STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	06/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDEPENDENCE VILLAGE OF AVON	182 S COUNTY ROAD 550 E, AVON, , 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00382334. Complaint IN00382334 - Substantiated. State deficiencies related to the allegations are cited at R0088. Survey date: June 6, 2022. Facility number: 003902 Residential Census: 91 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on June 20, 2022.	R 0000		
R 0088	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(c)(1-2)(d)(1-2) c) The licensee shall: (1) appoint an administrator with	R 0088	-What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;	06/22/2022

	either a: (A) comprehensive care facility administrator license as required by IC 25-19-1-5(c); or (B) residential care facility administrator license as required by IC 25-19-1-5(d); and (2) delegate to that administrator the authority to organize and implement the day-to-day operations of the facility. (d) The licensee shall notify the director: (1) within three (3) working days of a vacancy in the administrator's position; and (2) of the name and license number of the replacement administrator Based on observation, interview, and record review, the facility failed to appoint a licensed Administrator to manage the overall responsibilities of the facility. This deficient practice had the potential to effect 91 of 91 residents who resided in the building. Findings include: On 6/8/22 at 10:05 a.m., during an interview the Executive Director (ED) indicated she had worked at the facility since January, in the role of ED. She had completed the administrator		**No residents were affected by the alleged deficient practice.** -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; **The Community realizes that residents could have had the potential to be affected by the alleged deficient practice.** -What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; **An interim Health Facility Administrator has been hired to function in the role as Executive Director of the Community. (Please see exhibits A and B). Recruitment efforts will be on-going until a Health**	

	course but had not passed the test yet. She needed to retake the test. The corporation provided her with a support person to consult with. The support person was her mentor and oversaw her work. She provided the name of the Administrative Consultant (AC). The facility followed the State rules, they had reported her status of waiting to take test, not licensed, to the state back in January when she had accepted the position. Documents to support the consult dates and times with the AC were requested, but not provided. The ED indicated a record of the meetings and support consults had not been documented. On 6/8/22 at 10:50 a.m., the facility provided a current list of all employees. This list identified the ED as the Administrator.		**Facility Administrator or Residential Care Administrator is appointed to the position of Executive Director of the Community. (Please see Exhibit C).** -How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and **The licensee will notify the Director within three (3) working days of a vacancy in the Administrator's position. Recruitment efforts will begin immediately until a replacement is found. An interim Administrator will be hired.**	

On 6/8/22 at 11:00 a.m., the ED provided a copy of the Indiana Department of Health facility Administrators licensing exam results, dated 4/8/22, from the Indiana Professional Licensing Agency (PLA) which indicated "we regret to inform you that your application for licensure is denied because you failed the NAB/State Law Examination." An application to retest could have been submitted within 90 days.

A second document was provided. This document was an email from pla@pla.in.gov, dated 5/13/22 at 1:24 p.m. The email indicated the application to retest was incomplete because the criminal history background check had not been provided. The application was pending. The applicant needed to register for the criminal background check.

On 5/13/22 at 3:52 p.m., another email from the PLA indicated the Indiana Licensure Application had been received.

On 6/8/22 at 11:00 a.m., a current review of the PLA license search website indicated the ED's application for license was pending.

On 6/8/22 at 11:50 a.m., during an interview, Resident B indicated he had lived at the facility since December of 2000.

He did not know who the facility administrator was. He did not know of the AC.

On 6/8/22 at 11:53 a.m., during an interview, Resident C indicated she had lived at the facility for 5 years. She did not know who the administrator was. She thought it was the ED.

On 6/8/22 at 11:55 a.m., during an interview, Resident D indicated she had been at the facility for 5 months and the ED was the facility administrator.

On 6/8/22 at 11:57 a.m., during an interview, in the resident dining room, Resident E indicated she knew the ED. She did not know who the facility administrator was.

On 6/8/22 at 11:59 a.m., during an interview, Resident F indicated she had resided at the facility for 3 years. She only knew the ED and was not aware of an administrator or the AC.

On 6/8/22 at 12:07 p.m., during an interview with the AC, she indicated she was the Health Facility Administrator (HFA) of another (Name of Corporation) building. She was the support person/mentor for the ED at this facility. She had been available for support to the community and the facility ED 24 hours a day and 7 days a week, by phone, since the beginning of January. Sometimes she

dropped in for an in person visit. She did not have any responsibility for this building. She did not complete any reports or documents for the building, just offered support. She was a mentor for the ED. This facility did not have a licensed administrator. The consumer reports showed there was no administrator for this facility. Administrator was blank on the reports. The corporation was aware of the situation and her (the AC) license was not associated with this building. They followed the state regulations, and an administrator could not manage two facilities.

This state residential finding relates to Complaint IN00382334.

Based on observation, interview, and record review, the facility failed to appoint a licensed Administrator to manage the overall responsibilities of the facility. This deficient practice had the potential to effect 91 of 91 residents who resided in the building.

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	was aware of the situation and her (the AC) license was not associated with this building. They followed the state regulations, and an administrator could not manage two facilities. This state residential finding relates to Complaint IN00382334.			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE