PRINTED: 01/23/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER			A. BUILDING 00 COM			COMPL	TE SURVEY MPLETED 27/2023	
NAME OF PROVIDER OR SUPPLIER DEMAREE CROSSING ASSISTED LIVING AND MEMORY CAF			.RE	STREET ADDRESS, CITY, STATE, ZIP COD 1255 DEMAREE ROAD RE GREENWOOD, IN 46143				
(X4) ID PREFIX TAG R 0000	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
Bldg. 00	IN00423710. Complaint IN0042 to the allegations a Survey date: Decer Facility number: 0 Residential Census This State Residen accordance with 41	14079 :: 60 tial Finding is cited in	R 00	000	This Plan of Correction is submitted under regulations applicable to long term care providers. This Plan of Correctis 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 apple Submission of this Plan is evidence of compliance.	the e ne or ot ings hat		
R 0052 Bldg. 00	(1) sexual abuse; (2) physical abus (3) mental abuse (4) corporal punis (5) neglect; and (6) involuntary se Based on observati review, the facility resident's right to be	e; chment; clusion. on, interview, and record neglected to protect the reference from physical abuse by a of 3 residents reviewed for	R 00	052	a What corrective actions was be accomplished for those residents found to have been affected by the deficient practic Resident B had pain and skin assessment completed on 12/7/2023 with no concerns no Police report made; case #	ice?	01/12/2024	

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

TITLE

(X6) DATE

Erika Hamilton Administrator 01/16/2024

Any definency 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 natients (see instructions.) Except for pursing homes, the findings stated above are disclosable.

Any defiencystatement 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.

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STATEMENT OF DEFICIENCIES X13		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
		B. WING			12/27/2023		
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
DEMADE		SISTED LIVING AND MEMORY OF	DE		EMAREE ROAD		
DEMARE	E CKOSSING 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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	During an interview	v on 12/27/23 at 8:24 a.m., the			G23L26125. Resident B is on		
	DON (Director of N	Nursing) indicated CNA 1			hospice services and has bee	n	
	(Certified Nursing	Aide) was terminated after			seen by Hospice MD since the	e	
	Resident B's daught	ter showed the facility a video			incident, with no concerns.		
	of CNA 1 in Reside	ent B's apartment on night shift.			Community has separated		
	On 12/7/23 at appro	oximately 4:00 a.m., CNA 1 went			employment with employee		
	into Resident B's ap	partment and was very			number 1.		
	aggressive during R	Resident B's care. Resident B			b How will the facility identi	fy	
		rms at CNA 1, but the DON			other residents having the		
		nt B knew what was happening.			potential to be affected by the		
		esident B over. CNA 1 held			same deficient practice and w	hat	
		lown. CNA 1 pulled a sheet			corrective actions will be taker	า?	
	out from under Res	ident B, while Resident B was			Community's Health and Well	ness	
	still lying in bed, w	ithout positioning him			Director completed skin		
	appropriately.				assessments on 12/7/2023 of		
					Memory Care residents to obs		
	-	v on 12/27/23 at 9:54 a.m.,			for any other concerns. Health	n and	
	•	ndicated on the morning of			Wellness Director and Assista	nt	
		ed a video from Resident B's			Executive Director interviewed	t	
	-	previous night shift. On			residents on 12/29/2023 with I		
		nately 4:00 a.m., CNA 1 pulled			findings. Current residents in t	he	
		ınder Resident B instead of			community's Memory Care		
	-	de to side. CNA 1 was rough			environment were assessed b		
		ater that same day on 12/7/23,			community's Health and Wellr		
		vent to the facility, and showed			Director 12/29/2023 for signs	or	
		nager. On several occasions			symptoms of physical or		
	•	vatched CNA 1 transfer			psychological injury; no conce	rns	
		any help. CNA 1 would put a			noted.		
		B's mouth and then transfer			c What measures will be p	ut	
		vith the cookie still hanging			into place or what systematic		
	out of his mouth.				changes the facility will make		
	m 1' ' ' ' '	C D 11 (D)			ensure that the deficient pract	ice	
		for Resident B was reviewed			does not reoccur?		
	on 12/27/23 at 10:01 a.m. The diagnoses included,				Assistant Executive Director h		
	but were not limited	d to, dementia and weakness.			in-serviced staff on Abuse pol	-	
		10/10/22			Resident rights and managing		
	-	ed 9/18/23 and current through			challenging behaviors		
		Resident B was not cognitively			on 12/8/2023-12/13/2023. Nev		
	intact.				Team Members will be trained		
			I		abuse policy and resident righ	ts	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/27/2023			
NAME OF PROVIDER OR SUPPLIER DEMAREE CROSSING ASSISTED LIVING AND MEMORY CAR			STREET ADDRESS, CITY, STATE, ZIP COD 1255 DEMAREE ROAD GREENWOOD, IN 46143				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE		
	indicated it was repumember that she had Resident B's room the with her father was while providing carreported to AED (A and AED reported to immediately placed investigation. Reside pain or discomfort, On 12/27/23 at 11:1 was not dated nor tivideo was sent to be 10:55 a.m. and poin video was sent on 1 entered Resident B's legs hanging over the left side of the bed was awake. CNA Resident B's bed and them back on the bed and pulled a Resident B. CNA 1 and while Resident pulled another sheet without positioning Then CNA 1 walked Resident B's bed and B's brief without tel doing. Resident B in wasn't going to put that time, CNA 1 hand and indicated matter with you, look pee and poop all day your wet and your estarted to wipe Resident Resident Resident Populated was not pee and poop all day your wet and your estarted to wipe Resident Resident Resident Populated was not pee and your estarted to wipe Resident Populated Resident Populated	ted 12/8/23 at 5:39 p.m., orted by Resident B's family d seen on the camera in hat the CNA who was working being rough with the resident e. Resident B's family member ssistant Executive Director) to DON. Employee was on suspension for further ent is showing no signs of no injuries are noted. 5 a.m., observed the video that med. The AED indicated the er on the morning of 12/7/23 at ted to the timestamp that the 2/7/23 at 10:55 a.m. CNA 1 is room. Resident B had both her right side of the bed. The was against the wall. Resident 1 walked to the right side of d grabbed both legs and put ed. CNA 1 stood at the side of a sheet out from under walked to the foot of the bed B was lying in bed CNA 1 to out from under Resident B Resident B appropriately. d back to the mid right side of d started to unfasten Resident ling Resident B what she was indicated to CNA 1 that he up with CNA 1 grabbing him. It grabbed Resident B's right to Resident B what is the bek at you. If you want to lay in you that's fine with me, stop it, entire bed is wet. CNA 1 dent B's mattress then its right hand in an aggressive		within the community's New F Orientation program. d How will the corrective actions be monitored to ensur the deficient practice will not reoccur; i.e. what quality assurance program will be pu place? Skin assessments to be completed by the community's Health and Wellness Director, their designee, with a random sample of residents on month basis x3 months. Results report and reviewed by ED or design e By what date will the systematic changes be completed? 1/12/2024 ![if !supportAnnotations]>	t into s or		

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PRINTED: 01/23/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 12/27/2023					
NAME OF PROVIDER OR SUPPLIER DEMAREE CROSSING ASSISTED LIVING AND MEMORY CAR			STREET ADDRESS, CITY, STATE, ZIP COD 1255 DEMAREE ROAD ARE GREENWOOD, IN 46143				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
R 0053 Bldg. 00	indicated to Resider his hand get your ha away from the bed a toward the right side back to the right side back to the right side pushed his legs tow. Resident B indicated CNA 1 replied loud her finger at Resider B she was not kiddin On 12/27/23 at 9:15 Director provided a Abuse and Neglect 11/1/22, and indicated used by the facility. Indicated the facility environment for all This citation relates 410 IAC 16.2-5-1.2 Residents' Rights (w) Residents have verbal abuse. Based on observation review, the facility is resident's right to be staff member for 1 of abuse. (Resident B, Finding includes: During an interview DON (Director of National Certified Nursing A Resident B's daught Resident B's daught side of the right side o	to Complaint IN00423710. 2(w) - Deficiency e the right to be free from on, interview, and record neglected to protect the e free from verbal abuse by a of 3 residents reviewed for CNA 1) on 12/27/23 at 8:24 a.m., the fursing) indicated CNA 1 Aide) was terminated after er showed the facility a video	R 0053	a What corrective actions to be accomplished for those residents found to have been affected by the deficient pract Resident B had pain and skin assessment completed on 12/7/2023 with no concerns in Police report made; case # G23L26125. Resident B is on hospice services and has been by Hospice MD since the incident, with no concerns. Community has separated	oted.		
	of CNA 1 in Reside	nt B's apartment on night shift.		employment with employee			

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AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/27/2023			
NAME OF PROVIDER OR SUPPLIER DEMAREE CROSSING ASSISTED LIVING AND MEMORY CA			STREET ADDRESS, CITY, STATE, ZIP COD 1255 DEMAREE ROAD CARE GREENWOOD, IN 46143				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R I SC IDENTIFYING INFORMATION		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
TAG	On 12/7/23 at approinto Resident B's an aggressive during F at Resident B. Resi at CNA 1, but the I knew what was hap and whispered som knows what CNA 1 During an interview Family Member 1 is 12/7/23, she watche apartment from the 12/7/23 at approxin Resident B's room yelling at Resident Later that same day went to the facility manager. The clinical record on 12/27/23 at 10:0 but were not limited A service plan, dated 12/18/23, indicated intact. A progress note, day indicated intact. A progress note, day indicated it was represented by some with her father was Resident B's family (Assistant Executive to DON. Employee suspension for further was represented by the suspension further was represented by	R LSC IDENTIFYING INFORMATION Doximately 4:00 a.m., CNA 1 went Doximately 4:00 a.m., CNA 1 went Doximately 4:00 a.m., CNA 1 yelled dent B was swinging his arms DON didn't think Resident B Dopening. CNA 1 leaned down ething in his ear and no one I said to Resident B. I said to Resident B. I said to Resident B's previous night shift. On mately 4:00 a.m., CNA 1 was in and was pointing her finger and B like CNA 1 was scolding him. I on 12/7/23, Family Member 1 I and showed the video to the for Resident B was reviewed I a.m. The diagnoses included, I d to, dementia and weakness. Ded 9/18/23 and current through Resident B was not cognitively atted 12/8/23 at 5:39 p.m., Dorted by Resident B's family and seen on the camera in that the CNA who was working yelling at the resident. The member reported to AED The Directory and AED reported The was immediately placed on The investigation. Resident is The pain or discomfort, no		TAG	number 1. b How will the facility idention other residents having the potential to be affected by the same deficient practice and wo corrective actions will be taken Health and Wellness Director Assistant Executive Director interviewed residents on 12/29/2024 with no findings. Current residents in the community's Memory care environment were assessed be community's Health and Wellth Director on 12/29/2023 for any signs or symptoms of physical psychological injury; no concernoted. c What measures will be printo place or what systematic changes the facility will make ensure that the deficient practic does not reoccur? Community's Assistant Execut Director has in-serviced all states Abuse policy, Resident rights managing challenging behavior New team members will be trained and the community's Hire Orientation program. d How will the corrective actions be monitored to ensure the deficient practice will not reoccur; i.e. what quality assurance program will be purplace? Community's Health and Well Director, or their designee, to observe residents for any signs.	fy hat h? and y the less / l or rns ut to lice tive ff on and ors. hined New e	DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION N		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
		B. W	B. WING			12/27/2023	
		l .		CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			EMAREE ROAD		
DEMAREE CROSSING ASSISTED LIVING AND MEMORY CA							
DEMARE	E CROSSING ASC	SISTED LIVING AND MEMORT CA	\I\L	GIVEEN	ENWOOD, 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' DEFICIENCY)	ΓE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG		DATE	
		15 a.m., observed the video that			symptom of physical or		
		imed. The Assistant Executive			physiological abuse using verb		
		he video was sent to her on			and nonverbal communication	on	
	_	7/23 at 10:55 a.m. and pointed to			random sample of residents o	า	
	_	the video was sent on 12/7/23			monthly basis x3 months. Res	ults	
		1 entered Resident B's room.			reported and reviewed by ED	or	
		h legs hanging over the right			designee.		
		e left side of the bed was			e By what date will the		
	_	sident B was awake. CNA 1			systematic changes be		
		nt B's name. CNA 1 spoke very			completed?		
		CNA 1 indicated to Resident B			1/12/2024		
		B was a racist. CNA 1					
		nt B that he had better not put					
		1. Then CNA 1 pointed her					
	-	3 and indicated don't do that					
	· ·	didn't want to hear that so					
		yourself. CNA 1 indicated to					
	-	ot getting out of bed so stop.					
		d to CNA 1 that he wasn't					
		h CNA 1 grabbing him. At that					
	_	ed Resident B's right hand and					
		nt B what is the matter with					
		you want to lay in pee and					
		ine with me, stop it, your wet					
	-	is wet. Then CNA 1 loudly					
	-	n't touch me. CNA 1 indicated					
		e she was restraining his hand of me. Then CNA 1 leaned					
		ent B's head for approximately					
		CNA 1 was lifting her head					
		_					
	-	licated so keep your hands off started wiping Resident B's					
		Resident B remained					
	-						
	completely silent. Resident B indicated to CNA 1 don't do it, and CNA 1 replied loudly stop. Then						
		finger at Resident B and					
	_	nt B she was not kidding, stop.					
	The video ended.	at 2 one was not kidding, stop.					
	The video chided.						
	On 12/27/23 at 0.14	Sam the Assistant Executive					
	On 12/27/23 at 9:15 a.m., the Assistant Executive						

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	ì	JILDING	DNSTRUCTION 00	(X3) DATE COMPL 12/27	ETED
NAME OF PROVIDER OR SUPPLIER DEMAREE CROSSING ASSISTED LIVING AND MEMORY CAP				1255 DI	ADDRESS, CITY, STATE, ZIP COD EMAREE ROAD 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 TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION			DEFICIENCY)	MATE	DATE
	Director provided a	copy of a facility policy, titled					
	Abuse and Neglect	Reporting Policy, dated					
	11/1/22, and indicat	ted this was the current policy					
	used by the facility.	A review of the policy					
	indicated the facility strives to provide a safe environment for all residents.						
	This citation relates	to Complaint IN00423710.					

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