

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews, the facility failed to date items when opened and prepped for 1 of 1 kitchen observation. Findings include: On 7/27/25 at 10:02 a.m., a tour of the kitchen was conducted. Observed a cell phone lying next to pies that were defrosting. [NAME] and chocolate milk had no date opened on the containers. A salad was prepped with no date on the wrap. On 7/27/25 at 10:30a.m., the cook indicated the milk should have had a date open on the container. A policy titled, Food Storage was provided by the Regional Director of Clinical Services (RDCS) on 7/30/25 at 11:30 a.m. It indicated, .All foods shall be covered or wrapped tightly, labeled and dated.3.1-21(j)(1)3.1-21(j)(3)		

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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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to provide a clean, comfortable, and homelike environment for residents residing in the Memory Care (MC) unit for 6 days of observations and 4 of 4 months of grievances reviewed. These deficiencies had the potential to lead to increased risk of infection, safety hazards, and an institutional rather than homelike setting for 20 of 20 residents residing in the MC unit. Findings include: 1. On 7/27/25 at 10:38 a.m., an Air Conditioning (AC) unit mounted to the wall in the MC front lounge was observed actively dripping water from built up condensation. The water leaked down the wall, and dripped on top of a cushioned chair. The paint on the wall under the AC unit was observed to peel away and showed evidence of long-term water damage. On 7/29/25 at 9:55 a.m., Resident 48 was observed as she sat in the cushioned chair under the mounted AC unit which continued to drip onto the back of the chair. During an interview on 7/30/25 at 9:45 a.m., Housekeeper (19) was observed as he wiped water from the wall and floor under the leaking AC. He indicated, Maintenance was supposed to come fix the units which had been leaking for a while. It needs to be fixed or it will start molding the wall. The issue remained unresolved throughout the survey period, and with the excessive outside temperature, the units were observed to condensate and drip for multiple days. 2. On multiple observations from 7/27/25 - 7/30/25 the following was observed in resident rooms and bathrooms: A shared bathroom for room [ROOM NUMBER] & 139: Non-skid flooring in front of toilet was dirty, tacky, and had gunk buildup. The toilet riser was missing rubber grips on the front two legs of the chair increasing risk for it slipping. room [ROOM NUMBER]'s toilet riser was rusted and speckled with feces, the floor was filthy with black grout in between tile seams, and a dark ring around the toilet base. There was no toilet paper holder. The bathroom ceiling air intake vent was coated with dust/debris. room [ROOM NUMBER]'s bathroom florescent light cover was observed duct-taped in place. room [ROOM NUMBER]'s dresser drawer handle dangled loose in disrepair. room [ROOM NUMBER]'s dresser drawer handle dangled loose in disrepair and cobwebs were noted in the window. In rooms [ROOM NUMBERS], cobwebs in window. room [ROOM NUMBER]'s Call light was wrapped and hung up on the wall, inaccessible to the resident. 3. Throughout the survey period, multiple wheelchairs (WC) were visibly dirty and in disrepair: Resident 8's WC had peeling tape and debris accumulated. Resident 49's WC was missing the rubber brake handle (noted on 7/31 and again on 8/1). Resident 7's WC brake handle were also missing. Resident 52 had a fall mat beside her bed which was observed to be built up with dirty and stains, the mat cover had become wrinkled and cracked on the edges. 4. Throughout the survey period, Resident 56 was observed in her room, lying in bed until it was brought to staff attention and she was assisted out of her room on 7/31/25. There was no visitor or personal chair in Resident 56's room for guests to visit. There were no pictures or decorations on the walls. There were no personalized items of comfort on her bed or bedside table. There were gauges in the wall with drywall debris on the floor behind the head of the bed. Several of the privacy curtains from the ceiling were noted to be detached and hung in disrepair. On 7/31/25 at 12:09 p.m., when Resident 56 was brought to main dining room, there was no available seat for her, and she was instead placed in a corner chair in the TV lounge. A CNA brought an over-bed table from another resident's room to set her lunch tray on. 5. Throughout the survey period, multiple observations of multiple residents were noted to be unclean, had torn or ill-fitted clothing, and lacked basic personal hygiene such as brushed hair and oral care. Multiple rooms were noted to feel warm and moist, and with the excessive heat outside, personal HVACs in rooms were not pulling the moisture from the air. The warm moist air contributed to lingering strong odors after incontinent episodes. Particularly rooms [ROOM NUMBERS]. 6. A grievance filed 1/23/25 indicated, family member states room is not being cleaned, the floors were a mess, need mopped. A grievance filed on 2/19/25 indicated, bathroom is left dirty after aides assist (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	neighbor to use the toilet . the sink has been filled with waste before.A grievance was filed on 4/17/25 which indicated, lack of cleanliness in room, no trash can, things spilled not cleaned up.A grievance filed 4/17/25 indicated, bathroom was not clean.A grievance filed on 6/30/25 indicated, concern that there are many gnats in the room.A Resident Council Concern filed on 12/4/24 indicated, wheelchairs need to be cleaned. Cross reference to F677. On 7/31/25 at 1:10 p.m., the Administrator provided a copy of current facility policy titled, Deep Cleaning Practices, revised 12/21. The policy indicated, Deep cleaning of resident rooms and common areas shall be scheduled by and maintained by the Housekeeping Supervisor and/or Environmental Service Supervisor . Each Housekeeper when completing a deep clean shall fill out a quality control deep cleaning checklist signed and dated, and provide it to the housekeeping supervisor upon completion of the deep clean . This citation relates to Complaints IN00162849 and IN00162850.3.1-19(f)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observations, interviews, and record review, the facility failed to provide necessary assistance with activities of daily living (ADLs) such as, dressing, grooming, hygiene, toileting, and repositioning for multiple dependent residents in the Memory Care (MC) unit for 5 of 8 residents reviewed for ADLs (Residents 27, 57, 34, 58 and 56). Findings include: During an initial observation in the secured memory care unit (MC) on 7/27/25 at 10:38 a.m., the following was observed: Multiple residents were observed in the main dining/activity lounge who wore unclean, ill-fitted socks and clothing with unkempt, tangled or greasy hair. Resident 27 sat in a wheelchair (wc) which had a copious amount of bright orange duct tape to the brake handles and inside panel. The tape was peeled away in several areas with bits of unidentifiable debris, hair and lint stuck to the peeled sides. Her hair had been pulled into a ponytail, but the band was loose, and her hair was falling out around it, and appeared as if she slept on it. She wore a long-sleeve purple shirt which appeared too big for her and fell off her shoulder. She also had on a pair of blue non-skid socks that were dirty on the bottom. Resident 43 had on a pair of blue non-skid socks with a hole in the toe of her left sock, so that her toenail stuck out. Resident 71 was observed seated in a wc pulled up to a table. Her eyes were closed and her head was bowed, she appeared to be asleep. She had on a pair of yellow non-skid socks that appeared to be too small and cut into the skin around the top of her ankles as her feet. Resident 57 ambulated independently. As she spoke, her teeth and gums were observed with copious amounts of built up plaque/tartrate, and/or unidentifiable, build up food debris. Her breath had a foul odor. Resident 58 ambulated independently with a rollator walker into the main activity/dining room briefly, but returned to her room. Her hair was observed flattened and matted at the back and appeared greasy and unbrushed. Resident 34 was observed lying in bed without pants or a brief. A saturated brief lay on the floor, and the room smelled of urine. Resident 34 indicated, she had removed the brief herself because no one came to change me. Resident 56 was observed lying in bed. She wore a badly faded hospital gown that fell off her shoulder. Her room was bare with no personalization. The TV was not on. There was no music, and she stared blankly at the ceiling. The MC unit Spa room was observed. The tiles, sink, shower curtain and shower head were all dry. There was no moisture or humidity in the air to indicate recent showers had taken place. During a continuous observation on 7/28/25 from 11:00 a.m. until 11:20 a.m., following was observed: Resident 27 was observed. Her hair appeared to have been brushed and put back into a neat ponytail, but she remained in the same purple long-sleeve shirt, and had on the same blue dirty socks. Her wheelchair remained in unclean conditions with the orange duct tape and debris stuck in it. Resident 34 was observed dressed in a pink pull over style sweatshirt with what appeared to be a pink shirt underneath, grey velvet style lounge pants and a pair of house shoes. Residents 34, 58, 43 and 71 all appeared to be wearing the same dirty socks. Resident 56 remained in her bed and appeared to be in the same faded hospital gown. Resident 56 did not have a wc in her room, a visitor's chair, or comfortable personal chair to sit in should she prefer to get out of bed. The CNA on the MC was observed as she briskly moved from one room to the next, at times she spent less than 2 minutes in a resident's room. She stepped into some residents' rooms and simply asked, did they need to use the restroom, and did not encourage them to try before she moved on to the next resident. On 7/29/25 from 9:55 a.m. until 11:35 a.m., no residents were observed to be offered a shower. The MC unit Spa room was observed. The tiles, sink, shower curtain and shower head were all dry. There was no moisture or humidity in the air to indicate recent showers had taken place. Resident 34 was observed to wear the same outfit as the day before. On 7/30/25 from 9:20 a.m., until 9:45 a.m. the following was observed: Resident 27 remained in a long-sleeve purple shirt which appeared to be too big for her and fell off her shoulder. She wore the same dirty blue socks. Resident 58's hair remained flattened/matted at the back and appeared greasy. Resident 57's still had very poor hygiene and her breath had a foul odor. Resident 56 remained in the same faded hospital gown, and stared blankly at the ceiling with no TV or radio, no visitor chair (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and nothing on the walls to look at. The MC unit Spa room was observed. The tiles, sink, shower curtain and shower head were all dry. There was no moisture or humidity in the air to indicate recent showers had taken place. On 7/31/25 from 9:50 a.m., until 10:15 a.m., the following was observed: There were now 2 CNAs on the MC unit. One CNA was observed as she assisted a resident out of the spa room. Resident 43 was observed in her wc in her room as she was about to be assisted to bed. She was observed to have the same pair of dirty blue socks on with a hole in her left sock seam, her toenail jutting out and now there was a ball of dust and hair stuck to her toenail from under her foot. Resident 49 was observed in her room. She was lying on her left side/stomach with her head rested on her arm, as there were no sheets or pillows observed on her bed. Her incontinent brief was heavily soiled as it had seeped and stained the back of her pants and up to the bottom of her shirt. The room smelled strongly of urine, and the air was stagnant. Resident 27 had been put in a new bright orange shirt, but it also appeared to be too big for her and fell off her shoulders and there were two ripped holes in the bottom of the shirt. Resident 56 was observed dressed in a new shirt and was assisted out of her bed and into the main TV lounge for lunch. On 8/1/25 at 9:00 a.m., Resident 49 was observed laying directly on top of her mattress, as her bed remained without sheets. During a confidential interview, it was indicated, there was a nurse and only 1 Certified Nursing Aide, (CNA) on the MC unit. It was indicated, the CNA had to assist and take care of all 20 residents ADL and morning routines by themselves, and sometimes could not get everything done. During a confidential interview, it was indicated, there was only 1 CNA on the MC unit and they often struggled to get everything done for everyone. They were supposed to be able to ask for help from CNAs from other halls, but they were usually all too busy to help. On 7/31/25 at 10:00 a.m., Residents 27, 57, 34, 58, 56, 43, 71, and 49's records were reviewed for ADLs. Resident 27 was a long term care resident with diagnoses which included but were not limited to, Alzheimer's disease and was severely cognitively impaired. Her Resident Profile indicated, Assist with bathing as needed per resident preference. Offer showers two times per week, partial bath in between. Prefers to have AM showers. Resident 27's shower sheets were reviewed for the month of July. She had a bed bath on 7/7 a shower on 7/14, shower on 7/17 and 2/21, then was given a shower during survey on 7/31. The shower sheets did not indicate a time it had been provided and did not include details of what if any items were completed. Resident 27 had a care plan initiated 11/11/21 which indicated, she required assistance with ADLs including bed mobility, transfers, eating and toileting related to her diagnoses. The care plan did address her preferences for clothing. Resident 57 was a long term care resident with diagnoses which included, but were not limited to, Alzheimer's disease and was moderately cognitively impaired. Her resident profile indicated, Assist with bathing as needed per resident preference. Offer showers two times per week, partial bath in between. There were only two shower sheets for Resident 57 on 7/8 and 7/22, she refused on both dates. The shower sheets did not indicate any re-approaches were attempted for either date. She had a care plan initiated on 8/7/24 which indicated, Resident does refuse to change clothing daily regardless of how many approaches and refuses showers. Family is aware and would like to be informed when this happens so they can assist her due to her behaviors. An intervention for this plan of care dated 4/17/25 indicated, Contact family to assist and come in for showers as needed, they are willing to complete if all interventions fail. The record lacked documentation that family had been contacted for the days she reused. She had a second care plan initiated 8/6/24 which indicated, she was at risk for impaired dental hygiene and had her own teeth with an intervention to assist her with oral care. The care plan lacked revisions if needed, that she would refuse oral care. The record lacked documentation that oral care had been provided or approaches to assist her were updated. Resident 58 was a long term care resident with diagnoses which included, but were not limited to, unspecified dementia and was moderately cognitively impaired. Her resident profile indicated, Assist with bathing as needed per resident preference. Offer showers two times per week, partial bath in between. Her shower sheets for the month of July were reviewed. On the 3rd at 9:00 a.m., she allowed the CNA to wash her up in the bathroom but would not (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	take a shower. A shower sheet dated the 7th at 10:15 a.m., was left completely blank. Nothing was checked off, and no notes were written so it was indeterminable if she had been given a shower. On the 10th a shower sheet was timed at 9:05 a.m., and indicated, she had refused the shower, but accepted a bed bath. on the 14th, (with no time) it was indicated in the comments: washed her up, but no additional details or checkmarks to indicate what that included. On the 28th (with no time) she refused a shower, with no noted redirection or additional attempts. She had a care plan initiated 1/29/25 which indicated she required assistance with ADLs including hygiene and showers. There was a second care plan initiated on 4/9/25 which indicated, Resident will refuse shower, care, and to get up from bed at times. There were only two interventions, both initiated 4/9/25 which indicated inform resident of risks of refusals in calm manner and offer different staff. The record lacked documentation of refusals since 4/8/25, and there was no documentation that different staff had been offered to assist her to shower for the July dates she refused. Resident 56 was a long term care resident with diagnoses which included but were not limited to, Alzheimer's disease and frontotemporal neurocognitive disorder. She was severely cognitively impaired. Her profile indicated, Assist with bathing as needed per resident preference. Offer showers two times per week, partial bath in between. Prefers AM showers. Her shower sheets for the month of July were reviewed. There was no documented shower sheet after 7/19/25. She had a care plan initiated on 6/19/2020 which indicated she required assistance with ADLs due to her diagnoses. No new interventions had been added sine 8/21/24 and the care plan was not revised to include her preference for staying in bed. Resident 43 was a long term care resident with diagnoses which included but were not limited to, Alzheimer's disease and she was severely cognitively impaired. There was only one documented shower sheet for the month of July on 7/28/25 which indicated, was not in a good mood and refused. The record lacked documentation of re-approaches or interventions for redirection. Her resident profile indicated, Assist with bathing as needed per resident preference. Offer showers two times per week, partial bath in between. Prefers bed baths in the evening hours. Resident 34 was a long term care resident with diagnoses which included, but were not limited to, dementia and was severely cognitively impaired. Her Resident Profile indicated, Assist with bathing as needed per resident preference. Offer showers two times per week, partial bath in between. Current preference for bathing. She had a care plan initiated on 2/22/18. The care plan indicated she required assistance with ADLs and sometimes refused assistance with care and an intervention created on 2/22/18 indicated, Resident sometimes refuses assistance with ADL care, but did not offer options/preference/redirections for her refusals. During an interview on 8/1/25 at 8:40 a.m., the Administrator (ADM) indicated, there was no policy for Resident ADLs, and the MC unit did not utilize CNA Assignment Sheets, but were instead were expected to follow instructions from their Resident Profiles. At that time the ADM provided a CNA to do list which included, but was not limited to, ensure all residents are provided am care and are up for breakfast and taken to the dining room . reposition and provide incontinences care for dependent residents . ensure unmade bed is clean and made . complete meal; and fluid documentation if applicable . toilet and lay down dependent residents . pass ice water . complete remaining showers . complete POC charting . pass trays . These tasks and more were required of one CNA for 20 residents who resided in the memory care unit and could have an additional layer of difficulty added considering residents who had behaviors. This citation relates to Complaints IN00162849 and IN00162850. Cross reference F725. 3.1-38(a)(3)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 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 (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 Administrator (ADM) indicated, Resident B's NOMNC was faxed to the facility after business hours on a Friday, and there were no administrative or Social Service staff in over the weekend to check the fax and notify Resident B. 3. Resident Council Minutes were reviewed from September 2024 until July 2025. The following was noted: On 9/3/24 twelve residents were in attendance for the meeting. Previous concerns from 8/2024, which included, but were not limited to, need more nursing staff . were discussed but the resolution was not accepted and at the time of the meeting, the residents complained again that they needed more nursing staff. On 10/1/24 fourteen residents were in attendance for the meeting. Concerns for adequate nursing staff from the previous meeting was reviewed, but again not resolved, as they resident requested more nursing staff at the October meeting as well. On 3/4/25 fifteen residents were in attendance for the meeting. At that time, they brought up concerns for adequate nursing staff and requested, if the facility could please provide more staff on the halls. The council received a response, dated 3/5/25, which indicated, continue to actively interview applicants. Halls are staffed adequately to census. On 6/3/25 eleven residents were in attendance for the meeting. at that time they brought up concerns that weekend staff were not answering all lights and were on their cellphones. 4. Resident/Family grievances were reviewed from January 2025 until July 2025. The following was noted and revealed unresolved, ongoing concerns related to incontinent care, call light response time, and customer service. On 1/7/25, Resident stated that staff takes a long time to change her . On 1/11 and 1/12 2025, Residents POA [power of attorney] came to visit both days in afternoon. Both days she came, she noticed [the resident] was incontinent of bowel and bladder. On Sunday, POA notified nurse that urine was not accumulating in drainage bag, the nurse then told her she noticed it as well, but no action was taken to fix the problem. On 1/15/25 a resident expressed concerns for incontinent care and customer service was slow. On 2/14/25 a resident expressed concerns for slow call light response time. On 2/26/25 a resident complained, the turned on the call light and he didn't see staff turn off light but they did pick up a blanket off the floor and place it at the foot of the bed and didn't bother to even ask if he needed anything, staff later apologized and stated, the shift was ending and they had things to get done. On 2/20/25 a complaint was filed on behalf of a resident which indicated, resident reported that [named resident] is being change/cleaned up in the mornings between 5 a.m. and 7 a.m., but no one is changing her after that until the evening around 9 p.m. On 2/20/25 a resident expressed concerns for incontinence, incontinent care with ADLs did not receive water, aides said they would return but did not. On 3/24/25 a resident complained, strong odor in room, resident roommate needs a shower, couldn't eat breakfast in room due to odor. On 3/31/25 a family member complained on behalf of their loved one, concerns about checking and changing every 2 hours since she cannot push her call light button. Concerned about wound/skin breakdown with positioning. On 3/31/25 a resident expressed concerns that a CNA comes in with his phone in his hand [and] told he would clean [the resident] with wipes instead of warm soapy water. Resident feels wipes not good for him. On 4/3/25 a resident expressed concerns for, slow on incontinent care. On 4/17/25 a complaint on behalf of a resident indicated, he has to wait to get incontinent care . On 4/4/25 a resident expressed concerns, overnight staff slow on answering call light. On 6/3/25 a resident complained that staff overnight were not filling up oxygen tanks. On 6/28/25 a complaint on behalf of a resident indicated, they didn't get a breathing treatment until after waiting for over an hour. On (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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	
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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7/15/25 concerns on behalf of a resident were noted, oxygen tanks were not being checked/changed every 4 hours, and the residents oxygen tanks had been found empty on three separate occasions. During a confidential interview, it was noted there were not enough nursing staff to get what needed to be done completed or at least completed in an effective and appropriate manner. There were too many high acuity residents for so few aides, and ADLs often went undone. On 7/31/25 at 1:10 p.m. the ADM provided a copy of current facility policy titled, Staffing Policy, revised 9/2018. The policy indicated, The staffing policy of ASC is to maintain adequate staffing in each facility . Home Office and facility leadership determine the budgeted staffing for all department during budget meetings . adjustments/changes to the budgeted staffing PPD amount can be adjusted anytime based on specific circumstances . and increase in acuity of levels of the residents. This additional staffing coverage is determined at the discretion of the Executive Director and the Facility based interdisciplinary team During the survey entrance conference on 7/27/25 at 10:00 a.m., a copy of the Facility Assessment Tool was requested and provided. The Assessment was dated 8/2024 and indicated, the average daily census was 72 . minimum staffing required (these requirements may fluctuate due to PPD and census) Licensed Nurse Staff: 2 on day, 2 on evening and 1 on nights. Non-Licensed Staff (CNA): 5 on days, 5 on evening and 3 on nights. Qualified Mediation Aides (QMA): 1 per shift . On the weekends there is an assigned nurse on call who would fill vacant shifts from call-outs This citation relates to Complaints IN00162849 and IN00162850.3.1-17(a)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, interviews and record reviews, the facility failed to ensure infection control practices were in place for 4 of 4 residents randomly observed for infection control during the survey (Residents 10, 47, 20, and 34). Findings include: 1. On 7/28/25 at 10:00 a.m., Resident 10 was observed resting on her right side with her eyes closed. Resident 10 had a catheter bag in a basin on the floor draining urine. There was an EBP sign on the bathroom door and a PPE cart across the hall between two rooms. On 7/28/25 at 1:35 p.m., Resident 10 was observed as she received peri care from Certified Nursing Aide (CNA) 5. The CNA was wearing gloves only while providing care. On 7/29/25 at 12:04 p.m., Resident 10's medical record was reviewed. She was a long-term care resident whose diagnoses included, but were not limited to, chronic heart failure, chronic obstructive pulmonary disease (COPD) and personal history of methicillin resistant staphylococcus aureus infection (MRSA). A care plan that was last reviewed 5/14/25 indicated Resident 10 was at risk of transferring or becoming colonized with an Multidrug Resistant Organism (MDRO) and required EBP due to a history of MRSA and Extended-Spectrum Beta-Lactamase (ESBL) (enzymes produced by certain bacteria that make them resistant to many common antibiotics) in her urine- related to her urostomy (a surgical procedure that diverts urine away from a damaged or removed bladder, creating an opening on the abdomen to allow urine to exit the body and be collected in a pouch). The interventions for this care plan included, but were not limited to, wear gown and gloves prior to high contact resident care activities and EBP. 2. On 7/30/25 at 9:00 a.m., Registered Nurse (RN) 9 was observed as she administered Gastrointestinal Tube (G-Tube) medications to Resident 47. There was an EBP sign on the wall above the head of the bed, but the RN 9 did not use proper PPE for EBP she only used gloves. At this time the Staff Development Coordinator was also in the room observing the nurse. She did not come into direct contact with Resident 47, but she failed to remind RN 9 of the proper use of PPE in rooms where the Resident was on EBP. 3. On 7/30/25 at 8:30 a.m., RN 9 was observed as she prepared medications for Resident 20. While preparing the medication she accidentally knocked the medication cup over and two unidentified pills fell out of the cup onto the top of the medication cart. RN 9 then took a spoon and scooted the pills back into the medication cup and proceeded to administer the medications to Resident 20. When speaking with RN 9 afterward, she indicated she didn't think about the potential for contamination and in the future would throw those medications away and prepare new ones. 4. On 7/29/25 at 11:32 a.m. an unidentified CNA entered Resident 34's room carrying linens pressed against their body (no linen cart). During the entrance conference on 7/27/25 at 11:45 a.m. a current facility policy related to infection control was requested and provided. The policy was titled, Infection Control and Prevention Program, and dated 11/2017. This policy indicated, . The facility shall establish and maintain infection prevention and control program (IPCP) designed to provide a safe, sanitary and comfortable environment and help prevent the development and transmission of communicable diseases and infections. The IPCP is a comprehensive system for preventing, identifying, reporting, investigating and controlling infections and communicable diseases for all residents, staff, volunteers, visitors and other individuals providing services under contractual arrangement, is based on the facility assessment and following accepted national standards. the goals of the infection prevention and control program are to: 3. Implementation of acceptable standard of practice to correct problems related to infection control and prevention practices. 5. Maintain compliance with state and federal regulations related to infection prevention and control. 3.1-18(b)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on record reviews and interview, the facility failed to ensure a resident's medical record accurately reflected the resident's wishes related to advance directives for 1 of 1 residents reviewed for advanced directives (Resident 75). Findings include: On 8/1/25 at 9:35 a.m. Resident 75's medical record was reviewed. She was a long term care resident whose diagnoses included but were not limited to atrial flutter (a heart rhythm disorder where the heart's upper chambers beat rapidly and regularly, but not in a coordinated manner with the lower chambers) and myasthenia gravis (a chronic autoimmune disease that causes weakness in the voluntary muscles.). Resident 75 had an order for Do Not Resuscitate (DNR), dated 4/15/25, with a discontinue date of 4/15/25. Resident 75 had an order for full code, dated 4/15/25 with a discontinue date of 5/9/25, when the resident was discharged. A progress note, dated 4/22/25 at 1:31 p.m., indicated social services found that the Out of Hospital Do Not Resuscitate (OHDNR) paperwork was not filled out correctly. The note indicated social services spoke to Resident 75 and the resident indicated she fully understood what it meant to be a DNR and that was what she wanted, not a full code status, but she felt more comfortable with her Power of Attorney (POA) filling the paperwork out for her. A progress note, dated 4/22/25 at 2:53 p.m., indicated social services left a blank OHDNR form in the resident's room to fill out. An OHDNR form, dated 4/14/25, was signed by the attending physician but was not filled out by the resident or Resident Representative. An OHDNR form, dated 4/23/25, was signed by the resident's POA but was not signed by the attending physician. In order for an OHDNR form to be valid it must be signed by both the resident or Resident Representative and the attending physician. A care plan, dated 4/14/25, indicated the resident was a full code. On 7/29/25 at 12:30 p.m. the Executive Director (ED) provided a current facility policy titled, Advanced Directives (POST, DNR, Health Care Rep) dated 7/23 and it indicated it was current. This policy indicated, . it is the policy of this facility to provide information to resident/resident representative his/her rights to formulate advanced directives. if a resident has capacity to make decisions, the resident makes decisions regarding their medical decisions, advanced directives and healthcare appointments. Resident representatives, health care representatives and/or power of attorneys should only make decisions when a resident no longer has capacity to make his/her own decisions and/or specifically designates the representative to make decisions on their behalf. Out of hospital do not resuscitate form: new admissions: 1. The admitting nurse will review the hospital/admission paperwork for the presence of an existing out of hospital do not resuscitate form. If there is a form present the nurse will review the form for completeness including signature of the resident/representative, witnesses and physician, advanced practice nurse or physician's assistant. 5. A resident cannot be considered a DNR until the out of hospital do not resuscitate declaration and order form has been signed/dated by the resident/representative, 2 witnesses and the attending physician, advanced practice nurse or physician's assistant. (Note, the out of hospital do not resuscitate declaration form may be honored with a verbal order from the physician and signed by the physician, advanced practice nurse or physicians assistant within 10 days).3.1-4(d)3.1-4(e)3.1-38(f)3.1-4(l)(4)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on record review and interview, the facility failed to complete a pre and post dialysis assessment for a resident on his dialysis days for 1 of 1 resident reviewed (Resident 40) . The deficient practice was corrected 2/20/25 and was therefore past noncompliance. Findings include: On 7/29/25 at 12:43 a.m., a record review was completed for Resident 40. He had the following diagnoses which included but were not limited to end stage renal disease, essential hypertension, hyperlipidemia, chronic obstructive pulmonary disease (COPD), anxiety, sleep apnea, insomnia, and heart failure. Resident 40 had an order, dated 1/27/25, for dialysis on Monday, Wednesday, and Friday. He was missing dialysis pre and post assessments for the following days: 2/3/25, 2/5/25, 2/7/25, 2/10/25, 2/12/25, 2/14/25, 2/17/25, 2/19/25, 2/21/25, 2/24/25, 2/26/25, 3/5/25, 3/7/25, 3/14/25, 3/17/25, 3/21/25, 3/24/25, 3/26/25, 3/28/25, and 3/31/25. Resident 40 had a care plan dated 1/27/25. It indicated Resident was receiving hemodialysis and was at risk for complications such as fluid imbalance, bleeding or infection, right arm fistula. It lacked an intervention for pre and post dialysis assessments. On 7/30/25 at 10:32 a.m., during an interview with the Director of Nursing (DON), she indicated the pre and post dialysis events were missing due to staffing concerns prior to June 2025. Now that she has a stable nurse, the events have been completed. On 7/30/25 at 1:15 p.m., during an interview with the Executive Director (ED) and DON, they indicated after identifying dialysis pre and post assessment were not being completed in February 2025, they completed a Quality Assurance Performance Improvement (QAPI) plan to address the identified concern effective 2/20/25. A copy of the QAPI plan was provided. A policy titled, Dialysis Care was provided by the Regional Nurse Consultant Specialist (RNCS) on 7/30/25 at 12:35 p.m. It indicated, .Ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility.A dialysis event will be initiated in the electronic medical record (EMR) to include time of transfer and completed on return to the unit.3.1-37(a)		