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	03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00455862. Complaint IN00455862 - State deficiencies related to the allegations are cited at R349. Survey date: March 27, 2025 Facility number: 014079 Residential Census: 75 This State Residential Findings is cited in accordance with 410 IAC 16.2-5. Quality review completed March 31, 2025.	R 0000	Plan of Correction Survey Event ID DNAB11 Exit Date 3/27/2025 **What Corrective Action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Responsible (QMA/Licensed Nurses) staff will be re-educated on timely documentation, falls management and proper record maintenance by 4/30/2025. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be take.** Record review will be completed for any resident with a fall event to ensure that progress notes will be completed to ensure compliance with fall management process. Weekly the IDT team will review to ensure that progress notes and follow up has been completed. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.** All direct care nursing staff will receive in-service on documentation standards, including; timeliness of entries,	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Julia Berry	Executive Director	04/11/2025

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 disclo days 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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			accuracy and completeness, HIPAA and confidentiality protocols. Any new hires will be educated on standards for documentation. **How the corrective action will be monitored to ensure the deficient practice will not recur i.e.., what quality assurance program will be put into place.** The Director of Health and Wellness or designee will conduct random audits of 5 clinical records weekly for the next 90 days to ensure compliance with documentation standards. ED/DHW or designee will ensure continued staff education will be provided quarterly. Any ongoing issues will be addressed through progressive discipline and additional training. ED will complete random review of IDT meetings and documentation. **By what date the systemic changes will be completed.** All corrective actions will be completed by 4/30/2025 and systemic monitoring will be ongoing.	
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance Based on interview and record review the facility failed to ensure resident records were complete and accurate for 1 of 3 residents reviewed for falls. (Resident D) Findings include:	R 0349	Plan of Correction Survey Event ID DNAB11 Exit Date 3/27/2025 **What Corrective Action(s) will be accomplished for those**	04/30/2025

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	On 3/27/25 at 9:05 a.m., the Administrator provided a copy of a list of resident who had fallen. A review of the list of falls indicated Resident D had a fall, on 3/3/25, 3/5/25, 3/7/25, and 3/10/25. The clinical record for Resident D was reviewed on 3/27/25 at 10:30 a.m. The diagnoses included, but were not limited to, dementia, bipolar disorder, and delusional disorder. A progress note, dated 3/3/25 at 3:33 p.m., indicated the CNA was doing rounds when she found Resident D on her bathroom floor on her right side. Resident D stated she was trying to go to the bathroom and fell on the floor. Resident D denied hitting her head and had no complaints of pain at that time. A progress note, dated 3/5/25 at 1:46 a.m., indicated writer was summoned by the CNA to report to Resident D's room. Upon arrival Resident D was noted to be sitting upright on her buttocks in front of her bed. Resident D stated she slid off of the bed. The clinical record for Resident D lacked progress notes when she fell on 3/7/25 and 3/10/25. During an interview on 3/27/25 at 10:59 a.m., LPN 1 indicated there should have been a progress note entered into Resident D's record after each fall. On 3/27/25 at 12:11 p.m., the Administrator provided a copy of a facility policy, dated 12/9/24, titled Managing Falls and Fall Risk, and indicated this was the current policy used by the facility. A review of the policy indicated document fall details and known results within the resident's		**residents found to have been affected by the deficient practice?** Responsible (QMA/Licensed Nurses) staff will be re-educated on timely documentation, falls management and proper record maintenance by 4/30/2025. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be take.** Record review will be completed for any resident with a fall event to ensure that progress notes will be completed to ensure compliance with fall management process. Weekly the IDT team will review to ensure that progress notes and follow up has been completed. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.** All direct care nursing staff will receive in-service on documentation standards, including; timeliness of entries, accuracy and completeness, HIPAA and confidentiality protocols. Any new hires will be educated on standards for documentation. **How the corrective action will be monitored to ensure the deficient practice will not recur i.e.., what quality assurance**	

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	electronic medical record. This citation relates to Complaint IN00455862.		**program will be put into place.** The Director of Health and Wellness or designee will conduct random audits of 5 clinical records weekly for the next 90 days to ensure compliance with documentation standards. ED/DHW or designee will ensure continued staff education will be provided quarterly. Any ongoing issues will be addressed through progressive discipline and additional training. ED will complete random review of IDT meetings and documentation. **By what date the systemic changes will be completed.** All corrective actions will be completed by 4/30/2025 and systemic monitoring will be ongoing.	