STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	10/20/2023

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INDEPENDENCE VILLAGE OF FISHERS SOUTH	9745 OLYMPIA DR FISHERS, IN 46038

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R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00417075, IN00419230, and IN00419251. Complaint IN00417075- State deficiencies related to the allegations are cited at R0091 and R0240. Complaint IN00419230- State deficiencies related to the allegations are cited at R0052, R0053, R0091 and R0240. Complaint IN00419251- State deficiencies related to the allegations are cited at R0052, R0091 and R0240 Survey date: October 19 and 20, 2023 Facility number: 002999 Residential Census: 79 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on October 24, 2023	R 0000	The submission of the Plan of Correction does not indicate an admission by Independence Village of Fishers South that the findings and allegations contained herein are an accurate and true representation of the Quality of Care provided to the residents of Independence Village of Fishers South. The Community hereby maintains it is in substantial compliance with the requirements of participation for residential health care communities. To this end, the Plan of Correction shall serve as the Credible Allegation of Compliance with all State requirements governing the operations of this Community.	
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on interview and record review, the facility failed to protect residents from physical abuse by other residents during physical altercations in the	R 0052	1 The identified residents were affected by the deficient practice. Service plans were updated for	12/06/2023

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

Christine Bright | Executive Director | 11/06/2023

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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	memory care unit for 3 of 4 residents reviewed for abuse. (Resident's B, D, and E) Findings include: 1a. The clinical record for Resident D was reviewed on 10/19/23 at 2:30 p.m. The diagnoses for Resident D included, but were not limited to, dementia, psychotic disturbance, mood disturbance and anxiety. 1b. The clinical record for Resident B was reviewed on 10/19/23 at 2:35 p.m. The diagnoses for Resident B included, but were not limited to, dementia, psychotic disturbance, mood disturbance and anxiety. 1c. The clinical record for Resident E was reviewed on 10/19/23 at 2:45 p.m. The diagnoses for Resident E included, but were not limited to, dementia, psychotic disturbance, mood disturbance and anxiety. A nursing progress note for Resident D dated 9/19/23 indicated "This writer notified by staff that this resident and resident [E] were involved in a verbal/physical altercation. This resident was arguing with female resident [E] over a vase that [Resident E] was holding. This resident wanted the vase, claiming the vase was hers. Resident [E] refused to give this resident the vase and this resident attempted to hit [Resident E]. [Resident E] prevented the hit by grabbing this resident hand. This resident received a skin tear to hand and first aid given. Staff intervened and ensured both residents were safe." A reportable incident to the Indiana Department of Health dated 9/20/23 indicated on 9/19/23, Resident D and Resident E were involved in an		identified residents. First aid was administered for injured resident. 2 The community realizes that all residents have the potential to be affected by the deficient practice. 3 All staff have been educated regarding behavior monitoring and abuse. Any resident with combative behaviors will be placed on 1:1 until placement can be found at a behavioral health facility or family will be responsible for providing 1:1 care. 4 4.The Wellness Director and Executive Director will be notified immediately of any allegations of resident-to-resident abuse. The WD and ED will notify the physician and family to immediately begin 1:1 care prior to placement at a behavioral health facility. The Wellness Director/Executive Director will review the 24-hour report for any reported allegations. This will be monitored daily and tracked with the use of the sign off sheet.	

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	incident. A brief description of the occurrence indicated Resident D argued with Resident E over a vase Resident E was holding. Resident D thought the vase belonged to her and wanted Resident E to give her the vase. Resident D started to hit Resident E and Resident E trying to prevent the hit grabbed Resident D's hand causing a skin tear on Resident D's hand. "Immediate Action Taken...Residents separated, first aide to hand of [Resident D]. Monitored both residents throughout shift to ensure safety..." A nursing progress note for Resident E dated 9/21/23 indicated "This writer notified by QMA [Qualified Medication Aide] that resident [D]...was attempting to hit this resident [E]. This resident was trying to stop [Resident D] from hitting her and was holding [Resident E]'s hands. Another resident [B] tried to assist this resident from being hit and [Resident D] then hit [Resident B]...." A nursing progress note for Resident B dated 9/21/23 indicated "This writer notified by QMA [Qualified Medication Aide] that this resident [B] was hit by [Resident D] for trying to help [Resident E] from being hit. Resident was hit in stomach area by [Resident D]. Staff immediately separated residents and ensured all were safe. 1 on 1 with [Resident D]. No injuries noted..." A reportable incident to the Indiana Department of Health dated 9/22/23 indicated an incident had occurred on 9/21/23 between Resident D, Resident B and Resident E. A description of the occurrence indicated "...QMA heard woman yelling for help and when QMA arrived resident [E] was holding the hands of [Resident D] to prevent from being hit. At that time resident [B] was trying to assist [Resident E] from being hit when [Resident E]			

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	then hit [Resident B] in stomach area...Immediate Action Taken...1 on 1 with [Resident E] with QMA. 2 other residents [Resident B and D] taken to safety of their rooms with staff. Ensured residents were safe and had no injuries..." An interview was conducted with the Director of Nursing on 10/20/23 at 11:12 a.m. She indicated on 9/19/23, Resident D was upset Resident E had a vase she wanted which resulted in Resident D causing a skin tear to Resident E during the altercation. On 9/21/23, a 2nd altercation occurred between Resident D and Resident E. Resident B got involved during that incident. She was trying to protect Resident D from hitting Resident E which resulted in Resident E hitting her in the stomach. An interview was conducted with Executive Director (ED) on 10/20/23 at 11:25 a.m. She indicated the incidents that occurred on 9/19/23 and 9/21/23 between Residents' E, D, and B were resident to resident abuse. An abuse policy was provided by the ED on 10/20/23 at 11:30 a.m. It indicated "..Purpose. 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...3. Supervision. a. Community will address situations in which abuse, neglect, or exploitation are more likely to occur. This includes, but is not limited to, the following:...Assignment of staff that have knowledge of the individual resident's care needs. Supervision of staff to identify and address inappropriate behaviors..." This citation relates to Complaints IN00419251 and IN00419230.			

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R 0053 Bldg. 00	410 IAC 16.2-5-1.2(w) Residents' Rights - Deficiency (w) Residents have the right to be free from verbal abuse. Based on interview and record review, the facility failed to ensure a resident's right to be free from verbal abuse which resulted in psychosocial harm by a staff member on the memory care unit for 1 of 4 residents reviewed for abuse. (Resident D) Findings include: The clinical record for Resident D was reviewed on 10/19/23 at 11:22 a.m. Resident D's diagnoses included, but not limited to, dementia and anxiety disorder. A reportable incident to the Indiana Department of Health dated on 10/6/23 indicated, Resident D "was in the nursing station while the nursing staff was outside the office. [Resident D's name] had a bowel movement in the office on the the floor and personal items of [name of QMA, qualified medication assistant, 6]. [Name of QMA 6] entered the station to notice this and yelled 'what are you doing? Get the f***[expletive] out of here'. Telling other employees to 'come get here[sic, her]'. Action taken by the facility was to ask QMA 6 to leave and not return until the investigation was complete, employees who were present were asked to write a statement of the incident of what they saw and heard, and the facility was to complete an internal investigation and make a determination based on that. The report indicated, there was no injury to the resident. A facility follow-up to the above incident dated 10/11/23 was received from the ED (Executive Director) on 10/19/23 at 11:27 a.m. indicated,	R 0053	1 The identified residents were affected by the deficient practice. Service plans were updated for identified residents. 2 The community realizes that all residents have the potential to be affected by the deficient practice. 3 The community has educated on Abuse and Neglect and Resident rights. The identified staff member was terminated after an investigation was completed. Ongoing abuse, dementia, and resident rights training will continue for all current staff members and any new staff. All reports of abuse must be reported to the Executive Director immediately. 4 All allegations of staff/resident abuse will be reported to the ED immediately. Any staff involved in an alleged abuse incident will be removed from the schedule and will not return until that investigation has been completed. Staff will be terminated if the investigation determines evidence of abuse. The Wellness Director/Executive Director will review the 24 hour report for any reported allegations.	12/07/2023

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	"After investigation we did end employment with the employee. [name of QMA 6] was terminated on 10/11/23. We have also had an in-service with staff and review the resident rights and abuse and neglect policy." An interview with the Memory Care unit Coordinator (MCC) conducted on 10/19/23 at 3:09 p.m. indicated, she was not present when the altercation between Resident D and QMA 6 occurred, but was present when QMA 6 had returned to the unit after the incident. Once informed of the incident, MCC stated she had gone to the nursing office to help with the clean up and noted that Resident D was crying. When QMA 6 returned to the unit, MCC was walking down the hallway and QMA 6 immediately started saying, in a loud voice, "oh do you know what happened here? This is bulls***, I'm fed up with this sh**. Why do we have people like this living here? Why do we have to put up with that?" An interview with CNA (certified nursing assistant) 3 conducted on 10/19/23 at 3:31 p.m. indicated, she had been present during the incident between Resident D and QMA 6 on 10/6/23. She stated, she was cleaning tables in the dining room when she heard QMA 6 yelling. CNA 3 left the dining room and saw QMA 6 at the nursing office doorway and Resident D in the nursing office. QMA 6 was yelling saying, "Get the f*** out...somebody come get her [Resident D] out of here...she needs psych" and that when Resident D came out of the nursing office with feces on her hands repetitively saying "I'm sorry, I'm sorry". CNA 3 indicated she believed QMA 6 had scared Resident D because she (QMA 6) was "yelling that bad".		This will be monitored daily and tracked with the use of the sign off sheet.	

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	An interview with QMA 6 was conducted on 10/20/23 at 9:14 a.m. QMA 6 explained that on 10/6/23, she was running around getting supplies for her medication cart when she opened the door to the nursing office and found Resident D in the office with feces on her hands. QMA 6 indicated, Resident D had bowel movement everywhere and was using food and envelopes to wipe herself. QMA 6 stated, she yelled for staff to come get her (Resident D) because Resident D can be violent and the other staff members just laughed. She indicated, she cussed at them to come and help. QMA 6 indicated Resident D was still inside the office when she said "Get the f*** up and help me" to the other nearby staff. An interview with QMA 4 conducted on 10/20/23 at 9:24 a.m. indicated, on October 6, 2023, she was in the dining room helping file paperwork for another staff member when QMA 6 carrying a box of medications, opened the nursing office door and yelled, "What the f***, get the f*** out of here, she's sh**ing everywhere, get her the f*** out of here". The box of medications QMA 6 had been carrying was on the floor by the nursing office. QMA 6 kicked the box of medications with her foot and yelled, "you need psych" as Resident D was walking out of the office. QMA 4 indicated, Resident D looked "shook up", her hands were shaking, and she kept saying "I'm sorry, I'm sorry". According to QMA 4, she (QMA 6) was yelling and cussing at Resident D saying "she should be in psych". QMA 4 stated after she took Resident D down to her room to get her cleaned up, Resident D hugged her and for the rest of the day every time she saw CNA 4, she hugged her. CNA 4 went on to say that this was not the only time QMA 6 had cussed in front of residents or their family. She indicated, she had reported QMA 6's inappropriate behavior several			

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	times to the scheduler. An interview with ED conducted on 10/19/23 at 1:19 p.m. indicated, the way in which QMA 6 had spoke to Resident D on 10/6/23 was considered verbal abuse. An Abuse, Neglect, or Exploitation policy received from ED on 10/19/23 at 11:56 a.m. indicated, "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...Definitions...Abuse-Harm or threatened harm to and adult's health or welfare caused by another person...Exploitation-Misuse of and adult's funds, property, or personal dignity (e.g., humiliation, objectification, degradation, dehumanization) by another person..." This citation relates to Complaint IN00419230.			
R 0091 Bldg. 00	410 IAC 16.2-5-1.3(h)(1-4) Administration and Management - Noncompliance (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 available to residents upon request. Based on interview and record review, the facility failed to implement their Abuse, Neglect, or Exploitation policy for investigations of abuse and/or exploitation for 4 of 4 residents reviewed for abuse. (Residents B, C, D, and E)	R 0091	1 No residents were affected by the alleged deficient practice. 2 The community realizes that residents have the potential to be affected by the alleged deficient	12/06/2023

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	Findings include: 1. The clinical record for Resident D was reviewed on 10/19/23 at 11:22 a.m. Resident D's diagnoses included, but not limited to, dementia and anxiety disorder. A reportable incident to the Indiana Department of Health dated on 10/6/23 indicated, Resident D "was in the nursing station while the nursing staff was outside the office. [Resident D's name] had a bowel movement in the office on the the floor and personal items of [name of QMA, qualified medication assistant, 6]. [Name of QMA 6] entered the station to notice this and yelled 'what are you doing? Get the f***[expletive] out of here'. Telling other employees to 'come get here[sic, her]'. Action taken by the facility was to ask QMA 6 to leave and not return until the investigation was complete, employees who were present were asked to write a statement of the incident of what they saw and heard, and the facility was to complete an internal investigation and make a determination based on that. The report indicated, there was no injury to the resident. A facility follow-up to the above incident dated 10/11/23 was received from the ED (Executive Director) on 10/19/23 at 11:27 a.m. indicated, "After investigation we did end employment with the employee. [name of QMA 6] was terminated on 10/11/23. We have also had an in-service with staff and review the resident rights and abuse and neglect policy." An interview with the Memory Care unit Coordinator (MCC) conducted on 10/19/23 at 3:09 p.m. indicated, she was not present when the altercation between Resident D and QMA 6		practice. 3 The wellness staff has been educated in proper documentation processes. This includes all events that impact residents and their safety. All staff will document and communicate all altercations to WD and/or ED to complete through investigation. 4 The Wellness director and Executive Director will review the 24-hour report daily for any communications and verify any service plans have been updated accordingly. Tracking will be required using the daily checklist that must be completed by the Wellness Director and Executive Director. This will be monitored for the next 3 months and any adjustments will be made if necessary.	

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	occurred, but was present when QMA 6 had returned to the unit after the incident. Once informed of the incident, MCC stated she had gone to the nursing office to help with the clean up and noted that Resident D was crying. When QMA 6 returned to the unit, MCC was walking down the hallway and QMA 6 immediately started saying, in a loud voice, "oh do you know what happened here? This is bulls***, I'm fed up with this sh**. Why do we have people like this living here? Why do we have to put up with that?" An interview with CNA (certified nursing assistant) 3 conducted on 10/19/23 at 3:31 p.m. indicated, she had been present during the incident between Resident D and QMA 6 on 10/6/23. She stated, she was cleaning tables in the dining room when she heard QMA 6 yelling. CNA 3 left the dining room and saw QMA 6 at the nursing office doorway and Resident D in the nursing office. QMA 6 was yelling saying, "Get the f*** out...somebody come get her [Resident D] out of here...she needs psych" and that when Resident D came out of the nursing office with feces on her hands repetitively saying "I'm sorry, I'm sorry". CNA 3 indicated she believed QMA 6 had scared Resident D because she (QMA 6) was "yelling that bad". An interview with QMA 6 was conducted on 10/20/23 at 9:14 a.m. QMA 6 explained that on 10/6/23, she was running around getting supplies for her medication cart when she opened the door to the nursing office and found Resident D in the office with feces on her hands. QMA 6 indicated, Resident D had bowel movement everywhere and was using food and envelopes to wipe herself. QMA 6 stated, she yelled for staff to come get her (Resident D) because Resident D can be violent			

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	and the other staff members just laughed. She indicated, she cussed at them to come and help. QMA 6 indicated Resident D was still inside the office when she said "Get the f*** up and help me" to the other nearby staff. An interview with QMA 4 conducted on 10/20/23 at 9:24 a.m. indicated, on October 6, 2023, she was in the dining room helping file paperwork for another staff member when QMA 6 carrying a box of medications, opened the nursing office door and yelled, "What the f***, get the f*** out of here, she's sh**ing everywhere, get her the f*** out of here". The box of medications QMA 6 had been carrying was on the floor by the nursing office. QMA 6 kicked the box of medications with her foot and yelled, "you need psych" as Resident D was walking out of the office. QMA 4 indicated, Resident D looked "shook up", her hands were shaking, and she kept saying "I'm sorry, I'm sorry". According to QMA 4, she (QMA 6) was yelling and cussing at Resident D saying "she should be in psych". QMA 4 stated after she took Resident D down to her room to get her cleaned up, Resident D hugged her and for the rest of the day every time she saw CNA 4, she hugged her. CNA 4 went on to say that this was not the only time QMA 6 had cussed in front of residents or their family. She indicated, she had reported QMA 6's inappropriate behavior several times to the scheduler. An interview with ED conducted on 10/19/23 at approximately 12 p.m. indicated, the way in which QMA 6 had spoke to Resident D on 10/6/23 was considered verbal abuse. 2. a. The clinical record for Resident D was reviewed on 10/19/23 at 2:30 p.m. The diagnoses for Resident D included, but were not limited to,			

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	dementia, psychotic disturbance, mood disturbance and anxiety. 2. b. The clinical record for Resident B was reviewed on 10/19/23 at 2:35 p.m. The diagnoses for Resident B included, but were not limited to, dementia, psychotic disturbance, mood disturbance and anxiety. 2. c. The clinical record for Resident E was reviewed on 10/19/23 at 2:45 p.m. The diagnoses for Resident E included, but were not limited to, dementia, psychotic disturbance, mood disturbance and anxiety. A nursing progress note for Resident D dated 9/19/23 indicated "This writer notified by staff that this resident and resident [E] were involved in a verbal/physical altercation. This resident was arguing with female resident [E] over a vase that [Resident E] was holding. This resident wanted the vase, claiming the vase was hers. Resident [E] refused to give this resident the vase and this resident attempted to hit [Resident E]. [Resident E] prevented the hit by grabbing this resident hand. This resident received a skin tear to hand and first aid given. Staff intervened and ensured both residents were safe." A reportable incident to the Indiana Department of Health dated 9/20/23 indicated on 9/19/23, Resident D and Resident E were involved in an incident. A brief description of the occurrence indicated Resident D argued with Resident E over a vase Resident E was holding. Resident D thought the vase belonged to her and wanted Resident E to give her the vase. Resident D started to hit Resident E and Resident E trying to prevent the hit grabbed Resident D's hand causing a skin tear on Resident D's hand.			

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	"Immediate Action Taken...Residents separated, first aide to hand of [Resident D]. Monitored both residents throughout shift to ensure safety..." A nursing progress note for Resident E dated 9/21/23 indicated "This writer notified by QMA [Qualified Medication Aide] that resident [D]...was attempting to hit this resident [E]. This resident was trying to stop [Resident D] from hitting her and was holding [Resident E]'s hands. Another resident [B] tried to assist this resident from being hit and [Resident D] then hit [Resident B]...." A nursing progress note for Resident B dated 9/21/23 indicated "This writer notified by QMA [Qualified Medication Aide] that this resident [B] was hit by [Resident D] for trying to help [Resident E] from being hit. Resident was hit in stomach area by [Resident D]. Staff immediately separated residents and ensured all were safe. 1 on 1 with [Resident D]. No injuries noted..." A reportable incident to the Indiana Department of Health dated 9/22/23 indicated an incident had occurred on 9/21/23 between Resident D, Resident B and Resident E. A description of the occurrence indicated "...QMA heard woman yelling for help and when QMA arrived resident [E] was holding the hands of [Resident D] to prevent from being hit. At that time resident [B] was trying to assist [Resident E] from being hit when [Resident E] then hit [Resident B] in stomach area...Immediate Action Taken...1 on 1 with [Resident E] with QMA. 2 other residents [Resident B and D] taken to safety of their rooms with staff. Ensured residents were safe and had no injuries..." An interview was conducted with the Director of Nursing on 10/20/23 at 11:12 a.m. She indicated on			

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	9/19/23, Resident D was upset Resident E had a vase she wanted which resulted in Resident D causing a skin tear to Resident E during the altercation. On 9/21/23, a 2nd altercation occurred between Resident D and Resident E. Resident B got involved during that incident. She was trying to protect Resident D from hitting Resident E which resulted in Resident E hitting her in the stomach. An interview was conducted with Executive Director (ED) on 10/20/23 at 11:25 a.m. She indicated the incidents that occurred on 9/19/23 and 9/21/23 between Residents' E, D, and B were resident to resident abuse. The facility's Abuse, Neglect, or Exploitation policy did not indicate to report allegations of abuse, neglect, or exploitation not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury. An interview with ED conducted on 10/19/23 at 1:19 p.m. indicated, each of the abuse investigations of the above mentioned instances did not have an investigation file thus, not having evidence of a thorough investigation. She indicated, interviews with staff, family, and/or witnesses were not documented; lack of documentation of notification of the responsible party; and no written statements were collected. An Abuse, Neglect, or Exploitation policy received from ED on 10/19/23 at 11:56 a.m. indicated, "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...Definitions...Abuse-Harm or threatened harm to and adult's health or welfare			

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	caused by another person...Exploitation-Misuse of and adult's funds, property, or personal dignity (e.g., humiliation, objectification, degradation, dehumanization) by another person...Initial response Protect the Resident...A supervisor should perform an initial check of the resident. The check should generally include the following: range of motion (ROM), full body check for signs of injury; and vital signs... Employees are to immediately report any witnessed or suspected incidents of abuse, neglect, or exploitation to the supervisor on duty and the Wellness Director or designee...'immediately' means as soon as possible, but will not exceed twenty four (24) hours after the incident or discovery of the injury...Investigation...An investigation of the allegation or suspicion will be completed timely but not later than 14 days after the incident...obtain written statements from the resident, if possible, the accused, and each witness...If an employee is suspected in the incident, review his/her employment status...Documentation...The investigation should be documented using investigation forms adopted by the community." A State of Indiana Long-Term Care Abuse and Incident Reporting Policy with an effective date of 12/8/2022 - 12/8/2023 indicates: Definitions contained herein apply to comprehensive care facilities and/or licensed residential facilities as applicable. 1. Abuse: Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all			

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	residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Abuse means any physical or mental injury or sexual assault inflicted on a resident in the facility, other than by accidental means...Immediately: Immediately means as soon as possible, in the absence of a shorter state time frame requirement, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury...Verbal abuse: Verbal abuse may be considered a type of mental abuse. Verbal abuse includes the use of oral, written, or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability." This citation relates to Complaints IN00417075, IN00419230 and IN00419251.			
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when			

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	appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature.			
	Based on interview and record review, the facility failed to ensure resident rights training/education was completed at least annually. This had the potential to effect all 79 residents who reside in the facility. Findings include: The residential care employee records were received on 10/19/23 at 11:27 a.m. QMA (qualified medication assistant) 7 was listed on the form.	R 0120	1 No residents were affected by the alleged deficient practice. 2 The community realizes that residents have the potential to be affected by the alleged deficient practice. 3 All staff have been educated regarding Abuse and Neglect, Resident Rights and Resident incident/accident reporting. All	12/07/2023

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	An interview with ED (Executive Director) conducted on 10/20/23 at 11:28 indicated, QMA 6 did not appear on the residential care employee sheet as QMA 6 was no longer working at the facility, but indicated she had worked at the facility from approximately 9/14/23 to 10/11/23. A review of the employee records for QMA 6 and 7 was conducted on 10/20/23 at 11:25 a.m. Upon review, the following was found: QMA 6's employee file was unable to be located nor was there evidence of her Resident Rights training; QMA 7's employee file did not indicate she had Resident Rights training within the last year and the last time QMA 7 completed Resident Rights training was 4/26/22. The Resident Rights-Indiana (Residential Care Facility) was provided by ED on 10/20/23 at 11:20 a.m. It indicated, "A resident has the right to a dignified existence, self-determination, and communication with access to persons and services inside and outside of the community...Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality.		staff are to report and allegations of abuse to the Executive Director immediately. All staff are required to complete the General Dementia Overview training in addition to the previous training. 4 A monthly audit of all employee files will be completed to ensure all staff have the required training. The Wellness Director and Executive Director will audit employee files monthly and any staff that have not completed the training will be removed from the schedule until they are in compliance. This will be monitored for 3 months and then re-evaluated and changes made accordingly.	
R 0240 Bldg. 00	410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on interview and record review, the facility failed to ensure medications were administered as ordered for 2 of 3 residents reviewed for medications (Resident C and Resident D); and failed to notify Resident Representatives of injuries/accidents/incidents, resident to resident altercations, and allegations of verbal abuse for 1 of 4 residents reviewed for abuse (Resident D).	R 0240	1 Residents were affected. Nurses' notes indicate that no injuries from the incident. 2 The community realizes that residents have the potential to be affected by the deficient practice.	12/06/2023

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	Findings include: 1. The clinical record for Resident C was reviewed on 10/19/23 at 1:30 p.m. The diagnoses for Resident C included, but were not limited to, hyperlipidemia (elevated cholesterol in blood), anemia and major depression. A physician order dated 8/4/23 indicated the resident was to receive 325 milligrams of ferretts medication for anemia daily. A physician order dated 8/4/23 indicated the resident was to receive 15 milligrams of mirtazapine daily for depression. A physician order dated 8/4/23 indicated the resident was to receive 20 milligrams of rosuvastatin daily for elevated cholesterol. The August 2023 Medication Administration Record (MAR) indicated the following days Resident C did not receive his 325 milligrams ferretts, 15 milligrams of ferretts and 20 milligrams of rosuvastatin as ordered: 325 milligrams of Ferretts medication: 8/19/23, 8/20/23, 8/21/23 and 8/22/23, 15 milligrams of mirtazapine: 8/18/23 and 8/19/23 20 milligrams of rosuvastatin: 8/29/23, 8/30/23 and 8/31/23 The September 2023 MAR indicated the following days Resident C did not receive his 20 milligrams of rosuvastatin as ordered due: 20 milligrams of rosuvastatin: 9/1/23, 9/2/23,		3 All wellness staff were educated in Medication Management and documentation for medication administration. Also, education on Medication order fill and pending order approval process for the Wellness Director and Assistant Wellness Director. 4 The Executive Director and Wellness Director will review the pending order for approval daily and review the orders are placed in the resident file. The Executive Director will sign off on all pending orders using the checklist and store in the Wellness director's office. This will be reviewed after 3 months for effectiveness and changes will be made accordingly.	

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	9/3/23, 9/4/23, 9/5/23, 9/6/23, 9/7/23, 9/8/23, 9/9/23, 9/10/23, 9/11/23 and 9/12/23 An interview was conducted with Family Member 5 on 10/19/23 at 3:29 p.m. She indicated Resident C's medication was messed up. He does not receive his scheduled medications routinely. She was unsure what was going on with his cholesterol medication, but he didn't receive that medication for a long time. 2. The clinical record for Resident D was reviewed on 10/19/23 at 2:30 p.m. The diagnoses for Resident D included, but were not limited to, dementia, psychotic disturbance and mood disturbance and anxiety. A physician order dated 9/22/23 indicated Resident D was to receive 500 milligrams of cephalexin for urinary tract infection twice a day. The September 2023 Medication Administration Record (MAR) indicated the following days the resident had not receive the 500 milligrams of cephalexin as ordered: 500 milligrams of cephalexin: 9/23/24, 9/24/23 and 9/2523 in am dosage. An interview was conducted with Qualified Medication Aide (QMA) 4 on 10/20/23 at 8:37 a.m. She indicated there are problems with administering medications to the residents timely. "It's frustrating." There are times, the availability of medications are not always the problem. The medications are put in a pending status in the electronic record due to a nurse needs to put the order in and/or a nurse's signature was needed. The medications that are in a pending status are unable to be administered until they are removed			

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	from that status. It causes delays in administering the medications to the residents. An interview was conducted with Executive Director on 10/20/23 at 8:47 a.m. She indicated there are problems with medications that are placed in pending status. The nurses's do have to sign or place the order in the electronic record, so staff can administer the medications. There are delays in removing the medications out of pending status, so the medications can be administered as ordered. A medication administration policy was provided by the Executive Director on 10/19/23 at 11:56 a.m. It indicated "...Purpose. The purpose of the Administering Medications policy is to ensure that medications are administered to residents consistent with good infection control and standards of practice...4. Procedure. Medications will be administered to residents as prescribed...The facility has sufficient staff to allow administering of medications without unnecessary interruptions..." 2. The clinical record for Resident D was reviewed on 10/19/23 at 11:22 a.m. Resident D's diagnoses included, but not limited to, dementia and anxiety disorder. Resident D's significant change evaluation dated 5/5/23 indicated, she had moderate to severe cognition impairment. Resident D resided on the memory care unit within the facility. A Nursing note dated 9/12/23 at 6:43 p.m. indicated, Resident D reported to the care staff that she had a new skin tear to her right hand. Resident D reported she cut her hand on the bathroom door. Staff held pressure to the site and after 5 minutes, it was still bleeding. Hospice was			

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	notified and was to sent out the nurse that night for further evaluation. The nursing note did not indicate Resident D's representative, her daughter, was notified of the new wound. A Nursing note dated 9/18/23 at 7:05 p.m. indicated, Resident D was very aggitated and combative towards staff. She was unable to be re-directed. Resident was hitting staff with closed fists, kicking and yelling uncontrollably. QMA (qualified medication assistant) and CNA (certified nursing assistant) were in the nursing office when Resident D entered the office and began hitting staff. A prn (as needed) order for Ativan was given. Hospice was notified. The note did not indicate Resident D's representative was notified. A Behavior note dated 9/19/23 at 7:30 p.m. indicated, the writer of the note was notified by other staff that Resident D and Resident E were involved in a verbal/physical altercation. Resident D was arguing with Resident E over a vase that Resident E was holding. Resident D wanted the vase and attempted to hit Resident E. When Resident E grabbed her hand to prevent her from striking her, Resident D sustained a skin tear to her hand. The note did not indicate Resident D's representative had been notified of the incident. An interview with Resident D's representative FM 2 (family member), conducted on 10/20/23 at 10:34 a.m. indicated, when asked if she had been made aware of the alleged verbal abuse that occurred between her mother and a staff member on 10/6/23 she replied, "no". Neither was she notified of the incident where her mom was found to have a black eye and blood on her pillow on 10/8/23 and she replied, "no" nor the altercation between Resident			

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	C and E when she (Resident D) hit Resident C in the stomach on 9/21/23. FM 2 indicated, she will sometimes get a call from the facility regarding an injury or situation but not always immediately. She stated that sometimes the facility will call much later in the day (another shift) or when she comes to visit, she will see marks and/or bruises on her mom and will have to seek out staff to find out what happened. For example, she had visited Resident D and found two cuts behind her ear and bruising around her right eye. She stated, from the cuts behind her ear, Resident D's hair was matted to the side of her head because the blood had dried. FM 2 indicated, she had not been notified of that injury and went out of Resident D's room to find staff to explain what had occurred. FM 2 further stated, once Resident D had a cut on her hand and she went to the Wellness Director to ask what happened and she said that her mom and another resident had an argument of a vase and her mom sustained a skin tear. A Resident Incident/Accident Reporting policy received on 10/20/23 by sister facility Director of Nursing (SFDON), last reviewed and updated on 1/20/23, indicated, "A Resident Incident/Accident Report is completed when ever there is a need to explain/investigate an unwitnessed injury or unexplainable event to include but not limited to bruises, skin tears, fall with injury...Procedure...8. Upon completion of Incident/Accident Report, staff is to document, in the resident's chart , a brief summary of the incident including...that MD [sic, medical doctor] and family have been notified. An Abuse, Neglect, or Exploitation policy received from ED on 10/19/23 at 11:56 a.m. indicated, "The purpose of the Abuse, Neglect, or Exploitation policy is to outline the process for the			

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	prevention, investigation and reporting of abuse, neglect, or exploitation...Initial Response...Documentation in the resident chart should include...Notification of the physician and the responsible party..." This citation relates to Complaints IN00417075, IN00419230 and IN00419251.			