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	02/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
INDEPENDENCE VILLAGE OF GREENWOOD	2339 S STATE ROAD 135 GREENWOOD, IN 46143

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00397266. Complaint IN00397266 - Substantiated. State deficiencies related to the allegations are cited at R0095. Survey dates: February 17 and 20, 2023 Facility number: 005722 Residential Census: 61 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed February 22, 2023.	R 0000	The submission of the Plan of Correction does not indicate an admission by Independence Village of Greenwood 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 Greenwood. 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. Independence Village of Greenwood respectfully requests a desk review for paper compliance.	
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Karen Yarnell Rumple	Administrator	04/03/2023

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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	conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on interview and record review, the facility failed to ensure that fire drills were conducted for 8 of 12 months reviewed. This had the potential to effect 61 of 61 residents at the facility. Finding includes: On 2/20/23 at 9:50 a.m., the Administrator provided documentation of fire drills performed at the facility for the last 12 months. A review of the records indicated that 8 of 12 required fire drills were missing. The documentation indicated that fire drills were not conducted in October 2022, September 2022, August 2022, July 2022, June 2022, May 2022, April 2022, and March 2022. During an interview on 2/20/23 at 10:00 a.m., the Administrator indicated that there had been "some turnover with maintenance staff and that some fire drills might be missing." During an interview on 2/20/23 at 1:05 p.m., the Administrator indicated that additional fire drills for the past year could not be located. On 2/20/23 at 9:50 a.m., the Administrator	R 0092	1. No residents were affected by the alleged deficient practice. 2. The Community realizes that residents could have the potential to be affected by the alleged deficient practice. 3. The Executive Director has reviewed with the Maintenance Director the fire drill procedures that clearly delineates the required frequency of drills and the expectation that he conduct the drills in accordance with the Community's Standard operating procedures. (Please see Exhibit "A"). In addition, a schedule was developed for the remainder of 2023 that ensures quarterly drills reflective on each shift and at random times. (Please see exhibit "B"). An attempt will be made to coordinate a Fire and Disaster drill with the Greenwood fire Department every six (6)	03/15/2023

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	provided a policy dated, 9/22/17, titled "Fire Drill Procedure" and indicated it was the policy currently in use. A review of the document indicated, " ...a total of 12 drills a year with four on each shift are required."		months. 4. The Monthly Safety Committee will review all drills to ensure the schedule is being maintained and make any necessary recommendations/adjustments as needed.	
R 0095 Bldg. 00	410 IAC 16.2-5-1.3(l)(1-2) Administration and Management -Noncompliance (l) In facilities that are required under IC 12-10-5.5 to submit an Alzheimer's and dementia special care unit disclosure form, the facility must designate a director for the Alzheimer's and dementia special care unit. The director shall have an earned degree from an educational institution in a health care, mental health, or social service profession or be a licensed health facility administrator. The director shall have a minimum of one (1) year work experience with dementia or Alzheimer's residents, or both, within the past five (5) years. Persons serving as a director for an existing Alzheimer's and dementia special care unit at the time of adoption of this rule are exempt from the degree and experience requirements. The director shall have a minimum of twelve (12) hours of dementia-specific training within three (3) months of initial employment as the director of the Alzheimer's and dementia special care unit and six (6) hours annually thereafter to: (1) meet the needs or preferences, or both, of cognitively impaired residents; and (2) gain understanding of the current standards of care for residents with dementia. Based on interview and record review, the facility	R 0095	1. No residents were affected by	03/15/2023

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	failed to ensure the Director of the Memory Care Unit had the required education to oversee the unit, potentially effecting 15 of 15 residents that reside on the Memory Care Unit. (QMA 3) Finding include: During an interview on 2/17/23 at 11:50 a.m., the Executive Director (ED) indicated Qualified Medication Aide (QMA) 3 was the Director of the Memory Care (MC) unit. The ED also indicated QMA 3 had her 12 hours of dementia training. QMA 3 had no other certifications or education. The ED also indicated 15 residents reside on the MC unit. On 2/20/23 at 12:37 p.m., the employee record of QMA 3 was reviewed. Employee 3's employment application, dated 6/23/22, indicated QMA 3 was a QMA. No other credentials were listed on QMA 3's employment application. During an interview on 2/20/23 at 10:33 a.m., the ED indicated QMA 3 had been the Director of the Memory Care unit since her date of hire on 7/5/22. The ED indicated she was not sure of the required qualifications for the Memory Care Director position. On 2/20/23 at 9:00 a.m., the ED provided a job description, undated, and indicated it was the current job description for the Memory Care unit. A review of the job description indicated "Memory Care Director Position Summary: ...Required Experience for Memory Care Director: Bachelor's degree in gerontology, Health Care Administration or related field ..." This State tag relates to Complaint IN00397266.		the alleged deficient practice. 2. The Community realizes that residents could have had the potential to be affected by the alleged deficient practice. 3. The licensed Health Facility Administrator has been appointed as the Director of the Alzheimer's and Dementia Special Care Unit. The licensed Health Facility Administrator meets the educational requirements holding a Bachelor's degree in Health Facility Administration (Please see exhibit "C"). In addition, the licensed Health Facility Administrator has met the requirement of having earned twelve (12) hours of dementia-specific training (Please see exhibit "D"). In addition, a Standard Operating Procedure has been developed for the Director of the Alzheimer's and Dementia Special Care Unit (Please see Exhibit "E"). 4. The Regional Wellness Director will ensure that the Director of the Alzheimer's and Dementia Special Care Unit receives six (6) hours of dementia-specific training annually thereafter. In addition, should there be a vacancy in this role going forward, a qualified Director of the Alzheimer's and Dementia Special Care Unit will fulfill that	

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			position.	
R 0148 Bldg. 00	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on observation, interview, and record review, the facility failed to provide an environment free from hazards for 2 of 2 days during the survey. Lint was built up in the laundry room and supplies were not locked up. (Laundry room, First floor Electrical closet, First floor Mechanical closet, Fire Control Room, Riley Room, First floor Janitor closet, Second floor Mechanical closet, Second floor Electrical closet, Second floor Housekeeping closet, Second floor Storage room, Third floor Storage room, Third floor Housekeeping closet) Finding includes: 1. During a tour of the facility on 2/17/23 at 10:33 a.m., the laundry room on the first floor was	R 0148	1. No residents were affected by the alleged deficient practice. 2. The Community realizes that residents could have had the potential to be affected by the alleged deficient practice. 3. The systemic change will be that Housekeeping has been delegated the duty of checking all laundry rooms daily Monday through Friday for lint behind the dryers (Please see exhibit "F"). In addition, all of the doors that should be maintained in a locked position to be free of hazards have functioning locks on them and will	03/15/2023

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	observed. The laundry room had 3 dryers. The middle dryer had an area of lint measuring 18 inches by 10 inches. The depth of the area was 2 inches thick. During an observation on 2/20/23 at 11:30 a.m., the laundry room on the first floor was observed. The laundry room had 3 dryers. The middle dryer had area of lint measuring 18 inches by 10 inches. The depth of the area was 2 inches thick. During an interview on 2/20/23 at 11:35 a.m., Housekeeper 4 indicated she did not see the area and stated "I missed it, we usually check that area one time a week." During an interview on 2/20/23 at 11:50 a.m., Maintenance Staff 5 indicated there should not be any lint behind the dryer. During an interview on 2/20/23 at 12:00 p.m., the Executive Director (ED) indicated there should not be any lint behind the dryer. On 2/20/23 at 12:15 p.m., the ED provided a policy titled Standard operating procedure, dated 1/6/21, and indicated it was the current policy being used by the facility. A review of the policy indicated "1. Purpose: The purpose of the laundry equipment ... policy is to ensure inspection of laundry areas/rooms, appliances, and equipment to ensure presentable impression and functionality for residents laundries..." 2. On 2/17/23 from 12:05 p.m. to 12:20 p.m., during a facility tour, with the Administrator, the following was observed on the first floor of the facility: - The electrical closet was located between		be checked daily by the use of an Addendum to the "1440 Walks" (Please see exhibit "G"). All work orders needed generated by the report will be given to the receptionist to generate a work order to the Maintenance Director in our automated system. 4. The "1440 walks" will be reviewed by the Executive Director weekly. Any recommendations will be made to the Safety Committee as identified.	

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	resident rooms 112 and 114. The electrical closet door was observed to be unlocked. Inside the room was an unlocked electrical panel. No staff were visible in the area. - The mechanical closet was located between the maintenance office and the employee lounge. The mechanical closet door was observed to be unlocked. The mechanical closet door lacked a working locking mechanism on the door. Inside the room was a large "Acqua Therm" system tank. No staff were visible in the area. - The fire control room was located between the maintenance office and the memory care door. The fire control room door was observed to be unlocked. Inside the room were multiple pipes, hoses, nozzles, and various machines. No staff were visible in the area. - The Riley Room was located next to the Theater Room and across from the elevator. The Riley Room door was observed to be unlocked. The following items were observed in the room: - two - full one-gallon cans of Kilz All purpose Primer. The label indicated "keep out of reach..." - four various sized metal scrapers - a wooden ladder - two - full 3.5-gallon buckets of Dust Control. The label indicated "keep out of reach..." - one - full 13-ounce can of Mold Blocking primer. The label indicated "keep out of reach..." - one partial bag of Easy Sand. The label indicated "keep out of reach..." No staff were visible in the area. 3. During a follow-up facility tour, on 2/20/23 from 11:30 a.m. to 11:55 a.m., the following was observed:			

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	On the first floor: - The mechanical closet was located between the maintenance office and the employee lounge. The mechanical closet door was observed to be unlocked. The mechanical closet door lacked a working locking mechanism on the door. Inside the room was a large "Acqua Therm" system tank. No staff were visible in the area. - The fire control room was located between the maintenance office and the memory care door. The fire control room door was observed to be unlocked. Inside the room were multiple pipes, hoses, nozzles, and various machines. No staff were visible in the area. - The Riley Room was located next to the Theater Room and across from the elevator. The Riley Room door was observed to be unlocked. The following items were observed in the room: - two - full one-gallon cans of Kilz primer. The label indicated "keep out of reach..." - four various sized metal scrapers - a wooden ladder - two - full 3.5-gallon buckets of Dust Control. The label indicated "keep out of reach..." - one - full 13-ounce can of Mold Blocking primer. The label indicated "keep out of reach..." - one partial bag of Easy Sand. The label indicated "keep out of reach..." No staff were visible in the area. - The electrical closet was located between resident rooms 112 and 114. The electrical closet door was observed to be unlocked. Inside the room was an unlocked electrical panel. No staff were visible in the area. - The janitor closet was located to the left of			

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	resident room 110. The janitor closet door was observed to be unlocked. The following items were observed in the room: - one gallon bottle, ¾ full, of Spic and Span Disinfecting All Purpose Spray and Glass Cleaning agent. The label indicated "keep out of reach..." - one - full 32-ounce bottle of 409 Stone and Steel Cleanser. The label indicated "keep out of reach..." - one - full 9.7-ounce bottle of Pledge Multi Service Cleaner. The label indicated "keep out of reach..." - two - full 32-ounce bottles of Clorox Urine Remover agent. The label indicated "keep out of reach..." - one - 22-ounce bottle, ¼ full, of Resolve Spot and Stain Remover. The label indicated "keep out of reach..." No staff were visible in the area. On the second floor: - The mechanical closet was located between resident rooms 224 and 222. The mechanical closet door was observed to be unlocked. Inside the room was a large "Acqua Therm" system tank. No staff were visible in the area. - The electrical closet door was located between resident rooms 221 and 223. The electrical closet door was observed to be unlocked. Inside the room was a closed electrical panel. No staff were visible in the area. - The housekeeping closet was located between resident rooms 211 and 213. The housekeeping closet door was observed to be unlocked. The following items were observed in the room: - one - gallon bottle, ¾ full, of Shurguard HP - US			

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	Cleanser. The label indicated "keep out of reach..." - one - full 32-ounce bottle of Clorox Urine Remover agent. The label indicated "keep out of reach..." - one - 32-ounce bottle, ¾ full, of Comet Disinfecting and Sanitizing Bathroom Cleaner. The label indicated "keep out of reach..." - one - 32-ounce bottle, ½ full, of 409 Stone and Steel Cleaner. The label indicated "keep out of reach..." - one - gallon bottle, ¾ full, of Fabuloso Professional All Purpose Cleaner and Degreaser. The label indicated "keep out of reach..." No staff were visible in the area. - The storage room was located between resident room 212 and the laundry room. The storage room door was observed to be unlocked. The following items were observed in the room: - one - full 32-ounce bottle of ZEP - Acidic Toilet Bowl Cleaner. The label indicated "keep out of reach..." - one - full 9.7-ounce bottle of Pledge Polish. The label indicated "keep out of reach..." - one - 32-ounce bottle, ¾ full, of Comet Disinfecting and Sanitizing Bathroom Cleaner. The label indicated "keep out of reach..." - five - full one-gallon bottles of Spic and Span Disinfecting All Purpose Spray and Glass Cleaning agent. The label indicated "keep out of reach..." No staff were visible in the area. On the third floor: - The storage room was located to the right of resident room 312. The storage room door was observed to be unlocked. The following items were observed in the room:			

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	- one - full 9.7-ounce bottle of Pledge Polish. The label indicated "keep out of reach..." - one - full 32-ounce bottle of ZEP - Acidic Toilet Bowl Cleaner. The label indicated "keep out of reach..." - one - gallon bottle, ¾ full, of Comet Disinfecting and Sanitizing Bathroom Cleaner. The label indicated "keep out of reach..." - one - full gallon bottle of Spic and Span Disinfecting All Purpose Spray and Glass Cleaning agent. The label indicated "keep out of reach..." - one - full gallon bottle of Fabuloso Professional All Purpose Cleaner and Degreaser. The label indicated "keep out of reach..." No staff were visible in the area. - The housekeeping closet was located across the hall from storage room and near resident room 312. The housekeeping closet door was observed to unlocked. Inside the housekeeping closet a full 32-ounce bottle of Clorox Urine Remover agent was observed. The label indicated "keep out of reach..." No staff were visible in the area. During an interview on 2/17/23 at 12:25 p.m., the Administrator indicated the mechanical room, electrical closet, fire control room, and the Riley Room doors should have been kept locked. During an interview on 2/20/23 at 11:00 a.m., the Administrator indicated there were 46 of 61 residents who did not reside in the facility's secured memory care unit. Of the 46 residents, 3 were self-mobile and were cognitively impaired. During an interview on 2/20/23 at 12:18 p.m., the Life Enrichment Director indicated all housekeeping, mechanical rooms, and electrical room doors were to be kept locked.			

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	During an interview on 2/20/23 at 12:25 p.m., Housekeeper 4 indicated all the housekeeping, mechanical, and electrical room doors were to be kept locked. During an interview on 2/20/23 at 12:30 p.m., the Director of Housekeeping and Maintenance indicated all the housekeeping, mechanical, and electrical room doors were to be kept locked. There were "numerous" doors that lacked a functioning locking system. On 2/20/23 at 1:05 p.m., the Administrator indicated the facility lacked a policy regarding hazardous materials being kept in a secured location.			
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to ensure food was served in a sanitary manner for 4 of 4 kitchen observations. This had the potential to affect 61 of 61 residents residing in the facility who received foods from the kitchen. (Dining Room Manager, Chef 2) Findings include: 1. On 2/17/23 from 9:20 a.m. to 9:50 a.m., the initial kitchen tour with the Dining Room Manager was conducted. The Dining Room Manager was observed walking through out the kitchen area.	R 0273	1. No residents were affected by the alleged deficient practice. 2. The Community realizes that resident could have had the potential to be affected by the alleged deficient practice. 3. Staff have been educated as to food handler's hair having to be restrained and fully covered by hairnets, hats, hair coverings and beard restraints for facial hair. Please see Exhibit "H").	03/15/2023

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	Observed the Dining Room Manager's hair in front of and behind the ears to the neckline area was not covered. Multiple loose hairs behind the ears and below the neckline area, approximately 4 inches in length, were observed to not be covered. 2. On 2/17/23 from 11:00 a.m. to 11:10 a.m., during a follow-up kitchen tour, observed the Dining Room Manager walking through out the kitchen area where the noon meal was being prepared. Observed the Dining Room Manager's hair in front of and behind the ears to the neckline area was not covered. Multiple loose hairs behind the ears and below the neckline area, approximately 4 inches in length, were observed to not be covered. 3. On 2/17/23 from 11:25 a.m. to 11:30 a.m., during a follow-up kitchen tour, observed the Dining Room Manager at the steamtable where the noon meal food starting temperatures were being taken. Observed the Dining Room Manager's hair in front of and behind the ears to the neckline area was not covered. Multiple loose hairs behind the ears and below the neckline area, approximately 4 inches in length, were observed to not be covered. 4. On 2/17/23 from 12:55 p.m. to 1:00 p.m., during a follow-up kitchen tour, observed the Dining Room Manager at the steamtable where the noon meal food ending temperatures were being taken. Observed the Dining Room Manager's hair in front of and behind the ears to the neckline area was not covered. Multiple loose hairs behind the ears and below the neckline area, approximately 4 inches in length, were observed to not be covered. At that same time, observed Chef 2 at the steamtable where the noon meal foods were being		4. The Executive Chef and or Executive Director will ensure this standard is being met by frequent observations on a daily basis. and will be an on-going practice indefinitely. Any negative findings will be corrected and forwarded to the Safety Committee.	

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	02/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
INDEPENDENCE VILLAGE OF GREENWOOD	2339 S STATE ROAD 135 GREENWOOD, IN 46143

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	held. Chef 2's facial hair, approximately ½ inch in length, was observed to not be covered. During an interview on 2/17/23 at 9:15 a.m., the Administrator indicated the facility census was 61. During an interview on 2/17/23 at 11:13 a.m., the Dining Room Manager indicated all residents residing in the facility received food from the kitchen. During an interview on 2/17/23 at 1:05 p.m., the Dietary Manager indicated he was unsure if the facility had a policy regarding hair being covered while in the kitchen. Staff's hair was to be covered while in the kitchen; however, the Dietary Manager was unsure if the facial hair was required to be covered. During a interview on 2/20/23 at 9:30 a.m., the Administrator indicated the facility did not have a policy regarding staff hair being covered while in the kitchen. On 2/17/23 at 3:00 p.m., a review of the Indiana Food Establishment Sanitation Requirements, Title 410 IAC 7-24, effective November 13, 2004, indicated, "...food employees shall wear hair restraints, such as hats, hair coverings or nets...beard restraints...that are designed and worn to effectively keep their hair from contacting...exposed food..."			