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	09/26/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00435470, IN00440010 and IN00442237. Complaint IN00435470-State deficiencies related to the allegations were cited at R0064. Complaint IN00440010-State deficiencies related to the allegations were cited at R0029. Complaint IN00442237-No deficiencies related to the allegations are cited. Survey dates: September 25 and 26, 2024 Facility number: 013297 Residential Census: 56 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-5. Quality review was completed on October 4. 2024.	R 0000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility. This plan of correction is submitted as the facility's credible allegation of compliance.	
R 0029 Bldg. 00	410 IAC 16.2-5-1.2(d) Residents' Rights - Deficiency Based on observation, interview, and record review, the facility failed to ensure a resident was treated with respect and dignity when a staff member "handling the resident inappropriately" during personal care for 1 of 3 residents reviewed for resident rights. (Resident C) Finding includes: A document, titled "Indiana State Department of Health Survey Report System," undated, indicated	R 0029	R29 Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility. This plan of correction is submitted as the facility's credible allegation of compliance.	10/17/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dana Larson	Executive Director	10/17/2024

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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	CNA 1 was witnessed handling Resident C in an inappropriate manner while trying to take her to the toilet. Resident C was refusing to go to the bathroom, while being soaked with urine. CNA 1 did not follow policy and re-approach the resident. She made contact with the resident by "grabbing her arm and taking her to the restroom." CNA 1 was terminated for not following the policy and procedure for resident handling. A written statement by CNA 1, dated 7/30/24, indicated Resident C often refused care when she was "soaked with urine" and she had a history of behavioral issues such as fighting, kicking, scratching and biting staff members every time she needed care. CNA 1 indicated her priority was to make sure residents were clean and dry and free from bed sores or wounds. CNA 1 attempted to change the resident's brief in the bed, but the resident had started kicking and hitting CNA 1. CNA 1 removed her from the bed and transferred her to the wheelchair to transport her to the restroom. She stood the resident up at the grab bars in the bathroom to change her brief and pants, since she was "soaking wet." She gave incontinent care and placed the resident on the toilet as the resident was hitting and biting CNA 1. With her back facing the resident, she placed the resident's clean brief on her, then transferred her back into the wheelchair. Another CNA came into the resident's room to help her, and they placed the resident to bed. CNA 1 knew resident's had rights, but to her it was "abuse" when a resident was soiled with urine or vomit, and she refused care. It did not make any sense to CNA 1 for Resident C to be "looking and smelling like that," to her it was not "healthy." A written statement by CNA 2, dated 7/30/24, indicated CNA 1 asked CNA 2 to assist her. CNA		R29 Residents' Rights Independence Village of Carmel ensures that all residents are treated with consideration, respect, and recognition of their dignity and individuality. The Corrective Actions which were accomplished for those residents who were found to have been affected by the deficient practice. Resident C does not have any recollection of the incident on. She was closely observed following the incident and did not show any signs or symptoms of emotional distress. No other residents were affected. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected. No other residents were identified during the post investigation. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: C.N.A. 1 was terminated and ineligible for rehire. After the incident on 7/30/2024 the facility began its corrective action by holding an in-service on 8/7/2024 on Abuse and residents'	

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	1 informed CNA 2 Resident C was dressed and dry, but the resident fought with her while she was trying to get the resident dressed. CNA 2 then asked the resident if she wanted to go down to breakfast or go back to bed. The resident did not answer fast, which was the normal for her because it took her some time to respond to staff when asked a question. CNA 2 asked her the question again and that was when CNA 1 indicated she was placing her in the bed. When CNA 1 tried the first time to place Resident C in the bed, the resident started fighting back against the CNA. CNA 2 stepped back. CNA 1 kept trying to get Resident C up and the resident was fighting her. CNA 2 then tried to place her in the bed and based off the resident's body language, she did not want to go to bed, so CNA 2 stopped trying. CNA 1 then tried to pick Resident C up by the back of her neck multiple times. The resident continued to fight back against CNA 1, then CNA 1 picked the resident up from under both her arms, put her in her bed, and "threw" her blanket on her. A facility email document from Employee 4, untitled, dated 9/26/24, indicated CNA 1 was terminated from the facility for "Abuse." On 9/26/24 at 2:15 p.m., Resident C was observed on the memory care unit. She would not carry on a conversation and was not able to indicate if she had been mistreated by any staff member. The clinical record for Resident C was reviewed on 9/26/24 at 1:03 p.m. The diagnoses included, but were not limited to, type II diabetes mellitus, chronic kidney disease, and major depressive disorder. The resident's service plan included, but were not limited to, the following services:		rights. The Wellness Director or her designee will monitor staff performance and interview residents to ensure residents are treated with respect and dignity. How the corrective actions will be monitored to ensure the deficient practice will not recure. An ad hoc safety/quality meeting was held with all department leaders to discuss the deficient practice. Any deficiencies noted in internal audits will be addressed at monthly safety meetings Date of Compliance: October 17, 2024	

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	a. Resident C required assistance with communication (extra time, multiple approaches, cue cards, word finding). Care staff should report any changes in the ability for the resident to communicate to the nurse or QMA. b. Resident C required assistance with toileting activity, toileting schedule, and peri care. c. Resident C required reminders for the ability to get in and out of bed, chair and car. Reminders to get out of bed, mealtime, activities, and to go to the restroom. Care Staff should report any changes in her ability to transfer. During an interview, on 9/26/24 at 2:42 p.m., the Scheduler indicated a staff member reported to her another staff member (CNA 1) had aggressively handled Resident C during care. She reported what she had been told to the Director of Nursing (DON). She did not witness the aggressive treatment from CNA 1 herself. A current policy, titled "Abuse, Neglect or Exploitation," dated as last reviewed 6/7/23 and provided by the ED on 9/25/24 at 2:25 a.m., indicated "...Definitions: Abuse-Harm or threatened to an adult's health or welfare caused by another person...Procedure: Abuse, neglect, or exploitation of any resident will not be tolerated...." This citation relates to Complaint IN00440010.			
R 0064 Bldg. 00	410 IAC 16.2-5-1.2(hh) Residents' Rights- Noncompliance Based on interview and record review, the facility failed to ensure a resident's credit card was kept safe and secure during her admission for 1 of 1 resident being reviewed for misappropriation of property. (Resident D)	R 0064	R64 Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider that a deficiency	10/17/2024

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	Finding includes: A document, titled "Indiana State Department of Health Survey Report System," dated 7/12/24, indicated on 5/24/24 at 11:01 a.m., Resident D's brother reported there were unexplained charges on her bank statement. When he arrived to visit his sister, on 5/24/24, he found her debit card was not present in her apartment or purse. The city police department was notified of the missing debit card and the unexplained charges on the resident's bank statement. On 7/11/24, the police notified the Executive Director (ED) that Dietary Server 5 was the employee identified as using Resident D's credit card at the store. Dietary Server 5 was terminated for misappropriation of property. During an interview, on 9/26/24 at 9:45 a.m., the ED indicated she received a call from Officer 7 indicating there was $35.11 charged onto the resident's credit card in one county and $514.38 charged onto her credit card in another county. An untitled and undated document provided by the ED indicated the ED received a call from Officer 7 who indicated Dietary Server 5 had agreed to work with the city Police Department and had identified a second employee (Dietary Server 6), which also had access to Resident D's credit card. After being interviewed and verifying her involvement in the theft of the resident's credit card by Officer 7, Dietary Server 6 was also terminated. A facility email document from Employee 4, untitled, dated 9/26/24, indicated Dietary Server 5 was terminated for "Stole from a resident used a credit card of a person of elder age." Dietary		exists. This response is also not to be construed as an admission of fault by the facility. This plan of correction is submitted as the facility's credible allegation of compliance. R64 Residents Rights Independence Village of Carmel ensures that the facility exercises reasonable care for the protection of residents' property from loss and theft. The Executive Director investigates all reports of lost or stolen resident property and notifies the Division of Long-Term Care. The Corrective Actions which were accomplished for those residents who were found to have been affected by the deficient practice. Resident D did not suffer any emotional effects from the incident. All residents have the potential to be affected. No other residents were affected. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: Upon admission, residents and families are encouraged not to bring valuables of great value, cash or credit cards to the community if the resident is unable to monitor those items. What measures will be put	

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	Server 6 was terminated for "Was under investigation for theft. This was not her first offense." A current policy, titled "Abuse, Neglect or Exploitation," dated as last reviewed 6/7/23 and provided by the ED on 9/25/24 at 2:25 a.m., indicated "...Definitions: Exploitation-Misuse of an adult's funds, property, or personal dignity by another person...Procedure: Abuse, neglect, or exploitation of any resident will not be tolerated...." This citation relates to Complaint IN00435470.		into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: Staff are instructed to report items such as cash and credit cards left unsupervised by the residents to the Executive Director or Wellness Director so the family can be informed. Monthly staff meetings are conducted where abuse and residents' rights are addressed. How the corrective actions will be monitored to ensure the deficient practice will not recure. An ad hoc safety/quality meeting was held with all department leaders to discuss the deficient practice. Any missing resident items would be discussed at morning stand up and the monthly safety meeting. Date of Compliance: October 17, 2024	