PRINTED: 11/14/2024 FORM APPROVED OMB NO. 0938-039

| i ' | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING 00 B. WING | | | COMPL | X3) DATE SURVEY COMPLETED 10/17/2024 | |
|---|--|---|--|---------------------|---|--|--------------------------------------|--|
| NAME OF PROVIDER OR SUPPLIER DEMAREE CROSSING ASSISTED LIVING AND MEMORY CAF | | | STREET ADDRESS, CITY, STATE, ZIP COD 1255 DEMAREE ROAD ARE GREENWOOD, IN 46143 | | | | | |
| (X4) ID PREFIX TAG R 0000 | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ATE | (X5) COMPLETION DATE | |
| Bldg. 00 | IN00444760. Complaint IN00444 to the allegations and Survey date: October Facility number: 01 Residential Census This State Resident accordance with 41 | er 17, 2024 4079 : 74 ial Finding is cited in | R 00 | 000 | What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Director of Health and Wellne updated this resident's wander assessment and service plan reflect the recent elopement. Before staff take this resident the unit, they are informing the nurse, signing the resident off neighborhood, and staff membragrees to stay with the resident the duration that she is out of neighborhood. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Director of Health and Wellned designee will complete Wander Risk Assessments on current residents who have been identified as potential to elope to exit seeking behaviors have interventions put into place in service plan. We have update these residents service plans include interventions to be completed by 11/30/2024 What measures will be put in place or what systemic | nss ering to to off e the ber nt for the ss or ering attified avior. | | |

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

(X6) DATE

TITLE

Julia Berry Executive Director 11/13/2024

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: 4GVS11 Facility ID: 014079 If continuation sheet Page 1 of 5

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/14/2024 FORM APPROVED OMB NO. 0938-039

| | T OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | r í | JILDING | onstruction 00 | (X3) DATE COMPI 10/17 | |
|--|----------------------------------|---|--|---------------------|--|--|----------------------------|
| NAME OF PROVIDER OR SUPPLIER DEMAREE CROSSING ASSISTED LIVING AND MEMORY CARE | | | STREET ADDRESS, CITY, STATE, ZIP COD 1255 DEMAREE ROAD GREENWOOD, IN 46143 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY) | BE PRIATE | (X5) COMPLETION DATE |
| | | | | | changes the facility will means to ensure that the deficient practice does not recurred. Executive Director provided re-training of memory care implementation of new form implemented a binder at the desk to show a picture of a resident who is an elopement Demaree's Director of Healt Wellness and Memory Care Director or designees are deaudits of 5 random current memory care residents a with enext 3 months. Executive Directror provided retraining on Elopement to current staff of memory care Oct 10th. Executive Director developed a process for stafamilies to sign any resident live on memory care, in and the neighborhood and they accept care of the resident in their care. How the corrective action will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be into place Binder at the front desk is a weekly by the Director of Health and Wellness or designee. Demaree's Memory Care Demaree's | staff, staff, ss, se front ny ent risk. th and el oing eek for d the e on or aff and ts who d out of will while (s) re the e put updated ealth birector review thly for | |

State Form Event ID: 4GVS11 Facility ID: 014079 If continuation sheet Page 2 of 5

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER | | A. BUILDING <u>00</u> COMPI | | (X3) DATE SURVEY COMPLETED 10/17/2024 | |
|---|--|--|---------------------|--|-----------------------------------|
| | ROVIDER OR SUPPLIER | SISTED LIVING AND MEMORY CA | 1255 D | ADDRESS, CITY, STATE, ZIP COD EMAREE ROAD IWOOD, 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 0052 | 410 IAC 16.2-5-1.: | 2(v)(1-6) | | interventions that are in place those residents identified who might be at risk for elopement The Executive Director/design will review monthly audits and make necessary corrective actimmediately. Residents who are identified a wandering risk are reviewed in weekly IDT meeting and servi plan is updated as needed for changes. By what date the systemic changes will be completed. 11/30/2024 | tion as a ce |
| Bldg. 00 | review the facility fright to be free from reviewed for elopen resulted in a MCU (exiting the facility wandering off facilitiescorted back to the off facility property Findings include: During an interview Administrator indicapproximately 2:00 activities staff from in the main lobby of service ended at app. Resident B exited the | on, interview, and record ailed to protect the resident's a neglect for 1 of 3 residents ment. This deficient practice (Memory Care Unit) resident without staff knowledge and ty property. The resident was facility until a visitor saw her (Resident B) | R 0052 | What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Director of Health and Wellnes updated this resident's wander assessment and service plan reflect the recent elopement. Before staff take this resident the unit, they are informing the nurse, signing the resident off neighborhood, and staff memble agrees to stay with the resident the duration that she is out of neighborhood. How the facility will identify other residents having the potential to be affected by the same deficient practice and | nss ring to coff e the oer nt for |

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/14/2024 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. BUILDING <u>00</u> | | COMPLETED | | |
| | | | B. WING | | | 10/17/ | |
| | | | | CTREET | ADDRESS CITY STATE ZID COD | | |
| NAME OF I | PROVIDER OR SUPPLIEF | t | | | ADDRESS, CITY, STATE, ZIP COD | | |
| | | | | | EMAREE ROAD | | |
| DEMARE | EE CROSSING ASS | SISTED LIVING AND MEMORY CA | AKE. | GREEN | NWOOD, IN 46143 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID PROVIDED'S DI AN OF CORRECTION | | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE | | TE | COMPLETION |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | visitors. Resident B | was found standing in front | | | what corrective action will be | • | |
| | of a house in the ne | ighborhood next to the facility | | | taken? | | |
| | by a visitor. | | | Director of Health and Wellness | | ss or | |
| | - | | | | designee will complete Wande | ering | |
| | During a continuou | s observation, on 10/17/24 | | | Risk Assessments on current | J | |
| | from 8:20 a.m. thro | ugh 8:30 a.m., the main lobby | | | residents who have been identified | | |
| | | oom located approximately 25 | | | as having exiting seeking beha | avior. | |
| | feet from the front | | | | Residents who have been | | |
| | and the man of the mention. | | | | identified as potential to elope | | |
| | On 10/17/24 at 8:46 | 6 a.m., the Administrator | | | to exit seeking behaviors have | | |
| | provided a copy of an undated screenshot of an | | | interventions put into place in their | | | |
| | employee statement. The statement indicated | | | service plan. We have updated | | | |
| | Resident B was taken to an activity outside the | | | these residents service plans to | | | |
| | MCU by the activity staff. The activity was over | | | include interventions to be | | | |
| | at approximately 3:00 p.m. A visitor saw Resident | | | | completed by 11/30/2024 | | |
| | B walking, west, down the main road at | | | | What measures will be put in | ito | |
| | approximately 3:15 p.m., so he stopped and picked | | | | place or what systemic | | |
| | up Resident B. QMA 1 saw Resident B and the | | | | changes the facility will make | е | |
| | visitor return to the MCU at approximately 3:20 | | | | to ensure that the deficient | | |
| | p.m. The visitor told QMA 1 that Resident B said | | | | practice does not recur | | |
| | she had gotten lost on her way to church. | | | | Executive Director provided | | |
| | | | | | re-training of memory care staff, | | |
| | During an interview on 10/17/24 at 9:42 a.m., | | | | implementation of new forms, | , | |
| | _ | on Aide (QMA) 1 indicated, on | | | implemented a binder at the f | ront | |
| | | nately 4:30 p.m., Resident B | | | desk to show a picture of any | | |
| | returned to the MCU with a visitor. | | | | resident who is an elopement | | |
| | | | | | Demaree's Director of Health | | |
| | During an interview on 10/17/24 at 9:48 a.m., | | | | Wellness and Memory Care | | |
| | Activity Assistant 1 indicated she was not aware | | | | Director or designees are doing | | |
| | Resident B was outside the facility until after her | | | audits of 5 random current | | Ŭ | |
| | shift ended on 10/5/24 at approximately 4:30 p.m. | | | memory care residents a week for | | k for | |
| | The last time Activity Assistant 1 saw Resident B | | | | the next 3 months. | | |
| | that day was at approximately 2:45 p.m. | | | Executive Directror provided | | | |
| | , 11 5 = 10 pm | | | retraining on Elopement to the | | | |
| | The clinical record for Resident B was reviewed on 10/17/24 at 10:03 a.m. The diagnoses included, | | | | current staff of memory care o | | |
| | | | | | Oct 10th. Executive Director | | |
| | | d to, Alzheimer's disease and | | | developed a process for staff | and | |
| | osteoporosis. | | | | families to sign any residents | | |
| | _ ^ | | | | live on memory care, in and or | | |
| | A Service Plan Ass | essment, dated 9/11/24, | | | the neighborhood and they wil | | |

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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| STATEMENT OF DEFICIENCIES | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
|---|---|--------------------------------|----------------------------|--|--|------------------|--------------------|
| AND PLAN OF CORRECTION IDENTIFICATION I | | IDENTIFICATION NUMBER | | | 00 | COMPLETED | |
| | | | B. WING 10/17/2024 | | | | |
| NAME OF PROVIDER OR SUPPLIER | | | | | ADDRESS, CITY, STATE, ZIP COD EMAREE ROAD | | |
| DEMAREE CROSSING ASSISTED LIVING AND MEMORY CAI | | | ARE | | IWOOD, IN 46143 | | |
| (X4) ID | SUMMADV | STATEMENT OF DEFICIENCIE | I | ID | <u> </u> | | (X5) |
| PREFIX | | | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | ACTION SHOULD BE | |
| TAG | (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | | | TAG CROSS-REFERENCED TO THE APPR DEFICIENCY) | | ATE | COMPLETION DATE |
| | | B expressed a desire to go | | | accept care of the resident wh | nile | |
| | home or felt lost. | 1 8 | | | in their care. | | |
| | | | | | | | |
| | A Service Plan, dat | ed 9/13/24, indicated Resident | | | How the corrective action(s) | | |
| | B had moderate der | mentia with significant short | | | will be monitored to ensure the deficient practice will not | | |
| | term memory loss a | and required frequent safety | | | | | |
| | checks. | | | | recur, i.e., what quality | | |
| | | | | | assurance program will be p | ut | |
| | A Wander Risk Assessment, dated 9/28/24, | | | | into place | | |
| | indicated Resident B had a history of wandering. | | | | Binder at the front desk is upd | | |
| | Resident B was at a | a moderate risk for wandering. | | | weekly by the Director of Heal | lth | |
| | 0 10/15/01 0 | | | | and Wellness or designee. | | |
| | On 10/17/24 from 10:15 a.m. until 10:20 a.m., the | | | | Demaree's Memory Care Dire | ector | |
| | location where the visitor found Resident B was | | | | and Director of Health and | | |
| | observed. Resident B was located standing in | | | | Wellness or designees will rev | | |
| | front of the first house entering the residential | | | | resident service plans monthly | y for | |
| | neighborhood approximately 0.1 miles from the | | | three months to ensure that | | | |
| | facility. A sidewalk along the main road led back | | | interventions that are in place for | | | |
| | to the facility parking lot approximately 50 yards | | | | those residents identified who | | |
| | from the front door of the facility. | | | | might be at risk for elopement | | |
| | On 10/17/24 at 8:46 a.m., the Administrator | | | | The Executive Director/design will review monthly audits and | | |
| | provided a facility policy, titled Elopement | | | | make necessary corrective ac | | |
| | Response - Simulated and Actual, dated 3/22/24, | | | | immediately. | ,cion | |
| | and indicated this was the current policy used by | | | | Residents who are identified a | as a | |
| | the facility. A review of the policy indicated an | | | wandering risk are reviewed in | | | |
| | | event in which an unassisted | | | weekly IDT meeting and servi | | |
| | - | y threshold of which they | | | plan is updated as needed for | | |
| | were categorized as being unable to leave | | | | changes. | | |
| | unassisted. An example was a resident who | | | | By what date the systemic | | |
| | resided on the memory care unit who existed | | | | changes will be completed. | | |
| | without accompani | ment. | | | 11/30/2024 | | |
| | | | | | | | |
| | This citation relates | s to Complaint IN00444760. | | | | | |

State Form Event ID: 4GVS11 Facility ID: 014079 If continuation sheet Page 5 of 5