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	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FORUM AT THE CROSSING	8505 WOODFIELD CROSSING BLVD INDIANAPOLIS, IN 46240

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00452215 and IN00449992. Complaint IN00452215-No deficiencies related to the allegations are cited. Complaint IN00449992-No deficiencies related to the allegations are cited. Survey dates: April 15 & 16, 2025 Facility number: 015281 Residential Census: 26 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on April 21, 2025.	R 0000	This Plan of Correction represents Forum at the Crossing (community) allegation of compliance. Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency Based on interview and record review, the facility failed to ensure a staff member with current cardiopulmonary resuscitation (CPR) and first aid certificates was always on site for 8 of 21 shifts reviewed for CPR and first aid. (April 6, 7, 8, 9, 10, 11 and 12, 2025) Findings include: The CPR and first aid certificates were reviewed,	R 0117	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** CPR/First Aid training was provided to nursing team on April 16, 2025 **How the facility will identify other residents having the**	05/30/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lorna Ray	Executive Director	05/03/2025

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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	on 4/15/25 at 1:30 p.m., and indicated the following: 1. On 4/6/25, the 3rd shift did not have a staff member who had CPR or first aid training. 2. On 4/7/25, the 1st and 3rd shift did not have a staff member who had CPR or first aid training. 3. On 4/8/25, the 3rd shift did not have a staff member who had CPR or first aid training. 4. On 4/9/25, the 3rd shift did not have a staff member who had CPR or first aid training. 5. On 4/10/25, the 1st shift did not have a staff member who had CPR or first aid training. 6. On 4/11/25, the 1st shift did not have a staff member who had CPR or first aid training. 7. On 4/12/25, the 1st shift did not have a staff member who had CPR or first aid training. During an interview, on 4/16/25 at 10:45 a.m., the Executive Director indicated the facility knew there were issues with CPR and first aid. They did not have any additional CPR or first aid certificates to provide. During an interview, on 4/16/25 at 12:50 p.m., the Director of Nursing (DON) indicated the facility did try to staff someone on each shift with CPR and first aid. The facility knew there would be an issue. A current facility policy, titled "CPR and First Aid Training for Team Members," dated as effective 4/1/24 and received from the Executive Director on 4/16/25 at 12:40 p.m., indicated "...It is the policy		**potential to be affected by the same deficient proactive and what corrective action will be taken?** All residents have the potential to be affected by the deficient practice. **What measures will be put in place or what systemic changes the facility will makes to ensure the deficient practice will not reoccur?** Director of Health and Wellness or designee will audit schedule weekly to ensure there is at least 1 person scheduled that has current CPR/First aid certification. **How the corrective actions will be monitored to ensure the deficient practice will not reoccur i.e., what quality assurance program will be put into place?** The Executive Director or designee will audit staff schedule weekly x 4 weeks. Audits will then continue monthly until 100% compliance is achieved.	

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	of the community that current CPR and First Aid certification training is required for the Assisted Living Manager, any licensed nursing personnel and all direct care staff of the community...The community takes reasonable and appropriate steps to ensure that each resident is provided CPR and First Aid by team members as necessary...."			
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance Based on interview and record review, the facility failed to ensure employees received annual resident rights and dementia training for 9 of 10 staff members reviewed for employee records. (LPN 2, CNA 3, CNA 4, QMA 5, CNA 6, CNA 7, CNA 8, CNA 9 and CNA 10) Findings include: The employee staffing records were reviewed on 4/16/25 at 9:30 a.m., and indicated the following: 1. Licensed Practical Nurse (LPN) 2 had not completed their annual resident rights or dementia training. 2. Certified Nursing Assistant (CNA) 3 did not have their new hire dementia training or resident rights training completed. 3. CNA 4 did not have their annual resident rights or dementia training completed. 4. Qualified Medication Aide (QMA) 5 did not have their new hire dementia training or resident rights training completed. 5. CNA 6 did not have their annual resident rights	R 0120	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Team members will have completed required annual training by date of compliance. They will complete education on resident rights and dementia. **How the facility will identify other residents having the potential to be affected by the same deficient proactive and what corrective action will be taken?** All residents have the potential to be affected by the deficient practice. **What measures will be put in place or what systemic changes the facility will makes to ensure the deficient practice will not reoccur?** Director of Health and Wellness or designee will audit all employee training plans to ensure all team members are in compliance with	05/30/2025

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	or dementia training completed. 6. CNA 7 did not have their annual resident rights or dementia training completed. 7. CNA 8 did not have their annual resident rights or dementia training completed. 8. CNA 9 did not have their new hire dementia training or resident rights training completed. 9. CNA 10 did not have their annual resident rights or dementia training completed. During an interview, on 4/16/25 at 10:45 a.m., the Administrator indicated the facility knew there was some missing dementia and resident rights training. The facility did not have any additional resident rights or dementia training to provide. During an interview, on 4/16/25 at 10:58 a.m., the Executive Director indicated the system did not automatically populate for the employees to complete the training. During an interview, on 4/16/25 at 12:50 p.m., the Director of Nursing (DON) indicated the staff members were supposed to have 6 hours of dementia training upon hire and complete resident rights training as well. A current facility policy, titled "Annual Training and Documentation," dated as effective 4/1/24 and received from the Executive Director on 4/16/25 at 12:40 p.m., indicated "...All assisted living employees will complete annual education on the following topics...Assisted living bill or rights...Effective approaches for communication and care of residents with dementia, Alzheimer's disease or related disorder...."		the required annual training. Any team member found to not be in compliance will be required to complete their annual training by date of compliance. **How the corrective actions will be monitored to ensure the deficient practice will not reoccur i.e., what quality assurance program will be put into place?** The Executive Director or designee will audit team member education monthly. Audits will then continue monthly until 100% compliance is achieved.	

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R 0296 Bldg. 00	410 IAC 16.2-5-6(b) Pharmaceutical Services - Noncompliance Based on interview and record review, the facility failed to ensure staff followed a physician's order to administer medication three times a day, to follow the physician's hold parameter order, and notified the physician when the orders were not followed for 1 of 6 residents reviewed for medications. (Resident 5) Findings include: The clinical record for Resident 5 was reviewed on 4/16/25 at 11:05 a.m. The diagnoses included, but were not limited to, orthostatic hypotension, atrial fibrillation, and essential primary hypertension. a. A physician's order, dated 11/21/24 and discontinued on 1/7/25, indicated to give midodrine (a medication to raise blood pressure) three times a day and to hold the medication if the systolic blood pressure was greater than 140. A Medication Administration Record (MAR), dated 11/1/24 through 11/30/24, indicated midodrine was given two times a day from 11/22/24 through 11/30/24. Midodrine was also given on 11/26/24 with a systolic blood pressure of 153 and on 11/29/24 with a systolic blood pressure of 148 and 144. A MAR, dated 12/1/24 through 12/31/24, indicated midodrine was given two times a day from 12/1/24 through 12/31/24. Midodrine was also given on 12/6/24 with a systolic blood pressure of 142. A MAR, dated 1/1/25 through 1/31/25, indicated midodrine was given two times a day from 1/1/25 through 1/7/25. Midodrine was also given on	R 0296	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** All medication times were reviewed to match physician orders and medication administration times adjusted to match physician order. **How the facility will identify other residents having the potential to be affected by the same deficient proactive and what corrective action will be taken?** All residents have the potential to be affected by the deficient practice **What measures will be put in place or what systemic changes the facility will makes to ensure the deficient practice will not reoccur?** Medication training regarding administration and documentation will be completed with all current team members who are passing medication (QMA and Nursing staff). Director of Health and Wellness or designee will audit resident MAR daily to assure compliance with Medication Administration. All orders will have been reviewed to look at proper administration time of medication.	05/30/2025

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	1/5/25 with a systolic blood pressure of 153. b. A physician's order, dated 1/7/25 and discontinued on 2/3/25, indicated to give midodrine (a medication to raise blood pressure) three times a day and to hold the medication if the systolic blood pressure was greater than 140. A MAR, dated 2/1/25 through 2/28/25, indicated midodrine was given on 2/15/25 with a systolic blood pressure of 144 and on 2/20/25 with a systolic blood pressure of 150. c. A current physician's order, dated 2/3/25, indicated to give midodrine (a medication to raise blood pressure) three times a day and to hold the medication if the systolic blood pressure was greater than 140. A MAR, dated 3/1/25 through 3/31/25, indicated midodrine was given on 3/6/25 with a systolic blood pressure of 152, on 3/15/25 with a systolic blood pressure of 147, and on 3/22/25 with a systolic blood pressure of 142. A MAR, dated 4/1/25 through 4/16/25, indicated midodrine was given on 4/6/25 with a systolic blood pressure of 146. The nursing progress notes, dated 10/23/24 through 4/16/25, did not indicate the physician was notified of the medication errors. During an interview, on 4/16/25 at 10:38 a.m., QMA 1 indicated for a medication with a hold order, the resident's vital signs would be taken, and the medication would be held based on the results and the specific hold parameter. For the midodrine order, if the systolic blood pressure was greater than 140, the medication should not		**How the corrective actions will be monitored to ensure the deficient practice will not reoccur i.e., what quality assurance program will be put into place?** The Executive Director or designee will audit MAR weekly x 4 weeks. Audits will then continue monthly until 100% compliance is achieved.	

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	have been administered. During an interview, on 4/16/25 at 12:20 p.m., the Director of Nursing (DON) indicated she was unaware the midodrine was only given twice a day instead of three times as ordered in November and December. The facility had an issue with medications scheduled on the night shift because there was not a nurse in the facility often on the night shift. The medication should have been given three times a day per the physician's order. The medication should not have been given when the resident's systolic blood pressure was over 140. She had been unaware of the medication errors and could not indicate if the physician had been made aware. A current facility policy, titled "Medication Management Guidelines," dated 4/1/19 and received from the Executive Director on 4/16/25 at 1:40 p.m., indicated "...Medication errors are immediately reported to the resident's healthcare provider...."			