STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155291	A. BUILDING 00 B. WING	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EAGLE VALLEY MEADOWS	3017 VALLEY FARMS RD INDIANAPOLIS, IN 46214

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00440154, IN00441304, and IN00439554 Complaint IN00441304 - Federal/state deficiencies related to the allegations are cited at F550. Complaint IN00440154 - No deficiencies related to the allegations are cited. Complaint IN00439554 - No deficiencies related to the allegations are cited. Survey dates: August 20 and 21, 2024 Facility number: 000188 Provider number: 155291 AIM number: 100266310 Census Bed Type: SNF/NF: 69 Total: 69 Census Payor Type: Medicare: 0 Medicaid: 51 Other: 18 Total: 69 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 4, 2024.	F 0000		
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights	F 0550	This plan of correction constitutes	08/22/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nicole Holder	Executive Director	09/10/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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	Based on observation, interview, and record review, the facility failed to maintain the dignity and the right to refuse services of 1 of 5 residents reviewed for resident rights (Resident S). Findings include: On 8/20/24 at 11:43 a.m., during an initial observation and interview, Resident S was observed the resident lying in bed. The call light was within reach on the right side of her bed attached to her bed rail. She was on a low air loss mattress to facilitate comfort and prevent skin breakdown. The resident was cognitively intact, alert, and pleasant. The resident indicated she was able to stand and transfer to her wheelchair with assistance from the staff. She preferred to have meals in her room, but she was able to go to the dining room. The resident indicated on 8/17/24 (she was unsure of the time), she was in the lobby with her daughter, and she removed her oxygen tubing from her nose because she did not feel any air in the tube. She indicated Licensed Practical Nurse (LPN) 5 was sitting at the nurse's desk and she asked the nurse three times for help. She indicated LPN 5 yelled at Resident S and told her she was not her nurse. Another nurse, she did not recall the nurse's name, came to the area she was at and filled the portable oxygen tank for her. Later in the evening Registered Nurse (RN) 6 came into her room to give her the evening dose of medications. Resident S saw LPN 5 come into the room with RN 6. Resident S indicated she yelled at LPN 5 to get out of her room. She told LPN 5 she did not want her in her room because she was upset over the conversation she had with her earlier at the nurse's station about her oxygen. LPN 5 yelled at Resident S and said she was not going anywhere and continued to play on her phone. Resident S indicated she knew she should		this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's Inspection Report. Eagle Valley Meadows respectfully requests consideration for a desk review of this plan of correction in lieu of post survey revisit. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident S receives assistance staff to ensure dignity is maintained and right to refuse services is honored. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: Interviews with residents were completed by Care Companions to ensure that resident needs and dignity is being maintained. An inservice was completed by DNS/Designee on 8/22/24 regarding maintaining dignity and honoring resident's right to refuse. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Inservice nursing staff completed by DNS/Designee to include maintaining dignity and honoring resident's right to refuse completed 8/22/24. Observational	

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	not have done it, but she picked up her styrofoam water cup and threw the water towards LPN 5. The cup hit the floor and splashed onto the nurse's pants. LPN 5 threatened to call the police and remained in the room. On 8/20/24 at 2:00 p.m., the medical record of Resident S was reviewed. Diagnosis included but were not limited to: Chronic obstructive pulmonary disease (COPD) (a group of diseases that cause airflow blockage and breathing-related problems) with (acute) exacerbation (sudden worsening), morbid (severe) obesity due to excess calories, type 2 diabetes mellitus without complications (a disease that occurs when your blood glucose, also called blood sugar, is too high), hypertensive heart disease with heart failure, chronic systolic (congestive) heart failure (a group of heart problems that occur when high blood pressure is present over a long period of time), anxiety disorder (a feeling of fear, dread, and uneasiness). An Admission Minimum Data Set (MDS) assessment, dated 8/13/24, indicated the resident was cognitively intact. A care plan, dated 8/20/2024, indicated. Resident experienced behavior expressions such as at times cursing and yelling at staff, throwing cups at staff, refusing when offered a shower/bathing and then making accusations of staff not offering or bathing her, refusing peri care when staff offer stating "No, I am asleep" or "No not right now" and then accusing staff of not giving peri care. Approaches with start date of 8/20/2024 included continue with care in pairs, ensure safety, allow resident time to cool off, provide calm, unhurried, and supportive approach, notify family of refusals, notify MD of refusals, and remove from		rounds will be completed by Care Companions/Nursing staff daily to ensure that needs and dignity are being maintained. 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: POC QAPI tools completed by the DNS/Designee will be utilized for Dignity and Privacy weekly x4 weeks then monthly x5 months, with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action and/or including termination of the responsible employee. By what date the systemic changes will be completed: 8/22/24	

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	immediate area to further evaluate needs. On 8/20/24 at 2:31 p.m., during an interview with the Administrator. She indicated a care plan meeting with the resident and her daughter was completed on 8/17/24. She indicated the resident had said a nurse had spoken inappropriately to her and suggestions for her care were discussed. The Administrator indicated she had not received any reports from the DON or the Assistant DON (ADON), regarding reports of verbal abuse to a resident. She indicated if a resident was care planned for care to be provided in pairs it is for a specific reason. The staff member could ask another person to stand in the room if it was a non-clinical issue as a witness. A non-medical person could be a stand in if there was a need. She indicated Resident S had made false accusations against the staff and she was care planned for all care to be administered with two persons. A review of the progress notes lacked documentation of a care plan meeting on the date specified by the Administrator. On 8/20/24 at 2:45 p.m., during an interview with the DON and the Administrator. The DON indicated she had not received a report of anyone submitting a complaint about a nurse. She then indicated LPN 5 had called her regarding a situation with Resident S. She indicated Resident S, had yelled at her and she was 5 seconds from calling the police because the resident threw water on her. She indicated RN 6 was administering medication and she was there as a witness. She was on her phone looking up the resident's medication when the resident threw water on her. The DON acknowledged the nurse should have			

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	left the room when told to leave by the resident. The Administrator indicated the resident yelled and cursed at the staff and told false allegations about the staff. She indicated this was the first time she had heard about the incident; however, the staff should not be assaulted by the residents. The DON was unable to indicate why the nurse felt threatened to the point she would believe she needed to call the police for protection. The DON indicated she had not reported this to the Administrator, and she had not completed any employee education. The Administrator indicated the facility provided customer service education to all staff. On 8/21/24 at 10:31 a.m., during an interview with CNA 8. She indicated she has had education regarding dealing with residents with behaviors. She indicated she would leave the room if a resident request her to leave. If she was asked to be second person to assist and the resident asked her to leave, she would leave and ask another CNA to assist. On 8/21/24 at 10:43 a.m., during an interview with RN 9. She indicated she had no issues with residents refusing care. On August 17th she worked with Resident S for the first time and indicated the resident was very pleasant. She indicated she had received education on how to work with residents with behaviors and residents with dementia. She indicated if a resident asked her to leave their room, she would explain why she needed to be there. If the resident became upset, she would try to calm them but at some point, she would leave and ask another staff member to assist. On 8/21/2024 at 12:30 p.m., the provided an undated document titled, "Your Rights and			

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	Protections as a Nursing Home Resident," and indicated it was the policy currently being used by the facility. The policy indicated, "...At a minimum, Federal law specifies that nursing homes must protect and promote the following rights of each resident. You have the right to ...Be treated with respect: You have the right to treated with dignity and respect ...Be free from Abuse and Neglect ...You have the right to be free from verbal abuse ...Make complaints ...You have the right to make a complaint to the staff of the nursing home, or any other person ...." This citation relates to Complaint IN00441304. 3.1-3(a)(1)			