STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ANTHOLOGY OF MERIDIAN HILLS	8549 N MERIDIAN STREET INDIANAPOLIS, IN 46260

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00402328. Complaint IN00402328 - No deficiencies related to the allegations are cited. Survey dates: May 8, 9 and 10, 2023 Facility number: 013933 Residential Census: 42 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on May 22, 2023.	R 0000		
R 0026 Bldg. 00	410 IAC 16.2-5-1.2(a) Residents' Rights - Noncompliance (a) Residents have the right to have their rights recognized by the licensee. The licensee shall establish written policies regarding residents ' rights and responsibilities in accordance with this article and shall be responsible, through the administrator, for their implementation. These policies and any adopted additions or changes thereto shall be made available to the resident, staff, legal representative, and general public. Each resident shall be advised of residents ' rights prior to admission and shall signify, in writing, upon admission and thereafter if the residents ' rights are updated or changed. There shall be documentation that each resident is in receipt of the described residents ' rights and			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jessica Charette	Executive Director	07/11/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	responsibilities. A copy of the residents ' rights must be available in a publicly accessible area. The copy must be in at least 12-point type and a language the resident understands. Based on interview and record review, the facility failed to ensure a resident was advised of their rights upon admission for 1 of 7 residents reviewed for resident rights. (Resident G) Finding includes: The record for Resident G was reviewed on 05/09/2023 at 10:00 a.m. Diagnoses included, but were not limited to, vascular dementia, anemia, malnutrition, hypertension, hyperlipidemia, sleep apnea, and osteoporosis. Resident G's record lacked documentation the resident or responsible party had signed and dated acknowledgment of the resident rights upon admission. During an interview, on 05/09/2023 at 4:23 p.m., the Executive Director indicated an acknowledgement of receipt of the resident rights upon admission for Resident G could not be located. A facility policy, titled "GP 06 - Personal Rights," dated as last revised 02-2022 and received from the Executive Director on 05/10/2023 at 12:23 p.m., indicated "...In accordance with state laws, a written description of state specific resident rights will be given to the resident upon admission and upon request...."	R 0026	**Immediate:** Will in-service all residents on Resident Right during our June Resident Council Meeting. Resident Rights are posted in the community as well. **Audit:** The Business Office Director will audit resident files to ensure that all residents have signed off that they have received a copy of Residents' Rights. **Systemic:** All Resident Contracts are signed electronically now and have Resident Rights included where Appendix G acknowledges receipt of Resident Rights. A signature is required in order to submit electronically. The business office director will audit monthly resident files to ensure appropriate documentation for all residents is noted. **Monitoring:** The Business Office Director will audit 5 Resident Charts on a quarterly basis through 12/2023. The Executive Director will complete random audits to ensure ongoing compliance.	06/30/2023
R 0052	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense			

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Bldg. 00	(v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on observation, record review and interview, the facility failed to ensure a resident was free from physical and mental abuse from a staff member for 1 of 3 residents reviewed for abuse. (Resident J) The resident was fearful and had episodes of crying. Finding includes: An Indiana Department of Health reportable, dated 02/16/2023, indicated Resident J "...reported to a staff member that she had been mistreated by someone on the night shift. Staff member is mean to me and is rough with me. She pulls my hair, grabs my arms & it hurts. When changing my brief, she rolls me over fast and roughly and has me on the edge of the bed and I feel like I am going to fall off." During an observation, on 05/09/2023 at 10:30 a.m., Resident J could be seen from the hallway lying in her bed with her eyes closed. The resident did not respond to knocks on her door or calling her name loudly. Resident J was covered with blankets but had kicked off the bottom portion of the blankets revealing her legs. Her legs were bent at the knees and pulled up toward her torso. The record for Resident J was reviewed on 05/09/2023. Diagnosis included, but were not limited to, anxiety disorder, depression, cognitive changes and impairment, hypertension, difficulty walking, malnutrition, chronic pain, and	R 0052	**Immediate:** Suspended the QMA and began an investigation. In-Serviced staff on Abuse/Neglect. Will provide abuse training to all employees at monthly all staff meetings through 12.31.2023. **Audit:** BOD will audit employee files to ensure that training for abuse and neglect policy is completed upon new hire orientation. **Systemic:** BOD/designee will run a Relias (Learning Management System) completion training report quarterly to ensure Abuse course has been completed for all employees. DHW/BOD will ensure training has been completed annually. **Monitoring:** BOD will audit 5 employee files monthly to ensure appropriate training has happened through 9/30/2023. DHW/designee will complete random audits & inspections using abuse competency to monitor for ongoing education and validation of knowledge.	06/30/2023

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	osteoarthritis. A facility "Investigation Summary Report" received from the Executive Director (ED) on 05/09/2023, indicated the resident was "non-ambulatory", was confined to a "wheelchair" when up and was "confused at times." The report indicated Resident J was first interviewed regarding the allegations on 02/16/2023 at 12:30 p.m., by the ED. Resident J indicated the event occurred "maybe 10 days ago." When asked the time of day the allegations occurred, the resident indicated she didn't know the time but, "definitely at night, late. Some time on the night shift". When asked the name of the employee, Resident J indicated "she is a night shift worker...I've only seen her at night. She is a black girl with long braids with silver in them. She is mean to me. She talks mean to me and she is very rough with me. She pulls my hair, grabs my arms and it hurts. When she is changing my brief, she rolls me over fast and roughly and has me on the edge of the bed and I feel like I'm going to fall off. I tell her I'm scared, and she doesn't stop". Below the documentation of the interview, the ED had written "She has bruising on her right arm that is a mix of colors, bright red, faint red, fading with a < (less than) 1 cm open are in the middle. The area was cleansed, and a clean dry dressing placed. Hospice was notified...they responded saying that they will come to see resident today". The report contained documentation of a statement from QMA 6 who was working the day shift following the allegation. The statement, dated 02/17/2023, indicated the resident, "told this writer on February 16, 2023, that she has been mistreated by someone on night staff...Her words were 'I felt like I was going to fall out of bed when she changed me. She took my pendent away from		The ED/DHW will interview 4 residents quarterly for 1 year to ensure residents are free from abuse in addition to reviewing incident reports 2x weekly to ensure appropriate investigation is completed if warranted.	

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	around my neck and put it where I couldn't reach it. She put this gown on me that's too tight. She pulled my hair. She put her finger inside my mouth and said you are going to swallow these pills'. The writer asked her who did it. She replied, 'she works at night and has silver hair. I told her to get out of my room'. She asked this writer if the person would be working again that night. She said she did not want her back in her room". A statement, dated 02/17/2023, by CNA 3 indicated "resident told me someone grab (sic) her pendent that was around her neck and pull (sic) it. Also, resident stated she pull arm and resident got a skin tear and it was bleeding on her arm..." The ED interviewed the resident's primary hospice nurse (RN 8) on 02/20/2023. RN 8 indicated she had visited 02/16/2023 at 4:30 p.m. As the RN was dressing the new wound on the right arm, the resident asked her if she knew how this happened. The RN indicated she did not, and the resident told her an aide came in around 4:00 a.m. who was rough with her physically as far as repositioning her in bed and checking her brief. Resident J indicated she caused the right arm wound. When asked if she knew her name, the resident stated she did not. When describing her, Resident J stated, "I remember her having long braids in her hair" RN 8 indicated the resident "teared up and stated I am afraid of her. I don't like when she takes care of me." A review of the "Pay Summary Report" indicated QMA 5 had worked 57 shifts, 1 day shift, 6 evening shifts and 50-night shifts. On 02/15/2023, QMA 5 clocked in at 10:39 p.m., and clocked out on 02/16/2023 at 6:58 a.m. The facility progress notes did not describe the			

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	allegation, injury to resident's arm, or the treatment of the area. During an interview, on 05/09/2023 at 9:42 a.m., the Executive Director indicated QMA 5 (Qualified Medication Aide) was terminated on 02/23/2023. QMA 5 had worked the night shift. During an interview, on 05/09/2023 at 11:11 a.m., the Director of Health and Wellness (DHW) indicated Resident J was dependent for care, incontinent and required the use of the stand-up-lift to transfer from the bed. The resident told her she did not want QMA 5 to take care of her. The resident indicated QMA 5 was "very rough" with her. The DHW indicated when she was interviewing Resident J, she had observed the resident had a bruise on her upper arm, but she did not know if it was related to the allegation. The resident told her QMA 5 would pull her cheek back and force the medication into her mouth. She felt Resident J was afraid of QMA 5. The QMA worked the night shift and was responsible for passing medication in the locked dementia unit when she was on duty. On 05/10/2023 at 11:42 a.m., with the assistance of the DHW, Resident J was interviewed regarding the allegations. Due to the resident's severe hearing loss, it was necessary to communicate with the resident through writing questions on paper and speaking loudly directly into the resident's ear. Resident J shook her head affirmatively when asked if she recalled the events surrounding the allegations and indicated the staff member was "mean" to her and she felt she was "going to fall off the bed" when she turned her over. She declined to demonstrate the allegation regarding the administration of medication. Resident J's eyes swelled with tears			

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	when she indicated she was afraid of the staff member. A facility policy, titled "GP 08 - Elder Abuse, Neglect, and Exploitation," with a revision date of 02/2022 and received from the DHW on 05/10/2023 at 11:13 a.m., indicated "...Resident abuse, neglect and exploitation are prohibited. Should any resident experience abuse by staff, residents, family, or others or when any form of abuse is suspected, staff and volunteers are required to immediately provide notification to persons/agencies as described in this policy...The term abuse as used in this policy also includes, but is not limited to, neglect, abandonment, exploitation and any other form of abuse...."			
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for			

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	every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review, the facility failed to ensure nursing staff with first aid certification was onsite for 1 of 21 shifts reviewed. (April 18, 2023) Finding includes: During a review of staffing for the week of April 16 through April 22, 2023, the following shift was found to be without staff trained in first aid: April 16, 2023, the night shift did not have staff training in first aid on duty. During an interview, on 05/09/2023 at 3:34 p.m., the Executive Director (ED) indicated she was unable to locate a certificate of first aid for the nursing staff who worked the night shift on 04/18/2023. The facility policy related to first aid coverage was requested at this time. The ED indicated the facility did not have a policy for first aid coverage.	R 0117	**Immediate:** All Nursing Staff members are in the process of taking CPR/First Aid Certified class. **Audit:** ED/designee audited all employee files to ensure all nursing staff members are CPR/First Aid Certified w/in the first 30 days of employment. **Systemic:** The Director of Health & Wellness will educate clinical staff upon hire regarding the need for CPR/First Aid certification. CPR/First Aid will be validated at time of hire, any nursing employee who is not CPR and/or First Aid certified will be required to take CPR/First Aid course within the first 30 days of employment. A record system for licenses & CPR/First Aid certifications has been created. This will be reviewed monthly by the ED/BOD. **Monitoring:** The Business Office Director will audit 5 employee records monthly through 9/30/2023. The Executive Director will complete random audits to ensure ongoing compliance.	06/30/2023

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R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia.			

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	(3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on interview and record review, the facility failed to ensure staff having contact with cognitively impaired residents received 6 hours of dementia training within 6 months of hire and 3 hours of dementia training annually for 2 of 5 staff members reviewed for dementia training. (Employee 1 and 2) Findings include: During a review of the employee records, on 05/09/2023 at 2:34 p.m., with the Executive Director (ED), the following was observed: 1. Employee 1, with a hire date of 09/21/2022, lacked documentation of the required 6 hours of dementia training within 6 months. 2. Employee 2, with a hire date of 11/18/2021, lacked documentation of the required 3 hours of annual dementia training. During an interview, at the time of the review, the ED indicated the training had not been completed. A facility policy, titled "Employee Training," dated as last revised on 04-2022 and received from the ED on 05/10/2023 at 12:23 p.m., indicated the facility staff would receive "...initial orientation and ongoing in-service training based on state regulations and the needs of the resident being	R 0120	**Immediate:** Dementia Training for all Memory Care staff will be completed by 6/30/2023. **Audit:** Executive Director audited all employee files for Dementia Specific training. **Systemic:** DOV will conduct a 4 hour Dementia Specific Training during Day 2 of Orientation and annually thereafter. In addition will provide Dementia Specific training quarterly to all staff. For the remainder of the year training will be scheduled for: 8/10/2023 @ 1 p.m., 8/29/2023 @ 10 a.m., 11/1/2023 @ 7 a.m. & 11/21/2023 @ 4 p.m. **Monitoring:** All employee files will be audited on a quarterly basis to ensure that state specific training/education are met by the Business office director. The executive director will complete random audits of the binder system to monitor for ongoing compliance.	06/30/2023

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	served in this community...."			
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on interview and record review, the facility failed to ensure residents' service plans were signed and dated for 7 of 7 residents reviewed for service plans. (Residents B, C, D, E, F, G, H) Findings include:	R 0217	**Immediate:** DHW/designee will review care plans with resident B,C,D,E,F,G,H if they currently reside with us. **Audit:** Review of all residents will	06/30/2023

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	1. The record for Resident B was reviewed on 05/09/2023 at 9:16 a.m. Diagnoses included, but were not limited to, vascular dementia, anemia, heart failure, hypertension, glaucoma, anxiety disorder, chronic kidney disease, and hypothyroidism. The current service plan lacked Resident B's signature and date of the review. 2. The record for Resident C was reviewed on 05/09/2023 at 9:21a.m. Diagnoses included, but were not limited to, dementia, hyperlipidemia, hypertension, and hypertensive heart disease. The current service plan lacked Resident C's signature and date of the review. 3. The record for Resident D was reviewed on 05/09/2023 at 9:32 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disorder, anxiety disorder, hypertension, coronary heart disease, and depression. The current service plan lacked Resident D's signature and date of the review. 4. The record for Resident E was reviewed on 05/09/2023 at 9:41 a.m. Diagnoses included, but were not limited to, hypertension, depression, anxiety disorder, chronic fatigue, Alzheimer's disease, and dementia. The current service plan lacked Resident E's signature and date of the review. 5. The record for Resident F was reviewed on 05/09/2023 at 9:51 a.m. Diagnoses included, but were not limited to, blindness, dementia, anxiety		be completed to verify that all service plans are personalized and match the care being received to reflect the current assessment & needs of each resident & are signed by residents or families **Systemic:** ED will meet with the DHW bi-weekly and review all CP's that were completed during that time period to ensure meetings were conducted and CP's were signed. ED educated the DHW on CP policy, DHW will set up Care Plan meeting with resident and families with any MI, 6 month or COD. **Monitoring:** Executive Director/Director of Health & Wellness will conduct a monthly audit for Service Plan Signatures.	

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ANTHOLOGY OF MERIDIAN HILLS	8549 N MERIDIAN STREET INDIANAPOLIS, IN 46260

(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
	disorder, gastro esophageal reflux disease, and depression. The current service plan lacked Resident F's signature and date of the review. 6. The record for Resident G was reviewed on 05/09/2023 at 10:00 a.m. Diagnoses included, but were not limited to, vascular dementia, anemia, malnutrition, hypertension, hyperlipidemia, sleep apnea, and osteoporosis. The service plan lacked Resident G's signature and date of the review. 7. The record for Resident H was reviewed on 05/09/2023 at 10:05 a.m. Diagnoses included, but were not limited to, Parkinson's disease, spinal stenosis, rheumatoid arthritis, repeated falls, and sleep apnea. The service plan lacked Resident H's signature and date of the review. During an interview, on 05/09/2023 at 10:14 a.m., the Executive Director (ED) indicated the service plans were not signed and dated by the residents or the resident's representative. A current policy, titled "Resident Assessment and Negotiated Service Agreement," dated as last revised 02.2022 and received from the ED on 05/10/2023 at 10:41 a.m., indicated "...Assessment and Negotiated Service Agreements will be updated as frequently as necessary to ensure they reflect current resident care needs and preferences. Individualized Negotiated Service Agreements are used to plan for and meet resident needs using an interdisciplinary approach...The family, resident and any other significant			

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	individuals are included in the development...." 410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities.			
R 0407 Bldg. 00	Based on interview and record review, the facility failed to develop and implement an Infection Control program which included, but was not limited to, a system to analyze patterns of known infectious symptoms. This deficient practice had the potential to affect 42 of 42 residents who resided in the facility. Finding includes: The facility policy for the Infection Control program was requested on 05/08/2023 at 9:21 a.m. The Executive Director (ED) provided polices regarding, "Infection Control 01 - Standard Precautions/Infection Control" with a revision date of 02.2022, and "Infection Control 02 - Exposure Response and Reporting" dated as last revised on 02/2022. Documentation was lacking an overall policy describing the Infection Control program to include a system to track current and ongoing	R 0407	**Immediate:** ED & DHW are educated on the Anthology Policy & Procedures. **Audit:** A review of the Anthology Policies and procedures were completed to ensure an understanding and knowledge of location. **Systemic**: Implemented Infection Control Tracking Log, DHW will in-service staff on infection prevention and control including universal precautions. During an outbreak we will educate residents on specific transmissions & report any communicable disease to public health authorities. **Monitoring:** ED/designee will monitor infection control tracking log monthly through 12/31/2023.	06/30/2023

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	infections. During an interview, on 05/09/2023 at 2:38 p.m., the Executive Director and Director of Health Services indicated they were unaware of additional policies related to the Infection Control program which included, but was not limited to, a system to analyze current and ongoing infections and indicated they were unaware such a system was required. They indicated no system was currently in place at the time of the survey.		The results of the infection control tracking log will be reviewed at each Continuing Improvement/Quality Assurance meeting.	