STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	01/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDEPENDENCE VILLAGE OF CARMEL	13390 N ILLINOIS STREET, CARMEL, , 46032

(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 IN00371543. Complaint IN00371543 - Substantiated. State deficiencies related to the allegations are cited at R64 and R216. Survey date: January 31, 2022 Facility number: 013297 Residential Census: 43 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on February 7, 2022.	R 0000	submitted as required under state and federal law. The submission of this plan of correction does not constitute an admission on the part of Senior Living Carmel, LLC D/B/A: Independence Village of Carmel as to the accuracy of the surveyor's findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute a deficiency or that the scope or severity regarding the deficiency cited are correctly applied. Any changes to the community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidences and any corresponding state rules of civil procedure should be inadmissible in any proceeding on that basis. The community submits this Plan of Correction	

			with the intention that it be inadmissible by any third party in any civil or criminal action against the community or any employee, agent, officer, director, attorney or shareholder of the community or affiliated companies.	
R 0064	Residents' Rights- Noncompliance 410 IAC 16.2-5-1.2(hh) (hh) The facility shall exercise reasonable care for the protection of residents ' property from loss and theft. The administrator or his or her designee is responsible for investigating reports of lost or stolen resident property and that the results of the investigation are reported to the resident. Based on observation, interview and record review, the facility failed to ensure medications for Resident C were stored in a secure manner in her apartment and personal items for Resident's B and D were free from theft by a facility staff member for 3 of 3 resident's reviewed for misappropriation of property (Resident C, B and D) and failed to ensure reference checks were obtained on a new employee prior to hire for 1 of 1 employee record reviewed (Housekeeper 3). Findings include:	R 0064	Plan of Correction for Survey Completed on 1/31/2022. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the true facts alleged or conclusion set forth in the statement of deficiencies. This Plan of Correction is prepared and executed because it is required by Federal State Laws. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? a. The community has educated the effected residents on proper medication storage in apartments and lock boxes will be utilized.	08/31/2022

	1. The record for Resident C was reviewed on 01/31/2022 at 10:00 a.m. Diagnoses included, but were not limited to, hypertension, heart failure and insomnia. A current physician's order, dated 09/02/2021, indicated the resident required a self-medication evaluation every 6 months. A current Self-Administration of Medication Evaluation document, dated 01/11/2022, indicated the resident had a physician's order and was granted approval to self-administer medications. A current service plan, dated 07/2021, indicated the resident was able to safely self-administer all medications and the facility was to provide weekly housekeeping services. During an interview, on 01/31/2022 at 3:06 p.m., Resident C indicated housekeeping was cleaning her room weekly and at times had come in her room when she was not there. She did self-administer her own medications and had some of her medications taken from her room recently. She kept her pain pills in a drawer, "but I don't keep them there anymore," her everyday medication were on the shelf in her kitchen and her		b. The community will take reasonable care for the protection of resident's property from loss and theft. Following the investigation, the involved employee's employment was terminated. c. Reference Check audits will be completed on all current employees and new employees going forward. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken? a. The community will complete medication evaluation assessments on all residents who are currently self-administering medications, which will include proper medication storage evaluation. New residents will be assessed as part of the admissions evaluation. Residents will be evaluated semiannually and upon known change of condition. The service plan will be	

	"strong ones" were kept hidden. She would not elaborate on where she kept her hidden medication. At that time, Resident C's medications were observed on a small shelf in her kitchen. She did not always lock her door when she left her room. 2. The record for Resident B was reviewed on 01/31/2022 at 10:20 a.m. Diagnoses included, but were not limited to, dementia and depressive disorder. A current service plan, dated 07/10/2020, indicated the facility was to provide weekly housekeeping services. During an interview, on 01/31/2022 at 3:34 p.m., Resident B indicated housekeeping was cleaning her room weekly. She had personal items taken from her room without her permission recently. 3. The record for Resident D was reviewed on 01/31/2022 at 11:00 a.m. Diagnoses included, but were not limited to, diabetes mellitus, glaucoma and history of falling. A current service plan, dated 06/03/2021, indicated the facility provided weekly housekeeping services. A facility incident report, dated 01/21/2022, indicated on		updated accordingly. 3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur? a. Wellness completed self-administration medication assessments on all residents who self-administer medications by 2/15/2022. New residents will be assessed as part of the admissions evaluation. Residents will be evaluated semiannually and upon change of condition and service plan updated accordingly. Semiannual evaluation reminders will be tracked via electronic system to ensure timely assessments. Residents deemed appropriate to self-administer medications, will receive and be educated on properly using the provided medication lockbox. Medication lockboxes were ordered on 2/14/2022. Residents will be educated on the importance of locking their apartment door as an additional means of security.	

	01/21/2022 Housekeeper 3 was found in Resident B's apartment after hours, wearing street clothes and in the possession of Resident B's items. Her cell phone was found at the end of the hallway with items of Resident D's. Resident B's son and daughter-n-law was in her apartment at the time when the Wellness Director found Housekeeper 3. He was able to identify the items as belonging to his mother. At that time, Housekeeper 3 stated the items belonged to her and not Resident B. The Wellness Director called the police department for possible theft. After the police escorted Housekeeper 3 out of the building and after further search, the police found medication which belonged to Resident C, a narcotic and an additional medication bottle. The police and Wellness Director was unable to tell if any of the medications were missing due to the direction of use on the prescription. Resident C took both medications only as needed. During an interview, on 01/31/2022 at 12:54 p.m., CNA 1 indicated when she went to assist Resident B to the dining room the evening of 01/21/2022 there was a "lady" in her room. As she pushed the resident to dinner, the "lady" stayed behind in her room. At that time, the		Staff will be reeducated on recognizing a change of condition and notifying the Wellness Director/DON immediately when a change of condition occurs. b. The administrator or a designated director will follow the facility policy for theft protocol and exercise reasonable care for the protection of resident's personal items from loss or theft. The administrator or designated director will investigate reports of lost or stolen items immediately including receiving a statement from resident. Investigation results will be reported to the effected resident in a timely manner. Residents will be educated on the importance of locking their apartment door as an additional means of security. c. Employees will be reeducated on policy for entering a resident apartment as well as the policy for accepting gifts from a resident. d.	

	resident did not offer any information or comment about the lady and she did not ask her. She indicated she had never known housekeeping to go into a residents room other than for cleaning or straightening up and never in street clothes. During an interview, on 01/31/2022 at 2:54 p.m., CNA 2 indicated she pushed Resident B and another resident back to their room after dinner. She dropped off Resident B to her room and as she was pushing the other resident to his room, she noticed a Christmas bag in the hall across from his door. Next to the Christmas bag, there was a cell phone which was charging. She thought the bag and cell phone might have been the missing cell phone a housekeeper asked her about earlier in the day. She bent down and picked up the bag and cell phone to return it to the housekeeper when the handle broke. She noticed a pink box, which she knew was a Christmas gift for Resident D, and a pair of Resident D's pajama's. She took care of Resident D frequently and was sure it was her personal items. She reported this to the Wellness Director. Later, while she provided care for Resident D, she attempted to plug her cell phone in to be charged and noticed her charger was		The community's HR team will follow the state regulation and facility policy for Employee Background Checks and will conduct prescreening reference checks as part of the application process for all potential applicants. 4. 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? a. Semiannual assessments will be tracked electronically. Monthly audits will be done by the Wellness Director/DON to ensure that assessments happen by the appropriate date and service plans are updated accordingly. The Executive Director will review to ensure 100% compliance. b. During the assessment, residents will be evaluated on their current use and ability to use medication lockbox appropriately as part of the	

	missing. While taking the resident's close out of the dryer, she noticed a red scrub top which she remembered seeing Housekeeper 3 had on earlier in the day. She also remembered observing the housekeeper being escorted out of the building wearing a T-shirt and a white cardigan of Resident D's. This was also reported to the Wellness Director. During an interview, on 01/31/2022 at 3:07 p.m., the Wellness Director indicated she was passing medications on the second floor around 6:30 p.m., when she went to give Resident B her medications. When she went inside, she noticed a young female in the resident's bathroom. The girl had on street clothes and her hair was up in knit cap making it unable to see the color of her hair. She noticed the girl had sprayed body spray on herself which belonged to the resident. She was not aware of who this girl was and she did not ask as she thought it might have been a granddaughter or friend of the resident's. When she left the room, the girl remained in the resident's bathroom. An hour later, CNA 2 reported to her something she felt was suspicious. CNA 2 indicated she had a short conversation about a missing cell phone with a housekeeper earlier in the day. The housekeeper told CNA 2		self-administer medication process. c. The community's local HR person will ensure that employee background and reference checks are complete for all new employees and employee record files include this information. The community's Property Administrator will audit employee files for background and reference checks; 10 employee files/week until all files have been checked. The PA will reach out to corporate HR for background and reference records as needed to complete employee files. Then, random audits of 10 files/month will be done by the PA and reviewed by the Executive Director, using the State of Indiana's Residential Care Employee Record form for 6 months following the completion of the original audit. New employee files will follow the company policy and the State of Indiana's Residential Care Employee Record Form. New employee files will be part of the random audit for 3 months or until all files are found without error.	

	she had lost her phone and asked her if she had seen it. CNA 2 indicated to the housekeeper she had not seen it. CNA 2 reported after the conversation with the housekeeper, she noticed a cell phone at the end of the hallway which was plugged in and charging. She also noticed a big gift bag on the floor next to the phone. CNA 2 indicated she thought it was the housekeeper's phone and bag. When she looked down and picked up the bag, one of the handles broke and she saw a pink box and a pair of pajamas inside. She recognized the gift set as something which had been in Resident D's room since Christmas and the pajamas were familiar to her also as she took care of Resident D often. The Wellness Director told CNA 2 she saw somebody in Resident B's room earlier and thought maybe it might have been the housekeeper CNA 2 was referring to. She went back to Resident B's room, knocked on the door, and when the door was opened Resident B's son and daughter in law were also in the room. The girl from earlier was still in the resident's room sitting on the couch. The resident was in her wheelchair, the son was in the laundry room area and the daughter-n-law was standing directly across from the girl looking at her. She asked the resident's son if he		5. By what date the systemic changes will be completed. a. Self-medication Assessments on all residents currently self-medicating were completed on 2/15/2022. b. Medication Lockboxes were ordered on 2/14/2022. Lockboxes will be distributed, and residents educated immediately upon arrival. c. Auditing of current employee files for background and reference checks will be completed by 5/13/2022. Then, random audits of all employee files will be conducted monthly for 3 months until 8/31/2022.	

	knew who this girl was, to which he indicated he did not. At that point, the resident's son realized his mother had some missing items and started to pull out things which were in a gift bag at the girls feet. The son indicated the items belonged to his mother and she asked the girl if the items belonged to her. The girl replied yes they were hers and not the resident's. The son again indicated "no, they were not, they belonged to his mother" At that point, she dialed 911 and the police came out to the facility. She directed the police to Resident B's room and talked alone with the them outside the resident's room. She and the police went into the resident's room. The police was shown the gift bag at the girls feet containing Resident B's items. The police then took the girl out of the room in handcuffs and out of the facility. After the police officers searched the girl more thoroughly, they returned into the facility with 2 bottles of medication belonging to Resident C. The medications were Naprosyn and hydrocodone-acetaminophen. Both police and the Wellness Director looked at the number of pills which remained in the bottles but were unable to say how many were missing because the directions on the prescription indicated the resident took the medications on an as needed basis. On the			

	security camera earlier in the day, the girl was observed going in and out of Resident C's room. She also indicated, at that time, Resident C did self-administer her own medication and all resident's medications kept in their apartments should be kept secure. During an interview, on 01/31/2022 at 3:16 p.m., the Executive Director indicated she had reviewed the security cameras as part of the investigation and Housekeeper 3 was observed going in and out of Resident D's room. She left the door ajar and each time she came out of the room the camera would show her wearing different clothes which did not fit her. The camera footage also showed Housekeeper 3 at Resident B's door where she only had to turn the knob and walk in. At Resident C's door, she had to struggle to find a key to open the door.			

	During an interview, on 01/31/2022 at 3:42 p.m., the Housekeeping Supervisor indicated housekeepers were given 2 keys, one for the storage room and a master key which provided access to all the residents rooms. She also indicated housekeepers should not enter residents rooms unless it was to provide an intended and appropriate service. During an interview, on 01/31/2022 at 5:05 p.m., Resident B's son indicated he came by the facility to drop off supplies for his mother. He let himself into his mother's apartment. His mother was sitting in her recliner and he noticed a lady standing in the kitchen area. He asked who she was and she replied her name and she was a recently hired housekeeper. He went to the kitchen to look into the refrigerator and he noticed a gift bag lying on the top shelf. As he was looking into the kitchen, the housekeeper moved into the living room and sat on his mother's sofa. He thought it was odd to find a gift bag in the refrigerator so he removed it and took it into the living room and proceeded to remove some of the items inside. He recognized at least 5 or 6 things which belonged to his mother so he confronted Housekeeper 3 about these items. He asked her			

	how his mother's belongings got inside the bag and her response was "your mom said I could have some things." At the same time he was confronting her about the items, the Wellness Director came to the door. He opened it and began to tell her what was going on. The Wellness Director came inside and saw Housekeeper 3 sitting on the sofa and began to ask her some questions about the items in the gift bag. She indicated to the Wellness Director, they belonged to her and Resident's B's son indicated they belonged to his mother. At that point, she called the Police Department for a questionable theft. The police came out to the facility and escorted her off the premises. During an interview, on 01/31/2022 at 5:15 p.m., the Executive Director indicated each new employee should have reference checks prior to hire and she could not produce any reference checks for Housekeeper 3. A current facility policy, titled "Theft Protocol," dated 3/15/18 and provided by the Wellness Director on 1/31/22 at 10:57 a.m., indicated "...5. [Name of facility] staff may enter a resident apartment only when performing a task as assigned on a current service agreement...2. If money,			

	medications, or personal items are found missing an incident report is to be filled immediately...3. The manager of duty will obtain a statement from the person or persons that are missing items...this may include a count of medication missing...." A current facility policy, titled "Resident Rights Know Your Rights under Federal Nursing Home Regulations," dated 03/15/2017 and provided by the Executive Director on 01/31/2022 at 5:00 p.m., indicated "...you have the right...to be free from abuse...misappropriation of your property...." A current facility policy, titled "Abuse, Mistreatment, Neglect or Misappropriation of Resident Property MI," dated 01/18/2019 and provided by the Executive Director on 01/31/2022 at 5:45 p.m., indicated "...Standard Operating Procedure...1. Purpose: The purpose of the Abuse, Mistreatment, Neglect or Misappropriation of Resident Property is to ensure immediate and appropriate action is taken to protect the resident...3. Prerequisites Screening of employees...." A current facility policy, titled "Employee Background Checks," dated 03/20/2019 and provided by the Executive			

Director on 01/31/2022 at 5:45 p.m., indicated "...Standard Operating Procedure...5. Procedure: The Human Resource Director or Designee will conduct...reference checks...on persons making application for employment with a community. Such investigations will be initiated during the application process...."

This State Residential Findings relates to Complaint IN00371543.

Based on observation, interview and record review, the facility failed to ensure medications for Resident C were stored in a secure manner in her apartment and personal items for Resident's B and D were free from theft by a facility staff member for 3 of 3 resident's reviewed for misappropriation of property (Resident C, B and D) and failed to ensure reference checks were obtained on a new employee prior to hire for 1 of 1 employee record reviewed (Housekeeper 3).

Findings include:

1. The record for Resident C was reviewed on 01/31/2022 at 10:00 a.m. Diagnoses included, but were not limited to, hypertension, heart failure and insomnia.

A current physician's order,

	dated 09/02/2021, indicated the resident required a self-medication evaluation every 6 months. A current Self-Administration of Medication Evaluation document, dated 01/11/2022, indicated the resident had a physician's order and was granted approval to self-administer medications. A current service plan, dated 07/2021, indicated the resident was able to safely self-administer all medications and the facility was to provide weekly housekeeping services. During an interview, on 01/31/2022 at 3:06 p.m., Resident C indicated housekeeping was cleaning her room weekly and at times had come in her room when she was not there. She did self-administer her own medications and had some of her medications taken from her room recently. She kept her pain pills in a drawer, "but I don't keep them there anymore," her everyday medication were on the shelf in her kitchen and her "strong ones" were kept hidden. She would not elaborate on where she kept her hidden medication. At that time, Resident C's medications were observed on a small shelf in her kitchen. She did not always lock her door when she left her			

room.

2. The record for Resident B was reviewed on 01/31/2022 at 10:20 a.m. Diagnoses included, but were not limited to, dementia and depressive disorder.

A current service plan, dated 07/10/2020, indicated the facility was to provide weekly housekeeping services.

During an interview, on 01/31/2022 at 3:34 p.m., Resident B indicated housekeeping was cleaning her room weekly. She had personal items taken from her room without her permission recently.

3. The record for Resident D was reviewed on 01/31/2022 at 11:00 a.m. Diagnoses included, but were not limited to, diabetes mellitus, glaucoma and history of falling.

A current service plan, dated 06/03/2021, indicated the facility provided weekly housekeeping services.

A facility incident report, dated 01/21/2022, indicated on 01/21/2022 Housekeeper 3 was found in Resident B's apartment after hours, wearing street clothes and in the possession of Resident B's items. Her cell phone was found at the end of the hallway with items of Resident D's. Resident B's son

	and daughter-n-law was in her apartment at the time when the Wellness Director found Housekeeper 3. He was able to identify the items as belonging to his mother. At that time, Housekeeper 3 stated the items belonged to her and not Resident B. The Wellness Director called the police department for possible theft. After the police escorted Housekeeper 3 out of the building and after further search, the police found medication which belonged to Resident C, a narcotic and an additional medication bottle. The police and Wellness Director was unable to tell if any of the medications were missing due to the direction of use on the prescription. Resident C took both medications only as needed. During an interview, on 01/31/2022 at 12:54 p.m., CNA 1 indicated when she went to assist Resident B to the dining room the evening of 01/21/2022 there was a "lady" in her room. As she pushed the resident to dinner, the "lady" stayed behind in her room. At that time, the resident did not offer any information or comment about the lady and she did not ask her. She indicated she had never known housekeeping to go into a residents room other than for cleaning or straightening up and never in			

	street clothes. During an interview, on 01/31/2022 at 2:54 p.m., CNA 2 indicated she pushed Resident B and another resident back to their room after dinner. She dropped off Resident B to her room and as she was pushing the other resident to his room, she noticed a Christmas bag in the hall across from his door. Next to the Christmas bag, there was a cell phone which was charging. She thought the bag and cell phone might have been the missing cell phone a housekeeper asked her about earlier in the day. She bent down and picked up the bag and cell phone to return it to the housekeeper when the handle broke. She noticed a pink box, which she knew was a Christmas gift for Resident D, and a pair of Resident D's pajama's. She took care of Resident D frequently and was sure it was her personal items. She reported this to the Wellness Director. Later, while she provided care for Resident D, she attempted to plug her cell phone in to be charged and noticed her charger was missing. While taking the resident's close out of the dryer, she noticed a red scrub top which she remembered seeing Housekeeper 3 had on earlier in the day. She also remembered observing the housekeeper being escorted out of the			

	building wearing a T-shirt and a white cardigan of Resident D's. This was also reported to the Wellness Director. During an interview, on 01/31/2022 at 3:07 p.m., the Wellness Director indicated she was passing medications on the second floor around 6:30 p.m., when she went to give Resident B her medications. When she went inside, she noticed a young female in the resident's bathroom. The girl had on street clothes and her hair was up in knit cap making it unable to see the color of her hair. She noticed the girl had sprayed body spray on herself which belonged to the resident. She was not aware of who this girl was and she did not ask as she thought it might have been a granddaughter or friend of the resident's. When she left the room, the girl remained in the resident's bathroom. An hour later, CNA 2 reported to her something she felt was suspicious. CNA 2 indicated she had a short conversation about a missing cell phone with a housekeeper earlier in the day. The housekeeper told CNA 2 she had lost her phone and asked her if she had seen it. CNA 2 indicated to the housekeeper she had not seen it. CNA 2 reported after the conversation with the housekeeper, she noticed a cell phone at the end of the hallway			

	which was plugged in and charging. She also noticed a big gift bag on the floor next to the phone. CNA 2 indicated she thought it was the housekeeper's phone and bag. When she looked down and picked up the bag, one of the handles broke and she saw a pink box and a pair of pajamas inside. She recognized the gift set as something which had been in Resident D's room since Christmas and the pajamas were familiar to her also as she took care of Resident D often. The Wellness Director told CNA 2 she saw somebody in Resident B's room earlier and thought maybe it might have been the housekeeper CNA 2 was referring to. She went back to Resident B's room, knocked on the door, and when the door was opened Resident B's son and daughter in law were also in the room. The girl from earlier was still in the resident's room sitting on the couch. The resident was in her wheelchair, the son was in the laundry room area and the daughter-n-law was standing directly across from the girl looking at her. She asked the resident's son if he knew who this girl was, to which he indicated he did not. At that point, the resident's son realized his mother had some missing items and started to pull out things which were in a gift bag at the girls feet. The son indicated the items belonged to			

	his mother and she asked the girl if the items belonged to her. The girl replied yes they were hers and not the resident's. The son again indicated "no, they were not, they belonged to his mother" At that point, she dialed 911 and the police came out to the facility. She directed the police to Resident B's room and talked alone with the them outside the resident's room. She and the police went into the resident's room. The police was shown the gift bag at the girls feet containing Resident B's items. The police then took the girl out of the room in handcuffs and out of the facility. After the police officers searched the girl more thoroughly, they returned into the facility with 2 bottles of medication belonging to Resident C. The medications were Naprosyn and hydrocodone-acetaminophen. Both police and the Wellness Director looked at the number of pills which remained in the bottles but were unable to say how many were missing because the directions on the prescription indicated the resident took the medications on an as needed basis. On the security camera earlier in the day, the girl was observed going in and out of Resident C's room. She also indicated, at that time, Resident C did self-administer her own medication and all resident's medications kept in their apartments should be kept			

	secure. During an interview, on 01/31/2022 at 3:16 p.m., the Executive Director indicated she had reviewed the security cameras as part of the investigation and Housekeeper 3 was observed going in and out of Resident D's room. She left the door ajar and each time she came out of the room the camera would show her wearing different clothes which did not fit her. The camera footage also showed Housekeeper 3 at Resident B's door where she only had to turn the knob and walk in. At Resident C's door, she had to struggle to find a key to open the door. During an interview, on 01/31/2022 at 3:42 p.m., the Housekeeping Supervisor indicated housekeepers were given 2 keys, one for the storage room and a master key which provided access to all the residents rooms. She also indicated housekeepers should not enter residents rooms unless it was to provide an intended and appropriate service. During an interview, on 01/31/2022 at 5:05 p.m., Resident B's son indicated he came by the facility to drop off supplies for his mother. He let himself into his mother's apartment. His mother was			

	sitting in her recliner and he noticed a lady standing in the kitchen area. He asked who she was and she replied her name and she was a recently hired housekeeper. He went to the kitchen to look into the refrigerator and he noticed a gift bag lying on the top shelf. As he was looking into the kitchen, the housekeeper moved into the living room and sat on his mother's sofa. He thought it was odd to find a gift bag in the refrigerator so he removed it and took it into the living room and proceeded to remove some of the items inside. He recognized at least 5 or 6 things which belonged to his mother so he confronted Housekeeper 3 about these items. He asked her how his mother's belongings got inside the bag and her response was "your mom said I could have some things." At the same time he was confronting her about the items, the Wellness Director came to the door. He opened it and began to tell her what was going on. The Wellness Director came inside and saw Housekeeper 3 sitting on the sofa and began to ask her some questions about the items in the gift bag. She indicated to the Wellness Director, they belonged to her and Resident's B's son indicated they belonged to his mother. At that point, she called the Police Department for a questionable theft. The police came out to the			

	facility and escorted her off the premises. During an interview, on 01/31/2022 at 5:15 p.m., the Executive Director indicated each new employee should have reference checks prior to hire and she could not produce any reference checks for Housekeeper 3. A current facility policy, titled "Theft Protocol," dated 3/15/18 and provided by the Wellness Director on 1/31/22 at 10:57 a.m., indicated "...5. [Name of facility] staff may enter a resident apartment only when performing a task as assigned on a current service agreement...2. If money, medications, or personal items are found missing an incident report is to be filled immediately...3. The manager of duty will obtain a statement from the person or persons that are missing items...this may include a count of medication missing...."			

	A current facility policy, titled "Resident Rights Know Your Rights under Federal Nursing Home Regulations," dated 03/15/2017 and provided by the Executive Director on 01/31/2022 at 5:00 p.m., indicated "...you have the right...to be free from abuse...misappropriation of your property...." A current facility policy, titled "Abuse, Mistreatment, Neglect or Misappropriation of Resident Property MI," dated 01/18/2019 and provided by the Executive Director on 01/31/2022 at 5:45 p.m., indicated "...Standard Operating Procedure...1. Purpose: The purpose of the Abuse, Mistreatment, Neglect or Misappropriation of Resident Property is to ensure immediate and appropriate action is taken to protect the resident...3. Prerequisites Screening of employees...." A current facility policy, titled "Employee Background Checks," dated 03/20/2019 and provided by the Executive Director on 01/31/2022 at 5:45 p.m., indicated "...Standard Operating Procedure...5. Procedure: The Human Resource Director or Designee will conduct...reference checks...on persons making application for employment with a community. Such investigations will be initiated			

	during the application process...." This State Residential Findings relates to Complaint IN00371543.			
R 0216	Evaluation - Noncompliance 410 IAC 16.2-5-2(c)(1-4)(d) (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility.	R 0216	Plan of Correction for Survey Completed on 1/31/2021. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the true facts alleged or conclusion set forth in the statement of deficiencies. This Plan of Correction is prepared and executed because it is required by Federal State Laws. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? a. Wellness Director/DON completed a self-medication evaluation on the effected resident on 2/1/2022. 2. How will the facility identify other residents	02/15/2022

	Based on observation, interview and record review, the facility failed to obtain a self-administration medication evaluation in a timely manner for 1 of 3 residents reviewed for self-administration of medications (Resident F). Finding includes: During a random observation, on 01/31/2022 at 1:08 p.m., Resident F's medications were observed on the kitchen table in his apartment. During an interview, at that time, the resident indicated he could administer his own medications. The record for Resident F was reviewed on 01/31/2022 at 11:18 a.m. Diagnoses included, but were not limited to, major depressive disorder and anxiety disorder. A physician's order, dated 04/29/2018, indicated a self-medication assessment (an assessment done by a nurse indicating the resident could safely administer his own medication) was to be completed every 6 months.		having the potential to be affected by the same deficient practice and what corrective actions will be taken? a. Per policy and state regulation, residents who self-medicate will be assessed by the Wellness Director/DON semiannually or when a change of condition occurs. All residents who currently self-administer medications were assessed by 2/15/2022. The service plans have been updated accordingly. A semiannual self-administration assessment has been scheduled electronically for each resident. 3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?	

	A current document, titled "Self-administer medications," dated 07/03/2021 and provided by the Wellness Director, on 01/31/2022 at 11:47 a.m., indicated the resident was safe to administer his own medications. An updated self-administration evaluation assessment was not located in the resident's record. During an interview, on 01/31/2022 at 2:44 p.m., the Wellness Director indicated the medication assessments were due every 6 months and she was aware this was not completed. A current facility policy, titled "Medication Resident Self Administration," dated 08/01/2017 and provided by the Wellness Director on 01/31/2022 at 10:15 a.m., indicated "...Any resident who wishes to self-administer medications must have an order to self-administer from the healthcare provider and pass the Self-Medication Evaluation as determined by the Wellness Director or designee...Reviews shall be performed before resident begins self-administer medications, following a significant change in condition and quarterly (per state regulations)...." This State Residential Findings		a. A self-administration medication evaluation will be scheduled electronically to ensure timely assessment by the Wellness Director/DON. 4. How does the facility plan to monitor its performance to make sure that solutions are sustained? a. Each month, the Wellness Director/DON will be tasked with auditing the self-administration medication assessments of all residents to ensure that they have been assessed promptly. The Executive Director will review with the DON to ensure 100% compliance. 5. Plan of correction completion date? Completed. 2/15/2022	

relates to Complaint IN00371543.

Based on observation, interview and record review, the facility failed to obtain a self-administration medication evaluation in a timely manner for 1 of 3 residents reviewed for self-administration of medications (Resident F).

Finding includes:

During a random observation, on 01/31/2022 at 1:08 p.m., Resident F's medications were observed on the kitchen table in his apartment. During an interview, at that time, the resident indicated he could administer his own medications.

The record for Resident F was reviewed on 01/31/2022 at 11:18 a.m. Diagnoses included, but were not limited to, major depressive disorder and anxiety disorder.

A physician's order, dated 04/29/2018, indicated a self-medication assessment (an assessment done by a nurse indicating the resident could safely administer his own medication) was to be completed every 6 months.

A current document, titled "Self-administer medications," dated 07/03/2021 and provided by the Wellness Director, on 01/31/2022 at 11:47 a.m.,

indicated the resident was safe to administer his own medications.

An updated self-administration evaluation assessment was not located in the resident's record.

During an interview, on 01/31/2022 at 2:44 p.m., the Wellness Director indicated the medication assessments were due every 6 months and she was aware this was not completed.

A current facility policy, titled "Medication Resident Self Administration," dated 08/01/2017 and provided by the Wellness Director on 01/31/2022 at 10:15 a.m., indicated "...Any resident who wishes to self-administer medications must have an order to self-administer from the healthcare provider and pass the Self-Medication Evaluation as determined by the Wellness Director or designee...Reviews shall be performed before resident begins self-administer medications, following a significant change in condition and quarterly (per state regulations)...."

This State Residential Findings relates to Complaint IN00371543.

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