STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	12/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00423710. Complaint IN00423710 - State deficiencies related to the allegations are cited at R0052 and R0053. Survey date: December 27, 2023 Facility number: 014079 Residential Census: 60 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed December 28, 2023.	R 0000	This Plan of Correction is submitted under regulations applicable to long term care providers. This Plan of Correction is not to be construed as an admission or agreement with the findings and conclusions in the Statement of Deficiencies. The preparation/ submission and/or execution of this Plan does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are correctly applied. Submission of this Plan is evidence of compliance.	
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on observation, interview, and record review, the facility neglected to protect the resident's right to be free from physical abuse by a staff member for 1 of 3 residents reviewed for abuse. (Resident B, CNA 1) Finding includes:	R 0052	a What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident B had pain and skin assessment completed on 12/7/2023 with no concerns noted. Police report made; case #	01/12/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Erika Hamilton	Administrator	01/16/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	12/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview on 12/27/23 at 8:24 a.m., the DON (Director of Nursing) indicated CNA 1 (Certified Nursing Aide) was terminated after Resident B's daughter showed the facility a video of CNA 1 in Resident B's apartment on night shift. On 12/7/23 at approximately 4:00 a.m., CNA 1 went into Resident B's apartment and was very aggressive during Resident B's care. Resident B was swinging his arms at CNA 1, but the DON didn't think Resident B knew what was happening. CNA 1 "flipped" Resident B over. CNA 1 held Resident B's hand down. CNA 1 pulled a sheet out from under Resident B, while Resident B was still lying in bed, without positioning him appropriately. During an interview on 12/27/23 at 9:54 a.m., Family Member 1 indicated on the morning of 12/7/23, she watched a video from Resident B's apartment from the previous night shift. On 12/7/23 at approximately 4:00 a.m., CNA 1 pulled the sheet out from under Resident B instead of rolling him from side to side. CNA 1 was rough with Resident B. Later that same day on 12/7/23, Family Member 1 went to the facility, and showed the video to the manager. On several occasions Family Member 1 watched CNA 1 transfer Resident B without any help. CNA 1 would put a cookie in Resident B's mouth and then transfer Resident B to bed with the cookie still hanging out of his mouth. The clinical record for Resident B was reviewed on 12/27/23 at 10:01 a.m. The diagnoses included, but were not limited to, dementia and weakness. A service plan, dated 9/18/23 and current through 12/18/23, indicated Resident B was not cognitively intact.		G23L26125. Resident B is on hospice services and has been seen by Hospice MD since the incident, with no concerns. Community has separated employment with employee number 1. b How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken? Community's Health and Wellness Director completed skin assessments on 12/7/2023 of Memory Care residents to observe for any other concerns. Health and Wellness Director and Assistant Executive Director interviewed residents on 12/29/2023 with no findings. Current residents in the community's Memory Care environment were assessed by the community's Health and Wellness Director 12/29/2023 for signs or symptoms of physical or psychological injury; no concerns noted. c What measures will be put into place or what systematic changes the facility will make to ensure that the deficient practice does not reoccur? Assistant Executive Director has in-serviced staff on Abuse policy, Resident rights and managing challenging behaviors on 12/8/2023-12/13/2023. New Team Members will be trained on abuse policy and resident rights	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	12/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A progress note, dated 12/8/23 at 5:39 p.m., indicated it was reported by Resident B's family member that she had seen on the camera in Resident B's room that the CNA who was working with her father was being rough with the resident while providing care. Resident B's family member reported to AED (Assistant Executive Director) and AED reported to DON. Employee was immediately placed on suspension for further investigation. Resident is showing no signs of pain or discomfort, no injuries are noted. On 12/27/23 at 11:15 a.m., observed the video that was not dated nor timed. The AED indicated the video was sent to her on the morning of 12/7/23 at 10:55 a.m. and pointed to the timestamp that the video was sent on 12/7/23 at 10:55 a.m. CNA 1 entered Resident B's room. Resident B had both legs hanging over the right side of the bed. The left side of the bed was against the wall. Resident B was awake. CNA 1 walked to the right side of Resident B's bed and grabbed both legs and put them back on the bed. CNA 1 stood at the side of the bed and pulled a sheet out from under Resident B. CNA 1 walked to the foot of the bed and while Resident B was lying in bed CNA 1 pulled another sheet out from under Resident B without positioning Resident B appropriately. Then CNA 1 walked back to the mid right side of Resident B's bed and started to unfasten Resident B's brief without telling Resident B what she was doing. Resident B indicated to CNA 1 that he wasn't going to put up with CNA 1 grabbing him. At that time, CNA 1 grabbed Resident B's right hand and indicated to Resident B what is the matter with you, look at you. If you want to lay in pee and poop all day that's fine with me, stop it, your wet and your entire bed is wet. CNA 1 started to wipe Resident B's mattress then grabbed Resident B's right hand in an aggressive		within the community's New 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 put into place? Skin assessments to be completed by the community's Health and Wellness Director, or their designee, with a random sample of residents on monthly basis x3 months. Results reported and reviewed by ED or designee. e By what date will the systematic changes be completed? 1/12/2024 !--[if !supportAnnotations]-->	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	12/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	manner and looked at Resident B. CNA 1 indicated to Resident B while she was restraining his hand get your hands off of me. CNA 1 walked away from the bed and Resident B started to move toward the right side of the bed. CNA 1 walked back to the right side of Resident B's bed and pushed his legs toward the left side of the bed. Resident B indicated to CNA 1 don't do it, and CNA 1 replied loudly stop. Then CNA 1 pointed her finger at Resident B and indicated to Resident B she was not kidding, stop. The video ended. On 12/27/23 at 9:15 a.m., the Assistant Executive Director provided a copy of a facility policy, titled Abuse and Neglect Reporting Policy, dated 11/1/22, and indicated 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.			
R 0053 Bldg. 00	410 IAC 16.2-5-1.2(w) Residents' Rights - Deficiency (w) Residents have the right to be free from verbal abuse. Based on observation, interview, and record review, the facility neglected to protect the resident's right to be free from verbal abuse by a staff member for 1 of 3 residents reviewed for abuse. (Resident B, CNA 1) Finding includes: During an interview on 12/27/23 at 8:24 a.m., the DON (Director of Nursing) indicated CNA 1 (Certified Nursing Aide) was terminated after Resident B's daughter showed the facility a video of CNA 1 in Resident B's apartment on night shift.	R 0053	a What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident B had pain and skin assessment completed on 12/7/2023 with no concerns noted. Police report made; case # G23L26125. Resident B is on hospice services and has been seen by Hospice MD since the incident, with no concerns. Community has separated employment with employee	01/12/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	12/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 12/7/23 at approximately 4:00 a.m., CNA 1 went into Resident B's apartment and was very aggressive during Resident B's care. CNA 1 yelled at Resident B. Resident B was swinging his arms at CNA 1, but the DON didn't think Resident B knew what was happening. CNA 1 leaned down and whispered something in his ear and no one knows what CNA 1 said to Resident B. During an interview on 12/27/23 at 9:54 a.m., Family Member 1 indicated on the morning of 12/7/23, she watched a video from Resident B's apartment from the previous night shift. On 12/7/23 at approximately 4:00 a.m., CNA 1 was in Resident B's room and was pointing her finger and yelling at Resident B like CNA 1 was scolding him. Later that same day on 12/7/23, Family Member 1 went to the facility, and showed the video to the manager. The clinical record for Resident B was reviewed on 12/27/23 at 10:01 a.m. The diagnoses included, but were not limited to, dementia and weakness. A service plan, dated 9/18/23 and current through 12/18/23, indicated Resident B was not cognitively intact. A progress note, dated 12/8/23 at 5:39 p.m., indicated it was reported by Resident B's family member that she had seen on the camera in Resident B's room that the CNA who was working with her father was yelling at the resident. Resident B's family member reported to AED (Assistant Executive Director) and AED reported to DON. Employee was immediately placed on suspension for further investigation. Resident is showing no signs of pain or discomfort, no injuries are noted.		number 1. b How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken? Health and Wellness Director and Assistant Executive Director interviewed residents on 12/29/2024 with no findings. Current residents in the community's Memory care environment were assessed by the community's Health and Wellness Director on 12/29/2023 for any signs or symptoms of physical or psychological injury; no concerns noted. c What measures will be put into place or what systematic changes the facility will make to ensure that the deficient practice does not reoccur? Community's Assistant Executive Director has in-serviced all staff on Abuse policy, Resident rights and managing challenging behaviors. New team members will be trained on abuse policy and resident rights within the community's New 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 put into place? Community's Health and Wellness Director, or their designee, to observe residents for any sign or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	12/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 12/27/23 at 11:15 a.m., observed the video that was not dated nor timed. The Assistant Executive Director indicated the video was sent to her on the morning of 12/7/23 at 10:55 a.m. and pointed to the timestamp that the video was sent on 12/7/23 at 10:55 a.m. CNA 1 entered Resident B's room. Resident B had both legs hanging over the right side of the bed. The left side of the bed was against the wall. Resident B was awake. CNA 1 was yelling Resident B's name. CNA 1 spoke very loud to Resident B. CNA 1 indicated to Resident B twice that Resident B was a racist. CNA 1 indicated to Resident B that he had better not put his hands on CNA 1. Then CNA 1 pointed her finger at Resident B and indicated don't do that it's not cute, CNA 1 didn't want to hear that so keep your hands to yourself. CNA 1 indicated to Resident B you're not getting out of bed so stop. Resident B indicated to CNA 1 that he wasn't going to put up with CNA 1 grabbing him. At that time, CNA 1 grabbed Resident B's right hand and indicated to Resident B what is the matter with you, look at you. If you want to lay in pee and poop all day that's fine with me, stop it, your wet and your entire bed is wet. Then CNA 1 loudly indicated stop it don't touch me. CNA 1 indicated to Resident B while she was restraining his hand get your hands off of me. Then CNA 1 leaned down next to Resident B's head for approximately 10 seconds. When CNA 1 was lifting her head back up, CNA 1 indicated so keep your hands off of me. Then CNA 1 started wiping Resident B's mattress again and Resident B remained completely silent. Resident B indicated to CNA 1 don't do it, and CNA 1 replied loudly stop. Then CNA 1 pointed her finger at Resident B and indicated to Resident B she was not kidding, stop. The video ended. On 12/27/23 at 9:15 a.m., the Assistant Executive		symptom of physical or physiological abuse using verbal and nonverbal communication on random sample of residents on monthly basis x3 months. Results reported and reviewed by ED or designee. e By what date will the systematic changes be completed? 1/12/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	12/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Director provided a copy of a facility policy, titled Abuse and Neglect Reporting Policy, dated 11/1/22, and indicated 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.			