEMAREE ROAD<br>NWOOD, IN 46143   |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN       | STATEMENT OF DEFICIENCIE<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPR<br>DEFICIENCY)   | (X5) COMPLETION DATE   |
|                          |                      |  |                     | within 72 hours from the date move-in.  The community's Director of Health and Wellness (Care) team members regard Admission Policy and standard obtaining and documenting residents' weight upon move An in-service attendance log be maintained as evidence of completion of re-education, a shall be maintained with the community's training files  The community's Director of Health and Wellness (Care) team members on community's Admission Polic during the community pre-set training.  4: How the corrective action will be monitored to ensure deficient practice will not refice, what quality assurance program will be put into plath and Wellness/design will complete daily monitoring ensure that new move in resident(s) have an admission weight documented. Results such monitoring shall be reput 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 | ess ding and for in. shall of and ess  Ey rvice  the ecur ace? ctor gnee g to on of orted es |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 146 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | T OF DEFICIENCIES  OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER                                    | (X2) MULTIPLE ( A. BUILDING B. WING | OO OO  | (X3) DATE SURVEY COMPLETED 05/09/2025          |
|--------------------------|----------------------------------|---|-------------------------------------|--|--|
|                          | ROVIDER OR SUPPLIE               | R<br>SISTED LIVING AND MEMORY O   | 1255                                | r address, city, state, zip cod<br>DEMAREE ROAD<br>ENWOOD, IN 46143  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIE                    | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | ID<br>PREFIX<br>TAG                 | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)   | (X5) COMPLETION DATE                           |
|                          |                                  |   |                                     | 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 3 Resident 48, Resident 85, Resident 90, Resident 103 and Resident 104) 1: What corrective action(s) who be accomplished for those residents found to have been affected by the deficient practice?  Current service plans for Residents 25, 39, 48, 85, and 9 service plans have been review 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 who identified and what corrective action will be taken The community's Director Health and Wellness shall complete an audit of all current resident's service plan to validat signature by resident or responsible party by June 9, 20  3: What measures will be put into place or what systemic | eg, vill  ego ved  F  g vill  n. of tate  025. |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 147 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | T OF DEFICIENCIES<br>DF CORRECTION    | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER                                    | r í | JILDING             | onstruction<br>00  | (X3) DATE<br>COMPL<br>05/09/              | ETED                       |
|--------------------------|---------------------------------------|---|-----|---------------------|--|---|----------------------------|
|                          | ROVIDER OR SUPPLIEI<br>E CROSSING ASS | R<br>BISTED LIVING AND MEMORY C   | ARE | 1255 DI             | ADDRESS, CITY, STATE, ZIP COD<br>EMAREE ROAD<br>IWOOD, IN 46143  |   |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                        | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION |     | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPI<br>DEFICIENCY)  | E<br>E<br>RIATE                           | (X5)<br>COMPLETION<br>DATE |
|                          |                                       |   |     |                     | changes will be made to ensure that the deficient practice does not recur  The community's Dire of Health and Wellness will re-educate the Wellness teamember on the community's Evaluation policy which inclurequirement for review and signature on plan of care. An in-service attendance log shimaintained as evidence of completion of re-education, shall be maintained with the community's training files  4: How the corrective action will be monitored to ensure deficient practice will not rive., what quality assurance program will be put into plant the community's Dire of Health and Wellness or the designee shall complete ran weekly audits of at least 2 n resident records weekly to evaluate compliance with significant program will be reported to and reviewed with community's Executive Dire Date of completion June 9, 2025 | m des |                            |
|                          |                                       |   |     |                     | R 306 Pharmaceutical<br>Services-Noncompliance<br>"Facility failed to ensure dru<br>dispositions for all medication<br>including non-controlled  |   |                            |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 148 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|               | IT OF DEFICIENCIES<br>OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER        | A. B | IULTIPLE CO<br>UILDING<br>/ING | ONSTRUCTION 00  | (X3) DATE SURVEY COMPLETED 05/09/2025 |                 |
|---------------|-------------------------------------|--|------|--------------------------------|---|---------------------------------------|-----------------|
| NAME OF P     | PROVIDER OR SUPPLIE                 | R  |      |                                | ADDRESS, CITY, STATE, ZIP COD<br>EMAREE ROAD  |                                       |                 |
| DEMARE        | EE CROSSING AS                      | SISTED LIVING AND MEMORY C                                 | ARE  |                                | NWOOD, IN 46143   |                                       |                 |
| (X4) ID       |                                     | STATEMENT OF DEFICIENCIE                                   |      | ID                             | PROVIDER'S PLAN OF CORRECTION   |                                       | (X5)            |
| PREFIX<br>TAG | · ·                                 | NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION |      | PREFIX<br>TAG                  | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)   | ATE                                   | COMPLETION DATE |
|               |                                     |  |      |                                | substance medications were<br>accounted for and documente<br>2 of 2 closed records reviewe<br>(Resident 103, Resident 104)  | d                                     |                 |
|               |                                     |  |      |                                | 1: What corrective action(s) be accomplished for those residents found to have been affected by the deficient practice?  Drug disposition forms been completed for Residents and 104 on [ADD DATE]  2: How other residents having the potential to be affected by the same deficient practice.  | n<br>have<br>s 103                    |                 |
|               |                                     |  |      |                                | be identified and what corrective action will be take The community's Direct of Health and Wellness shall implement the use of Drug disposition form for all resider discharged from the communi June 9, 2025.  | tor<br>hts<br>ity by                  |                 |
|               |                                     |  |      |                                | 3: What measures will be puinto place or what systemic changes will be made to ensure that the deficient practice does not recur.  The community's Direct 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 maintained as evidence of | tor                                   |                 |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 149 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER                                      | A. BUILDING <u>00</u> CO |                    |   | COMPLETE  | 3) DATE SURVEY COMPLETED 05/09/2025 |  |
|--|--|--------------------------|--------------------|---|---|-------------------------------------|--|
| NAME OF PROVIDER OR SUPPLIE                      | SISTED LIVING AND MEMORY C   |                          | 1255 DE            | DDRESS, CITY, STATE, ZIP COD<br>EMAREE ROAD<br>WOOD, IN 46143   |   |                                     |  |
| PREFIX (EACH DEFICIE                             | T STATEMENT OF DEFICIENCIE  NCY MUST BE PRECEDED BY FULL  OR LSC IDENTIFYING INFORMATION |                          | ID<br>REFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)  | .TE CC  | (X5)<br>OMPLETION<br>DATE           |  |
|  |  |                          |                    | completion and maintained wi<br>the community's training files.   | th  |                                     |  |
|  |  |                          |                    | 4: How the corrective action will be monitored to ensure to deficient practice will not recise., what quality assurance program will be put into place. The community's Direct of Health and Wellness or the designee shall complete randoweekly 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 share reported to and reviewed with community's Executive Director Date of completion:  June 9, 2025.  R409- Infection  Control-Noncompliance  "Facility failed to ensure that to annual health assessment statement (a statement by the physician indicating the reside free of communicable disease was documented as required of 7 residents reviewed. (Resident)."  1: What corrective action(s) be accomplished for those residents found to have been affected by the deficient practice?  Resident 48 electronic medical record reviewed, and annual health statement upda | ee? or ir om en en ent is ent |                                     |  |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 150 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | T OF DEFICIENCIES<br>DF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER                                    | (X2) MUL<br>A. BUIL<br>B. WING | DING               | nstruction 00  | (X3) DATE<br>COMPI<br>05/09  | LETED                      |
|--------------------------|------------------------------------|---|--------------------------------|--------------------|--|--|----------------------------|
|                          | ROVIDER OR SUPPLIEI                | R<br>BISTED LIVING AND MEMORY C   |                                | 1255 DE            | DDRESS, CITY, STATE, ZIP COD<br>EMAREE ROAD<br>WOOD, IN 46143  |  |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                     | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | PF                             | ID<br>REFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)  | ON<br>BE<br>PRIATE   | (X5)<br>COMPLETION<br>DATE |
| TAG                      | REGULATORY O                       | R LSC IDENTIFYING INFORMATION   |                                | TAG                | by the primary physician.  2: How other residents had the potential to be affected the same deficient practice be identified and what corrective action will be to the designee conducted an aud 05/23/25 of all inhouse responding the process of the designee conducted an aud 05/23/25 of all inhouse responding the process of the designee conducted an aud 05/23/25 of all inhouse responding the process of the designee conducted an aud 05/23/25 of all inhouse responding the process of the practice does not recure that the deficient practice does not recure the practice does not r | d by ce will  aken. ector of eir dit on ident n annual ent ree of / June  put ic  th and shall eam on n ual ent ree of n chall be and unity's rector their unage | DATE                       |
|                          |                                    |   |                                |                    | residents' annual health   |  |                            |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 151 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | F OF DEFICIENCIES<br>OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER                                 | A. B | IULTIPLE CO<br>UILDING<br>/ING | onstruction<br><u>00</u>  | (X3) DATE S<br>COMPL<br>05/09/   | ETED                       |
|--------------------------|------------------------------------|---|------|--------------------------------|---|--|----------------------------|
|                          | ROVIDER OR SUPPLIEI                | R<br>SISTED LIVING AND MEMORY C   | ARE  | 1255 D                         | ADDRESS, CITY, STATE, ZIP COD<br>DEMAREE ROAD<br>NWOOD, IN 46143  |  |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                     | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION |      | ID<br>PREFIX<br>TAG            | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)   | ATE  | (X5)<br>COMPLETION<br>DATE |
|                          |                                    |   |      |                                | assessment including stateme indicating resident is free of communicable disease.   | ent  |                            |
|                          |                                    |   |      |                                | 4: How the corrective action will be monitored to ensure deficient practice will not reci.e., what quality assurance program will be put into place. The community's Direct of Health and Wellness or the designee shall complete daily monitoring to ensure new moveresident(s) have an annual he statement documented. Resu daily monitoring shall be report to the community's Executive Director.  The community's Executive Director will randomly review a 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 screening tuberculosis) was completed upon admission for 7 residents reviewed (Resident and Resident 90)."  1: What corrective action(s) be accomplished for those residents found to have been affected by the deficient practice?  Residents 39 and 90 | the cur  ce? tor ir //e-in ealth lts of rted  utive 2  for r 2 of nt 39 will |                            |
|                          |                                    |   |      |                                | two-step tuberculin skin tests been initiated by the Wellness   |  | ı                          |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 152 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|                          | OF CORRECTION        | IDENTIFICATION NUMBER  | A. BUILDING B. WING | 00   | COMPLETED<br>05/09/2025  |
|--------------------------|----------------------|--|---------------------|--|--|
|                          | PROVIDER OR SUPPLIER | SISTED LIVING AND MEMORY CA  | 1255 D              | ADDRESS, CITY, STATE, ZIP COD<br>DEMAREE ROAD<br>NWOOD, IN 46143   |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN       | STATEMENT OF DEFICIENCIE<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  | (X5) COMPLETION DATE   |
|                          |                      |  |                     | 2: How other residents having the potential to be affected by the same deficient practice of the identified and what corrective action will be taken.  The community's Director Health and Wellness or their designee shall complete an aurof inhouse resident's electronic health records to evaluate compliance with first and second step tuberculin skin tests.  Tuberculin skin tests will be administered as needed for auresidents identified as missing step 1 or step 2 skin tests by June 9, 2025.  3: What measures will be purinto 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 the designee shall complete monitoring to ensure that new move in resident(s) receive the first and second tuberculin skin test.  The community's Director of Health and Wellness or the designee shall complete daily review of new move in recording ensure compliance with tuberto skin test for the next 90 days. Results of the daily monitoring be discussed with Executive | en.  en.  or of  udit  c  ond  t  t  or  ir  eir  n  or  ir  s to  culin |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 153 of 154

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

|   | T OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER                                 | A. BU | X2) MULTIPLE CONSTRUCTION (X A. BUILDING 00 B. WING |   | (X3) DATE SURVEY<br>COMPLETED<br>05/09/2025 |                            |
|---|---------------------------------|---|-------|---|---|---|----------------------------|
| NAME OF PROVIDER OR SUPPLIER  DEMAREE CROSSING ASSISTED LIVING AND MEMORY CAF |                                 |   |       | 1255 D  | ADDRESS, CITY, STATE, ZIP COD<br>EMAREE ROAD<br>IWOOD, IN 46143   |   |                            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIE)                  | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION |       | ID<br>PREFIX<br>TAG                                 | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)   | TE  | (X5)<br>COMPLETION<br>DATE |
|   |                                 |   |       |   | Director and corrective actions taken to ensure compliance.  4: How the corrective action will be monitored to ensure the deficient practice will not receive, what quality assurance program will be put into place. The Executive Director their designee shall complete weekly random audits of at least resident records weekly for forweeks, then monthly X 6 monitor monitor compliance with tuberculin skin testing.  Date of completion: June 9, 2025 | he<br>cur<br>e?<br>or<br>ast 2              |                            |

State Form Event ID: 06WZ11 Facility ID: 014079 If continuation sheet Page 154 of 154