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	07/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDEPENDENCE VILLAGE OF ZIONSVILLE	11755 N MICHIGAN RD ZIONSVILLE, IN 46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 a State Residential Licensure Survey. Survey dates: July 6 and 7, 2021. Facility number: 012263 Residential Census: 66 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on July 22, 2021.	R 0000	accepted	
R 0006 Bldg. 00	410 IAC 16.2-5-0.5(f)(1-5) Scope of Residential Care - Deficiency (f) The resident must be discharged if the resident: (1) is a danger to the resident or others; (2) requires twenty-four (24) hour per day comprehensive nursing care or comprehensive nursing oversight; (3) requires less than twenty-four (24) hour per day comprehensive nursing care, comprehensive nursing oversight, or rehabilitative therapies and has not entered into a contract with an appropriately licensed provider of the resident ' s choice to provide those services; (4) is not medically stable; or (5) meets at least two (2) of the following three (3) criteria unless the resident is medically stable and the health facility can meet the resident ' s needs: (A) Requires total assistance with eating. (B) Requires total assistance with toileting. (C) Requires total assistance with			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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	transferring. Based on observation, interview and record review, the facility failed to initiate a transfer discharge for a resident who required 24 hour per day of total care (Resident 40) for 1 of 8 residents reviewed for service plans and scope of care. Findings include: On 7/6/21 at 11:45 a.m., Resident 40 was observed in the dining room during a random dining observation. She was being assisted to eat by a gentleman wearing street clothes. During an interview, at that time, he identified himself as her care giver. He indicated he attended to Resident 40 during the day, Monday through Friday. Resident 40 was not able to be interviewed. She appeared confused and disoriented. She indicated she was 56 years old and was not aware of time and place. Throughout the day on 7/6/21, the care giver was observed pushing Resident 40 around the facility in her wheelchair. On 7/7/21 at 12:10 p.m., Resident 40 was observed in the dining room, with her care giver having lunch. On 7/7/21 at 2:15 p.m., Resident 40 was observed in the activity room, during Bingo with her care giver. On 7/7/21 at 9:15 a.m., Resident 40's medical record was reviewed. The diagnoses included, but were not limited to, progressive supranuclear palsy (a progressive uncommon brain disorder that causes serious problems with walking, balance, and eye movements, and later with	R 0006	R0006 Please reference the enclosed "Plan of Correction for the July 6th and 7th, 2021 Survey" I am respectfully requesting paper compliance for this survey. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the true facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and executed because it is required by the Federal state laws. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident 40 is currently being assessed by Hospice services to see if she qualifies for services. If resident 40 is not admitted to hospice services, the Wellness Director will help family locate an appropriate facility. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? When a resident has a decline in health the Wellness Director will do an assessment to indicate if the resident is appropriate for their current setting. If the resident is no longer in the appropriate setting the Wellness Director will help family place	08/02/2021

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	swallowing). Resident 40 was 87 years old. She had resided at the facility since November of 2018. She had been seen and treated by speech therapy for swallowing difficulty. Resident 40's Service Plan, dated 5/21/21, indicated cognitive evaluation (0, no needs); AM-PM care and showers (0, no needs); Toileting (0, no needs); Dietary (0, no needs); Activities (0, no needs); Laundry (0, no needs); Other (0, no needs); Fall Risk Evaluation (4 needs); Medication Management (1 need); and Ambulation-Mobility-Transfers (2 needs). On 7/7/21 at 11:25 a.m., during an interview the Director of Nursing (DON) indicated Resident 40 required 24-hour continuous care, one on one around the clock, for 7 days a week. She was not on hospice services. The family took care of all the arrangements related to the scheduling of care givers. Resident 40 was not able to transfer or toilet herself. She required assistance with bathing and dressing. Occasionally she would attempt to fed herself, but sometimes she required assistance to eat. She had some days better than others. On 7/7/21 at 12:00 p.m., during an interview the Administrator (ADM) indicated he was not aware of resident's who required 24-hour care could not reside in AL (Assisted Living). On 7/7/21 at 12:17 p.m., the DON provided a current policy, dated 2/22/18, titled, "Resident Evaluation and Service Plan." This policy indicated "The purpose of the Resident Evaluation and Service Plan is to establish a process to evaluate and plan for the resident's needs. The purpose of the service plan is to provide a description of the services that will be provided to the resident based on his or her		resident in appropriate setting. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? All floor staff will be educated on informing the Wellness Director when there is a decline in a resident health and or if the resident is requiring more care than normal, so the Wellness Director can do an assessment to ensure that resident is in appropriate setting. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? If there are any change in condition and or Resident Evaluation and Service Plans to be done Wellness Director will immediately do the assessment and indicate if resident is in the appropriate setting if not Wellness Director will contact the family and MD and help with discharging resident to appropriate setting. This will be completed by August 2, 2021.	

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	individual needs and preferences."			
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 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			

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	by written signature. Based on record review and interview, the facility failed to ensure annual in-service education for resident's rights, dementia, and abuse had been provided for 4 of 5 randomly selected employees. Findings include: On 7/6/21 at 2:30 p.m., 5 randomly selected employee files were reviewed for annual in-service training on resident's rights, dementia, and abuse which should have been completed within the last 12 months. The Driver's record lacked documentation of in-service education for dementia. Qualified Medication Aid (QMA) 8's record lacked documentation of in-service education for dementia. Licensed Practical Nurse (LPN) 9's record lacked documentation of in-service education for resident's rights. Certified Nursing Assistant (CNA) 10's record lacked documentation of in-service education for resident's rights, dementia, and abuse. During an interview on 7/7/21 at 3:00 p.m., the DON indicated, a lot of the education which had been provided was lost during the recent acquisition of a new management company, and the facility could not get records from the previous management company. The facility followed the state rule to provide annual in-service education and maintain the records.	R 0120	R0120 Please reference the enclosed "Plan of Correction for the July 6 and 7, 2021 Survey" I am respectfully requesting paper compliance for this survey. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the true facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and executed because it is required by the Federal state laws. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Staff shall be in serviced educated and trained on resident rights, infection control and prevention, fire prevention, safety, accident prevention, dementia training, medication administration and nursing care. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The Property Administrator and Executive Director will keep track	08/02/2021

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			of nursing personnel's annual 8 hours of in-services and 4 hours for Non nursing personnel. There will also be tracking of 6 hours of dementia training within the first six months of employment and 3 hours annually thereafter for all staff who have contact with residents. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? Home office will send Property Administrator and Executive Director monthly updates on training progression along with links to print off completed trainings for personnel files. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Monthly audits will be completed by Property Administrator and Executive Director to ensure no trainings, education or that are due are missed. The audit will include looking at the next month to prepare for the upcoming due and training. This will be completed by August 2, 2021 and ongoing monthly thereafter.	

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R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on observation, interview, and record review, the facility failed to follow their policy for resident evaluation and Service Plan review for 1 of 8 residents reviewed for service plans (Resident 26).	R 0217	R0217 Please reference the enclosed "Plan of Correction for the July 6th and 7th, 2021 Survey" I am respectfully requesting paper compliance for this survey.	08/02/2021

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	Findings include: On 7/6/21 at 11:45 a.m., Resident 26 was observed and interviewed in his apartment. He indicated he had lived at the facility since November. He was independent with his medications. The facility had completed his Service Plan and evaluation when he moved in. On 7/6/21 at 1:30 p.m., the medical record was reviewed for Resident 26. The diagnoses included, but were not limited to, coronary (heart) artery disease and chronic obstructive pulmonary (lungs) disease. Resident 26's Service Plan was dated 11/30/20. There was an indication of "expired" in red letters on the electronic record. On 7/7/21 at 11:25 a.m., during an interview, the Director of Nursing indicated Resident 26's Service Plan was expired. It should have been updated in May. The facility should have completed a service plan every 6 months, on each resident. On 7/7/21 at 12:17 p.m., the DON provided a current policy, dated 2/22/18, titled, "Resident Evaluation and Service Plan." This policy indicated, "The purpose of the Resident Evaluation and Service Plan is to establish a process to evaluate and plan for the resident's needs. The purpose of the service plan is to provide a description of the services that will be provided to the resident based on his or her individual needs and preferences."		Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the true facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and executed because it is required by the Federal state laws. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident 26 service plan has been reviewed and completed. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The Wellness Director will keep track of the due Resident Evaluation and Service Plan. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? The Wellness Director will check the Evaluation Center daily to ensure there are no due Resident Evaluation and Service Plans and if any are due Wellness Director will complete. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Weekly audits will be completed	

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			by Wellness Director to ensure no Resident Evaluation and Service Plans are due or missed. The audit will include looking at the next month to prepare for the upcoming due Resident Evaluation and Service Plans. This will be completed by August 2, 2021.	
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on observation, interview, and record review, the facility failed to ensure a resident's advance directive preferences were updated and matched in the resident's medical record for 1 of 7 residents reviewed (Resident 1). Findings include: On 7/6/21 at 10:58 a.m., Resident 1 was	R 0356	R0356 Please reference the enclosed “Plan of Correction for the July 6th and 7th, 2021 Survey” I am respectfully requesting paper compliance for this survey. Preparation and/or execution of this plan of correction does not constitute admission or agreement	08/02/2021

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	observed. She was sitting upright in a recliner chair in her apartment as she watched TV She was observed to wear an oxygen nasal canula. On 7/7/21 at 2:36 p.m. a comprehensive record review of Resident 1's record was completed. An admission POST (physician order for scope of treatment) form indicated Resident 1's code status was "full code" and CPR (cardio pulmonary resuscitation) should be performed if needed but was not signed by the physician. An updated POST form, dated 2/8/19, indicated Resident 1's code status and advance directive preferences changed to DNR, it was signed by a physician. The electronic health record, and current face sheet report indicated Resident 1 was still a CPR/full code status. On 5/28/21 she had been re-admitted to the facility with new physician orders which included the specification of her Code Status as "DNR" (do not resuscitate). On 7/7/21 at 10:00 a.m., during a follow up interview with Resident 1, she indicated, her advance directive preference was to not end up hooked up to a lot of machines and be left in a hospital bed. If it was her time to go, she wanted to go. During an interview on 7/7/21 at 12:00 p.m., Resident 1's POA (power of attorney) indicated, Resident 1 should definitely be a DNR. Resident 1 and her family talked about it several years ago, and Resident 1 made it very clear she never wanted to be hooked up to machines and die in a		by the provider of the true facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and executed because it is required by the Federal state laws. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident 1 code status has since been updated in computer and on face sheet. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? When a resident has a new order for a code status change it will be immediately changed in computer, face sheet and order placed in computer. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? All code status orders will be double checked by the Wellness team to ensure the code status is placed in chart, computer, and face sheet. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Wellness Director will do monthly audits to ensure all the residents	

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	hospital. When Resident 1 first arrived at the facility she may have been a full code, but the POA indicated a distinct memory of singing an updated copy for a DNR. On 7/7/21 at 1:25 p.m., the Director of Nursing, (DON) provided a copy of current facility policy titled, "Living Will/Advance Directives," dated 9/27/11. The policy indicated, "... Residents will be given the option of completing a Living Will or Advance Directive if they have not already done so... Advance Directives allows the resident to ask for no life saving measures without the need for a terminal diagnosis...."		code status is accurate in computer, charts, and face sheet. This will be completed by August 2, 2021	
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on record review and interview, the	R 0410	R0410	08/02/2021

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	facility failed to ensure a two-step PPD, (purified protein derivative) Mantoux Tuberculin skin test (a skin test is performed by injecting a small amount of fluid [called tuberculin] into the skin on the lower part of the arm) was performed for a resident upon their admission, and failed to ensure a second step PPD was placed for a resident after their admission for 2 of 7 residents reviewed (Residents 72 and 37). Findings include: 1. On 7/7/21 at 10:00 a.m., a comprehensive record review for Resident 72 was completed. Resident 72 was admitted on 4/23/21. A document titled, "Resident TB/Immunization Record" was included in an admission packet but was blank. During an interview on 7/7/21 at 2:45 p.m., the Director of Nursing, (DON) indicated, she could not find documentation of Resident 72's admission PPD test. The nurse who administered the test was on vacation, and the records could not be located. Ideally, the records should have been recorded on the TB form in the resident's hard chart, but it had not been. 2. On 7/6/21 at 2:00 p.m., a comprehensive record review for Resident 37 was completed. Resident 37 was admitted on 1/4/21. A document titled, "Resident TB/Immunization Record," was included in an admission packet and the first step PPD was recorded. The first step skin test had been placed on Resident 37's right forearm on 1/4/21 and read as "negative" on		Please reference the enclosed "Plan of Correction for the July 6th and 7th, 2021 Survey" I am respectfully requesting paper compliance for this survey. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the true facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and executed because it is required by the Federal state laws. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident 37 was discharged from facility. Resident 72 was given the second step PPD and was entered into the computer on ALIS but not documented on paperwork in chart yearly TB test was noted in computer given on 3/23/2021. Once you place new TB information the old TB information will be deleted in computer. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? When the facility has a new admission the PPD information will be placed on MAR and in chart. What measures will be put into place or what systemic changes the facility will make to ensure that	

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	07/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	1/6/21. The second step was not recorded. During an interview on 7/7/21 at 9:19 a.m., the DON indicated the electronic health record system did not keep a full record of the TB skin tests. The only record she could locate was the date of the last placed PPD. When a new test was entered into the system, it did not keep the previous date. The system also did not allow input of other information such as: the name of the staff person who placed the PPD, the lot number, the expiration date of the solution, or date and result of the second test. Moving forward all PPDs would need to be recorded on paper to ensure appropriate record keeping could be maintained. During an interview on 7/7/21 at 9:30 a.m., the DON indicated, the facility followed the state rules for the administration of admission and annual PPD testing.		the deficient practice does not recur? The first and second step PPD will be placed on new admission paperwork so it can appear on MAR and placed in chart as well. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Wellness Director and nursing staff will check orders to ensure it is on MAR and written visibly in chart. This will be completed by August 2, 2021.	