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	11/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
INDEPENDENCE VILLAGE OF AVON	182 S COUNTY ROAD 550 E AVON, IN 46123

(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 Complaint IN00421978. Complaint IN00421978 - State deficiencies related to the allegations are cited at R0033. Survey date: November 27, 2023 Facility number: 003902 Residential Census: 92 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on November 30, 2023.	R 0000	ATT: Brenda Buroker Director of Division Long Term Care 2 North Meridian Street Indianapolis, Indiana 46204 Re: Complaint Survey Independence Village of Avon 182 S County Road 550 E Avon, IN 46123 Dear Ms. Buroker, On November 27, 2023, a Complaint survey with complaint no. (IN00421978) and Survey Event ID E2HY11 was conducted by the Indiana State Department of Health. Enclosed please find the Statement of Deficiencies with our facilities Plan of Correction for the alleged deficiency.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Romeo Behl	Executive Director	12/07/2023

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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			Please consider this letter and Plan of Correction to be the facility's credible allegation of compliance. We respectfully request a desk review to ensure that the facility has achieved substantial compliance with the applicable requirements as of the date set forth in the Plan of Correction of December 27, 2023. Please feel free to call me with any further questions at 317-745-2766 Respectfully submitted, Romeo Behl Independence Village of Avon 182 S County Road 550 E Avon, IN 46123	
R 0033 Bldg. 00	410 IAC 16.2-5-1.2(h)(1-2) Residents' Rights - Noncompliance (h) The facility must furnish on admission the following: (1) A statement that the resident may file a complaint with the director concerning resident abuse, neglect, misappropriation of			

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	resident property, and other practices of the facility. (2) The most recently known addresses and telephone numbers of the following: (A) The department. (B) The office of the secretary of family and social services. (C) The ombudsman designated by the division of disability, aging, and rehabilitation services. (D) The area agency on aging. (E) The local mental health center. (F) Adult protective services. The addresses and telephone numbers in this subdivision shall be posted in an area accessible to residents and updated as appropriate. Based on record review and interview, the facility failed to ensure a resident was sent out to the hospital, after receiving a physician's order, causing a delay in treatment for 1 of 3 resident reviewed for quality of care (Resident B). Finding includes: A complaint intake document, dated 11/15/23, indicated Resident B had received a physician's order on 11/14/23 at 4:30 p.m., to be sent out to the hospital due to complaints of abdominal pain and high heart rate. The resident had not been sent out until the morning of 11/15/23, because the nurse had forgotten to call 911 (any situation that requires immediate assistance from the police, fire department, or ambulance) to have the resident transferred out on the afternoon of 11/14/23. Resident B's record was reviewed on 11/27/23 at 11:10 a.m. An admission document, dated 8/9/23, indicated the resident's diagnoses included, but	R 0033	**R033** **Residents' rights and non-compliance** **The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.** **1)Immediate actions taken for those residents identified:** Resident B orders were reviewed and verified for accuracy and QMA	12/27/2023

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	were not limited to, dementia (the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities), history of kidney stones (hard, pebble-like pieces of material that form in one or both of your kidneys when high levels of certain minerals are in your urine), and history of falls. A nurse's note, dated 11/15/23 at 9:00 a.m., indicated a new order had been received from the resident's physician to send the resident to the ER (emergency room) for acute (new onset) abdominal pain and tachycardia (fast heart rate). Emergency Medical Technicians (EMTs) came and transported to the hospital. Wellness Director and power of attorney (POA) were notified. The record lacked any other documentation of a physician's or nursing assessment of the resident's condition prior to the transport. A hospital Admitting History and Physical Note, dated 11/15/23, indicated the resident was unable to provide meaningful history due to dementia. According to the documentation and resident's daughter, the resident had worsening dyspnea for the past 2-3 days. Radiology reports showed a left moderate pleural effusion. Resident was placed on 15 liters high flow nasal cannula and admitted to the progress care unit. The admitting physician ordered a consult for a possible thoracentesis and started intravenous antibiotics and fluids for sepsis with possible empyema. A hospital procedure note, dated 11/16/23, indicated the resident had a left pleural effusion, pulmonary abscess and a image guided chest tube was placed in the left chest.		was educated on following MD orders. **2)How the facility identified other residents:** Any resident residing in the facility had the potential to be affected. An audit completed on all residents with new orders from the last 7 days to make sure that all orders are carried out and notifications have been made to all parties with any changes. **3)Measures put into place/ System changes:** In-service and education provided to all licensed nurses and QMA on following MD orders accurately and to notify POA and document any changes. Don/designee will review all new orders 3 times weekly for 4 weeks and then 2 times weekly x 4 weeks and then one time weekly for 1 months thereafter to ensure orders are carried out accurately and notification has been made to all required and documentation has been done. **4)How the corrective actions will be monitored:** Don/Designee will be responsible for this plan of correction and Audit findings will be presented to the QAA Committee monthly x 6 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will	

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	Hospital lab documents, dated 11/15/23 at 10:06 a.m., indicated the resident's white blood cells (WBC-a part of your immune system that protects your body from infection) count was high. High WBCs are an indication of an infection process in the body. During an interview, on 11/27/23 at 10:39 a.m., the Memory Care Program Director indicated she was not aware of any situation where a resident had an order to be sent out 911 to the hospital and had not been sent until the next day because the nurse had forgotten. The expectation would be that the nurse would act immediately if they received a physician's order to send someone out to the hospital. During an interview, on 11/27/23 at 11:18 a.m. the Assistant Wellness Director indicated there had been an incident where Resident B had a physician's order to be sent out to the hospital, but the staff on duty, Qualified Medication Aide (QMA) 5 had forgotten to send him out. On 11/14/23, the physician was in the building and saw Resident B. The Assistant Wellness Director and QMA 5 were with the physician when he gave the verbal order to send the resident out. It was around 4:30 p.m., or 5:00 p.m. When he arrived at work on the morning of 11/15/23, the staff working on the Memory Care Unit reported to him that the resident had been complaining of abdominal pain. He realized that the resident should have been sent out the evening prior. He immediately contacted 911 and sent the resident out to the hospital. He later spoke with QMA 5, via telephone, and she indicated to him that she had forgotten to send the resident out the evening prior. There had not been any other instances of anything like that happening before to the best of his knowledge. He was unsure of a		identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance:** 12/27/2023	

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	specific policy which would address the situation, but the expectation was that a resident should be transferred to the hospital immediately for evaluation whenever a physician's order is received. During a telephone interview, on 11/27/23 at 1:03 p.m., Resident B's granddaughter-in-law indicated the resident had been sent out to the hospital from the facility. He had been admitted to the hospital and diagnosed with left lobe pneumonia. He was being treated with IV (intravenous-medications administered within a vein) antibiotics (medications used to treat infection conditions) and a chest tube (a flexible plastic tube that is used to drain fluid from the chest) had been placed. The chest tube had been removed just on this date, but he remained on the IV antibiotic. This citation relates to complaint IN00421978.			