STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey and Investigation of Nursing Home Complaints IN00451302 and IN00452379. This visit included a State Residential Licensure Survey and Investigation of Residential Complaint IN00450714. Complaint IN00451302 - No deficiencies related to the allegations are cited. Complaint IN00452379 - No deficiencies related to the allegations are cited. Survey dates: February 18, 19, 20, 21, 24, and 25, 2025 Facility number: 000189 Provider number: 155292 AIM number: 100267330 Census Bed Type: SNF/NF: 128 Residential: 50 Total: 178 Census Payor Type: Medicare: 9 Medicaid: 81 Other: 38 Total: 128 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 5, 2025.	F 0000	=”” span=””> Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a Recertification and State Licensure survey on February 18, 2025. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance. =”” pthe=”” respectfully=”” requests=”” desk=”” review=”” with=”” paper=”” compliance=”” be=”” considered=”” establishing=”” that=”” substantial=”” p=””>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Gina Couch	Executive Director	03/17/2025

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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F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments Based on interview and record review, the facility failed to accurately complete a Minimum Data Set (MDS) assessment for 1 of 1 resident reviewed for dental services, 1 of 1 resident reviewed for Preadmission Screening and Resident Review, and 1 of 1 resident reviewed for skin conditions (Resident 22, Resident 49, and Resident 329). Findings include: 1. The clinical record for Resident 329 was reviewed on 02/21/25 at 9:59 a.m. The diagnoses included, but were not limited to, gangrene and pain. Resident 329 was admitted on 2/5/25. A wound progress note, dated 2/11/25, indicated the resident did have arterial insufficiency on bilateral feet. Areas noted to have arterial insufficiency are the top and bottom of all toes, bottom of both feet, and top of both feet. The Admission MDS assessment, completed on 2/12/25, indicated Resident 329 did not have arterial ulcers present. During an interview on 2/25/25 at 11:15 a.m., the Minimum Data Set Coordinator (MDSC) indicated she was not aware of the arterial insufficiency ulcers, and they should have been included on the Admission MDS assessment. 2. The clinical record for Resident 22 was reviewed on 2/18/25 at 3:10 p.m. The diagnoses included, but were not limited to, Parkinson's disease. A Nurse Practitioner Progress Note, dated 10/23/24, indicated Resident 22 was being seen	F 0641	F641 Accuracy of Assessments What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · MDS assessment for resident 329 dated 2/12/2025 was modified to accurately reflect resident's wound · MDS assessment for resident 22 dated 11/27/2025 was modified to accurately reflect resident's dental status · MDS assessment for resident 49 dated 11/25/2025 was modified to accurately reflect resident's level 2 How will you 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 by the alleged deficient practice · Audit completed of resident's dental, level 2, and wound sections of MDS to ensure accuracy. · All staff who complete sections of MDS assessments educated on accuracy of assessments by RAI support by 3/21/25. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · All staff who complete sections	03/21/2025

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	due to two broken teeth that were causing her to have issues with eating. A Significant Change Minimum Data Set assessment, completed 11/27/24, indicated she was severely cognitively impaired and had no dental issues. A care plan, last reviewed 12/2/24, indicated she was at risk for caries (cavities) or missing teeth. The goal was for her to be free from mouth pain, red or bleeding gums, and oral lesions. The approaches included, but were not limited to, dental consult as indicated, observe and document red/bleeding gums, lesions, loose teeth, and symptoms of pain, and notify physician as needed. During an interview on 2/21/25 at 11:53 a.m., the Minimum Data Set Coordinator (MDSC) indicated she would check on the dental coding of the MDS. 3. The clinical record for Resident 49 was reviewed on 2/19/25 at 11:27 a.m. The diagnoses included, but were not limited to, anxiety disorder and post-traumatic stress disorder. On 2/20/25 at 10:50 a.m., the Executive Director provided Resident 49's Notice of Preadmission Screening and Resident Review (PASAR) Level II outcome, dated July 6, 2021, which indicated Resident 49 was approved for long term care without specialized services. Based on his diagnoses, treatment history, symptoms and services needed, he had met the PASRR criteria. A Significant Change MDS assessment, dated 11/25/24, did not indicate Resident 49 had been evaluated for a PASRR Level II Assessment and		of MDS assessments educated on accuracy of assessments. · 5 MDS assessments to be reviewed by MDSC weekly to ensure accuracy of assessments How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director · If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	

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	was determined to have a mental illness. During an interview on 2/20/25 at 3:01 p.m., the MDSC indicated Resident 49's PASRR Level II assessment should have been captured on the MDS Assessment. The facility used the Resident Assessment Instrument Manual as the policy for completing the MDS assessment.			
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 a person-centered care plan timely for refusal to change clothes for 1 of 9 residents reviewed for activities of daily living (ADL) care. (Resident 19) Findings include: The clinical record for Resident 19 was reviewed on 2/18/25 10:30 a.m. The diagnoses included, but were not limited to, dementia, mild intellectual disabilities, and need for assistance with personal care. A Quarterly Minimum Data Set (MDS) assessment, dated 12/10/24, indicated the resident was cognitively impaired and required supervision and setup assistance during dressing. On 2/18/25 at 12:19 p.m., Resident 19 was observed sitting in the dining room for lunch wearing a green shirt and khaki pants with suspenders On 2/19/25 at 11:05 a.m., Resident 19 was observed in his room wearing the same clothing as the day prior, a green shirt and khaki pants with	F 0656	F656 Comprehensive Care Plan What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Resident 19 care plan was reviewed and updated to reflect refusal to change clothes How will you 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 by the alleged deficient practice · IDT to audit all memory care resident care plans regarding refusals · Any variance in care plan to be corrected immediately What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · IDT team educated on bed side care plan review and care plan updates by RAI support by	03/21/2025

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	suspenders. On 2/20/25 at 1:59 p.m., Resident 19 was observed in the activities room with other residents, wearing the same clothing previously worn on 2/18/25 and 2/19/25. During an interview on 2/20/25 at 2:01 p.m., Certified Nurse Aide (CNA) 7 indicated Resident 19 sometimes refused to change his clothing. The clinical record was reviewed on 2/20/25 at 2:19 p.m. and did not contain a care plan for Resident 19's refusal to change clothing. During an interview with the Director of Nursing (DON) on 2/24/25 at 3:00 p.m., she indicated a lot of times the resident refused to change his clothing because he had some favorite clothing to wear and becomes fixated on those items. On 2/25/25 at 10:04 a.m., the DON provided a Comprehensive Care Plan Policy, dated 1/2010 and revised on 8/2023, it indicated the following, " ...It is the policy of this facility that each resident will have an interdisciplinary comprehensive person-centered care plan developed and implemented based on Resident Assessment Instrument (RAI) process. The care plan must include measurable goals and resident specific interventions based on resident needs and preferences to promote the resident's highest level of functioning including medical, nursing, mental, and psychosocial well-being ..." 3.1-35(b)(1) 3.1-35(b)(2)		3/21/25. · IDT team to initiate weekly bedside care plan review to ensure care plan is accurate and implemented. How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director · If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	
F 0684 SS=D	483.25 Quality of Care			

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Bldg. 00	Based on interview and record review, the facility failed to ensure lidocaine patches were administered as ordered for 1 of 1 resident reviewed for pain, and to obtain weights three times weekly and inform the physician of weight changes, as ordered by the physician, for 1 of 1 resident reviewed for edema (Resident 3 and Resident 63). Findings include: 1. The clinical record for Resident 63 was reviewed on 2/18/25 at 12:29 p.m. The diagnoses for Resident 63 included, but were not limited to, pain and neuropathy. A physician order, dated 1/29/25, indicated Resident 63 was to receive lidocaine patches twice a day. The staff were to apply the patches to both feet on day and evening shift. The February 2025 Treatment Administration Record (TAR) indicated the following days and shifts the resident did not receive the lidocaine patches, due to not being available: 2/10/25 - day and evening shift, 2/12/25 - day shift, 2/13/25 - day and evening shift, 2/16/25 - evening shift, 2/17/25 - day and evening shift, 2/18/25 - day and evening shift, 2/19/25 - day shift, 2/20/25 - day shift, and 2/21/25 - day shift. A nursing progress note, dated 2/17/25, indicated pharmacy was notified regarding lidocaine patch	F 0684	F684 QOC What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Resident 63 lidocaine patch order clarified per pharmacy request. Resident patch is being administered as ordered. · Resident 3 weighed, and MD was updated on weight How will you 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 by the alleged deficient practice · Full audit of medication administration to be completed by DNS/Designee. · Full audit of weights to be completed by DNS/Designee · DNS/Designee will conduct an in-service with all nursing on staff on medication administration and weight management policy by 3/21/25. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · DNS/Designee will conduct an in-service with all nursing on staff on medication administration and weight management policy by 3/21/25. · Medication Administration report	03/21/2025

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	availability. The pharmacy reported the order needed clarification by the medical provider prior to sending a supply. The resident cannot wear lidocaine patches all the time. The order needed to state a timeframe the resident will not be wearing the lidocaine patches. An interview was conducted with the Director of Nursing on 2/24/25 at 3:00 p.m. She indicated the nursing staff should have received clarification of the order sooner. 2. The clinical record for Resident 3 was reviewed on 2/19/25 at 11:14 a.m. The diagnoses included, but were not limited to, congestive heart failure and diabetes. A physician's order, dated 1/29/25, indicated she was to have her weight done once a day on Monday, Wednesday, and Friday. The physician was to be notified of a weight gain of three pounds. The February 2025 Medication Administration Record (MAR) did not contain documentation that a weight had been obtained on Wednesday 2/5/25, Friday 2/7/25, and Monday 2/10/25. A weight of 184 pounds was recorded on 2/12/25 and a weight of 189.2 pounds was recorded on 2/14/25. The MAR did not include documentation of the physician being notified of the 5.2 pound weight gain. During an interview on 2/20/25 at 3:08 p.m., Unit Manager 3 indicated Resident 3 should have weights obtained and the physician should be notified of a weight gain of three pounds or more per the physician's order. On 2/20/25 at 3:40 p.m., the Executive Director provided the Resident Weight Monitoring policy,		to be run daily in clinical meeting to ensure residents are receiving medications as prescribed. · DNS/ Designee to review weights daily How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director · If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	

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	last reviewed September 2024, which indicated, "...It is the policy of this facility to weigh residents no less that monthly or per physician order..." 3.1-37(a)			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility Based on observation, interview, and record review, the facility failed to apply splints, as care-planned, for 1 of 1 resident reviewed for limited range of motion (ROM) (Resident 40). Findings include: The clinical record for Resident 40 was reviewed on 2/18/25 at 1:05 p.m. The diagnoses included, but were not limited to, Alzheimer's disease, multiple sclerosis, osteoarthritis, and chronic pain. A Quarterly Minimum Data Set (MDS) assessment, dated 1/22/25, indicated Resident 40 was cognitively impaired. A care plan, last reviewed 1/23/25, indicated Resident 40 was on the Passive Range of Motion (PROM) program, she was able to tolerate wearing left hand resting splint/brace for four hours, apply in the morning. She has a diagnosis of multiple sclerosis (MS) which contributes to her risk of contractures and need for assistance with daily care. The goal was to reduce the risk of contractures. On 2/18/25 at 3:06 p.m., Resident 40 was observed sitting in her wheelchair in the activities room, with no splint or brace in place.	F 0688	F688 Prevent Disease in ROM What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Resident 40 splint placed per order How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · All residents utilizing splints have the potential to be affected by the alleged deficient practice · Full audit of splints to be completed by DOT/Designee. · DNS/Designee will conduct an in-service with all nursing on staff on splint utilization by 3/21/25. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · DNS/Designee will conduct an in-service with all nursing on staff on splint utilization by 3/21/25. · A daily rounding tool including splint placement to be utilized by DNS/designee How the corrective action (s) will	03/21/2025

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	On 2/19/25 at 10:25 a.m., Resident 40 was observed without a splint or brace in place on her left hand while sitting in her wheelchair in the activities room. On 2/20/25 at 10:32 a.m., Resident 40 was observed sitting in her wheelchair without a splint or brace on her left hand. During an interview on 2/20/25 at 2:08 p.m. with Certified Nurse Aide (CNA) 6, she indicated she did not know why Resident 40 did not have her splint or brace on and she should wear her brace. During an observation of Resident 40's room on 2/20/25 at 2:10 p.m., CNA 6 was unable to locate Resident 40's splint or brace and indicated it may be in the laundry. During an interview with the Director of Nursing (DON) on 2/24/25 at 1:45 p.m., she indicated Resident 40 should have her splint or brace on as care planned. On 2/25/25 at 10:04 a.m., the DON provided a Comprehensive Care Plan Policy, dated 1/2010 and revised on 8/2023, it indicated the following, " ...It is the policy of this facility that each resident will have an interdisciplinary comprehensive person-centered care plan developed and implemented based on Resident Assessment Instrument (RAI) process. The care plan must include measurable goals and resident specific interventions based on resident needs and preferences to promote the resident's highest level of functioning including medical, nursing, mental, and psychosocial well-being ..." 3.1-42(a)(2)		be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director · If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	

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F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia Based on observation, interview, and record review, the facility failed to timely develop a person-centered behavior management care plan with individualized interventions and document approaches to care for a resident with dementia who exhibited behaviors for 1 of 1 resident reviewed for behaviors. (Resident 62) Findings include: The clinical record for Resident 62 was reviewed on 2/18/25 at 10:55 a.m. The diagnoses included, but were not limited to, dementia, depression, and cognitive communication deficit. An Admission Minimum Data Set (MDS) assessment, dated 12/11/24, indicated Resident 62 was severely cognitively impaired. A hospice Master of Social Work (MSW) Visit Note, dated 12/06/24, indicated Resident 62 was experiencing fluctuating emotions, staff reported she had been crying all morning and yelling out. MSW encouraged husband to coordinate care needs with facility to reduce stress and the facility Registered Nurse (RN) was notified. The clinical record did not contain documentation from facility staff of the noted behaviors from the MSW or interventions initiated on 12/06/24. An Acute Care Progress Note, dated 12/12/24, indicated, " ...Due to progression in dementia with increasing behaviors - agitation, restlessness, wandering, going into other residents' rooms, it was decided to transfer patient to the nursing	F 0744	F744 Dementia What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Resident 62 care plan was reviewed and updated How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · All residents on memory care unit have the potential to be affected by the alleged deficient practice · Care plan audit completed on all memory care residents with updated completed as needed · ED/Designee to educated MCSS on dementia care planning by 3/21/25. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · ED/Designee to educated MCSS on dementia care planning by 3/21/25. · IDT team educated on bed side care plan review and care plan updates by 3/21/25. · IDT team to initiate weekly bedside care plan review to ensure care plan is accurate and implemented. How the corrective action (s) will	03/21/2025

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	memory care unit for more assistance ..." A physician order for scheduled lorazepam (antianxiety medication) 0.5 milligrams (mg) oral tablet every four hours was started, on 12/22/24, as well as an order for as needed lorazepam 0.5 mg oral tablet every two hours with the same start date. A hospice RN Recertification Note, dated 12/26/24, indicated the hospice MSW was to coordinate with the facility and hospice team to encourage proper supervision and assessment of behaviors. A Psychiatry Progress Note, dated 1/07/25, indicated staff had reported increased anxiety, irritability, and agitation when Resident 62's husband visited. Included in the progress note plan was to continue lorazepam 0.5 mg as ordered. Non-pharmacological interventions were not included in the plan. The clinical record for Resident 62 did not include a care plan for monitoring behavior when the resident's husband was present in the facility. On 1/17/25 at 3:56 p.m., during a care plan meeting, Resident 62's husband indicated he had concerns the resident was too drowsy at times and too anxious at other times, hospice nurse indicated a change in administration times for lorazepam might help. A physician order for as needed lorazepam 0.5 mg oral tablet every hour was placed on 1/21/25. A Psychiatry Progress Note, dated 1/28/25, indicated staff endorsed concerns for lethargy, per hospice, addition of lorazepam 0.5 mg oral		be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director · If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	

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	155292	A. BUILDING 00 B. WING	02/25/2025

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	tablet every hour was indicated following spouse concerns for increasing anxiety. Facility reports patient often appeared agitated or anxious when husband was visiting but otherwise calm with no behavioral concerns in his absence. A decrease in frequency of administration of as needed lorazepam 0.5 mg was ordered. A nursing progress note, dated 2/02/25 at 9:29 p.m., by Licensed Practical Nurse (LPN) 22, indicated the resident was yelling and crying while visiting with her husband. The resident took her oral medications and let staff perform activities of daily living (ADLs). There was no documentation to indicate non-pharmacological interventions were used in the clinical record. A Psychiatry Progress Note, dated 2/04/25, indicated Resident 62 was seen at the request of the facility for increasing behaviors. Staff indicated an increase in anxiety, agitation, and distressful yelling out since dose reduction. Dosage of lorazepam 0.5 mg was increased in frequency from every six hours to every five hours. The progress note plan indicated to monitor and hold for sedation. The clinical record for Resident 62 did not include an order for behavior monitoring or any daily documentation of behavior monitoring. A nursing progress note, dated 2/13/25 at 3:17 p.m., by LPN 23, indicated Resident 62 had increased agitation and anxiety during this shift. Hospice nurse was here and recommended to give as needed morphine and as needed lorazepam. LPN 23 indicated a voicemail was left to the Hospice nurse and had notified her that the resident had not changed behavior since she left. There was no documentation to indicate			

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	non-pharmacological interventions were used in the clinical record. On 2/15/25 at 8:17 p.m., Registered Nurse (RN) 26 indicated in a progress note that Resident 62 was attempting to get out of wheelchair and bed throughout shift. Resident sitting in common area with staff at that time. On 2/18/25 at 11:39 a.m., Resident 62 was observed sitting in her wheelchair grimacing and exhibiting tearfulness while alongside her husband. A Psychiatry Progress Note, dated 2/18/25, indicated the facility reported persistent and slightly worsening anxiety, tearfulness, restlessness, pacing, and distressful yelling out. The resident's order for lorazepam 0.5 mg (scheduled and as needed) was discontinued and was changed to clonazepam 0.25 mg oral half-tablet twice a day starting on 2/18/25. During an interview on 2/21/25 at 1:41 p.m., the Memory Care Support Specialist (MCSS) indicated Resident 62 gets tearful during the day, anything can set her off, it just depends. For the most part, she can be consoled or redirected. She has a fake cat we give her; she likes music, the main thing she likes is holding onto someone. During an interview on 2/21/25 at 2:04 p.m., the Director of Nursing (DON) indicated Resident 62 would become tearful all throughout the day and would try to grab onto whoever was near her to hold onto them, she really liked touch. During an interview on 2/21/25 at 2:09 p.m., Registered Nurse (RN) 25 indicated Resident 62 had moments of tearfulness throughout the day.			

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	The DON provided the resident's care plans on 2/21/25 at 2:33 p.m. A care plan for mood and behaviors related to a diagnosis of dementia was not included. A Behavior Management Policy, dated 7/1/22, revised 8/22, was provided by the DON on 2/25/25 at 10:14 a.m. The policy indicated the following, " ...Policy: It is the policy of [name of corporation] to provide behavior interventions for residents with problematic or distressing behaviors. Interventions provided are both individualized and non pharmacological and part of a supportive physical and psychosocial environment that is directed toward preventing, relieving, and/or accommodating a resident's behavioral expressions ... Procedure: 1. Care plans should be initiated for any behavioral expression that is problematic or distressing to the resident, other resident, or caregivers. Care plan interventions should include individualized and non pharmacological interventions which address both proactive and responsive interventions ..." 3.1-37(a)			
F 0745 SS=D Bldg. 00	483.40(d) Provision of Medically Related Social Service Based on observation, interview, and record review, the facility failed to ensure appropriate social services follow-up, related to a previous allegation of abuse of a resident by a family member, for 1 of 1 resident reviewed for dementia care. (Resident 62) Findings include:	F 0745	F745 Social Services What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Resident 62 care plan was reviewed and updated How will you identify other residents having the potential to be affected by the same deficient	03/21/2025

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	The clinical record for Resident 62 was reviewed on 2/18/25 at 10:55 a.m. The diagnoses included, but were not limited to, dementia, depression, and cognitive communication deficit. An Admission Minimum Data Set (MDS) assessment, dated 12/11/24, indicated Resident 62 was severely cognitively impaired. An incident report, dated 10/31/24, indicated Resident 62's husband was overheard by staff raising his voice at the resident while assisting her with activities of daily living (ADL) care on the attached Assisted Living (AL) unit of the facility. A Nursing Progress Note, dated 11/2/24, indicated Resident 62's husband had been overheard yelling at the resident. Once staff entered the resident's room the resident's husband began yelling at facility staff to leave the room. Facility staff stayed in the resident's room to ensure safety. The resident was tearful and indicated multiple times that she was scared and attempted to move away from her husband and towards staff, but the resident's husband prevented her from doing so. Facility staff asked the resident's spouse to leave the facility, and he refused. At the advisement of the Director of Nursing (DON), the facility staff called the police, upon their arrival the resident's spouse was escorted out of the facility. On 11/6/24, a follow-up note was provided to the original incident report indicating Resident 62's husband had supervised visitations. On 12/4/24, Resident 62 was discharged from the attached AL unit and admitted to the Skilled Nursing Facility (SNF) due to progression of dementia.		practice and what corrective action will be taken? · All residents on memory care unit have the potential to be affected by the alleged deficient practice · Care plan audit completed on all memory care residents with updated completed as needed · ED/Designee to educated MCSS on person centered care and individualized interventions by 3/21/25. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · ED/Designee to educated MCSS on person centered care and individualized interventions by 3/21/25. · IDT team educated on bed side care plan review and care plan updates by 3/21/25. · IDT team to initiate weekly bedside care plan review to ensure care plan is accurate and implemented. How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the	

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	A hospice Master of Social Work (MSW) Visit Note, dated 12/6/24, indicated Resident 62 was experiencing fluctuating emotions, staff reported she had been crying all morning and yelling out. MSW encouraged husband to coordinate care needs with facility to reduce stress and the facility Registered Nurse (RN) was notified. A Psychiatry Progress Note, dated 1/7/25, indicated staff had reported increased anxiety, irritability, and agitation when Resident 62's husband visited. Included in the progress note; the plan was to continue lorazepam (antianxiety medication) 0.5 milligrams (mg) as ordered. On 2/18/25 at 11:39 a.m., Resident 62 was observed in her wheelchair tearful and grimacing while her husband was wheeling her into her room. During this time, the resident's husband was not actively being supervised by facility staff. During an interview on 2/21/25 at 1:36 p.m., the Social Services Director (SSD) of the AL unit, indicated facility staff noticed Resident 62's husband exhibit aggressive behavior toward the resident. He was forceful while changing her, would get mad at her, and be rough with her. The resident would cry a lot. Initially, Resident 62 would walk a lot and smile a lot, but when her husband came around, she would become tearful and withdraw. We even talked to the children, and they indicated he had always acted in this manner towards the resident. There was a meeting once the incident occurred, and we asked the resident's husband to please just let staff provide ADL care. We scheduled times for him to come in and initiated supervised visits in open areas. During an interview on 2/21/25 at 1:41 p.m., the Memory Care Support Specialist (MCSS) of the		Executive Director · If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	

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	SNF, indicated Resident 62's husband was aggressive towards herself and staff, and liked to delegate where the resident was and who was involved with her care. Resident 62 gets tearful during the day, by herself, not just when the spouse was here. The MCSS then indicated that we (the SNF), don't provide one on one supervision here. We have never provided that overall. She did not know they were providing that (supervised visits) in the AL. During an interview on 2/21/25 at 2:04 p.m., the DON indicated Resident 62's husband and daughter share joint power of attorney. When the resident's husband visits, we try to keep the door open and keep an eye on him. He has been told several times not to provide ADL care and keep doors open; he is not compliant. They also try to keep an eye on him while he is feeding the resident because he tries to force feed her. During an interview on 2/21/25 at 2:31 p.m., hospice staff 1 indicated she was informed that Resident 62's door had to remain open and visits with the resident's husband had to be in an open area and supervised. During an interview on 2/24/25 at 9:44 a.m., hospice staff 2 indicated she had heard through the rest of the team and facility staff, that Resident 62's husband was possibly going to be banned from the facility. I saw Resident 62 for the first time on the secured memory care unit at the SNF part of the facility. I had been in contact with her daughter prior to the initial visit. I knew there had been some allegations of long-time abuse. I was under the impression that the resident's husband was not going to be there, however when I arrived, he was there. There were not any staff around and the door was open. Later, the staff			

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	walking down the hall saw me in the resident's room. On 2/21/25 at 3:24 p.m., the DON provided the Visitation Policy, dated 11/2016, revised 10/2022, which indicated, " ...Procedure: 4. Visitors must not behave in a way that imposes on the rights of other residents (i.e. using loud, abusive language; intimidating staff or other residents; appearing under the influence of drugs or alcohol, etc.) If a visitor is found to behave in a manner that imposes on the rights of other residents, the visitor will be asked to leave the facility ...6. The facility may either deny or provide supervised visitation for a visitor who is suspected of abuse until an investigation into the allegation is completed. If the visitor is found to be abusing, exploiting or coercing a resident, visitation may be denied, limited or supervised as determined by the Executive Director...." On 2/24/25 at 10:52 a.m., the DON provided the Social Services Policy, dated 8/1998, revised 11/2016, which indicated, " ...It is the policy to provide medically-related social services to attain or maintain each resident's highest practicable physical, mental, and psychosocial well-being of each resident including provision of mental health services as ordered by the attending physician ..." 3.1-34(a)(1) 3.1-34(a)(2)			
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation, interview, and record review, the facility failed to remove discontinued resident medications, refrigerate a medication requiring refrigeration, and label open medications	F 0761	F761 (E) med storage What corrective action(s) will be accomplished for those residents found to have been affected by the	03/21/2025

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	in 2 of 3 medication carts observed (Residents 22, 49, 60, 75, 76, 105). Findings include: 1. An observation was conducted of the 200-hall medication cart, on 2/24/25 at 9:55 a.m., with Licensed Practical Nurse (LPN) 4. The medication cart contained an insulin degludec pen (type of long-acting insulin for diabetes) for Resident 60 that was opened with no open date label. Another insulin degludec pen for Resident 60, delivered on 2/22/25, was unopened/unused and not being refrigerated per manufacturer instructions. A bottle of lactulose (liquid medication for constipation) for Resident 49 was open, but did not have an open date label. A bottle of liquid guaifenesin dextromethorphan (medication for cough/upper respiratory symptoms) for Resident 105 was open with no open date label. This medication was discontinued, on 1/8/25, but not removed from the cart. A bottle of lactulose for Resident 75 was open with no open date label. An interview was conducted with LPN 4 on 2/24/25 at 10:05 a.m. He indicated he was not sure if opened medications needed an open date label, and did not know why the medications were not labeled. The unopened insulin pen should be refrigerated, but he did not know why it was not refrigerated. 2. An observation was conducted of the 400-hall medication cart, on 2/24/25 at 10:10 a.m., with LPN 2. A bottle of nitroglycerin pills (used as needed for chest pain) for Resident 22 was open with no open date label. It was delivered to the facility on 11/20/24. Another bottle of nitroglycerin pills for the same resident also was open with no open date label. This bottle was delivered to the facility		deficient practice? · Medication cart was immediately audited and corrected by unit manager · All licensed nurses and QMAs educated on medication storage policy by 3/21/25. How will you 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 by the alleged deficient practice · DNS/Designee will conduct an in-service with all Licensed nurses and QMAs on medication storage policy · All medication carts were inspected to ensure medications were stored appropriately and labeled appropriately by DNS/ Designee by 3/21/25. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · DNS/Designee will conduct an in-service with all Licensed nurses and QMAs on medication storage policy by 3/21/25. · A daily rounding tool including medication storage to be utilized by DNS/designee to ensure medications are appropriately labeled and stored How the corrective action (s) will be monitored to ensure the deficient practice will not recur,	

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	on 6/14/24. A bottle of liquid ibuprofen (used as needed for pain) for Resident 76 was open with no open date label. It was delivered to the facility on 11/12/24. An interview was conducted with LPN 2 on 2/24/25 at 10:15 a.m. She indicated she was not sure why the medications did not have an open date label, and she was not sure if they needed that label. On 2/24/25 at 10:20 a.m., the Director of Nursing (DON) provided the current facility policy titled, "Medication Storage and Expiration Policy," dated 11/2024. It indicated, " ...Facility staff should record the date opened on the primary medication container (vial, bottle, inhaler) ...Facility should destroy and reorder medications with soiled, illegible, worn, makeshift, incomplete, damaged, or missing labels or cautionary instructions ...Medications should be stored in accordance with manufacturers' recommendations ...Facility should ensure that medications are stored at their appropriate temperatures according to the United States Pharmacopeia guidelines for temperature ranges ...Medications that are expired, discontinued, or belong to hospitalized patients should be stored separately, away from use, until destroyed or returned to the provider." 3.1-25(j) 3.1-25(m) 3.1-25(o)		i.e., what quality assurance program will be put into place? · POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director · If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview, and record review, the facility failed to ensure staff donned personal protective equipment (PPE) prior to a	F 0880	F880 Infection Control ¿ What corrective action(s) will be accomplished for those residents	03/21/2025

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	wound dressing for 1 of 1 random observation. (Resident 5) Findings included: The clinical record for Resident 5 was reviewed on 2/18/25 at 1:29 p.m. The diagnoses included, but were not limited to, Alzheimer's disease. A care plan, dated 2/3/25, indicated Resident 5 had pressure ulcer on her sacrum. A physician order, dated 2/3/25, indicated the staff was "to cleanse sacrum with wound cleanser, apply collagen powder, and cover with bordered gauze once a day." An observation was made of Resident 5's room on 2/21/25 at 11:30 a.m. Licensed Practical Nurse (LPN) 21 was observed leaving the resident's room with a treatment cart. She indicated she had provided a wound treatment to Resident 5. At that time, an observation was made of the resident's room with the Director of Nursing (DON). The DON had indicated the Enhanced Barrier Precaution signage was placed on the closet doors of Resident 5's room. The trash can in the resident's room did not contain discarded PPE. An interview was conducted with LPN 21 with the DON on 2/21/25 at 2:57 p.m. LPN 21 indicated she had donned gloves only to provide the wound treatment to Resident 5. She was unaware Resident 5 was on Enhanced Barrier Precautions. An Enhanced Barrier Precautions policy was provided by the DON on 2/21/25 at 10:39 a.m. It indicated, "Enhanced Barrier Precautions (EBP): An intervention designed to reduce the transmission of resistant organisms that employs		found to have been affected by the deficient practice;¿¿ · Enhanced Barrier Precautions sign placed on resident 5's side of the room to more clearly indicate resident needed Enhanced Barrier Precautions How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;¿ · All residents have the potential to be affected by alleged deficient practice. · An audit was completed by IP/designee to ensure all residents requiring Enhanced Barrier Precautions had appropriate indicators · All staff to be inserviced on Enhanced Barrier Precautions by the IP/Designee by 3/21/2025 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;¿¿ · All staff to be inserviced on Enhanced Barrier Precautions by the IP/Designee by 3/21/2025 · All Enhanced Barrier Precautions signs moved to resident's side of room to more clearly indicated the need for Enhanced Barrier Precautions · The consultant IP will provide ongoing training, oversight, resources and competencies as needed¿¿	

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	targeted use of gown and glove use during high contact resident care activities...Enhanced barrier precautions are used for: Resident(s) with chronic wounds and/or indwelling medical devices, regardless of their MDRO [Multidrug-Resistant Organisms] status...Wounds generally include: Chronic wounds, not shorter-lasting wounds, such as skin breaks or skin tears covered with a adhesive bandage (e.g., Band-Aid) or similar dressing. Examples of chronic wounds include, but are not limited to, pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers...Use of Personal Protective Equipment - gown and gloves: During high-contact resident care activities...wound care: any skin opening requiring a dressing..." 3.1-18(b)(2)		¿ How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed¿ · The POC QAPI Tool will be utilized by ED/designee weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director · If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance R216 Evaluation - Noncompliance What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Resident R20, R28 and R26 receiving all current medications per order	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey and Investigation of Residential Complaint IN00450714. This visit included a Recertification and State Licensure Survey and Investigation of Nursing Home Complaints IN00451302 and IN00452379. Complaint IN00450714 - No deficiencies related to	R 0000	=”” span=””> Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

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	the allegations are cited. Survey dates: February 18, 19, 20, 21, 24, and 25, 2025 Facility number: 000189 Residential Census: 50 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on March 5, 2025.		required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a Recertification and State Licensure survey on February 18, 2025. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance. ="" pthe="" respectfully="" requests="" desk="" review="" with="" paper="" compliance="" be="" considered="" establishing="" that="" substantial="" p="">	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance Based on observation, interview, and record review, the facility failed to ensure residents, who had medications stored in their apartment, were assessed for the ability to self-administer their medications, and failed to ensure a resident who utilized an electronic cigarette was assessed for appropriate utilization of such for 3 of 5 residents reviewed for medication administration. (Resident R20, Resident R28, and Resident R26) Findings include:	R 0216	R216 Evaluation - Noncompliance What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Resident R20, R28 and R26 receiving all current medications per order · Resident R28 discharged to home · Resident R20 and R26 self-administration of medication assessment completed	03/21/2025

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	1. An observation was conducted of medication administration for Resident R20 with Licensed Practical Nurse (LPN) 20 on 2/21/25 at 8:50 a.m. LPN 20 prepared Resident R20's morning medication and then placed the medication cup in Resident R20's apartment. LPN 20 did not stay in Resident R20's apartment to observe Resident R20 taking his medications. LPN 20 indicated Resident R20 preferred to take his medications on his own time. The clinical record for Resident R20 was reviewed on 2/24/25 at 10:35 a.m. The diagnoses included, but were not limited to, dementia, iron deficiency anemia, and diabetes mellitus. There was no self-administration of medication assessment located in Resident R20's clinical record. The physician orders were reviewed and indicated the following medications were scheduled in the morning for administration: Amlodipine 5 milligrams (mg), Vitamin D 2,000 units, Ferrous sulfate (iron) 325 mg, Meloxicam 15 mg, Omeprazole 20 mg, Potassium chloride 20 milliequivalents, and Senna 8.6 mg. 2a. An observation was conducted of medication administration for Resident R26 with LPN 20 on 2/21/25 at 9:05 a.m. Upon entering Resident R26's apartment for LPN 20 to administer her medications, there was a bottle of Mirilax on the kitchen counter in Resident R26's apartment. The clinical record for Resident R26 was reviewed		· Resident R26 smoking assessment completed How will you 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 by the alleged deficient practice · Full audit of medication administration to be completed by Clinical Director. · Full audit of residents who smoke to be completed by Clinical Director. · Clinical Director/Designee will conduct an in-service with all nursing staff on medication administration and smoking policy by 3/21/25. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · Clinical/Designee will conduct an in-service with all nursing on staff on medication administration and smoking policy on or before 3/21/25. · A daily rounding tool including medication at bedside and smoking paraphernalia. How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6	

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	on 2/24/25 at 12:05 p.m. The diagnoses included, but were not limited to, depression, anemia, and hypertension. There were no physician orders for Resident R26 to receive Mirilax. There was no self-administration of medication assessment located in Resident R26's clinical record. 2b. An observation was conducted of Resident R26's apartment on 2/21/25 at 9:05 a.m. There was a container that contained cartridges for an electronic cigarette along with a bin indicated it was for empty electronic cigarette cartridges. There was no smoking assessment located in Resident R26's clinical record. 3. An observation was conducted of Resident R28's apartment on 2/24/25 at 10:30 a.m. There were two oblong pills located on Resident R28's dining table. She indicated the nurse administered her morning medications, but she was in the process of going to do therapy. So, she took what medications she could and asked the nurse to leave the remaining two pills on the kitchen table. She stated she should have taken them when she returned to her apartment from therapy but hadn't yet. The clinical record for Resident R28 was reviewed on 2/24/25 at 12:15 p.m. There was no self-administration of medication assessment located in Resident R28's clinical record. A policy entitled Self Administration of		months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director · If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	

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	Medications, dated 11/15, was provided by the Director of Nursing (DON) on 2/24/25 at 3:08 p.m. The policy indicated the following, "...3. The nurse at the Community must also evaluate each resident who self-administers his or her medication by completing the 'Self-Administration of Medication Assessment' form. The nurse will approve each resident that self-administers medication to ensure safe and effective procedures are followed... 5. The resident will take his or her medications without staff supervision... 6. Periodic evaluations of the resident's ability to self-administer medications must be made to ensure that safe and effective procedures are followed...."			