

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155291	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/01/2025
NAME OF PROVIDER OR SUPPLIER  Eagle Valley Meadows		STREET ADDRESS, CITY, STATE, ZIP CODE  3017 Valley Farms Rd Indianapolis, IN 46214	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

TITLE

(X6) DATE

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on observations, interviews, and record review, the facility failed to ensure sufficient staffing was provided to meet resident care needs. This deficient practice had the potential to affect 20 of 20 residents who resided in the secured memory care unit and 1 of 3 residents reviewed for NOMNC notification. (Residents 17 and B) Findings include: 1. On 7/27/25 at 11:00 a.m., the day shift time and attendance records for nursing staff assignments on the 6:00 a.m. - 2:00 p.m. shift, with a resident census of 77, were reviewed. According to the timesheets, the following staff were physically present in the building during the 6-2 shift: Licensed Nurses: Registered Nurse (RN) 9: 6:52 a.m. - 2:52 p.m. Licensed Practical Nurse (LPN) 11: 7:45 a.m. - 11:40 a.m. LPN 12: 6:42 a.m. - 2:01 p.m. LPN 13: 5:44 a.m. - 2:13 p.m. Certified Nursing Assistants (CNAs): CNA 14: 5:44 a.m. - 10:00 p.m. CNA 15: 6:01 a.m. - 2:10 p.m. CNA 16: 5:56 a.m. - 10:00 p.m. CNA 17: 6:06 a.m. - 4:12 p.m. CNA 18: 6:04 a.m. - 2:11 p.m. The total actual CNA worked hours for the 6-2 shift was 72.43 hours, resulting in a staff-to-resident ratio of 0.94 hours per resident day (HPRD) for direct care staff. According to CMS expectations and industry benchmarks, this HPRD was below the recommended level of 1.5 - 2.0 HPRD for CNA coverage, not including licensed nursing staff. Multiple CNA and licensed nurse shift start times varied and overlapped slightly, with one licensed nurse, LPN 11, leaving the building prior to the end of the scheduled shift at 11:40 a.m., further reducing licensed coverage. This level of staffing did not reflect a sufficient number of qualified nursing personnel to meet the scheduled and unscheduled care needs of 77 residents, which included, but was not limited to, assistance with activities of daily living (ADLs), timely incontinence care, hydration needs, and a clean/comfortable homelike environment. On 7/27/25 at 10:12 a.m., Resident 17 was observed lying in bed with blankets over her. The room was very warm. She had a red face, and her lips were dry and cracked. She had long facial hair. Her bedside table was out of reach. On the table was a cup of warm water dated 7/23/25. On 7/28/25 at 10:30 a.m., Resident 17 was observed lying in bed with blanket over her. She continued to have a red face, and her lips were dry and cracked. She had long facial hair. Her bedside table was out of reach. She continued to have a cup of warm water with the date of 7/23/25 written on the cup. On 7/29/25 at 9:45 a.m., Resident 17 was observed lying in bed with a blanket over her. She had a face, and her lips were dry and cracked. She had long facial hair. Her bedside table was out of reach. She had a cup of water at her bedside that had warm water, and the cup did not have a date on it. On 7/30/25 a record review was completed for Resident 17. She had the following diagnoses which included but were not limited to Alzheimer's disease, schizophrenia, seizures, anxiety disorder, hypertension, and osteoarthritis. During an interview on 7/30/25 at 1:37 p.m., the Administrator (ADM) was notified of some staffing and environmental concerns and conducted a walk through in the memory care unit. The ADM indicated staffing was set to daily census and acuity needs. The CNAs in memory care did not utilize assignment sheets, but provided care based off the Resident Profile and should follow a CNA To Do List. On 8/1/25 at 8:40 a.m., the ADM provided a copy of the CNA To Do List which was reviewed at that time. The Day and Evening shift To Do List was broken into five sections: 1. Tasks before breakfast, (11 items) 2. Tasks after breakfast, (11 items) 3. Tasks after lunch, (9 items) 4. Tasks upon arrival and prior to evening meal, (13 items) and 5. Tasks after dinner, (13 items) for a total of 57 tasks. The list was not broken up or assigned shift by shift. The Night Shift To DO List was considerably shorter with only 18 tasks which included, but were not limited to: incontinent checks, safety rounds, wheelchair cleaning per schedule and ensuring supplies were stocked for the next shift. Several resident's wheelchairs were observed dirty and in disrepair during the survey. Considering a day shift, from 6:00 a.m., until 2:00 p.m. in the memory care unit, (addressing resident behaviors as needed) there were 31 tasks to be completed which included, but were not limited to: review CNA sheets (which were not available), ensure all residents are provided A.M. cares and up for breakfast, completing charting, ensure beds are made, pass ice water, turn and reposition dependent residents, toileting, showers and empty trash. Ice water was not observed passed in memory care during the survey period. Showers were not observed in progress until after 7/29/25 when it was brought to staff attention. Multiple personal hygiene and oral care concerns were observed. Cross reference F584, F677, and F692.2. On 7/29/25 at 11:19 a.m., Resident B's record was reviewed. He had been a short-stay rehab resident with diagnoses which included, but were not limited to, Parkinson's disease, Type 2 diabetes mellitus without complication and anxiety disorder. A NOMNC dated 4/20/25, was not signed as acknowledged by Resident B until 4/21/25, as the requirement states, residents must receive at least 48 hours notice for noncoverage. During an interview on 7/29/25 at 2:21 p.m. the</p>		