STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155472	A. BUILDING 00 B. WING	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HOOSIER VILLAGE	9875 CHERRYLEAF DR INDIANAPOLIS, IN 46268

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a Non-Certified Comprehensive (NCC) Licensure Survey. This visit included a State Residential Licensure. Survey dates: May 5, 6, 7, 8 and 9, 2025. Facility number: 000548 Provider number: 155472 Census Bed Type: SNF: 10 NCC: 52 Residential: 245 Total: 307 Census Payor Type: Medicare: 6 Private: 4 Total: 10 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 15, 2025.	F 0000	The submission of this Plan of Correction is not an admission by Hoosier Village that the facility has provided anything less than high-quality care to its residents. Rather, we view this process as part of our ongoing commitment to excellence and continuous improvement. Hoosier Village values its partnership with the Indiana Department of Health and other regulatory agencies. We believe that all feedback is an opportunity for growth, and we take it seriously. We remain fully committed to evaluating our practices and allocating the necessary resources to enhance outcomes and ensure the highest standard of care for our residents. In accordance with regulatory requirements, we respectfully submit the following Plan of Correction:	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive, person-centered care plan related to falls, intrusive wandering, and elopement for 1 of 5 residents (Resident 5) reviewed for care plan implementation.	F 0656	1. Although there was a fall risk care plan developed, and there was a wander guard mentioned in the care plan, there was not a specific care plan developed for his resident #5's overall elopement risk. Resident #5: A	06/06/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mindy Kantz	RN, Executive Director	05/30/2025

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	Findings include: On 5/5/25 at 11:04 a.m. Resident 5 was observed as he was walking into his room after his shower. He had a wander guard (a bracelet sensor used to prevent elopement) on his right wrist. Resident 5's son indicated his father had advanced Alzheimer's and was on hospice. On 5/7/25 at 10:33 a.m. Resident 5's medical record was reviewed. He was a long-term care resident whose diagnoses included but were not limited to Alzheimer's disease and dementia. A fall risk evaluation note, dated 3/29/25, indicated the Resident had 1 to 2 falls in the past three months. A nursing progress note, dated 4/1/25, indicated Resident 5 was observed walking out an exit door. An unknown staff member followed the Resident outside and asked where he was going. He explained he was trying to find a group that gets together weekly but was not sure where to go. The unknown staff member notified the nurse and was given a wander guard to put on the Resident. A health status note, dated 4/11/25, indicated at 10:55 a.m. Resident 5 had a fall. He was found face down on the floor by the A-wing nurse's station, with his hands between the floor and his forehead. The note indicated another staff member saw him lose his footing and tried to get to him in time before he fell, but was unable to get to him in time. A behavior note, dated 4/14/25, indicated the resident refused to go to his room and was attempting to enter other residents' rooms and administrative offices.		comprehensive, person-centered care plan was immediately developed and implemented to address all identified needs, preferences, and goals. This was completed in collaboration with the resident, their family, and the interdisciplinary team. All corrections were completed by 05/12/2025. 2. The Director of Nursing (DON) or designee conducted an audit of all residents admitted within the past 30 days to ensure that a comprehensive care plan for fall risk and elopement risk had been developed and implemented in accordance with regulatory timeframes. Any care plans found to be incomplete or delayed in regard to fall risk and elopement risk were immediately corrected and updated to meet federal requirements. 3. a. The facility's Care Plan Policy was revised to require: -Mandatory interdisciplinary care plan meetings within 7 days of comprehensive MDS completion. -Use of a structured care plan checklist to ensure that all relevant areas (e.g., ADLs, psychosocial status, medication use, and risk areas such as falls and elopement) are addressed. b. Staff training was conducted on 05/14/2025 and included education on: -Regulatory requirements for person-centered care planning	

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	A health status note, dated 4/22/25, indicated Resident 5 was restless, pacing and going into other residents' rooms after dinner. A behavior note, dated 4/30/25, indicated Resident 5 was wandering, going into other residents' rooms, moving things out of his room to the hallway, and exit seeking. A health status note, dated 5/1/25, indicated Resident 5 was up throughout the night intermittently roaming the halls indicated he had work to do. The note indicated the Resident walked to the front doors and tried to go outside. Resident 5's care plans were reviewed and lacked documentation of a care plan with interventions related to falls, elopement, or intrusive wandering. On 5/9/25 at 9:50 a.m., the Director of Nursing (DON) provided a copy of a current facility policy titled, "Comprehensive Care Plans," undated. This policy indicated, " ... it is the policy of this facility to develop and implement A comprehensive person-centered care plan for each resident ... other factors identified by the interdisciplinary team or in accordance with the residence preferences will also be addressed in the plan of care ... 3. The comprehensive care plan will describe at minimum the following: ... e. Resident specific interventions that reflect the resident's needs ...." 3.1-35(a)		under §483.21(b). -Timely development, implementation, and review of care plans. -Documentation best practices and accountability expectations. 4. a. The DON or designee will conduct weekly audits of all newly developed or revised care plans for a period of 8 weeks to ensure: Fall risk and elopement risk have been addressed in all care plans where appropriate; Each care plan is individualized and resident-specific; Implementation is timely and properly documented. b. Audit findings will be reviewed at the facility's monthly Quality Assurance and Performance Improvement (QAPI) Committee meetings to monitor compliance and identify any further needed interventions. c. Following the 8-week audit period, monthly random audits will continue for an additional 4 months to validate sustained compliance. These will also be reviewed at the facilities monthly Quality Assurance and Performance Improvement (QAPI) Committee meetings to monitor compliance and identify any further needed interventions.	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision			

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	Based on observation and record review, the facility failed to review and revise a care plan for 1 of 5 residents (Resident 9) reviewed for care plan revision. Findings include: On 5/5/25 at 11:04 a.m., Resident 9 was observed as he was walking out of the bathroom with his son. The Resident's son indicated his father had advanced Alzheimer's disease and would often forget his walker when he got up to go to the bathroom. On 5/7/25 at 12:02 p.m., Resident 9's medical record was reviewed. He was a long-term care resident whose diagnoses included but were not limited to displaced fracture of the base of the femur neck and an unspecified fall. An admission summary note, dated 2/20/25, indicated Resident 9 had a left hip fracture, was able to walk with assistance by staff, was alert to person but not to place or time, he was confused and needed to be cued. An incident note, dated 2/23/25, indicated an unknown Certified Nursing Assistant (CNA) notified an unknown Licensed Practical Nurse (LPN) that the CNA observed Resident 9 on the floor next to his bed on floor mat. Resident 9 stated he was trying to go to the restroom. An incident note, dated 2/25/25, indicated an unknown CNA found Resident 9 on the floor of his bedroom. The resident indicated he had to go to the bathroom. An incident note, dated 2/28/25, indicated Resident 9 was found next to the toilet sitting on	F 0657	1. Although there was a fall risk care plan developed with fall interventions, there was not a specific care plan developed for resident #9's tendency to ambulate without his walker to the restroom. Resident #9: The care plan was reviewed and revised to reflect recent changes in condition including resident's bathroom habits and his tendency to walk without assistance or his walker due to being unaware of his safety needs. All updates were completed and communicated to the interdisciplinary team by 5/12/2025. 2. The Director of Nursing (DON) or designee conducted a facility-wide audit of care plans for all residents with recent comprehensive or significant change MDS assessments (within the last 30 days). Any care plans not developed or revised in accordance with regulatory timeframes were immediately corrected. 3. a. The Care Plan Policy was reviewed and revised to emphasize: Mandatory care plan revision following any status change (e.g., hospitalization, new diagnoses, fall, weight change). b. All licensed nurses, MDS coordinators, and interdisciplinary team members received training on 5/14/2025 covering: Timing requirements for care plan completion; Triggers for care plan	06/06/2025

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	the floor. A behavior note, dated 3/1/25, indicated an unknown staff member witnessed Resident 9 walking without his walker attempting to go to the bathroom. A behavior note, dated 3/2/25, indicated an unknown staff member overheard Resident 9 talking loudly in his room. Upon investigation, Resident 9 was observed as he sat at the foot of his bed, grabbing his walker. He indicated he had to urinate right now. An incident note, dated 3/4/25, indicated Resident 9 was observed as he sat in the restroom doorway on the floor. The resident walked himself to the restroom without assistance or assistive devices. A behavior note, dated 3/6/25, indicated an unknown staff member witnessed Resident 9 up walking with walker. When the unknown staff member asked the resident what he was doing, the resident indicated he had to urinate. A behavior note, dated 3/7/25, indicated Resident 9 was observed as he attempted to transfer himself. The resident indicated he needed to go to the bathroom. A health status note, dated 3/12/25, indicated Resident 9 was heard talking to himself in his room. Upon entering the room, the Resident was observed as he attempted to walk unassisted to the bathroom. A behavior note, dated 3/16/25, indicated Resident 9 was heard talking to himself in his room. The Resident was observed as he attempted to walk by himself to the bathroom.		revision (clinical and psychosocial); Documentation and communication processes. 4. a. The DON or designee will conduct weekly audits for 8 weeks to ensure: Timely development of care plans after MDS assessments; Prompt revisions following resident condition changes. b. Audit results will be reported quarterly to the Quality Assurance & Performance Improvement (QAPI) Committee. After 8 weeks, random audits will be conducted monthly for an additional 4 months.	

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	A behavior note, dated 3/30/25, indicated Resident 9 was observed as he walked by himself out into the hallway with the use of his walker. The Resident indicated he was trying to park his walker out in the common area. An unknown staff member offered to assist the resident to the bathroom and the resident accepted. A health status note, dated 4/2/25, indicated an unidentified CNA observed Resident 9 as he sat on the floor against the closet cabinets. He indicated he was trying to walk to the bathroom. A behavior note, dated 4/13/25, indicated Resident 9 was observed as he was seated on the edge of his bed, attempting to get up to go to the bathroom. The resident indicated he needed to urinate. A behavior note, dated 4/18/25, indicated Resident 9 was attempting to walk by himself to the bathroom. A care plan titled, "Falls," indicated Resident 9 was at risk for falls. The care plan was initiated 2/21/25 and it was last revised 4/29/25. The interventions for this care plan were as follows: "anticipate the needs of the resident" dated 2/21/25, "Be sure the residents call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance." Dated 2/21/25, "encourage limited soda consumption in evening." Dated 2/26/25, "encourage resident to get ready for bed prior to day shift departure." Dated 4/3/25, "encourage resident to toilet with assistance upon arising, before and after meals and as needed." Dated 2/24/25, "Encourage resident to wear appropriate nonskid footwear			

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	when ambulating or mobilizing in wheelchair." Dated 2/21/25, "encourage to keep walker to be kept within Resident 9's reach." Dated 4/30/25, "follow facility fall protocol." Dated 2/21/25, "offer 1 on 1 activities to keep resident in sight as needed." Dated 4/30/25, "evaluate and treat as ordered or as needed." Dated 2/21/25. Upon review of the rest of Resident 9's care plans, there was no care plan that indicated anything about the Residents bathroom habits or his tendency to walk without assistance or his walker. 3.1-35(c)(1)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI Based on observations, interviews and record reviews, the facility failed to complete the proper testing to confirm an infection was present before putting a resident (Resident 5) on an antibiotic. This deficient practice affected 1 of 1 Resident's reviewed for bowel and bladder concerns. Findings include: On 5/7/25 at 10:33 a.m. Resident 5's medical record was reviewed.He was a long-term care resident whose diagnoses included but were not limited to Alzheimer's disease and dementia. A health status note, dated 3/29/25, indicated Resident 5 had a foley (an anchored urinary catheter). A health status note, dated 4/1/25, indicated Resident 5 pulled out his catheter around 3:40 a.m. A health status note, dated 4/2/25, indicated	F 0690	1. Educated hospice provider nurses on antibiotic stewardship and updated process so that hospice provider nurses can no longer order an antibiotic without it being approved by nursing management. 2. The DON or designee conducted a 30-day retrospective review of all residents who were initiated on antibiotic therapy for suspected urinary tract infections (UTIs). Each case was evaluated to confirm that appropriate laboratory testing (urinalysis and/or urine culture) and documentation of clinical symptoms were present. Hospice provider has been educated on antibiotic stewardship and can no longer order an antibiotic without it being approved by nursing	06/06/2025

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	Resident 5 started an antibiotic today for a Urinary Tract Infection (UTI). Resident 5's laboratory results were reviewed, and it was found that there was no urinalysis (UA) or culture and sensitivity (CNS) done on this resident. On 5/7/25 at 1:20 p.m. the Health Care Administrator provided copies of hospice notes for Resident 5. A hospice note, dated 4/1/25, indicated Resident 5's son indicated the resident pulled out his foley catheter early that morning. The note indicated at the time of that note the Resident was complaining of pain when urinating. The catheter was not replaced. The note indicated Resident 5's son was concerned about a possible UTI. There was no strong odor to urine, and no color change to urine at that time. The hospice note indicated the resident's son was educated on pain with trauma. The resident's son indicated he would like to talk with the case manager about potentially getting a urine sample if the nurse felt it was needed. A hospice note, dated 4/2/25, indicated Resident 5 had no longer complained of painful urination and there were no signs of pain or distress. The note indicated a new order for Macrobid (an antibiotic used to treat UTIs) was received for possible UTI. The note indicated the writer reviewed that the pain was most likely from the resident pulling out his catheter. During an interview on 5/7/25 at 1:25 p.m., the Director of Nursing (DON) indicated hospice put Resident 5 on an antibiotic after the Resident pulled his catheter out. She indicated that no UA		management. 3. a. The facility's Antibiotic Stewardship Policy was reviewed and revised to include the following updates: -Urinalysis and/or urine culture should be obtained prior to the initiation of antibiotic therapy unless emergent treatment is clinically justified. -Documentation should reflect the presence of clinical indications consistent with McGeer Criteria (e.g., fever, suprapubic pain, acute mental status change). b. Staff education was completed on 05/14/2025 and included: -Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) were educated on appropriate assessment and documentation of UTI symptoms. -Providers and Nurse Practitioners were educated on evidence-based protocols for initiating antibiotic therapy. 4. a. The DON or designee will conduct weekly audits for 8 weeks of all new antibiotic orders for suspected UTIs to ensure: -Lab testing was completed prior to antibiotic initiation (unless clinical urgency was documented). -Documentation supports the diagnosis and treatment rationale. b. Audit results will be reviewed during the facility's quarterly Quality Assurance and Assessment (QA&A) Committee	

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	or CNS was completed before, during or after putting the resident on an antibiotic. During the survey entrance conference on 5/5/25 at 9:15 a.m., a copy of the facility's infection prevention and control program was requested and provided by the Administrator. The policy was undated and titled, "Antibiotic Stewardship Program." The policy indicated, "It is the policy of this facility to implement an Antibiotic Stewardship Program as part of the facility's overall infection prevention and control program. The purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use ... nursing staff shall assess residents who are suspected to have an infection and notify the physician. Laboratory testing shall be in accordance with current standards of practice ...." 3.1-41(a)(1)		meetings. After the initial 8-week period, random audits will continue monthly for an additional four months to verify ongoing compliance and effectiveness of interventions.	
F 9999 Bldg. 00	3.1-41 URINARY INCONTINENCE (a) Based on the resident's comprehensive assessment and care plan, the facility must ensure the following: (2) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This state rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure a resident, (Resident 38) received a urinalysis for targeted treatments for a suspected urinary tract infection (UTI) for 1 of 3	F 9999	1. a. Resident #38: Educated hospice provider nurses on antibiotic stewardship and updated process so that hospice can no longer order an antibiotic without it being approved by nursing management. b. Resident #38: Resident was on a wide bed with a wide mattress. There was no gap between mattress and side rails, however the mattress was immediately adjusted to eliminate the gap between the head of the bed and the headboard with a	06/06/2025

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	residents reviewed for UTIs. Findings include: During an interview on 5/6/25 at 10:23 a.m., the Director of Nursing (DON) and Assistant Director of Nursing (ADON) provided the facility's Infection Control and Prevention binder for review. The DON indicated each month infections were mapped out and tracked to help identify any trends to help prevent the spread of infection. If residents experienced signs or symptoms of infection, the nurse would notify the doctor and use McGeer's criteria (a set of clinical guidelines used in long-term care facilities to identify potential infections and guide antibiotic use). For example, if a resident was suspected of having a UTI, they would order a urinalysis to determine if there was evidence of an infection and send for a culture to identify the type of bacteria so that the antibiotic which would be prescribed would be targeted and effective for that infection. On 5/6/25 at 9:17 a.m., Resident 38's medical record was reviewed. She was a long-term care resident with diagnoses which included, but were not limited to, repeated falls and Progressive Supranuclear Palsy ([PSP], is a rare, progressive brain disorder that affects movement, including eye movement, and causes dementia. It is characterized by difficulty with eye movements, particularly looking up or down, and can also lead to problems with balance and coordination). Resident 38 had a physician's order, dated 3/27/25, which indicated she was admitted to hospice and to discontinue all labs and therapies. A nursing progress note, dated 4/14/2025 at 7:52 p.m., indicated Resident 38's husband informed		mattress gap filler and securing blankets. A new headboard was ordered immediately and installed upon delivery. Bed safety assessment was completed, and the care plan was revised. c. Resident #38: Although seatbelt had been used in the past, the seatbelt was no longer in use at the time of tag. d. Residents affected had a side rail assessment completed to ensure side rails are appropriate. 2. a. A facility-wide inspection of all beds was conducted. Any mattresses with gaps or safety risks were corrected using appropriate safety devices. Bed safety assessments completed for all residents with cognitive impairment or bedbound status. b. A list of all residents using motorized scooters or adaptive wheelchairs was reviewed. Devices were inspected for functionality and proper safety belt use. Residents were evaluated for cognitive/functional capacity. Care plans were updated as needed. c. Hospice provider has been educated on antibiotic stewardship and can no longer order an antibiotic without it being approved by nursing management. d. A complete audit with all residents with side rails was conducted to verify clinical indication, proper assessment, and documented consent.	

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	the nurse that she had spelled out "UTI" on her communication board. The Hospice nurse and Nurse Practitioner gave new orders to start an antibiotic course. The record lacked documentation that Resident 38 had any other signs or symptoms of an infection and lacked documentation that the antibiotic would be ordered for comfort measures. During an interview on 5/8/25 at 10:00 a.m., the DON indicated they should have probably gotten a urinalysis for Resident 38 to be sure they were using an appropriate antibiotic for the infection but because she was on hospice, the DON followed her hospice orders. During the survey entrance conference on 5/5/25 at 9:15 a.m., a copy of the facility's infection prevention and control program was requested and provided by the Administrator. The policy was undated and titled, "Antibiotic Stewardship Program." The policy indicated, "It is the policy of this facility to implement an Antibiotic Stewardship Program as part of the facility's overall infection prevention and control program. The purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use ... nursing staff shall assess residents who are suspected to have an infection and notify the physician. Laboratory testing shall be in accordance with current standards of practice ...." 3.1-45 ACCIDENTS (a) The facility must ensure the following: (1) The resident's environment remains as free of accident hazards as is reasonably possible.		3. a. Bed Safety Policy was revised to require safety assessments: On admission; quarterly; After any bed change or concern is reported. b. All nursing staff were in-serviced on mattress/headboard safety, bed system risks, and CMS bed safety guidance (completed on: 5/14/2025). c. Scooter Safety Policy was revised to: Require quarterly safety evaluations; Ensure proper seatbelt use and operational safety; Mandate staff observation of scooter use in high-traffic areas. d. - All staff re-educated on safe scooter supervision and redirection protocols (completed on: 5/14/2025). -The facility's Antibiotic Stewardship Policy was reviewed and revised to include the following updates: uranalyis and/or urine culture should be obtained prior to the initiation of antibiotic therapy unless treatment is clinically justified; Documentation should reflect the presence of clinical indications consistent with McGeer Criteria (e.g., fever, suprapubic pain, acute, mental status change). - Licensed staff received in-service training on updated policy emphasizing assessment requirements, documentation, and alternative safety interventions. Training completed 5/14/25.	

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	This state rule was not met as evidenced by: Based on observation, interview, and record review, the facility failed to identify and prevent the potential for entrapment between a gap in the mattress and bedframe for a resident who had a history of falling out of bed, and failed to ensure that resident had appropriate assessments and ongoing safety monitoring for a seatbelt utilized in a motorized scooter for 1 of 5 residents reviewed for accidents (Resident 38) and the facility failed to accurately document the use of assist bars on a side rail assessment for 4 of 5 residents reviewed for accidents (Residents 39, 18, 26, and 25). Findings include: 1. On 5/5/25 at 11:00 a.m., Resident 38 was observed. She was seated in a recliner chair with her feet elevated. Her husband was with her for a visit. She was unable to have a conversation but could answer yes/no questions. Her husband indicated she had some minor confusion here and there, but overall was cognitively intact and could make her needs and wishes known. She used a communication board to spell out or point to items pictured. Resident 38's husband indicated, the only concern he had, and Resident 38 shared, was that the covers to her bed's headboard and footboard were missing for some reason, and he was worried that she would hurt her hand or feet on the metal bars and bolts that were exposed because she experienced frequent and major jerking/kicking motions due to her medical condition. Resident 38's bed was observed. The headboard and footboard were missing covers, and the metal		4. -The DON or designee will perform: Weekly audits for 8 weeks of 10% of facility beds for entrapment risks; Weekly audits for 8 weeks of scooter use to ensure safety compliance - Audit results will be reviewed during monthly QA&A Committee meetings. -After 8 weeks, audits will be conducted monthly for an additional 4 months. -The Director of Nursing (DON) or their designee will review side rail assessments regularly to ensure they are current and accurately reflect each resident's appropriate use of side rails. -The DON or designee will conduct weekly audits for 8 weeks of all new antibiotic orders for suspected UTIs to ensure: Lab testing was completed prior to antibiotic initiation (unless clinical urgency was documented); - Audit results will be reviewed during the facility's quarterly Quality Assurance and Assessment (QA&A) Committee meetings. After the initial 8-week period, random audits will continue monthly for an additional four months to verify ongoing compliance and effectiveness of interventions. ="" div="">	

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	bars and bolts that were a part of the frame were exposed on the side of the mattress. There was also a large gap noted between the headboard and the mattress edge. Resident 38's husband indicated, it had been like that since they had gotten her a new larger mattress for when her jerking/kicking was at its worst, so she could have more room. She could kick/jerk and wind up all over the bed, and often her kicks would roll her over and off the edge of the bed. If she ended up kicking herself sideways in the bed, her husband indicated he could see the potential that she may roll into the gap and become trapped. On 5/7/25 at 10:20 a.m., Resident 38 was observed seated in her recliner chair. Certified Nursing Aide (CNA) 3 indicated she was sitting with Resident 38 one on one as a new intervention since Resident 38 had repeated falls from her recliner and was not to be left alone when she was up in her chair. CNA 3 indicated Resident 38's bed had a gap between the mattress and frame for a long time, and they used to put a body pillow in the gap to keep her from falling into it. Because of her unpredictable movements, she could move and shift herself all over the bed, and it was dangerous to have the gap in case she scooted up too far and got trapped. On 5/7/25 at 10:53 a.m., the Maintenance Director observed Resident 38's bed. He measured the gap between the head of the mattress and frame to be 6 and a half inches. He indicated that the gap was too big and could potentially be dangerous for a resident if they were to become entrapped. He indicated he would find headboard and footboard covers and investigate how to fix the gap. On 5/7/25 at 11:00 a.m., the Executive Director (ED), Administrator (ADM), and Director of			

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	Nursing (DON) joined the Maintenance Director in Resident 38's room to observe the bed. The ED indicated Resident 38 would most likely not be able to push herself up in bed far enough to cause herself to become trapped because her uncontrolled movements were more of a forward lurch. The ADM indicated Resident 38 had jerking/kicking motions, but the majority of her fall were from her recliner chair and the ADM did not believe she would be able to get herself high enough on the bed to become entrapped. The ED indicated because of her kicking/jerking movements in bed, the Interdisciplinary (IDT) team had decided to get her an extra large mattress to give her more space. On 5/5/25 at 11:00 a.m., Resident 38 was observed. She was seated in a recliner chair with her feet elevated. Her husband was with her for a visit. There was a motorized scooter chair in the room. Resident 38's husband indicated she was not able to use the chair any longer and that made her upset because she did not like the new wheelchairs she needed. There was a seatbelt on the scooter and Resident 38's husband indicated, it was put on the scooter to keep her from falling forward when she used it, and then the seatbelt was moved to a high back wheelchair which didn't work well because she was unable to use her left hand and had difficulty taking the seatbelt on and off. On 5/6/25 at 9:17 a.m., Resident 38's medical record was reviewed. She was a long-term care resident with diagnoses which included, but were not limited to, repeated falls and Progressive Supranuclear Palsy ([PSP], is a rare, progressive brain disorder that affects movement, including eye movement, and causes dementia. It is characterized by difficulty with eye movements,			

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	particularly looking up or down, and can also lead to problems with balance and coordination). The record lacked documentation of when or why Resident 38 was provided with an extra large mattress, for what purpose it served and/or if she was safe to be on that mattress. The record lacked documentation or when or why Resident 38 required a seatbelt for her motorized scooter, for what purpose it served and/or if she was safe and able to utilize the seatbelt appropriately. The record lacked documentation if the seatbelt was still available and/or in use. A nursing progress note dated 3/31/25 at 7:36 p.m., indicated, Resident 38 had been heard yelling and was found on the floor still strapped into her electric wheelchair with her seatbelt in place. The nurse did not find any apparent injuries and the immediate intervention put into place at that time was to ensure supervision at all times when she was up in her wheelchair. The record lacked documentation of a referral to therapy for re-evaluation of Resident 38's ability and safety awareness for appropriate use and capabilities of self-release. Resident 38 had a comprehensive care plan initiated on 11/7/22 and most recently revised on 4/16/25. The care plan indicated she was a high risk for falls related to gait/balance problems, Incontinence and poor communication/comprehension. Interventions for this plan of care included, but was not limited to, "seat belt to remain on when up in motorized wheelchair, release every two hours." The care plan lacked revision to indicate if this intervention was still current or had been discontinued due to			

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	her inability to use her electric chair any longer. On 5/8/25 at 10:00 a.m., the DON indicated the mattress headboard and footboard should be covered to prevent the potential for injury, and the Maintenance Director was working on correcting the gap between the mattress and frame. At this time she also provided a copy of current, but undated facility policy titled, "Accidents." The policy indicated, " ...The resident's environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive device to prevent accidents. This includes: 1. Identifying hazard(s) and risk(s). 2. Evaluating and analyzing hazard(s) and risk(s) ... observing and identifying potential hazards in the environment, while taking in consideration the unique characteristics and abilities of each resident ...." On 5/8/25 at 10:00 a.m., the DON indicated, they did not have a specific policy related to the use of seatbelts, but provided a copy of current, but undated facility policy titled, "Restraint Free Environment." The policy indicated, "It is the policy of this facility that each resident shall attain and maintain his/her highest practicable well-being in an environment that prohibits the use of physical or chemical restraints ...."2. On 5/5/25 at 10:53 a.m., Resident 39's bed was observed. He had assist bars on both sides of his bed. On 5/7/25 at 10:30 a.m., Resident 39's bed was observed. He had assist bars on both sides of his bed. On 5/7/25 at 11:30 a.m., a record review was completed for Resident 39. He had the following diagnoses which included but were not limited to			

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	Alzheimer's disease, insomnia, vitamin D deficiency, and repeated falls. He had a side rail assessment dated 3/4/25. No assist bars were indicated at the time of the assessment. 3. On 5/5/25 at 11:00 a.m., Resident 18's bed was observed. She had assist bars on both sides of her bed. On 5/7/25 at 10:25 a.m, Resident 18's bed was observed. She had assist bars on both sides of her bed. On 5/7/25 at 1:30 p.m., a record review was completed for Resident 18. She had the following diagnoses which included but were not limited to hypertension, sleep apnea, dementia, and Parkinson's disease. She had a side rail assessment dated 4/21/25. No assist bars were indicated at the time of the assessment. 4. On 5/5/25 at 11:05 a.m., Resident 26's bed was observed. She had assist bars on both sides of her bed. On 5/7/25 at 11:35 a.m., Resident 26's bed was observed. She had assist bars on both sides of the bed. On 5/7/25 at 1:45 p.m., a record review was completed for Resident 26. She had the following diagnoses which included but were not limited to Alzheimer's disease, major depressive disorder, anemia, and sleep apnea. She had a side rail assessment dated 3/4/35. No			

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	assist bars were indicated at the time of the assessment. 5. On 5/5/25 at 11:15 a.m., Resident 25's bed was observed. She had assist bars on both sides of her bed. On 5/7/25 at 11:50 p.m., Resident 25's bed was observed. She had assist bars on both sides of her bed. On 5/7/25 at 2:15 p.m., a record review was completed for Resident 25. She had the following diagnoses which include but not limited to major depressive disorder, bipolar disorder, muscle weakness, and muscle weakness. She had a side rail assessment dated 5/3/35. No assist bars were indicated at the time of the assessment. On 5/8/25 at 10:12 a.m., an interview was conducted with the Director of Nursing. She indicated her nurses were not coding assist bars on the side rail assessment because they did not consider them to be an assist bar. She was in the process of reeducating them. A policy related to the use of and assessment of bedrails/mobility bars was requested during the survey but not provided at the time of exit.			
R 0000 Bldg. 00	This visit was for a State Residential Licensure. This visit included a Recertification and State Licensure Survey. This visit included a Non-Certified Comprehensive (NCC) Licensure Survey.	R 0000	The submission of this Plan of Correction is not an admission by Hoosier Village that the facility has provided anything less than high-quality care to its residents.	

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	Survey dates: May 5, 6, 7, 8 and 9, 2025. Facility number: 000548 Provider number: 155472 Census Bed Type: Residential: 245 Total: 245 Census Payor Type: Private: 245 Total: 245 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on May 15, 2025.		Rather, we view this process as part of our ongoing commitment to excellence and continuous improvement. Hoosier Village values its partnership with the Indiana Department of Health and other regulatory agencies. We believe that all feedback is an opportunity for growth, and we take it seriously. We remain fully committed to evaluating our practices and allocating the necessary resources to enhance outcomes and ensure the highest standard of care for our residents. In accordance with regulatory requirements, we respectfully submit the following Plan of Correction:	
R 0247 Bldg. 00	410 IAC 16.2-5-4(e)(7) Health Services - Deficiency Based on observation, interview, and record review, the facility failed to ensure residents were free from medication errors related to ensuring pharmacy labels and Electronic Medication Administration Record (EMAR) orders not matching for 1 of 2 residents (Resident 16) reviewed for medication errors. Findings include: During a medication pass on 5/9/25 at 12:30 p.m., Qualified Medication Aide (QMA) 35 was going to give Resident 16 her Metformin (a medication to help control blood sugar) when it was found that the EMAR order said Metformin 500 mg	R 0247	1.The medication label for Resident #12's Metoprolol Tartrate 50 mg was corrected immediately upon identification of the discrepancy. The pharmacy was notified on 05/08/2025, and a new label reflecting the current physician order of "50 mg by mouth daily at 9:00 AM" was applied. No medication administration errors were identified through review of the MAR, and the resident experienced no adverse outcomes.	06/06/2025

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	tablets, 1 tablet daily and the pharmacy label said Metformin 500 mg tablets, 1 tablet twice daily. QMA 35 indicated she would still give them medication because she knew the resident was supposed to take the medication during her shift. Licensed Practical Nurse (LPN) 38 told QMA 35 to hold the medication for now and she would call pharmacy to reconcile the discrepancy. After speaking with the pharmacy, it was found that the pharmacy label was correct, and the EMAR order was wrong. QMA 35 and LPN 38 both indicated that they would administer the medication now, notify the physician and pass on the discrepancy to the next shift. On 5/9/25 at 1:15 p.m., the Director of Nursing (DON) provided a copy of a current facility policy titled, "Medication Errors," dated 2/14/25. This policy indicated, " ...7. To prevent medication errors and ensure safe medication administration nurses should verify the following information: a. Right medication, dose, ..."		2.On 05/09/2025, the Assisted Living Coordinator and conducted a full audit of all medications stored on all medication carts and treatment rooms to ensure that pharmacy labels matched current physician orders and the . No other residents were found to have received medication in error. 3.The following systemic changes have been implemented: Licensed nursing staff received education on 05/14/2025 regarding the importance of verifying that medication labels match the physician's current orders and the before administration. 4.The Assisted Living Coordinator or will conduct weekly audits for 8 weeks of all newly received medications to ensure labeling accuracy against current orders and the . Findings from audits will be reviewed by the DON and reported quarterly to the QA&A Committee. After the initial 8 weeks, monthly audits will be conducted for 4 additional months to ensure sustained compliance. Ongoing education will be provided during quarterly in-services.	
R 0301 Bldg. 00	410 IAC 16.2-5-6(c)(5) Pharmaceutical Services - Deficiency			

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	Based on observation, interview, and record review, the facility failed to ensure all medications that had an expiration date different from the manufactures date were properly labeled with that expiration date for 1 of 1 residents (Resident 17) reviewed for proper medication labeling. Findings include: On 5/9/25 at 11:30 p.m., medication cart 3 was observed with Qualified Medication Aide (QMA) 35. The medication reviewed was as follows: Resident 17 had Erythromycin 0.5% eye ointment (a type of antibiotic eye ointment) with an open date of 3/25/25 and no expiration date. During an interview on 5/9/25 at 1:00 p.m., the Director of Nursing (DON) indicated that Erythromycin 0.5% eye ointment expired 28 days after opening. She indicated that the expiration date should have been written on the bottle and the medication was now expired and should be thrown away. On 5/9/25 at 1:15 p.m., the DON provided a copy of a current facility policy titled "Labeling of Medications and Biologicals" dated 2/14/25. This policy indicated. " ... all medications and biologicals used in the facility will be labeled in accordance with current state and federal regulations ...4. Individual drug containers may include: ... h. The expiration date when applicable ...."	R 0301	1. Resident #17's Erythromycin eye ointment was disposed of. 2. A facility-wide audit was conducted on 05/10/2025 to ensure no other expired medication remained in medication carts. No other residents were found to have expired medication. 3. Nurses were educated on 05/14/2025 on proper labeling of medication and expiration dates. 4. The Assisted Living Coordinator or designee will conduct weekly audits for 8 weeks on: medication is properly labeled when opened; medication is removed once it expires. Audit results will be submitted quarterly to the Quality Assurance & Assessment (QA&A) Committee for review. Following the 8-week period, monthly random audits will continue for an additional 4-months to ensure sustained compliance.	06/06/2025
R 0304 Bldg. 00	410 IAC 16.2-5-6(e) Pharmaceutical Services - Deficiency Based on observation, interview, and record review, the facility failed to ensure medication	R 0304	1. a. On 05/10/2025, all medications stored in residential	06/06/2025

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	carts were locked when unattended and medications were stored properly for 1 of 1 medication cart and 1 of 1 medication room. Findings include: On 5/9/25 at 11:00 a.m., a review of medication cart 1 was completed. After reviewing the medication cart Licensed Practical Nurse (LPN) 37 left the medication cart unlocked as she walked away. On 5/9/25 at 11:25 a.m., LPN 37 was observed as she opened medication cart 1. After she was done with the medication cart, she closed it but did not lock it before she walked away. On 5/9/25 at 12:15 p.m., medication storage room 1 was observed with LPN 36 who was the nursing manager. Upon review it was found that there were over the counter medications for staff use stored in a cabinet stored with these medications there was a bottle of Eliquis 5 mg (a blood thinner) that was not labeled. It was also found that there were overflow medications and medications to be destroyed being stored next to each other in a cabinet. During an interview on 5/9/25 at 12:30 p.m. LPN 36 indicated the bottle of Eliquis should not have been with the staff medications, it should have been with the medications to be destroyed and the overflow medications should not have been stored next to medications to be destroyed. LPN 36 also indicated medication carts should be locked any time the nurse walks away from it regardless of whether there are other staff in the medication room or not. On 5/9/25 at 1:15 p.m., the Director of Nursing (DON) provided a copy of a current facility policy		medication room were immediately removed, inspected for integrity, and placed in proper storage and/or destroyed per community policy if expired and/or discontinued. b. Medication carts were locked immediately. 2. a. The Assisted Living Coordinator conducted a comprehensive audit on 05/10/2025 of all medication storage areas throughout the facility to ensure compliance with storage requirements. b. All areas were brought into compliance; any medication found out of compliance was removed and replaced. No other issues affecting residents were identified. 3. a. The facility revised its Medication Storage and Handling Policy on 5/10/2025. b. Staff training was completed on 05/14/2025, emphasizing infection control and storage standards. 4. a. The Assisted Living Coordinator or will review medication storage weekly for 8 weeks to ensure consistent compliance. b. Monthly audits of all medication storage areas will continue for 4 months post-initial monitoring. c. Findings will be reported to	

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	155472	A. BUILDING 00 B. WING	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HOOSIER VILLAGE	9875 CHERRYLEAF DR INDIANAPOLIS, IN 46268

(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
	titled, "Medication Storage," dated 2/14/25. This policy indicated, " ...1. General guidelines: a. All drugs and biologicals will be stored in locked compartments (i.e. Medication carts ...."		the Quality Assurance & Assessment (QA&A) Committee quarterly for oversight and action planning.	