PRINTED: 02/26/2025 FORM APPROVED

DELAKTIVENT OF HEALTH AND HUMAN SERVICES						
CENTERS FOR MEDICARE & MEDIC	CAID SERVICES		OMB NO. 0938-039			
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>	COMPLETED			

		A. BUILDING B. WING	00	COMPLETED 02/07/2025		
	PROVIDER OR SUPPLIER		3895 S	STREET ADDRESS, CITY, STATE, ZIP COD 3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	(X5) COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
= 0000						
Bldg. 00	This visit was for th	ne Investigation of Complaints	F 0000			
	Complaint IN00450 the allegations are c	1922 - No deficiencies related to cited.				
	_	215 - Federal/State deficiencies tions are cited at F550, F761,				
	Unrelated deficienc	ies are cited.				
	Survey dates: Febru	nary 6 and 7, 2025				
	Facility number: 00 Provider number: 1: AIM number: 1002	55409				
	Census Bed Type: SNF/NF: 72 Total: 72					
	Census Payor Type: Medicare: 1 Medicaid: 65 Other: 6	:				
	Total: 72  These deficiencies raccordance with 410	reflect State Findings cited in 0 IAC 16.2-3.1.				
	Quality review com	pleted February 10, 2025.				
5 0550 SS=D	483.10(a)(1)(2)(b) Resident Rights/E					
Bldg. 00	Based on interview	and record review, the facility	F 0550	F550 Resident Rights/Exercise	e of 02/23/2025	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Alicia Harris Administrator 02/20/2025 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: PHX111 Facility ID: 000537 If continuation sheet Page 1 of 14

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			COMPLETED	
		155409	B. WI	NG		02/07	/2025	
				CEREE	ADDRESS COMMA STATE FOR SOR	<u> </u>		
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD			
\ \\\\ \TED(	OF INDIANADOL	IO THE			KEYSTONE AVE			
WATER	S OF INDIANAPOL	IS, THE		INDIAN	NAPOLIS, IN 46227			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	failed to ensure res	sident rights were maintained			Rights			
	when a cognitively	intact resident was not			It is the intent of this facility to			
	allowed to sign ou	t for a leave of absence for 1 of			ensure residents rights are			
	3 residents review	ed for resident's rights.			maintained by allowing reside	nts		
	(Resident C)				cognitively intact to sign-out for	or a		
					leave of absence.			
	Findings include:							
					what corrective action(s) will be	Эе		
	During an intervie	w on 2/6/25 at 9:42 a.m.,			accomplished for those reside	ents		
	Resident C indicat	ed the staff had told her that			found to have been affected b	y the		
	she cannot sign ou	t and leave the facility for a			deficient practice.			
	leave of absence as	nd they had not let her leave.						
					Resident C was assessed on			
	During an intervie	w on 2/6/25 at 1:09 p.m., the			2-17-25 with no signs of			
	Director of Nursin	g (DON) indicated Resident C			psychosocial distress by the			
	was allowed to sig	n out and leave the facility with			SSD/Designee			
	family or friends, l	out not with her boyfriend.						
	Resident C was no	t allowed to sign out on her			Order received on 2-17-25 that	at		
	own even though s	she was cognitively intact. The			resident may go on LOA, by the	he		
	DON did not think	Resident C's rights were			DON/Designee			
	violated.							
					how other residents having th	е		
		I was reviewed on 2/7/25 at 12:13			potential to be affected by the	:		
	p.m. The diagnose	s included, but were not limited			same deficient practice will be	<b>;</b>		
	to, alcohol abuse, j	psychoactive substance abuse,			identified and what corrective			
	and bipolar disord	er.			action(s) will be taken.			
		nimum Data Set (MDS)			Audit of orders for leave of			
		12/25/24, indicated Resident C			absences completed on 2-20-			
	was cognitively in	tact.			by the DON/Designee, no oth	er		
					residents were found to be			
		n's order, dated 12/24/24,			affected.			
		C may not go out on a leave of						
	absence. There wa	s no stop date noted.			measures will be put into place			
					and what systemic changes w	/ill		
		a.m., the DON provided a copy			be made to ensure that the		1	
		ity policy, titled Your Rights			deficient practice does not red	cur.		
		a Nursing Home Resident, and						
		the current policy used by the			The ADMIN/Designee staff or		1	
1	facility. A review	of the policy indicated residents			resident rights with emphasis	on		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

PHX111 Facility ID: 000537

If continuation sheet Page 2 of 14

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/26/2025 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION  OF CORRECTION  155409	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 02/07/2025
	PROVIDER OR SUPPLIER S OF INDIANAPOLIS, THE	3895 S	ADDRESS, CITY, STATE, ZIP COD KEYSTONE AVE JAPOLIS, IN 46227	
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	have the right to leave the facility.  This citation relates to Complaint IN00451215.  3.1-3(a)		leave of absence for cognitive intact residents was complete 2-23-25. Any staff that fails to comply with the points of education will be further educand/or disciplined.  how the corrective action(s) we monitored to ensure the defici practice will not recur, i.e., who quality assurance program with put into place; and  DON/Qualified designee will interview 10 random residents 10 random staff members on residents right for leave of absweekly for 4 weeks, then 5 random residents and staff members weekly for 4 weeks, then 3 random residents and staff members weekly x 4 months. The facility is within 95% compliance at the end of the months, the monitoring will be stopped. Any concerns noted be addressed immediately at time of audit. The results of the audit will be reviewed, reported and trended for compliance through the facility Quality Assurance and Performance Improvement Committee for a minimum of six months then randomly thereafter until substantial compliance is achieved.	ely d on ated  ated  will be ent at ll be sand the sence  staff If  will the ne ed

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

PHX111 Facility ID: 000537

If continuation sheet

Page 3 of 14

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/07/2025 155409 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227 WATERS OF INDIANAPOLIS, THE (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE F 0609 483.12(b)(5)(i)(A)(B)(c)(1)(4) SS=D Reporting of Alleged Violations Bldg. 00 Based on interview and record review, the facility F 0609 02/23/2025 p paraid="2231466" failed to report an allegation of abuse for 1 of 3 paraeid="{566b77a4-0459-4d8d-9b residents reviewed for abuse. Staff did not ab-1400b9668295}{240}" >F609 immediately report to the administrator when staff Reporting of Alleged Violations overheard a female resident tell a male staff member she would report him for hitting her and did not accurately report all known information It is the intent of this facility to regarding the allegation of abuse at the time the report an allegation of abuse and allegation was reported to the state survey for staff to report the allegation to agency. (Resident B, CNA 1, CNA 2, DON, Floor the abuse coordinator at the time Tech) of the allegation. Findings include: what corrective action(s) will be accomplished for those residents During an interview on 2/6/25 at 10:02 a.m., found to have been affected by the Resident B indicated a couple of weeks ago, in the deficient practice. morning, she was wheeling down the hall and attempted to pass the Floor Technician (Floor Resident B had Skin assessment Tech), from behind, as he was buffing the floor. completed on 2/9/2025 with no The machine was plugged in and the cord was alterations noted. Psycho-social across the floor, and Resident B was on his left. follow up completed by Social The Floor Tech stuck out his left arm and hit her Service Director on 2-17-25 with right shoulder. Resident B said I'm telling that you no negative psycho-social noted hit me. Resident B didn't think the Floor Tech. from alleged abuse. intended to hit her. Resident B couldn't remember the date this happened, but thought it happened how other residents having the between 1/20/25 and 1/22/25. potential to be affected by the same deficient practice will be During an interview on 2/6/25 at 10:16 a.m., the identified and what corrective Floor Tech indicated, on the morning of 1/22/25, action(s) will be taken. he was buffing the floor when Resident B wheeled the front wheels of her wheelchair over the power All residents that currently reside cord to the buffer. He told Resident B to back off in the facility have the potential to the cord and as the Floor Tech pulled the cord out be affected by the alleged deficient of the wall he touched Resident B's hand. The practice. A facility wide skin Floor Tech left work until approximately 1:30 p.m., sweep was completed by the that day until the Director of Nursing (DON) told DON/Designee on 2-20-25 on

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

PHX111

Facility ID: 000537

If continuation sheet

Page 4 of 14

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155409	B. W	ING		02/07	2025
		<u> </u>		CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			KEYSTONE AVE		
WATER	S OF INDIANAPOL	IS THE			IAPOLIS, IN 46227		
WATER	OF INDIANAFOL			INDIAN			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	him he had to leave	e due to the abuse allegation.			residents with a Bim's of 12 o	r	
					less. Abuse questionnaires w	/ere	
	During an interview	w on 2/6/25 at 10:32 a.m., the			completed by the SSD/Desigr	nee	
	Director of Nursing	g (DON) indicated on 1/22/25 at			on 2-17-25 for all residents wi	th a	
	approximately 6:01	a.m., Resident B reported she			Bim's score of 13 or higher. A	ny	
	was going down th	e hallway and tried to roll over			concerns for addressed or		
	the cord to the buff	Fer as the Floor Tech was			reported as needed.		
	buffing the floor. R	Resident B said the Floor Tech					
	jerked the cord out	of the wall and purposely hit			measures will be put into place	e	
	her right upper arm	n. The Floor Tech said he stuck			and what systemic changes w	/ill	
	his arm out, so Res	ident B didn't get hurt. CNA 1			be made to ensure that the		
	and CNA 2 heard I	Resident B tell the floor tech she			deficient practice does not red	cur.	
	was going to repor	t him for hitting her. The DON					
	wasn't sure if all of	that information should have					
	been included in th	e initial incident report for the			ul class="BulletListStyle1		
	state health departr	nent because the corporate			SCXW126038273 BCX8"		
	office had to appro	ve it before they filed it.			role="list"		
					style="-webkit-user-drag: non	e;	
	During an interview	w on 11:06 a.m., CNA 1			-webkit-tap-highlight-color:		
	indicated she never	heard Resident B tell anyone			transparent; margin: 0px; pad	ding:	
	she would report th	nem for hitting her. CNA 1 was			0px; user-select: text; cursor:		
	not aware of any ir	ncident that occurred with			text; font-family: verdana; ove	rflow:	
	Resident B and the	Floor Tech. This was the first			visible;"		
	time CNA 1 heard	anything about any incident			The Administrator/Designee		
	between Resident I	B and the Floor Tech.			completed education with faci	lity	
					staff including Floor Tech, CN	IA 1,	
	During an interview	w on 2/6/25 at 1:24 p.m., CNA 2			2 and DON on the Abuse		
	indicated when she	was standing in another			Reporting including ensuring		
	residents bathroom	getting ready to provide			residents were free from abus	se on	
	morning care when	she heard Resident B say she			2-23-25. Additionally, any		
	was going to repor	t that someone hit her. CNA 2			employee who fails to comply	with	
	didn't leave the oth	er resident's room to check on			the points of the in-service ma	ay be	
	Resident B nor rep	ort what Resident B said. CNA			further educated and/or		
	2 should have repo	rted what Resident B said.			progressively disciplined as		
					indicated.		
	The clinical record	for Resident B was reviewed,			how the corrective action(s) w	ill be	
	on 2/6/25 at 11:32	a.m. The diagnoses included,			monitored to ensure the defici		
		d to, bacteremia, acute			practice will not recur, i.e., wh		
		and pulmonary edema			quality assurance program wi		
		_ <del>-</del>			put into place; and		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155409		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction (2)	X3) DATE SURVEY COMPLETED 02/07/2025	
	PROVIDER OR SUPPLIER		3895 S	ADDRESS, CITY, STATE, ZIP COD KEYSTONE AVE JAPOLIS, IN 46227	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE  CY MUST BE PRECEDED BY FULL  LIGO IDENTIFYING DEFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
TAG	An admission Minin assessment, dated 1 was cognitively inta On 2/6/25 at 11:42 of a typed documen statements from sta allegation. A review CNA 2 overheard R going to report him On 2/6/25 at 11:44 of an undated facility Prevention Program current policy used policy indicated all report any incident abuse.  On 2/7/25 at 9:20 a reportable incident, indicated on 1/23/2: the Administrator the report him when she morning, on 1/22/2: pantry, and he was a tried to pass him an cord.  On 2/7/25 at 2:30 p provide a policy reghealth department.  3.1-28(c)	num Data Set (MDS) 2/18/24, indicated Resident B act and used a wheelchair.  a.m., the DON provided a copy t and indicated it was the ff about Resident B's of the document indicated esident B say that she was for hitting her.  a.m., the DON provided a copy ty policy, titled Abuse a, and indicated this was the by the facility. A review of the employees must promptly or suspected incident of  m., the DON provided the dated 1/22/25 at 6:01 a.m., the Floor Tech reported to nat Resident B was going to the tried to pass him this to, as she was going to the cutfing the floors when she d roll her wheelchair over the  m., the facility was unable to tarding reporting to the state	TAG	The Social Service Director/designee will conduct interviews 10 random residents week x 4 weeks, then 5 random residents a week x 4 weeks, the 3 random residents once a mor x 4 months.  The ADMIN will interview 10 random staff members on Abus reporting weekly x 4 weeks, the 5 random staff members weekly 4 weeks, then 3 random staff members monthly x 4 months.  If the facility is within 95% compliance at the end of the 6 months, the monitoring will be stopped. Any concerns noted w be addressed immediately at the time of audit. The results of the audit will be reviewed, reported and trended for compliance through the facility Quality Assurance and Performance Improvement Committee for a minimum of six months then randomly thereafter until substantial compliance is achieved.	en e
F 0610 SS=D Bldg. 00	Ü	nt/Correct Alleged Violation and record review, the facility	F 0610	p paraid="407376764"	02/23/2025
		abuse policy and ensure an	1 0010	paraeid="{6f9a641c-4500-4a84	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155409		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 02/07/2025	
	ROVIDER OR SUPPLIER		3895 S	ADDRESS, CITY, STATE, ZIP COD S KEYSTONE AVE NAPOLIS, IN 46227	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	removed from the f	of abuse was immediately acility for 1 of 3 residents (Resident B, Floor Tech, CNA		5-98f51ae0f796}{123}" >F610 Investigate/Prevent/Correct Alleged Violation	
	Findings include:				
	Resident B indicate morning, she was w attempted to pass the Tech), from behind The machine was p	on 2/6/25 at 10:02 a.m., d a couple of weeks ago, in the wheeling down the hall and the Floor Technician (Floor the as he was buffing the floor. lugged in, the cord was across ent B was on his left. The		It is the policy of this facility to ensure an alleged perpetrator abuse is immediately remove from the facility.	r of
	shoulder. Resident I me. Resident B did intended to hit her.	at his left arm and hit her right B said I'm telling that you hit n't think the Floor Tech Resident B couldn't remember ned, but thought it happened d 1/22/25.		what corrective action(s) will accomplished for those reside found to have been affected a deficient practice.  perpetrator of abuse was suspended pending investiga	ents by the
	Floor Tech indicate he was buffing the the front wheels of cord to the buffer. If the cord and as the of the wall he touch	on 2/6/25 at 10:16 a.m., the d, on the morning of 1/22/25, floor when Resident B wheeled her wheelchair over the power He told Resident B to back off Floor Tech pulled the cord out led Resident B's hand. The k at approximately 1:30 p.m.,		on 1-23-25.  Resident B was assessed on 1-23-25 by the DON/Designe with no negative outcome.	
	that day until the Dihim he had to leave  During an interview  Director of Nursing	irector of Nursing (DON) told due to the abuse allegation. on 2/6/25 at 10:32 a.m., the (DON) indicated CNA 1 and ent B tell the floor tech she		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.	e e
	was going to report  During an interview indicated she never			All residents that currently resin the facility have the potention be affected by the alleged depractice. A facility wide skin sweep was completed by the	al to ficient

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

PHX111 Facility ID: 000537

If continuation sheet

Page 7 of 14

PRINTED: 02/26/2025 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC	AID SEKVICES			OMB NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155409	B. WING		02/07/2025
		.55100	<u> </u>		32,01,2020
NAME OF F	PROVIDER OR SUPPLIER		STREE	T ADDRESS, CITY, STATE, ZIP COD	
NAME OF P	KOVIDEK OK SUPPLIER	<b>S</b>	3895	S KEYSTONE AVE	
WATERS	OF INDIANAPOLIS	S, THE	INDIA	ANAPOLIS, IN 46227	
	T	,		,	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	not aware of any inc	eident that occurred with		DON/Designee on 2-20-25 on	
		Floor Tech. This was the first		residents with a Bim's of 12 or	
		nything about any incident		less. Abuse questionnaires w	
		and the Floor Tech.		- I	
	between Resident B	and the Floor Tech.		completed by the SSD/Design	
				on 2-17-25 for all residents wi	
		on 2/6/25 at 1:24 p.m., CNA 2		Bim's score of 13 or higher. A	ny
		anding in another residents		concerns for addressed or	
	bathroom getting re	ady to provide morning care		reported as needed.	
	when she heard Res	ident B say Resident B was			
	going to report that	someone hit her. CNA 2		measures will be put into place	e
		er resident's room to check on		and what systemic changes w	
		ort what Resident B said. CNA		be made to ensure that the	""
	_	ted what Resident B said.			u ie
	2 should have repor	ted what Resident B said.		deficient practice does not rec	ur.
	701 1''' 1 1	6 D '1 (D ' 1			
		for Resident B was reviewed		The ADMIN or completed	
		The diagnoses included, but		education with facility staff on	the
		bacteremia, acute respiratory		Abuse Policy on 2-23-25.	
	failure, and pulmon	ary edema		Additionally, any employee wh	10
				fails to comply with the points	of
	An admission Minii	mum Data Set (MDS)		the in-service may be further	
		2/18/24, indicated Resident B		educated and/or progressively	,
		act and used a wheelchair.		disciplined as indicated.	
	was cognisively into			alcolpinioa ao malcatea.	
	On 2/6/25 at 11:42	a.m., the DON provided a copy			
		t and indicated it was the		ul alaga="Dullati intOtylad	
				ul class="BulletListStyle1	
		ff about Resident B's		SCXW261030798 BCX8"	
		of the document indicated		role="list"	
		or Tech. and Resident B but		style="-webkit-user-drag: none	e;
	did not see an inapp	ropriate interaction. CNA 1		-webkit-tap-highlight-color:	
	overheard Resident	B say she was going to report		transparent; margin: 0px; pade	ding:
	him for hitting her.	CNA 2 did not see an		0px; user-select: text; cursor:	
	_	ction but overheard Resident		text; font-family: verdana; ove	rflow:
		g to report him for hitting her.		visible;"	
				how the corrective action(s) w	ill he
	During an interview	on 2/7/25 at 8:06 a.m., the		monitored to ensure the defici	
	_				
		1/22/25 at approximately 6:01		practice will not recur, i.e., wh	
		d the DON that earlier that		quality assurance program wil	l be
	_	ed down the hallway and tried		put into place; and	
	to roll over the cord	to the buffer as the Floor		The ADMIN/Designee will aud	lit

FORM CMS-2567(02-99) Previous Versions Obsolete

Tech was buffing the floor. Resident B said the

Event ID:

PHX111

Facility ID: 000537

allegation of abuse and

If continuation sheet

Page 8 of 14

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155409		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 02/07/2025	
	PROVIDER OR SUPPLIER		3895 S	ADDRESS, CITY, STATE, ZIP COD S KEYSTONE AVE NAPOLIS, IN 46227	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE
	purposely hit her rig wasn't sure if all of been included in the state health departm office had to approve During an interview Administrator indic have stopped and re CNA 2 should have and ensured Resides should have been re time.  On 2/6/25 at 11:44 of an undated policy Program, and indicaused by the facility, indicated separate the ensure all resident's suspected of abuse states.	the cord out of the wall and that information should have that information should have to initial incident report for the tent because the corporate of it before they filed it.  If on 2/7/25 at 8:50 a.m., the that the Floor Tech should moved himself from the floor. It is stopped what she was doing that B's safety. The Floor Tech moved from the facility at that the a.m., the DON provided a copy of titled Abuse Prevention that this was the current policy. A review of the policy the alleged perpetrator and safety. Staff members who are shall immediately be barred intact with residents and be the staff of the policy.		suspension of the alleged perpetrator daily x 6 months. facility is within 95% compliar after months, the monitoring will be stopped. Any concerns not will be addressed immediately the time of audit. The results the audit will be reviewed, repand trended for compliance through the facility Quality Assurance and Performance Improvement Committee for a minimum of six months then randomly thereafter until substantial compliance is achieved.	orce  will  oted  y at  of  ported
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs	and Biologicals			
	review, the facility is were stored in accomprofessional princip observed for medical unlabeled medication medication cart and when opened. (Resi	on, interview, and record failed to ensure medications redance with accepted les for 2 of 3 residents ation administration. An on was not removed from the eye drops were not dated dent D, QMA 1, LPN 1)	F 0761	p paraid="1312258184" paraeid="{8aae392b-ac66-42 3a-7a1d85b57082}{16}" >F76 Label/Store Drugs and Biolog  It is the intent of this facility to store medications in accordar with accepted professional standards, remove medicatio	oicals nce

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

 $PHX111 \qquad {\tt Facility \, ID:} \quad 000537$ 

If continuation sheet

Page 9 of 14

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLETED	
		155409	B. W	ING		02/07/	2025
				CTREET	ADDRESS CITY STATE ZID COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
\A/A TED	OF INDIANADOLI	O TUE			KEYSTONE AVE		
WATERS	OF INDIANAPOLI	5, THE		INDIAN	IAPOLIS, IN 46227		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	тс	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	at 8:09 a.m., Qualif	ied Medication Aide (QMA) 1			that are unlabeled from the		
		out of the medication cart. The			medication carts, and date eye	e l	
		torn off so there was no			drops when opened.		
	1 ~	nedication name or strength,					
		Two white round pills with			what corrective action(s) will b	e l	
		f each pill were observed. At			accomplished for those reside		
		ndicated the medication packet			found to have been affected b		
	· ·	ved should not have been left			deficient practice.	y tile	
		art because she didn't know			denoient praduce.		
		was for, what the medication			The DON/Designee assessed		
	was, nor the direction				Resident D on 2-8-25 and was		
	was, nor the direction	5115.			affected undated eye drops.	5 1101	
	During an interview	on 2/6/25 at 10:32 a.m., the			anected undated eye drops.		
	_	(DON) indicated the			Evo drope for regident D		
	_	with the label removed should			Eye drops for resident D		
	_	from the medication cart.			destroyed and replaced on	_	
	nave been removed	from the medication cart.			2-11-25, by the DON/Designe	e.	
	On 2/6/25 at 11:44	a.m., the DON provided a copy			how other residents having the	۵	
		titled Prescription Labels,			potential to be affected by the		
		ndicated this was the current			same deficient practice will be		
		facility. A review of the policy			identified and what corrective	'	
		n containers having damaged			action(s) will be taken.		
	labels are returned t				action(s) will be taken.		
	labels are returned t	the pharmacy.					
	2 During a medicat	tion pass observation on 2/6/25					
	1	ed Practical Nurse (LPN) 1			DON/Designee audited medic	ation	
		er and opened a new bottle of			carts for un-labeled and un-da		
		e drops (antihistamine eye drop			medications. Any Medications		
	· ·	yes) for Resident D. LPN 1 did			that were found to not have la		
	_ ·	opened bottle before nor after				beis	
	the eye drops were	-			and not have dates were		
	me eye drops were	aummistereu.			destroyed and replaced on		
	During on interview	on 2/6/25 at 10:32 a.m., the			2-8-25.		
		(DON) indicated the bottle of			magauraa will be nut into -le-		
					measures will be put into place		
		hould have been dated when			and what systemic changes w	'III	
	the nurse opened it.				be made to ensure that the		
	0.0/5/05 : 0.00	4 6 72			deficient practice does not rec	ur.	
	_	.m., the facility was unable to					
		garding dating opened			The DON or completed educa		
	medications.				with and Qualified Medication		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

 $PHX111 \qquad {\tt Facility \, ID:} \quad 000537$ 

If continuation sheet Page 10 of 14

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/26/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155409		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 02/07/2025	
	PROVIDER OR SUPPLIEF		3895 S	ADDRESS, CITY, STATE, ZIP COD S KEYSTONE AVE NAPOLIS, IN 46227	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	This citation relates 3.1-25(j)	to Complaint IN00451215.		Assistances on Medication storage, dating medications we opened and removing any medication unlabeled from the medication carts on 2-8-25. Additionally, any employee where the in-service may be further educated and/or progressively disciplined as indicated.	no of
				ul class="BulletListStyle1 SCXW68741532 BCX8" role= style="-webkit-user-drag: nonwebkit-tap-highlight-color: transparent; margin: 0px; pad 0px; user-select: text; cursor: text; font-family: verdana; ove visible;" how the corrective action(s) w monitored to ensure the defici practice will not recur, i.e., wh quality assurance program wi put into place; and The DON/designee will complian audit of medication carts fo unlabeled medications and da of medications 5 x a week x 4 weeks, then 3 times a week x once a week x 4 months. If th facility is within 95% complian after months, the monitoring w be stopped. Any concerns now will be addressed immediately the time of audit. The results the audit will be reviewed, rep and trended for compliance through the facility Quality Assurance and Performance	e; ding:  rflow:  rill be dent at ll be lete or ating 4 e nce vill ted y at of

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

PHX111 Facility ID: 000537

If continuation sheet Page 11 of 14

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	A. BUILDING <u>00</u>			COMPLETED	
		155409	B. WI	NG		02/07	/2025
		_		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹		3895 S	KEYSTONE AVE		
WATERS	OF INDIANAPOLI	S, THE		INDIAN	NAPOLIS, IN 46227		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. TAG  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI.		TE.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG			DATE
					Improvement Committee for a		
					minimum of six months then		
					randomly thereafter until		
					substantial compliance is achieved.		
					acilieved.		
F 0880	483.80(a)(1)(2)(4)	)(e)(f)					
SS=D	Infection Preventi	on & Control					
Bldg. 00							
		on, interview, and record	F 08	380	p paraid="1752615662"		02/23/2025
		failed to ensure infection			paraeid="{8aae392b-ac66-429		
		ined during the administration			3a-7a1d85b57082}{204}" >F8		
		of 3 residents reviewed for			Infection Prevention and Cont	rol	
	medication adminis	stration. (Resident D, LPN 1)					
	Findings include:				It is the policy of this facility to		
	Findings metade.				maintain infection control during		
	During a medicatio	n pass observation on 2/6/25 at			the administration of eye drop	-	
	_	Practical Nurse (LPN) 1 carried			and damming allow or eye arep	<b>.</b>	
	a bottle of Zaditor (	The state of the s			what corrective action(s) will b	е	
	(antihistamine eye	drop used to treat itchy eyes)			accomplished for those reside		
	into Resident D's ro	oom. LPN 1 was not observed			found to have been affected b	y the	
	to be wearing glove	es. LPN 1 explained what she			deficient practice.		
		nister and took a pair of clean					
	~	and donned the gloves while			The DON/Designee assessed		
		ps. LPN 1 was not observed to			resident D on 2-8-25 and no		
		ene before donning the gloves.			negative outcome related to the	ıe	
		ident D was sitting up in his			cited deficient practice.		
		s head back, gently pulled ht eye lid, and administered one			how other residents having the	•	
		edge of the right eye and			how other residents having the potential to be affected by the		
	•	r three seconds. Then LPN 1			same deficient practice will be		
		r eye lid down, administered			identified and what corrective		
	-	uter left eye and applied			action(s) will be taken.		
	_	econds. LPN 1 asked Resident					
		emoved her gloves, and left the			All residents that currently res	ide	
	-	iene was observed. LPN 1			in the facility have the potentia		
		eye drops back into the			be affected by the alleged def		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

PHX111 Facility ID: 000537

If continuation sheet Page 12 of 14

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/26/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED		
		155409	B. WING			02/07/2025		
			<u> </u>	CTREET	ADDRESS CITY STATE ZID COD	<u> </u>		
NAME OF F	PROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP COD			
\A/A TED	OF INDIANADOLI	0. THE	3895 S KEYSTONE AVE					
WATERS	OF INDIANAPOLI	S, THE	INDIANAPOLIS, IN 46227					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		DDOVIDED'S DI AN OE CODDECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG				TAG	DEFICIENCY)	16	DATE	
	labeled baggy in the top drawer of the medication				practice, therefore this plan of			
	cart.	•		correction applied to all residen that reside in the facility.				
	During an interview	During an interview on 2/6/25 at 10:32 a.m., the			,			
	_	g (DON) indicated the nurse						
	_	d her hands before she put on			ul class="BulletListStyle1			
		r Resident D's eye drops.			SCXW207495430 BCX8"			
		-7 £0.			role="list"			
	On 2/6/25 at 11:44 a.m., the DON provided a co			style="-webkit-user-drag: n		÷.		
	of a facility policy, titled Eye Drop Administration,				-webkit-tap-highlight-color:	-,		
	dated 3/2023, and indicated this was the current				transparent; margin: 0px; pado	dina:		
	policy used by the facility. A review of the policy				Opx; user-select: text; cursor:	9.		
	indicated properly wash hands before and after				text; font-family: verdana; over	flow.		
	the administration of				visible;"			
	the administration of eye drops.				measures will be put into place	2		
	This citation relates to Complaint IN00451215.				and what systemic changes w			
	This citation relates to complaint 1100451215.				be made to ensure that the			
	3.1-18(b)(1)			deficient practice does not re				
					The DON or completed education			
					with nursing staff and Qualified			
				Medication Assistance on hand				
					hygiene during medication	u .		
					administration. Additionally, a	anv		
					employee who fails to comply	-		
					the points of the in-service ma			
					further educated and/or	y bc		
					progressively disciplined as			
					indicated.			
					maloatea.			
					how the corrective action(s) w	ill ha		
					monitored to ensure the deficie			
					practice will not recur, i.e., who			
					quality assurance program wil			
					put into place; and	. 50		
					pat into piaco, and			
					DON/Designee will complete			
					Medication administration aud	ite		
					for hand hygiene during	11.3		
					medication administration,			
				DON/Designee will audit 10				
					DON/Designee will audit 10			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

PHX111 Facility ID: 000537

If continuation sheet Page 13 of 14

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/26/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155409	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  02/07/2025		
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227				
(X4) ID PREFIX TAG	(EACH DEFICIE)	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE	
				random nurse/ for 4 weeks, the random nurse/QMA for weekly weeks, then 3 random nurse/Q weekly x 4 months. If the facili within 95% compliance after months, the monitoring will be stopped. Any concerns noted be addressed immediately at time of audit. The results of the audit will be reviewed, reporter and trended for compliance through the facility Quality Assurance and Performance Improvement Committee for a minimum of six months then randomly thereafter until substantial compliance is achieved.	y QMA ty is will will the		

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: PHX111 Facility ID: 000537 If continuation sheet Page 14 of 14