STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	07/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
INDEPENDENCE VILLAGE OF FISHERS SOUTH	9745 OLYMPIA DR FISHERS, IN 46038

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00411223. Complaint IN00411223 - State deficiencies related to the allegations are cited at R0052 and R0241. Survey dates: July 5,6, and 7, 2023 Facility number: 002999 Residential Census: 77 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on July 12, 2023	R 0000	The submission of the Plan of Correction does not indicate an admission by Independence Village of Fishers South that the findings and allegations contained herein are an accurate and true representation of the quality of care provided to the residents of Independence Village of Fishers South. The Community hereby maintains it is in substantial compliance with the requirements of participation for residential health care communities. To this end, the Plan of Correction shall serve as the credible allegation of compliance with all State requirements governing the operations of this Community. Independence Village of Fishers South respectfully requests a desk review for paper compliance.	
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (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 interview and record review, the facility failed to protect residents from physical abuse by other residents', resulting in a physical altercation	R 0052	1. Resident # 45 was sent to the ER for evaluation and treatment due to her bruised area around her eye and the skins	07/26/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Karen Yarnell Rumple	Administrator	08/16/2023

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	between 2 residents with one resident being evaluated at an emergency department and sustaining a black eye and skin tears for 3 of 4 residents reviewed for abuse (Resident 14, 45, and 58). Findings include: 1a. The clinical record for Resident 14 was reviewed on 7/5/23 at 2:30 p.m. The Resident's diagnosis included, but were not limited to, dementia, anxiety, and urinary tract infection. A Wellness Evaluation Form, dated 2/7/23, indicated Resident 14 needed assistance administering her medications and had behaviors that needed to be monitored. 1b. The clinical record for Resident 45 was reviewed on 7/5/23 at 3:00 p.m. The Resident's diagnosis included, but were not limited to, dementia and anxiety. A service plan, initiated 2/10/23, indicated Resident 45 had behaviors. The goal was for her to identify factors that help to prevent or minimize inappropriate behaviors and to not act out in a way that is harmful to herself or others. The intervention, initiated 2/10/23, was to report changes from baseline behaviors to nurse. Resident 14's clinical record contained a progress note, dated 4/25/23 at 2:40 p.m., which read "...Resident was observed on the floor by exit door with other resident after report of screaming by other resident alerted staff. This resident stated that 'the other lady had her radio from the dealership and wasn't going to give it back, so I pushed her, and we both ended up on the floor'.		tears. Resident was returned to the Community. Resident was monitored for signs and symptoms of pain and emotional distress. None noted. Resident # 14 was sent to acute care for evaluation and treatment instead of a psychological stay as per the Dr. ordered. Resident was being monitored by staff. Resident # 58 was separated from the aggressor, resident # 14. Resident # 58 had no visible injury. Resident # 58 was monitored for signs and symptoms of pain and emotional distress. None noted. 2. The Community realizes that residents have the potential to be affected by the deficient practice. 3. The Executive Director no longer works at Independence Village of Fishers South. An interim Executive Director has been appointed to the Community. The interim Executive Director is familiar with our company's abuse prohibition policy, how to conduct a thorough investigation and the incident reporting requirements. Staff have been educated regarding the Community's Abuse Prohibition policy and reporting requirements. 4. The Wellness Director/designee will review resident notes and the 24-hour report daily to ensure the Executive Director has been made aware of any unusual	

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	Alert and oriented to name. Full body assessed with no signs of abrasions, erythema [bruising], blood, swelling of the head, arms, knees. Resident able to follow command and move arms, legs, shoulders, fingers. Ambulated back to group room with aide. Family called...." Resident 45's clinical record contained a progress note, dated 4/25/23 at 2:47 p.m., which read "...upon arrival, two residents were on floor inside doorway. Resident was curled up in a ball with hands protecting head upon arrival. Two other staff were with both residents. Assessed on floor then moved to sitting position when a large knot was forming about right eye in brow line. Small skin tear above right brow and at right chin. Small skin tear on lift middle finger. Head palpated for other injury. Resident alert to name and followed directions. Able to move shoulders, arms, elbows, wrists, legs, knees, ankles. Assisted to standing position by other staff members and sat in rocker by door. Due to large knot to the brow line, triage called and 911 called. On 7/6/23 at 9:30 a.m., the ED (Executive Director) provided the Incident Report, dated 4/25/23 at 3:05 p.m., which indicated the incident was between Resident 45 and Resident 14. The brief description of the incident was added 4/28/23, indicating the residents were found entangled on floor upon arrival in doorway. Residents separated and evaluated by staff. Resident 45 was sent to the emergency department and Resident 14 was transported to an inpatient psychiatric hospital. 2. The clinical record for Resident 58 was reviewed on 7/7/23 at 10:45 a.m. The Resident's diagnosis included, but were not limited to,		occurrences. All findings will be forwarded to the quality assurance process improvement committee monthly for further review and recommendations for the next six (6) months.	

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	Alzheimer's disease and depression. Resident 45's clinical record contained a progress note, dated 5/26/23 at 7:29 p.m., indicated that a CNA (Certified Nursing Assistant) had witnessed Resident 45 hitting Resident 58 on the leg. No injuries were noted to Resident 45 or Resident 58. The ED was notified of incident. During an interview on 7/7/23 at 10:47 a.m., QMA 6 indicated she had been on duty when the incident between Resident 45 and Resident 58 had occurred. QMA 6 had been informed of the incident by the CNA who was working that evening. She helped to separate the residents and made sure there were no injuries. She had reported the incident to the ED. During an interview on 7/7/23 at 10:55 a.m., CNA 10 indicated he had witnessed the incident between Resident 45 and Resident 58. Resident 45 had been irritated because Resident 58 was sitting in one spot for a long period of time. Resident 45 does not like it when someone sits somewhere for too long. Resident 45 was using a balled fist to hit Resident 58 in the leg repeatedly. Resident 45 appeared to be angry while she was hitting resident 58. He had separated the residents and told the QMA on duty. CNA had written a statement about the incident, but had not been spoken to about it by the ED. During an interview on 7/7/23 at 12:45 p.m., the DON indicated there was no Reportable Incident or investigation file for the incident between Resident 45 and Resident 58. On 7/6/23 at 10:30 a.m., the ED provided the Abuse, Neglect, or Exploitation Policy, last updated 6/7/23, which read "...The purpose of the			

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	Abuse, Neglect, or Exploitation policy is to outline the process for the prevention, investigation and reporting of abuse, neglect, or exploitation...Definitions...Abuse- Harm or threatened harm to an adults' health or welfare caused by another person...Employees are to immediately report any witnessed or suspected incidents of abuse, neglect, or exploitation to the supervisor on duty and the Wellness Director or designee... All initial reports of an alleged or suspected incident will be reported as outlined in the state specific Resident Incident/ Accident Reporting policy..." This state residential finding relates to compliant IN00411223.			
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number			

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	published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request			
	Based on observation and interview, the facility failed to ensure the results to the Indiana Department of Health's survey reports were in an accessible location for residents to review. This had a potential to affect 77 of 77 residents that reside in the facility. Findings include: During an environmental tour with the Maintenance Director on 7/6/23 at 10:01 a.m., an observation was made of the front lobby. The	R 0090	1. No residents were affected by the alleged deficient practice. 2. The Community realizes that residents could have been affected by the alleged deficient practice. 3. The systemic change was that two (2) survey binders containing the survey results have been completed. One of them will be located in the lobby in an accessible location and will be	07/25/2023

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	Maintenance Director indicated he was unable to locate a survey reports binder for residents to review. An observation was made of the front lobby with the Administrator on 7/6/23 at 10:38 a.m. The survey reports binder was unable to be located. The Administrator indicated she would create one. An interview was conducted with the Director of Nursing on 7/6/23 at 4:30 p.m. She indicated the survey reports binder had been located, but it was not updated with current surveys.		available for review. The other binder will be kept in the Office of the Executive Director and will be placed in the lobby should the original binder become misplaced. 4. The receptionist will ensure daily that the survey binder remains in place within the lobby. In the event that the survey binder cannot be located, the duplicate survey binder will be retrieved from the Office of the Executive Director and placed in the lobby.	
R 0091 Bldg. 00	410 IAC 16.2-5-1.3(h)(1-4) Administration and Management - Noncompliance (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request. Based on interview and record review, the facility failed to implement the Abuse, Neglect, and Exploitation Policy by not timely reporting a witnessed incident of resident to resident physical abuse 1 of 4 residents reviewed for abuse (Resident 58) Findings include: 1a. The clinical record for Resident 58 was reviewed on 7/7/23 at 10:45 a.m. The Resident's diagnosis included, but were not limited to,	R 0091	1. Residents were affected. Nurses notes reflect no injury from incident. 2. The Community realizes that residents have the potential to be affected by the deficient practice. 3. The Executive Director no longer works at Independence Village of Fishers South. An	07/17/2023

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	Alzheimer's disease and depression. 1b. The clinical record for Resident 45 was reviewed on 7/5/23 at 3:00 p.m. The Resident's diagnosis included, but were not limited to, dementia and anxiety. Resident 45's clinical record contained a progress note, dated 5/26/23 at 7:29 p.m., indicated that a CNA (Certified Nursing Assistant) had witnessed Resident 45 hitting Resident 58 on the leg. No injuries were noted to Resident 45 or Resident 58. The ED was notified of incident. During an interview on 7/7/23 at 10:55 a.m., CNA 10 indicated he had witnessed the incident between Resident 45 and Resident 58. Resident 45 had been irritated because Resident 58 was sitting in one spot for a long period of time. Resident 45 does not like it when someone sits somewhere for too long. Resident 45 was using a balled fist to hit Resident 58 in the leg repeatedly. Resident 45 appeared to be angry while she was hitting resident 58. He had separated the residents and told the QMA on duty. CNA had written a statement about the incident, but had not been spoken to about it by the ED. During an interview on 7/7/23 at 12:45 p.m., the DON indicated there was no Reportable Incident or investigation file for the incident between Resident 45 and Resident 58. On 7/6/23 at 10:30 a.m., the ED provided the Abuse, Neglect, or Exploitation Policy, last updated 6/7/23, which read "...The purpose of the Abuse, Neglect, or Exploitation policy is to outline the process for the prevention, investigation and reporting of abuse, neglect, or exploitation...Definitions...Abuse- Harm or		interim Executive Director has been appointed to the Community. The interim Executive Director is familiar with and has been re-educated on our company's abuse prohibition policy, how to conduct a thorough investigation and the incident reporting requirements. Staff have been educated regarding the Community's Abuse Prohibition policy and reporting requirement and behavior monitoring. 4. The Wellness Director/designee will review resident notes and the 24-hour report daily to ensure the Executive Director has been made aware of any unusual occurrences.	

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	threatened harm to an adults' health or welfare caused by another person...Employees are to immediately report any witnessed or suspected incidents of abuse, neglect, or exploitation to the supervisor on duty and the Wellness Director or designee... All initial reports of an alleged or suspected incident will be reported as outlined in the state specific Resident Incident/ Accident Reporting policy..."			
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 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 1 staff person was certified in Cardiopulmonary Resuscitation (CPR) and first aid	R 0117	1. No residents were affected by the alleged deficient practice. 2. The Community realizes	08/18/2023

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	on each shift. This had a potential to affect 77 of 77 residents that resident in the facility. Findings include: A staff worked schedule was provided by the Administrator on 7/5/23 at 11:00 a.m. It indicated the following days and shifts a staff person was not certified in CPR and/or first aid: 6/28/23 - 2nd shift no first aid and 3rd shift no CPR or first aid, 6/29/23 - 2nd shift no first aid and 3rd shift no CPR or first aid, 6/30/23 - 2nd shift no first aid, 7/1/23 - 1st, 2nd and 3rd shifts no CPR or first aid, 7/2/23 - 1st and 3rd shift - no CPR or first aid, 2nd shift - no first aid, 7/3/23 - 2nd shift no first aid, 7/4/23 - 2nd shift no first aid, 7/5/23 - 2nd shift no first aid, 7/6/23 - 2nd shift no first aid, 7/7/23 - 2nd shift no first aid, 7/8/23 - 1st shift no CPR or first aid, 2nd shift no first aid and 7/9/23 - 1st no CPR or first aid and 2nd shift no first aid An interview was conducted with the Administrator on 7/6/23 at 2:55 p.m. She indicated she was trying to locate more CPR and first aid certification cards from the staff.		that residents had the potential to be affected by the alleged deficient practice. 3. The wellness employees that do not have both CPR and First Aid certifications have been identified. All the employees will be required to complete these certifications by August 18, 2023. Any wellness employee who does not complete the certifications will be removed from the schedule. All new hire wellness employees will be required to complete the certifications within the first seven (7) days of employment. All certifications will be placed in the licensure binder by month of certificate expiration dates. 4. The Wellness Director will review certifications monthly to ensure all certifications are up to date.	
R 0154 Bldg. 00	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24.			

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	Based on observation and interview, the facility failed to maintain a clean and sanitized kitchen environment. This had a potential to affect 77 of 77 residents that are served food from the kitchen. Findings include: A random observation was made on 7/5/23 at 10:41 a.m. Dietary Staff and Certified Nursing Assistants were observed entering the kitchen and making an immediate right entering in the food prep area without donning hairnets. An observation was made of the kitchen with the Dietary Manager (DM) on 7/5/23 at 11:17 a.m. The DM was observed with facial hair that was not contained with a covering. During food prep, Dietary Aide 1 was observed with shoulder length hair and facial hair not contained by covering of hair length nor of facial hair. Dietary Aide 2 had long braids that did have a hairnet on, but it did not contained the braid length. During the kitchen tour, along the back wall flooring of the dishwasher area, food prep area and the storage rooms were observed with food crumbs and paper product debris. The food prep area had dark brown black substance on the floor. The oven, fryer and stove appliances were observed with yellow and black spatter substance. An observation was made of the kitchen with the Dietary Manager on 7/5/23 at 2:30 p.m. The flooring in the dishwasher area, food prep area and dry storage rooms were observed. Along the back wall flooring were food crumbs and paper product debris. The stove was observed with food substance collected on foil inside and a black substance on the back wall of the stove.	R 0154	1. No residents were affected by the alleged deficient practice. 2. The Community realizes that residents have the potential to be affected by the alleged deficient practice. 3. All staff have been educated regarding the necessity of wearing hairnets and/or beard guards in the food prep areas. Dietary staff have been educated. The education included but was not limited to the following: · Wearing of hair coverings and beard guards for facial hair in the food prep areas · The daily cleaning schedules and all the associated expectations. · Lids must be kept on trash cans in the kitchen at all times. · Trash must be emptied when getting full. · Labeling, dating and storage of food · Dry storage dating and labeling 4. Daily cleaning checklists will be monitored by the Executive Chef. The Executive Director will inspect cleaning checklists bi-weekly for the next six (6) months.	08/18/2023

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	The oven and fryer was observed with a yellow and black splatter substance. An interview was conducted with the DM on 7/5/23 at 2:35 p.m. He indicated deep cleaning should be done monthly and wiping down of the appliances should be done in the evenings. He was unable to provide cleaning logs prior to July 3, 2023. The daily cleaning schedule was provided by the DM on 7/5/23 at 2:40 p.m. It indicated the flooring should be swept and mopped daily and clean the stovetop/grill. A culinary services policy was provided by the DM on 7/6/23 at 7:45 a.m. It indicated "...Food handlers must wear hairnets or caps to effectively keep hair from contacting exposed food, clean equipment, utensils and linens..."			
R 0155 Bldg. 00	410 IAC 16.2-5-1.5(l) Sanitation and Safety Standards - Deficiency (l) The facility shall have an effective garbage and waste disposal program in accordance with 410 IAC 7-24. Provision shall be made for the safe and sanitary disposal of solid waste, including dressings, needles, syringes, and similar items. Based on observation and interview the facility failed to ensure trash cans were covered when not in use for 1 of 2 trash cans observed. This had a potential to effect 77 of 77 residents that eat food served out of the kitchen. Findings include: An observation was made of the kitchen with the Dietary Manager on 7/5/23 at 11:17 a.m. One trash can was observed full to the top that contained	R 0155	1. No residents were affected by this alleged deficient practice. 2. The Community realizes that residents have the potential to be affected by the alleged deficient practice. 3. The Culinary staff have been educated regarding the trash cans being covered by lids at all times.	07/27/2023

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	food and paper products that was sitting on the side of the stove with food cooking. The trash can did not have a covered top and was not observed being used by staff at that time. An observation was made of the kitchen with the Dietary Manager on 7/5/23 at 2:30 p.m. One trash can was observed to be full to the top that contained paper products that was positioned on the side of the stove. The trash can did not have a covered top and was not observed being used by staff at that time. An interview was conducted with the Dietary Manager on 7/5/23 at 2:35 p.m. He indicated he was unaware the trash cans in the kitchen need to have a covered top.		4. The Executive Chef and Executive Director will monitor compliance by observations. Any negative findings will be corrected and will be forwarded to the Quality Assurance Process Improvement monthly for the next six months.	
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			

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	resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on observation, interview, and record review, the facility failed to timely update services plans for residents who experienced behaviors for 1 of 5 residents reviewed for service plans (Resident 45). Findings include: The clinical record for Resident 45 was reviewed on 7/5/23 at 3:00 p.m. The Resident's diagnosis included, but were not limited to, dementia and anxiety. A service plan, initiated 2/10/23, indicated Resident 45 had behaviors. The goal was for her to identify factors that help to prevent or minimize inappropriate behaviors and to not act out in a way that is harmful to herself or others. The intervention, initiated 2/10/23, was to report changes from baseline behaviors to nurse. Resident 45's clinical record contained a progress note, dated 5/26/23 at 7:29 p.m., indicated that a CNA (Certified Nursing Assistant) had witnessed Resident 45 hitting Resident 58 on the leg. No injuries were noted to Resident 45 or Resident 58. The ED was notified of incident. During an interview on 7/7/23 at 10:55 a.m., CNA 10 indicated he had witnessed the incident	R 0217	1. Residents were affected by the deficient practice. All service plans of the identified residents have been updated to reflect any updates. 2. The Community realizes that all residents have the potential to be affected by the deficient practice. 3. The wellness staff have been educated regarding the necessary updates included but not limited to the following: ADL's, Medication Management, physical needs, psychosocial needs, behavioral challenges and needs, any resident altercations. 4. The Wellness Director/designee will read the notes in Point Click Care for any updates to the service plan needed or any significant events, including changes in needs/behavior changes. Any pertinent issues will be reported to the Executive Director to ensure any altercations have already been	08/18/2023

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	between Resident 45 and Resident 58. Resident 45 had been irritated because Resident 58 was sitting in one spot for a long period of time. Resident 45 does not like it when someone sits somewhere for too long. Resident 45 was using a balled fist to hit Resident 58 in the leg repeatedly. Resident 45 appeared to be angry while she was hitting resident 58. He had separated the residents and told the QMA on duty. CNA had written a statement about the incident, but had not been spoken to about it by the ED. The service plan for Resident 45 had not been updated with the behavior of hitting other residents or not liking others to sit in one spot for a long period of time. On 7/6/23 at 11:15 a.m., the ED provided the Resident to Resident Contact Policy, last updated 12/20/21, which read "...The purpose of the Resident- to Resident Contact Policy is to ensure the safety of all individuals within the community if inappropriate behavior occurs between resident...If two residents are involved in an altercation, staff will...Make any necessary changes in the care plan approached to any or all of the involved individuals..." On 7/6/23 at 11:15 a.m., the ED provided the Resident Evaluation and Service Plan Policy, last updated 2/24/23, which read "...The purpose of the Resident Evaluation and Service Plan is to Establish a process to evaluate and plan for the Resident's needs. The purpose of the Service Plan is to provide a description of the services that will be provided to the resident based on his or her individual needs and preferences... Evaluation Frequency: 1. Immediately when a need for care is determined...4. Immediately with any change in care or change in condition..."		reported to the ED by staff.	

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R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on interview and record review, the facility failed to follow a physician's order to send a resident to an inpatient psychiatric hospital for a change of condition and failed to timely administer medications as ordered by a physician for 1 of 4 residents reviewed for abuse and 4 of 5 resident reviewed for medications (Resident B, C, 14, 45, and 71). Findings include: 1. The clinical record for Resident 14 was reviewed on 7/5/23 at 2:30 p.m. The Resident's diagnosis included, but were not limited to, dementia, anxiety, and urinary tract infection. A Wellness Evaluation Form, dated 2/7/23, indicated Resident 14 needed assistance administering her medications and had behaviors that needed to be monitored. A progress note, dated 4/10/23 at 10:36 a.m., indicated that Resident 14 had obtained a wooden rod and had indicated she was waiting to hit someone with it. The wooden rod was taken from Resident 14, and she had become angry and grabbed staff, scratching the staff with her nails. A progress note, dated 4/11/23 at 11:52 a.m.,	R 0241	1. The identified residents were affected by the deficient practice. 2. The Community realizes that all residents have the potential to be affected by the deficient practice. 3. The Community has been educated regarding following physician orders, and behavior monitoring. Any resident with combative behaviors will be placed on 1:1 until placement can be found at a behavioral health facility. 4. The Wellness Director/designee will review the 24-hour report in PCC to review Drs. orders and any behaviors. The Executive Director will be informed of any findings. Any negative findings will be forwarded to the Quality Assurance Committee for review and recommendations for the next six (6) months.	08/18/2023

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	indicated that NP (Nurse Practitioner) 3 had seen Resident 14 due to her behaviors and refusing to take medications, increased agitation, anxiety, and combativeness with staff. NP 3 had not wanted Resident 14 to go to an emergency room for evaluation but had wanted Resident 14 evaluated by an inpatient psychiatric hospital. A progress note, dated 4/11/23, 1:05 p.m., indicated Resident 14 was observed threatening other residents and staff with cane. Triage was called and they called 911. Fire and police arrived at transport resident to an acute care hospital. An order for a psychiatric evaluations was sent. A progress note, dated 4/11/23 at 10:53 p.m., indicated Resident 14 returned from acute care hospital with a prescription for Keflex (antibiotic). A physician's order, dated 4/11/23 at 11:52 a.m., read "...Please send patient to [name of psychiatric hospital] for urgent psychiatric evaluation and treatment..." A physician's order, dated 4/11/23 at 6:21 p.m., indicated Resident 14 was to receive Keflex 500 mg (milligram) 4 times daily for 10 days. The order was noted to be found in the Life Enrichment box on 4/12/23 at 5:15 p.m. It was faxed to the facility pharmacy on 4/12/23 at 5:15 p.m. The April MAR (Medication Administration Record) for April 2023 indicated Resident 14 did not receive the Keflex 500 mg, ordered on 4/11/23, until 4/13/23 at 4:00 p.m. The clinical record did not contain information about the inpatient psychiatric hospital being contacted to evaluate Resident 14, as ordered on 4/11/23.			

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	During an interview on 7/6/23 at 2:50 p.m., the DON (Director of Nursing) indicted she would have attempted to have Resident 14 evaluated by the inpatient psychiatric hospital as ordered and that the Keflex should have been ordered from the pharmacy on the day it was received and should have been started right away. 2. The clinical record for Resident C was reviewed on 7/5/23 at 1:30 p.m. The diagnosis for Resident C included, but were not limited to, Alzheimer's Disease and hypertension. The resident was admitted on 1/28/20. A physician order dated 4/26/23 indicated the resident was to receive 125 milligrams of divalproex three times a day. A physician order dated 4/26/23 indicated the resident was to receive 25 milligrams of hydrochlorot daily. A physician order dated 4/26/23 indicated the resident was to receive 25 milligrams of metoprolol daily. A physician order dated 4/26/23 indicated the resident was to receive 100 milligrams of sertraline daily. A physician order dated 4/26/23 indicated the resident was to receive 100 milligrams of trazadone daily. A physician order dated 4/26/23 indicated the resident was to receive 5 milligrams of buspirone daily.			

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	The May 2023 Medication Administration Record for Resident C indicated the following days and medications that were not available to administer: 100 milligrams of trazadone - 5/15/23, 5/16/23, 5/17/23, 5/18/23, 5/19/23, 5/21/23, 5/22/23, 5/23/23, and 5/24/23, 125 milligrams of divalproex - 5/16/23, 5/17/23, 5/18/23, 5/19/23, 5/21/23, 5/23/23 and 5/25/23, 5 milligrams of buspirone - 5/27/23 and 5/28/23, 100 milligrams of sertraline - 5/15/23 and 5/16/23 A medication note dated 5/27/23 indicated 5 milligrams of buspirone was ordered and waiting for new prescription. A medication note dated 5/28/23 indicated the buspirone was on order. A medication note dated 5/31/23 indicated waiting for buspirone to be delivered. Medication notes dated 5/15/23, 5/16/23, 5/17/23, 5/18/23, 5/19/23, 5/21/23, 5/22/23, 5/23/23, 5/24/23 indicated waiting for trazadone to be delivered by pharmacy. A medication note dated 5/16/23, 5/17/23, 5/18/23, 5/19/23, 5/21/23, 5/23/23 indicated 125 milligrams of divalproex was ordered and waiting for pharmacy to deliver. A medication note dated 5/16/23 and 5/31/23 indicated 100 milligrams of sertraline was on order. The June 2023 Medication Administration Record for Resident C indicated the following days and medications that were not available to administer: 100 milligrams of sertraline - 6/2/23, 6/4/23, and 6/9/23, 125 milligrams of divalproex - 6/15/23, 6/17/23 and			

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	6/19/23, 25 milligrams of hydrochlorot - 6/2/23, 6/4/23, and 6/6/23, 25 milligrams of metoprolol - 6/2/23, 6/4/23, and 6/6/23 A medication note dated 6/17/23 and 6/19/23 indicated 125 milligrams of divalproex was on order. 3. The clinical record for Resident 71 was reviewed on 7/7/23 at 9:45 a.m. The Resident's diagnosis included, but was not limited to, pulmonary embolism (blood clot in the lung). A physician's order dated 5/31/23. indicated Resident 71 was to receive warfarin (blood thinner) 4 mg daily until 6/6/23. The MAR for June 2023 indicated Resident 71 did not receive Warfarin 4 mg on 6/1, 6/2, 6/3, 6/4, 6/5, and 6/6/23. 4. The clinical record for Resident 54 was reviewed on 7/6/23 at 9:10 a.m. The resident's diagnosis included, but was not limited to, diabetes. A physician's order, dated 5/17/23, indicated he was to receive Ozempic 1mg to be injected subcutaneously once a week. On 7/6/23 at 9:10 a.m., QMA (Qualified Medication Aide) 5 was observed administering medications to Resident 54. While preparing the medications to be given, QMA 5 indicated that he did not administer Resident 54's Ozempic (diabetic medication). He was unsure who administered the Ozempic to Resident 54.			

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	The MAR for June and July 2023 indicated Resident 54 had not received his Ozempic on 6/29/23 and 7/6/23 due the medication not being available from the pharmacy. 5. The clinical record for Resident B was reviewed on 7/5/23 at 1:10 p.m. The Resident's diagnosis included, but was not limited to, Alzheimer's dementia and sleep disturbance. A service plan, initiated 2/10/23, indicated Resident B needed assistance with medications. The goal was for her to be supported in taking all medications safely and as ordered. The interventions, initiated 2/10/23, were to assist with ordering meds, help with medications due to cognitive loss, and requires daily supervision of medications. A physician's order, dated 4/4/23, indicated she was to receive pregabalin 25 mg twice daily. The April and May 2023 MAR indicated she did not receive her pregabalin 25 mg on the following 4/5, 4/8, 5/4, and 5/5/23. An interview was conducted with the Director of Nursing on 7/6/23 at 4:45 p.m. She indicated the facility utilizes an out of state pharmacy. The medications are delivered by a packaged delivery service. The facility did not have an emergency drug kit that stored medications for staff to utilize if the residents' medications run out. The staff need to reorder medications prior to running out to ensure they arrive timely. On 7/6/23 at 3:15 p.m., the DON provided the Medication Administration Policy, last updated 4/11/22, which read "...Medications are administered in accordance with written orders of			

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	the attending Healthcare provider..." This state residential finding relates to compliant IN00411223.			
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview and record review, the facility failed to ensure food items stored were labeled, dated, not expired, covered and not exposed to drippings of meats. This had a potential to affect 77 of 77 residents that eat food served from the kitchen. Findings include: An observation was made of the kitchen with the Dietary Manager (DM) on 7/5/23 at 11:17 a.m. The walk in refrigerator was observed that contained the following: 2 containers of fruit salad with no open dates = 1 container top opened and 1/4 of the container full with an expiration date of 7/4/23, 1 container full with expiration date of 7/4/23, 2 packages of turkey, 2 packages of pastrami, 1 package of corn beef, 2 packages of ham lunch meat sitting in a white container that contained a liquid substance on bottom of container, 6 clear plastic bags that contained boiled eggs lying in liquid substance unlabeled with no expiration date, 1 container of shredded chicken unlabeled and dated,	R 0273	1. No residents were affected by the alleged deficient practice. 2. The Community realizes that residents do have the potential to be affected by the alleged deficient practice. 3. Culinary staff have been educated regarding the labeling and dating food and the proper storage of food items. 4. Labeling and dating food and food storage will be monitored by the executive Chef. The Executive Director will inspect labeling and dating food and food storage bi-weekly for the next six (6) months. Findings will be forwarded to the Quality Assurance process Improvement Committe for review and recommendations.	08/18/2023

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	1 container of sausage/brats unlabeled and dated, 1 container of hot dogs unlabeled and dated, 1 tray that contained 1 log of beef lying in red juice substance with a brown box lying on the same tray that contained 1 pork loin, 1 box that contained a bag of opened exposed lettuce unlabeled and dated, 1 bag of chopped onions unlabeled and dated, 1 tray of broccoli heads sitting on tray exposed with no covering, and 1 container of apple crisp unlabeled and dated, The freezer was observed with the following: 2 boxes of corn dogs unlabeled and dated, and 1 clear plastic bag of frozen bread unlabeled and dated, During the tour, the dry storage area was observed with 3 bags of cereal bags unlabeled and dated. The DM indicated at that time, the dry storage area food items would not be dated or labeled. An interview was conducted with the DM at 7/5/23 on 11:55 a.m. He indicated food items should be stored with labels and dates and removed if expired. He receives a food shipment weekly and has gotten behind with labeling and dating food items. The proper food storage was provided by the DM on 7/6/23 at 2:45 p.m. It indicated food items in dry storage and cold storage areas should be labeled with open an expiration dates. "...All cooked or prepped foods need to be in containers that are covered, labeled, and dated with date made and date expires..."			
R 0298	410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency			

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Bldg. 00	(2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. Based on interview and record review, the facility failed to ensure pharmacy reviews were conducted every 60 days for 4 of 5 residents reviewed. (Resident C,H, 14, and 71) Findings include: 1. The clinical record for Resident C was reviewed on 7/5/23 at 1:30 p.m. The diagnosis for Resident C included, but was not limited to, Alzheimer's Disease. The resident was admitted on 1/28/20. 2. The clinical record for Resident H was reviewed on 7/5/23 at 12:30 p.m. The diagnosis for Resident H included, but was not limited to, heart failure. The resident was admitted on 12/31/19. 3. The clinical record for Resident 14 was reviewed on 7/5/23 at 2:30 p.m. The Resident's diagnosis included, but were not limited to, dementia, anxiety, and urinary tract infection. She was admitted on 11/18/2022. 4. The clinical record for Resident 71 was reviewed	R 0298	!. Consultant pharmacy reviews have been conducted on all identified residents. 2. The Community realizes that residents have the potential to be affected by the alleged deficient practice. 3. The Consultant pharmacy will develop a system to ensure every resident has had a drug regimen review every sixty (60) days. 4. The Wellness Director/designee will review the drug regimen for each resident monthly to ensure all have had a drug regimen review for the next six (6) months.	08/18/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	07/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
INDEPENDENCE VILLAGE OF FISHERS SOUTH	9745 OLYMPIA DR FISHERS, IN 46038

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	on 7/7/23 at 9:45 a.m. The Resident's diagnosis included, but was not limited to, pulmonary embolism (blood clot in the lung). She was admitted on 4/20/2023. An interview was conducted the Director of Nursing on 7/6/23 at 3:00 p.m. She indicated the facility had changed pharmacies. The last pharmacy review was conducted in February 2023. The new pharmacy was suppose to review in June, and it had not been done.			