

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/01/2024	
NAME OF PROVIDER OR SUPPLIER INDEPENDENCE VILLAGE OF FISHERS EAST		STREET ADDRESS, CITY, STATE, ZIP CODE 12950 TALBLICK STREET, FISHERS, , 46037					
(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 a Post Survey Revisit (PSR) to Investigation of Complaint IN00419078, IN00417996, IN00418345, and IN00417289 completed on 10/06/2023. This visit was in conjunction with the Investigation of Complaints IN00421699, IN00421835, IN00423264, IN00423452, and IN00423726. This visit was in conjunction with the Post Survey Revisit (PSR) to the State Residential Licensure Survey and Investigation of Complaint IN00410420 on 8/2/23. Complaint IN00417996 - Corrected Complaint IN00417289 - Corrected Complaint IN00419078 - State deficiencies related to the allegations are cited at R0091.	R 0000					

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Complaint IN00418345 - State deficiencies related to the allegations are cited at R0091.

Complaint IN00410420 - Corrected.

Complaint IN00421699 - No deficiencies related to the allegations are cited.

Complaint IN00421835 - No deficiencies related to the allegations are cited.

Complaint IN00423264 - No deficiencies related to the allegations are cited.

Complaint IN00423452 - No deficiencies related to the allegations are cited.

Complaint IN00423726 - No deficiencies related to the allegations are cited.

Survey dates: January 31 and February 1, 2024

Facility number: 13945

Residential Census: 68

These State Residential Findings are cited in accordance with 410 IAC 16.2-5.

Quality review completed on February 5, 2024

This visit was for a Post Survey Revisit (PSR) to Investigation of Complaint IN00419078,

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

IN00417996, IN00418345, and
IN00417289 completed on
10/06/2023.

This visit was in conjunction with
the Investigation of Complaints
IN00421699, IN00421835,
IN00423264, IN00423452, and
IN00423726.

This visit was in conjunction with
the Post Survey Revisit (PSR)
to the State Residential
Licensure Survey and
Investigation of Complaint
IN00410420 on 8/2/23.

Complaint IN00417996 -
Corrected

Complaint IN00417289 -
Corrected

Complaint IN00419078 - State
deficiencies related to the
allegations are cited at R0091.

Complaint IN00418345 - State
deficiencies related to the
allegations are cited at R0091.

Complaint IN00410420 -
Corrected.

Complaint IN00421699 - No
deficiencies related to the
allegations are cited.

Complaint IN00421835 - No
deficiencies related to the
allegations are cited.

Complaint IN00423264 - No
deficiencies related to the

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

	allegations are cited. Complaint IN00423452 - No deficiencies related to the allegations are cited. Complaint IN00423726 - No deficiencies related to the allegations are cited. Survey dates: January 31 and February 1, 2024 Facility number: 13945 Residential Census: 68 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on February 5, 2024			
R 0091	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(h)(1-4) (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made	R 0091	1. Two residents were affected by the alleged deficient practice. 2. The community realizes that all residents have the potential to be affected by the alleged deficient practice 3. Inservice for all staff on community's SOP for abuse & incident / accident reporting completed by the Wellness Director by 2-29-2024 which includes but is not limited to the following: *Notifying Wellness Director immediately regarding abuse allegations by any person,	02/29/2024

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

available to residents upon request.

Based on interview and record review, the facility failed to implement their Abuse, Neglect or Exploitation policy by not assuring that an altercation between 2 residents was documented in the clinical record and that the physicians of the residents were notified of the altercation for 2 of 2 residents reviewed for abuse (Resident H and Resident J).

Findings include:

1a. The clinical record for Resident H was reviewed on 1/31/24 at 1:10 p.m. The Resident's diagnosis included, but was not limited to, dementia with behavioral disturbance.

A service plan, created 11/8/23, indicated Resident H needed assistance with reasoning. The goal was for him to make appropriate decisions about his care and environment with assistance. The interventions were that he required assistance with redirection due to occasional confusion, a deficit in judgement, wandering or exit seeking, and care staff would report any changes in ability to reason.

1b. The clinical record for Resident J was reviewed on 1/31/24 at 1:00 p.m. The

resident to resident abuse, and injuries of unknown origin.

*Wellness Director to notify resident physician & legal representative of resident to resident abuse immediately to discuss interventions such as psychiatric evaluation or 1:1 care for 7-10 days following incident.

4. Memory Care Neighborhood employees will conduct 2 hour wellness checks on all residents within the community & document on 2 hour location check form & notify Wellness Director of any findings during these checks including but not limited to:

5. All incidents will be reviewed so all parties are notified, and signed off by nurse, Wellness Director and Executive Director.

6. Inservice staff on reporting and documenting incidents between residents.

*Change of Condition, Behaviors, Wandering, or Exit Seeking

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Resident's diagnosis included, but was not limited to, dementia and insomnia.

A Service plan, created 11/7/23, indicated Resident J needed assistance with reasoning. The goal was for her to make appropriate decisions about her care and environment with assistance. The interventions were that she required assistance with redirection due to occasional confusion, deficits in judgment, wandering, or exit seeking, and care staff would report any changes in ability to reason.

On 1/31/24 at 10:30 a.m., the ED (Executive Director) provided an Incident Reporting Form that had been sent the Indiana Department of Health on 12/5/23 which indicated that on 12/4/23, Resident J had been found on the floor being pulled out of a room by Resident H. The staff had intervened and assisted Resident J off of the floor. There were no injuries to either Resident J or Resident H. Resident J's family had come to sit with him, and the physician had been notified. The Wellness Director was notified.

The clinical record for Resident H and Resident J did not contain documentation that the incident had occurred, the physical condition of either resident after the incident, the

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

residents' physician or family had been notified, or that vital signs had been obtained.

On 1/31/24 at 3:33 p.m., the WD (Wellness Director) provided an incident report, dated 12/4/23 at 5:58 p.m., which indicated the report had been prepared for Resident H by the WD, the incident description was that employee heard a disturbance and employee saw Resident J on the floor being pulled out of the room on the floor by Resident H. Staff assisted Resident J. The immediate action taken was Resident H was removed from the room and family was called in to sit with Resident H. The physician was notified of the incident. Resident J was not included in the incident report.

During an interview on 1/31/24 at 3:33 p.m., the WD indicated she had noticed there were not notes the clinical record for the 12/4/23 incident between the residents. There should have been documentation in the clinical records of Resident H and Resident J about the 12/4/23 incident.

On 1/31/24 at 3:08 p.m., the ED provided the Abuse, Neglect, or Exploitation policy, last reviewed 6/7/23, which read "...The purpose of the Abuse, Neglect, or Exploitation policy is to outline the process for the

prevention, investigation and reporting of abuse, neglect, or exploitation...Initial Response...3. Documentation a. Documentation in the resident chart should include results of the resident's ROM [Range of Motion] Results of the body check Vital signs Notification of the physician and the responsible party treatment provided..."

This State Tag relates to complaint IN00419078 and IN00418345.

Based on interview and record review, the facility failed to implement their Abuse, Neglect or Exploitation policy by not assuring that an altercation between 2 residents was documented in the clinical record and that the physicians of the residents were notified of the altercation for 2 of 2 residents reviewed for abuse (Resident H and Resident J).

Findings include:

1a. The clinical record for Resident H was reviewed on 1/31/24 at 1:10 p.m. The Resident's diagnosis included, but was not limited to, dementia with behavioral disturbance.

A service plan, created 11/8/23, indicated Resident H needed assistance with reasoning. The goal was for him to make appropriate decisions about his

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

hare and environment with assistance. The interventions were that he required assistance with redirection due to occasional confusion, a deficit in judgement, wandering or exit seeking, and care staff would report any changes in ability to reason.

1b. The clinical record for Resident J was reviewed on 1/31/24 at 1:00 p.m. The Resident's diagnosis included, but was not limited to, dementia and insomnia.

A Service plan, created 11/7/23, indicated Resident J needed assistance with reasoning. The goal was for her to make appropriate decisions about her care and environment with assistance. The interventions were that she required assistance with redirection due to occasional confusion, deficits in judgment, wandering, or exit seeking, and care staff would report any changes in ability to reason.

On 1/31/24 at 10:30 a.m., the ED (Executive Director) provided an Incident Reporting Form that had been sent the Indiana Department of Health on 12/5/23 which indicated that on 12/4/23, Resident J had been found on the floor being pulled out of a room by Resident H. The staff had intervened and assisted Resident J off of the

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED

OMB NO. 0938-0391

floor. There were no injuries to either Resident J or Resident H. Resident J's family had come to sit with him, and the physician had been notified. The Wellness Director was notified.

The clinical record for Resident H and Resident J did not contain documentation that the incident had occurred, the physical condition of either resident after the incident, the residents' physician or family had been notified, or that vital signs had been obtained.

On 1/31/24 at 3:33 p.m., the WD (Wellness Director) provided an incident report, dated 12/4/23 at 5:58 p.m., which indicated the report had been prepared for Resident H by the WD, the incident description was that employee heard a disturbance and employee saw Resident J on the floor being pulled out of the room on the floor by Resident H. Staff assisted Resident J. The immediate action taken was Resident H was removed from the room and family was called in to sit with Resident H. The physician was notified of the incident. Resident J was not included in the incident report.

During an interview on 1/31/24 at 3:33 p.m., the WD indicated she had noticed there were not notes the clinical record for the 12/4/23 incident between the

residents. There should have been documentation in the clinical records of Resident H and Resident J about the 12/4/23 incident.

On 1/31/24 at 3:08 p.m., the ED provided the Abuse, Neglect, or Exploitation policy, last reviewed 6/7/23, which read "...The purpose of the Abuse, Neglect, or Exploitation policy is to outline the process for the prevention, investigation and reporting of abuse, neglect, or exploitation...Initial Response...3. Documentation a. Documentation in the resident chart should include results of the resident's ROM [Range of Motion] Results of the body check Vital signs Notification of the physician and the responsible party treatment provided..."

This State Tag relates to complaint IN00419078 and IN00418345.

Based on interview and record review, the facility failed to implement their Abuse, Neglect or Exploitation policy by not assuring that an altercation between 2 residents was documented in the clinical record and that the physicians of the residents were notified of the altercation for 2 of 2 residents reviewed for abuse (Resident H and Resident J).

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED

OMB NO. 0938-0391

Findings include:

1a. The clinical record for Resident H was reviewed on 1/31/24 at 1:10 p.m. The Resident's diagnosis included, but was not limited to, dementia with behavioral disturbance.

A service plan, created 11/8/23, indicated Resident H needed assistance with reasoning. The goal was for him to make appropriate decisions about his care and environment with assistance. The interventions were that he required assistance with redirection due to occasional confusion, a deficit in judgment, wandering or exit seeking, and care staff would report any changes in ability to reason.

1b. The clinical record for Resident J was reviewed on 1/31/24 at 1:00 p.m. The Resident's diagnosis included, but was not limited to, dementia and insomnia.

A Service plan, created 11/7/23, indicated Resident J needed assistance with reasoning. The goal was for her to make appropriate decisions about her care and environment with assistance. The interventions were that she required assistance with redirection due to occasional confusion, deficits in judgment, wandering, or exit seeking, and care staff would

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

report any changes in ability to reason.

On 1/31/24 at 10:30 a.m., the ED (Executive Director) provided an Incident Reporting Form that had been sent the Indiana Department of Health on 12/5/23 which indicated that on 12/4/23, Resident J had been found on the floor being pulled out of a room by Resident H. The staff had intervened and assisted Resident J off of the floor. There were no injuries to either Resident J or Resident H. Resident J's family had come to sit with him, and the physician had been notified. The Wellness Director was notified.

The clinical record for Resident H and Resident J did not contain documentation that the incident had occurred, the physical condition of either resident after the incident, the residents' physician or family had been notified, or that vital signs had been obtained.

On 1/31/24 at 3:33 p.m., the WD (Wellness Director) provided an incident report, dated 12/4/23 at 5:58 p.m., which indicated the report had been prepared for Resident H by the WD, the incident description was that employee heard a disturbance and employee saw Resident J on the floor being pulled out of the room on the floor by Resident H.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Staff assisted Resident J. The immediate action taken was Resident H was removed from the room and family was called in to sit with Resident H. The physician was notified of the incident. Resident J was not included in the incident report.

During an interview on 1/31/24 at 3:33 p.m., the WD indicated she had noticed there were not notes the clinical record for the 12/4/23 incident between the residents. There should have been documentation in the clinical records of Resident H and Resident J about the 12/4/23 incident.

On 1/31/24 at 3:08 p.m., the ED provided the Abuse, Neglect, or Exploitation policy, last reviewed 6/7/23, which read "...The purpose of the Abuse, Neglect, or Exploitation policy is to outline the process for the prevention, investigation and reporting of abuse, neglect, or exploitation...Initial Response...3. Documentation a. Documentation in the resident chart should include results of the resident's ROM [Range of Motion] Results of the body check Vital signs Notification of the physician and the responsible party treatment provided..."

This State Tag relates to complaint IN00419078 and IN00418345.

Based on interview and record review, the facility failed to implement their Abuse, Neglect or Exploitation policy by not assuring that an altercation between 2 residents was documented in the clinical record and that the physicians of the residents were notified of the altercation for 2 of 2 residents reviewed for abuse (Resident H and Resident J).

Findings include:

1a. The clinical record for Resident H was reviewed on 1/31/24 at 1:10 p.m. The Resident's diagnosis included, but was not limited to, dementia with behavioral disturbance.

A service plan, created 11/8/23, indicated Resident H needed assistance with reasoning. The goal was for him to make appropriate decisions about his care and environment with assistance. The interventions were that he required assistance with redirection due to occasional confusion, a deficit in judgement, wandering or exit seeking, and care staff would report any changes in ability to reason.

1b. The clinical record for Resident J was reviewed on 1/31/24 at 1:00 p.m. The

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Resident's diagnosis included, but was not limited to, dementia and insomnia.

A Service plan, created 11/7/23, indicated Resident J needed assistance with reasoning. The goal was for her to make appropriate decisions about her care and environment with assistance. The interventions were that she required assistance with redirection due to occasional confusion, deficits in judgment, wandering, or exit seeking, and care staff would report any changes in ability to reason.

On 1/31/24 at 10:30 a.m., the ED (Executive Director) provided an Incident Reporting Form that had been sent the Indiana Department of Health on 12/5/23 which indicated that on 12/4/23, Resident J had been found on the floor being pulled out of a room by Resident H. The staff had intervened and assisted Resident J off of the floor. There were no injuries to either Resident J or Resident H. Resident J's family had come to sit with him, and the physician had been notified. The Wellness Director was notified.

The clinical record for Resident H and Resident J did not contain documentation that the incident had occurred, the physical condition of either resident after the incident, the

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

residents' physician or family had been notified, or that vital signs had been obtained.

On 1/31/24 at 3:33 p.m., the WD (Wellness Director) provided an incident report, dated 12/4/23 at 5:58 p.m., which indicated the report had been prepared for Resident H by the WD, the incident description was that employee heard a disturbance and employee saw Resident J on the floor being pulled out of the room on the floor by Resident H. Staff assisted Resident J. The immediate action taken was Resident H was removed from the room and family was called in to sit with Resident H. The physician was notified of the incident. Resident J was not included in the incident report.

During an interview on 1/31/24 at 3:33 p.m., the WD indicated she had noticed there were not notes the clinical record for the 12/4/23 incident between the residents. There should have been documentation in the clinical records of Resident H and Resident J about the 12/4/23 incident.

On 1/31/24 at 3:08 p.m., the ED provided the Abuse, Neglect, or Exploitation policy, last reviewed 6/7/23, which read "...The purpose of the Abuse, Neglect, or Exploitation policy is to outline the process for the

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

prevention, investigation and reporting of abuse, neglect, or exploitation...Initial Response...3. Documentation a. Documentation in the resident chart should include results of the resident's ROM [Range of Motion] Results of the body check Vital signs Notification of the physician and the responsible party treatment provided..."

This State Tag relates to complaint IN00419078 and IN00418345.

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