STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>00</u>		(X3) DATE SURVEY COMPLETED 05/21/2025			
NAME OF PROVIDER OR SUPPLIER 1019 BELLE'S PLACE OF CRAWFORDSVILLE			STREET ADDRESS, CITY, STATE, ZIP COD 100 BICKFORD LN CRAWFORDSVILLE, IN 47933				
(X4) ID PREFIX TAG R 0000	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	(X5) COMPLETION DATE		
R 0092 Bldg. 00	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION This visit was for a State Residential Licensure Survey. Survey dates: May 20 and 21, 2025 Facility number: 003674 Residential Census: 28 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on June 3, 2025. 410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance Based on record review and interview, the facility failed to ensure fire drills had been completed quarterly on all shifts and failed to ensure the fire department had been invited to participate in a fire drill for 12 of 12 months (May 2024 through April 2025). Findings include: On 5/20/25 at 10:40 a.m., review of the facility's fire drill records, dated May 2024 through April 2025, indicated the following: a. A fire drill document, dated 5/8/24, indicated the drill had been conducted at 2:30 p.m. b. A fire drill document, dated 6/12/24, indicated the drill had been conducted at 2:41 p.m.		R 0000	The creation and submission this Plan of Correction does not constitute an admission by this provider of any conclusion see in the statement of deficiencies of violation of any regulations. This provider respectfully require that this 2567 Plan of Correct be considered the Letter of Credible Allegations of Compliance effective 1/24/202. No residents were affected, as had the protentional to be affected by the same deficients having the potential be affected by the same deficient practice and what corrective awill be taken. No residents were affected. What measures will be put into place or what systematic chain the facility will make to ensure that the deficient practice does recur: 1019 created a schedule that ensures quarterly fire drills on	Il 28 octed. ther to ident action onges es s not		
		VIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE ED	TITLE	(X6) DATE		
Γami Muss	Tami Mussche				06/11/2025		

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 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.

State Form Event ID: N3XD11 Facility ID: 003674 If continuation sheet Page 1 of 7

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 05/21/2025			
NAME OF PROVIDER OR SUPPLIER 1019 BELLE'S PLACE OF CRAWFORDSVILLE			STREET ADDRESS, CITY, STATE, ZIP COD 100 BICKFORD LN CRAWFORDSVILLE, IN 47933				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	DBE COMPLETION DATE		
	the drill had been of	nent, dated 7/10/24, indicated onducted at 2:30 p.m. nent, dated 8/14/24, indicated onducted at 2:00 p.m.		each shift totaling 12 fire d annually. The form was up to include signatures of sta participation. ED reached local Fire Department for coordination of fire drill and continue on a semi-annual	odated aff out to d will		
	e. The records lacked documentation that a fire drill had been conducted for September 2024. f. A fire drill document, dated 10/23/24, indicated the drill had been conducted at 6:45 a.m			How the corrective actions monitored to ensure the de practice will not recure, i.e. quality assurance program put into place.	will be eficient ., what		
	the drill had been of h. The records lack	nent, dated 11/6/24, indicated onducted at 7:15 a.m. ed documentation that a fire ucted for December 2024.		ED will monitor the said so monthly to ensure the drills being done in compliance regulations.	s are		
	i. The records lacked documentation that a fire drill had been conducted for January 2025.			By what date the systemic changes will be completed			
	drill had been cond k. A fire drill docur	d documentation that a fire ucted for February 2025. nent, dated 3/18/25, indicated onducted at 11:15 a.m.		June 14, 2025			
	l. The records lacke	d documentation that a fire ucted for April 2025.					
		locumentation of the local fire n invited to participate in a fire					
	Administrator (AD) aware that fire drill the regulations. She	y, on 5/20/25 at 10:25 a.m., the M) indicated she was not s had not been conducted per had noticed that the fire participated in a drill and was					

State Form Event ID: N3XD11 Facility ID: 003674 If continuation sheet Page 2 of 7

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULT A. BUILD B. WING	IPLE CONSTRUCTION ING 00	COMPI	x3) date survey completed 05/21/2025		
NAME OF PROVIDER OR SUPPLIER 1019 BELLE'S PLACE OF CRAWFORDSVILLE			STREET ADDRESS, CITY, STATE, ZIP COD 100 BICKFORD LN CRAWFORDSVILLE, IN 47933				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		II PRE T.	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	going to contact them in June 2025 to invite them to participate.						
During an interview, on 5/20/25 at 2:48 p.m., the Director of Nursing (DON) indicated the fire drill record indicated all of the drills, except the October 2024 drill, had taken place on the first (day) shift. On 5/20/24 at 1:50 p.m., the Corporate Consultant provided a document, with a revision date of 11/1/24, titled, "Emergency Preparedness," and indicated it was the policy currently being used by the facility. The policy indicated, "Procedure8. Fire/evacuation drills for staff and residents should be conducted on a regular							
		a document, with a revision date of titled, "Emergency Preparedness," and I it was the policy currently being used cility. The policy indicated, dure8. Fire/evacuation drills for staff					
R 0095	Administration and Management -Noncompliance Based on interview and record review, the facility failed to ensure a state required dementia unit disclosure form had been completed. This deficiency has the potential to affect 23 of 28 residents residing at the facility. Findings include: On 5/20/25 at 10:30 a.m., the entrance conference materials lacked documentation of a state required dementia unit disclosure form. During an interview, on 5/20/25 at 10:52 a.m., the Administrator (ADM) indicated she was not aware that a dementia unit disclosure form was needed to be completed, due to the facility having memory care/dementia residents. The facility was						
Bldg. 00			R 0095	No residents were affecte of 28 had the potential to affected. How the facility will identif residents having the potential be affected by the same of practice and what correction will be taken.	be y other ntial to leficient	06/13/2025	
				No residents were affecte			
				What measures will be purplace or what systemic character the facility will make to en that the deficient practice recur	anges sure does not		
	a secure facility and	d the doors were locked at all		1019 will complete the sta	ite	,	

State Form Event ID: N3XD11 Facility ID: 003674 If continuation sheet Page 3 of 7

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING 00		00	COMPL	ETED	
						05/21/	05/21/2025	
				STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF PROVIDER OR SUPPLIER								
1019 BELLE'S PLACE OF CRAWFORDSVILLE				100 BICKFORD LN CRAWFORDSVILLE, IN 47933				
1010 DEL		TO THE CONTROL OF THE		ONAWFORDSVILLE, IN 47933				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	•	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE		
	times and could on	ly be unlocked by a key fob.			required dementia unit disclos			
		5/01/05 + 0.50			form.			
	-	v, on 5/21/25 at 9:53 a.m., the						
		g (DON) indicated there were 23		How the corrective action will be				
		ents that were considered			monitored to ensure the defici			
	-	ents. This was calculated to			practice will not recur, i.e, wha			
	· ·	census being memory care			quality assurance programs w	III be		
	residents.				put into place			
	During on interview	v, on 5/21/25 at 9:55 a.m., the			With the completion of the form	m		
	_	ant indicated there was a			With the completion of the form the facility is compliant.	11,		
	_	mission agreement that			the facility is compliant.			
		y was a secure facility and that			By what date the systemic			
		ility would be locked at all			changes will be completed			
		time, she indicated there was			changes will be completed			
	not a specific policy related to the need for a				June 13, 2025			
dementia unit disclosure document					04110 10, 2020			
	completed. The facility would follow the state regulations for completion of the form.							
		•						
R 0151	410 IAC 16.2-5-1.	5(h)						
	Sanitation & Safe	ty Standards						
Bldg. 00	-Noncompliance							
	Based on interview and record review, the facility		R 0	151	No residents were affected. All 1		06/13/2025	
	failed to obtain and keep pet vaccination and				of 1 resident had the potential	to		
		le for 1 of 1 resident who had a			be affected.			
	dog that resided at	the facility (Resident 521).						
					How the facility will identify oth			
	Findings include:				residents having the potential			
	2 700/07				be affected by the same defici			
	-	During the entrance conference, on 5/20/25 at			practice and what corrective a	ction		
	10:25 a.m., the Administrator indicated they had a dog who belonged to a resident in the building.				will be taken.			
	The dog was the on	ly pet in the facility.			No residents were affected.			
	Resident 521's cens	sus information indicated she			What measures will be put into))		
	had a move in date				place or what systemic change			
	nad a move m date	OI 0/ //2T.			the facility will make to ensure			
	Resident 521's mou	e in agreement was reviewed			that the deficient practice does			
Resident 521's move in agreement was reviewed				I mar the delibient practice does	3 1101			

State Form Event ID: N3XD11 Facility ID: 003674 If continuation sheet Page 4 of 7

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
		B. WING		05/21/2025			
			STREE	T ADDRESS, CITY, STATE, ZIP COD			
NAME OF PROVIDER OR SUPPLIER				BICKFORD LN			
1019 BELLE'S PLACE OF CRAWFORDSVILLE			CRAWFORDSVILLE, IN 47933				
(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 CROSS-REFERENCED TO THE APPROPRIA			
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
	-	o.m. The agreement indicated		recur.			
	_	non-refundable pet deposit					
		uld "observe and abide by		Shot records were submitted.			
		procedures and governmental		11	II. Is		
	_	s applicable to the premises and the move in agreement on		How the corrective actions will			
	8/9/24.	ghed the move in agreement on		monitored to ensure the defici			
	0/9/24.			practice will not recur, i.e, what quality assurance program wi			
	During an interview	y, on 5/20/25 at 1:53 p.m., the		put into place.	i be		
	•	nt indicated they did not have		put into piace.			
	_	currently in the building for		Shot records will be checked			
	_	She was aware the facility		quarterly at service plan meet	ina		
	_	alth records and vaccination		quarterly at service plan meet	g.		
		in the building. The facility		By what date the systemic			
		he family to obtain the		changes will be completed.			
		heard anything back yet.					
				June 13, 2025			
	On 5/20/25 at 1:50	p.m., the Corporate Consultant					
	provided a document	nt titled, "1019 Senior Living,"					
	dated December 20	23, and indicated it was the					
		ng used by the facility. The					
		7. The community should					
		cord for all pets documenting					
	•	, phone number, address,					
	shots, and dates"	,					
R 0273	410 IAC 16.2-5-5.	4 (5)					
11 0273		nal Services - Deficiency					
Bldg. 00	FOOD AND NUMBER	ial Services - Deliciency					
Diag. 00			R 0273	No residents were affected. A	All 28 06/13/2025		
	Based on observation	on and interview, the facility	K 02/3	residents had the potential to			
		frozen foods contained use by		affected.			
		dietary service area					
	observation.	-		How the facility will identify ot	ner		
				residents having the potential			
	Findings include:			be affected by the same defic			
				practice and what corrective a			
	On 5/20/25 at 9:50	a.m., during observation of the		will be taken.			
	_	the Dietary Manager. Several					
	bags of frozen food was undated. Open bag of			No residents were affected			

State Form Event ID: N3XD11 Facility ID: 003674 If continuation sheet Page 5 of 7

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00	COMPLETED
B. WING	05/21/2025
STREET ADDRESS, CITY, STATE, ZIP COI	
NAME OF PROVIDER OR SUPPLIER 100 BICKFORD LN	ש
1019 BELLE'S PLACE OF CRAWFORDSVILLE CRAWFORDSVILLE, IN 47933	
1019 DELLE 3 FLAGE OF GRAVVFORDSVILLE CRAVVFORDSVILLE, IN 4/933	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORREC	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX GEACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APP	ULD BE COMPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY)	DATE
frozen broccoli was not dated.	
What measures will be p	
On 5/20/25 at 9:55 a.m., during an interview, the place or what systemic of	- I
Dietary Manager acknowledged the frozen foods the facility will make to e	
were not dated and she did not know the length of that he deficient practice	does not
time the foods had been in the freezer. recur.	
On 5/20/25 at 10:00 a.m., observed an ice scoop All food was inspected, u	
had been stored in the ice within the ice food was destroyed. Ice	• • • • • • • • • • • • • • • • • • •
dispenser. was placed in proper rec	• • • • • • • • • • • • • • • • • • •
and a new scoop was or	
On 5/20/25 at 10:05 a.m., during an interview, the Dishwasher temp log wa	as
Dietary Manager indicated the ice scoop should initiated.	
be placed in the designated holder and not left in	
the ice. How the corrective action	
monitored to ensure the	
On 5/20/25 at 10:10 a.m., observed the dishwasher practice will not recur, i.e	
temperature logs for the month of April. The quality assurance progra	am will be
record lacked evidence of dish washing put into place.	
temperature logs from 5/1/25 to 5/21/25.	
Dietary Manager will mo	
On 5/20/25 at 10:05 a.m., during interview, the food labeling with weekly	•
Dietary Manager indicated the staff had not made delivery. Ed to monitor lo	-
new copies of the temperature logs and no one monthly. Ice scoop place	
had recorded temperatures for the month of May. be monitored daily for 2 works.	
and weekly for 2 weeks	- ·
On 5/20/25 at 1:12 p.m., the Administrator designee. Dishwasher to indicated the facility did not have a policy and monitored weekly by ED	-
	, 01
follows the Indiana retail guidelines. designee.	
The Indiana Retail Food Establishment guidelines By what date the system	nic
indicated, "Except as specified in subsection (d), changes will be complete	
refrigerated, ready-to-eat, potentially hazardous	Cu.
food prepared and held in a retail food June 13, 2025	
establishment for more than twenty-four (24)	
hours shall be clearly marked to indicate the date	
or day by which the food shall be consumed on	
the premises, sold, or discarded"	
and promined, or diseases in	
The Indiana Retail Food Establishment guidelines	

State Form Event ID: N3XD11 Facility ID: 003674 If continuation sheet Page 6 of 7

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

PRINTED: 06/23/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/21/2025			
NAME OF PROVIDER OR SUPPLIER 1019 BELLE'S PLACE OF CRAWFORDSVILLE			STREET ADDRESS, CITY, STATE, ZIP COD 100 BICKFORD LN CRAWFORDSVILLE, IN 47933					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION	PROVIDER'S PLAN OF CORRECTION		
PREFIX	(EACH DEFICIEN	CH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR		TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	in a clean, protected	utensils; between-use storage I location if the utensils, such sed only with a food that is rdous"						
	The Indiana Retail Food Establishment guidelines indicated "water temperature measuring devices on warewashing machines shall have a numerical scale, printed record"							

State Form Event ID: N3XD11 Facility ID: 003674 If continuation sheet Page 7 of 7