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	06/05/2025

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 Complaints IN00460362, IN00460796, IN00460839. Complaint IN00460362 - State deficiencies related to the allegations are cited at R0296. Complaint IN00460796 - No deficiencies related to the allegations are cited. Complaint IN00460839 - No deficiencies related to the allegations are cited. Survey date: June 5, 2025 Facility number: 014079 Residential Census: 77 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed June 10, 2025.	R 0000	Survey Event ID EL3H11 R296 410 IAC 16.2-5-6(b) pharmaceutical services – non compliance. **What corrective actions will be accomplished for these residents found to have been affected by the deficient practice?** The facility immediately addressed the issue identified for the residents found to have been affected by the deficient practice. The QMAP received immediate re-education on the facility's policy and standard for medication administration following the 7 rights of medication administration. **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?** No other residents impacted by the deficient practice. No adverse effect to the identified resident. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Julia Berry	Executive Director	06/21/2025

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.

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	06/05/2025

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
			practice does not recur? The following systemic changes have been implemented to ensure ongoing compliance: All QMAP's will be re-educated on community policy for medication administration including the 7 rights of medication administration. Director of Health and Wellness or designee will complete medication pass observation on all QMAPs. Ongoing medication observations will be completed on a quarterly basis. . **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?** To monitor ongoing compliance and prevent recurrence of this deficient practice, the facility has established the following Quality Assurance measures: The Community Director of Health and Wellness or designee will conduct random medication pass observations twice a month for the next 60 days. Action plans will be immediately implemented for any identified concerns and the findings will be discussed with the Executive Director.	

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	06/05/2025

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
			. **By what date the systemic changes will be completed.** All corrective actions and systemic changes will be completed by **July 5, 2025**.	
R 0296 Bldg. 00	410 IAC 16.2-5-6(b) Pharmaceutical Services - Noncompliance Based on record review and interview, the facility failed to implement medication administration policies for 1 of 4 residents reviewed for medication administration. (Resident B) Findings include: On 6/4/25 at 10:45 a.m., Resident B's clinical record was reviewed. The diagnoses included, but were not limited to, cerebrovascular disease and memory deficit. The Progress Notes indicated, on 5/27/25 at 1:30 p.m., QMA 1 administered Resident B two medications intended for Resident C. Resident B was given 0.5 mg (milligrams) of lorazepam (an anti-anxiety medication) and 10-325 mg of hydrocodone (narcotic pain medication). The Physician's Orders, indicated Resident B was prescribed 5-325 mg of hydrocodone every 6 hours as needed for pain on 5/19/25. There was no physician's order for lorazepam. On 6/4/25 at 11:30 a.m., the Executive Director provided the Medication Management Guideline, revised 8/11/23, and indicated this was the	R 0296	Survey Event ID EL3H11 R296 410 IAC 16.2-5-6(b) pharmaceutical services – non compliance. **What corrective actions will be accomplished for these residents found to have been affected by the deficient practice?** The facility immediately addressed the issue identified for the residents found to have been affected by the deficient practice. The QMAP received immediate re-education on the facility's policy and standard for medication administration following the 7 rights of medication administration. **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?**	07/05/2025

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	06/05/2025

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
	guideline currently used by the facility. A review of the guideline indicated, "Staff assisting with or administering medications will follow the 7 rights of medication administration to include: right resident, right dose, right drug, right route, right time, right reason, right documentation." During an interview on 6/4/25 at 11:50 a.m., the Executive Director indicated QMA 1 had not ensured the medication was administrated as ordered and had given medications to Resident B rather than Resident C. During an interview on 6/4/25 at 12:15 p.m., QMA 1 indicated on 5/27/25 around 1:30 p.m., she mistook Resident B for Resident C, as they had the same first name and similar physical appearance. She did not verify the identity of the resident prior to administering the medication. This citation relates to Complaint IN00460362.		No other residents impacted by the deficient practice. No adverse effect to the identified resident. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?** The following systemic changes have been implemented to ensure ongoing compliance: All QMAP's will be re-educated on community policy for medication administration including the 7 rights of medication administration. Director of Health and Wellness or designee will complete medication pass observation on all QMAPs. Ongoing medication observations will be completed on a quarterly basis. . **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?** To monitor ongoing compliance and prevent recurrence of this deficient practice, the facility has established the following Quality Assurance measures:	

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	06/05/2025

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
			The Community Director of Health and Wellness or designee will conduct random medication pass observations twice a month for the next 60 days. Action plans will be immediately implemented for any identified concerns and the findings will be discussed with the Executive Director. . **By what date the systemic changes will be completed.** All corrective actions and systemic changes will be completed by **July 5, 2025**.	