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| | | A. BUILDING 00<br>B. WING | 07/21/2023 |

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| INDEPENDENCE VILLAGE OF AVON | 182 S COUNTY ROAD 550 E<br>AVON, IN 46123 |

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| R 0000<br><br>Bldg. 00 | This visit was for the Investigation of Complaints IN00412406 and IN00413370.<br><br>Complaint IN00412406 - State deficiencies related to the allegations are cited at R052, R063, R090, R117, R214, and R242.<br><br>Complaint IN00413370 - State deficiencies related to the allegations are cited at R090, R117, and R214.<br><br>Survey dates: July 19, 20, and 21, 2023<br><br>Facility number: 003902<br><br>Residential Census: 93<br><br>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.<br><br>Quality review completed on August 3, 2023. | R 0000 | ATT: Brenda Buroker<br><br>Director of Division Long Term Care<br><br>2 North Meridian Street<br><br>Indianapolis, Indiana 46204<br><br>Re: Complaint Survey<br><br>Independence Village of Avon<br>182 S County Road 550 E<br>Avon, IN 46123<br><br>Dear Ms. Buroker,<br><br>On July 21, 2023, a Complaint survey with complaint no. (IN00412406, IN00413370) and Survey Event ID Q9HM11 was conducted by the Indiana State Department of Health. Enclosed please find the Statement of Deficiencies with our facilities Plan of Correction for the alleged deficiency. | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| Romeo Behl | Executive Director | 08/25/2023 |

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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| | | | Please consider this letter and Plan of Correction to be the facility's credible allegation of compliance.<br><br>We respectfully request a desk review to ensure that the facility has achieved substantial compliance with the applicable requirements as of the date set forth in the Plan of Correction of Sept 07, 2023.<br><br>Please feel free to call me with any further questions at 317-745-2766<br><br>Respectfully submitted,<br><br>Romeo Behl<br><br>Independence Village of Avon<br>182 S County Road 550 E<br>Avon, IN 46123 | |
| R 0052<br><br>Bldg. 00 | 410 IAC 16.2-5-1.2(v)(1-6)<br>Residents' Rights - Offense<br>(v) Residents have the right to be free from:<br>(1) sexual abuse;<br>(2) physical abuse;<br>(3) mental abuse; | | | |

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| | (4) corporal punishment;<br>(5) neglect; and<br>(6) involuntary seclusion.<br>A. Based on observation, interview, and record review, the facility failed to prevent resident to resident physical abuse for a resident who had a history of aggressive behaviors for 3 of 6 residents reviewed for abuse (Resident C, F, and G), and the facility failed to ensure a resident was not physically abused by staff when the resident was physically held against his will for medication administration for 1 of 6 residents reviewed for abuse (Resident C).<br><br>B. Based on observation, interview, and record review, the facility failed to prevent neglect to a resident who sustained an injury after a fall which resulted in harm due to the facility continuing to transfer the resident despite the fracture and pain of the resident and the delay diagnosis and treatment of a fractured femur requiring surgery for 1 of 6 residents reviewed for quality of care (Resident M).<br><br>These deficiencies resulted in immediate jeopardy due to Resident C making continuous physical threats and engaging in several unprovoked attacks against his peers on the locked memory care unit where 27 residents resided with Resident C, and the facility failed to ensure a system for assessing, documenting, monitoring, follow-up of abuse and neglect for 6 of 6 residents reviewed for resident abuse (Residents B, C, D, E, F, G, and M).<br><br>Findings include:<br><br>A1. On 7/19/23 at 10:45 a.m., Resident C was observed in his room. He sat upright but slouched in a recliner chair. His eyes were closed, and his breathing was slow and steady. He did not arouse | R 0052 | **R052 Residents right -offense**<br><br>**The facility requests paper compliance for this citation.**<br>***This Plan of Correction is the center's credible allegation of compliance.***<br>***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.***<br>***1)Immediate actions taken for those residents identified:***<br>Resident B, C, D, E, F and G continue to reside in the community. Said residents' orders and service plans have been reviewed and updated. Resident M no longer resides in the community.<br>***2)How the facility identified other residents:***<br>Any resident residing in the facility was at risk of being adversely affected. Audit completed on all residents with behaviors to ensure that service plan has been updated accurately. New interventions (as stated below in section 4) have been initiated. | 09/07/2023 |

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| | to the call of his name.<br><br>On 7/19/23 at 2:10 p.m., upon entrance to the MC dining room and activity lounge, two staff members were observed on their personal cell phones. Certified Nursing Aid, (CNA) 15 sat at a dining room table, her back turned towards the resident and was observed to scroll through a social media page. CNA was observed in the corner of the activity lounge, with an ear bud in her left ear and carried on a personal conversation overtop of the movie which was playing for the resident's. There were 9 residents in the activity lounge and 4 residents seated in the dining room as staff used their personal phones.<br><br>On 7/20/23 from 9:02 a.m., until 10:05 a.m., Resident C was observed. He was seated by himself at a dining room table. He intermittently held his head up to watch other residents come and go. He was not invited to the activity lounge and was not invited to a nail care activity.<br><br>On 7/20/23 from 11:54 a.m., until 12:19 p.m., Resident C was observed during a lunch observation. He was seated at a table with 3 other male residents. One Resident required total assistance to eat his lunch, and Resident C was observed to become frustrated that the other resident received 1 on 1 (1:1) attention/assistance and was served dessert before he was. CNA 18 who assisted the tablemate assured Resident C he had been treated equally, but Resident C indicated, "he gets more than me." Resident C stood up and left the table. He was observed to have only one shoe on, and the other remained under the table.<br><br>On 7/20/23 at 12:30 p.m., Resident C returned to his seat at the dining room table. He was observed | | Physician and POA have been notified accordingly.<br>**3)Measures put into place/ System changes:**<br>In-service and education provided to all staff on abuse, neglect and residents rights. In-service also provided to staff to identify new behaviors, cell phone use and report DON/ED immediately for any unusual events.<br>Licensed nurses and QMA were in-serviced on med administration and refusal of medication and document refusal and notify MD and POA. See policy attached.<br>CNA and activities were re-educated on offering activities to all residents.<br>Don/designee will review 3 resident charts one time weekly for 4 weeks, 2 resident charts one time weekly for 4 weeks, and lastly one resident chart one time weekly for 4 weeks to ensure all behaviors have been documented accurately and service plan has been updated.<br>**4)How the corrective actions will be monitored:**<br>Documentation via PCC 24-hour report summary will be reviewed by DON/Designee daily for 4 weeks and every working day thereafter. All behavior concerns will be reviewed with an internal “Red Flag Call” process to include ED, DON, Regional Ops, and Regional Wellness Director for the goal of assuring initiation of | |

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| | to have on a new pair of shoes but began to fidget with the shoe he had left under the table. He appeared to be confused as he attempted to take one of his new shoes off, to put the other one back on. Eventually he raised the spare shoe and sat it on the table. CNA 18 who continued to assist a tablemate, asked him to remove the shoe from the table. He did but continued to play with it, turned it over in his hands, and tried to put it back on overtop of his new shoe. CNA 18 attempted to ask him to stop, or put the shoe down, or not to worry about it, Resident C became frustrated and indicated, "I don't know what to do."<br><br>On 7/20/23 at 1:00 p.m., an unscheduled activity was started in the activity lounge. Staff paused a movie that was playing and began to bounce balloons around and encouraged the residents to gently bat the balloons back and forth.<br><br>On 7/20/23 at 1:06 p.m., Resident C got up from the dining room table and entered the activity area. His pants were observed to sag. CNA 20 brought a belt into the activity lounge and attempted to assist Resident C to put the belt on. Resident C became agitated and raised his fist to the aid. CNA 20 left him alone and he sat in a chair. Resident C remained frustrated and confused. He indicated, as he pointed to the activity, "what's going on? It's not fair doing this playing. I don't want them to cheat him."<br><br>On 7/19/23 at 2:30 p.m., Resident C's medical record was reviewed. Resident C resided on the secured Memory Care Unit (MC) and had diagnoses which included, but were not limited to, dementia (a degenerative brain disorder that effects memory) with behavioral disturbance. | | effective measures/ interventions to maintain resident safety and service plan will be updated by DON.<br><br>**5) Date of compliance:** 9/7/2023 | |

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| | He admitted to the facility on 4/11/23 from an in-patient psychiatric unit.<br><br>A corresponding summary of present illness from the psychiatric unit, dated 2/26/23, indicated Resident C had resided in a previous secured memory care unit but began to display behaviors. " ...pushed a female staff member when she tried to redirect him while he was trying to pursue a fellow female resident. Staff reports that patient is possessive over items, such as his jeans and furniture. Staff reports that when a fellow resident sits on furniture patient will become upset and make a fist at them, showing aggression ...."<br><br>Resident C's service plans lacked documentation of his history of behaviors and/or in-patient psychiatric treatment..<br><br>Resident C's progress notes were reviewed and revealed repeated, unprovoked aggressive threats and physical attacks against his peers, which included, but were not limited to the following:<br><br>a. On 4/12/22 at 10:18 p.m., Resident C was alert with intermittent periods of aggressive behavior. A fellow resident on unit complained Resident C banged on his door to enter his apartment. When the peer opened the door, Resident C pushed his neighbor out of the doorway and entered the apartment. Verbal redirection from the nurse was unsuccessful.<br><br>The note lacked documentation of physician notification.<br><br>b. On 5/2/22 at 12:29 a.m., Resident C was noted to argue with another resident and make demeaning comments to them. | | | |

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| | The note lacked documentation of physician notification.<br><br>c. On 5/2/22 at 12:49 p.m. Resident C was noted to have continued behaviors that ranged from verbal aggression, to threatening staff, and urinating in hallways. He was not easily redirected. He refused care and treatment.<br><br>d. On 5/7/22 at 4:04 a.m., Resident C was noted to wander throughout the night. Around 3:20 a.m., he was not found in his room or any of the common areas. Upon a search of other resident's rooms, Resident C was found in a female resident's room. He was laying on top of her in bed with his shirt and shoes off. He was redirected to his room.<br><br>The record lacked documentation of assessment of follow up for either resident.<br><br>The record lacked documentation of physician notification.<br><br>e. On 5/15/22 at 5:28 p.m., Resident C exhibited combative and argumentative behaviors during dinnertime. He had been served pizza and asked for a knife to cut it into smaller pieces. Resident C was told no knives were available but offered to cut his pizza for him. Resident C became verbally abusive and pushed the nurse away and yelled profanities. A peer approached him and began to touch Resident C's meal plate, and Resident C pushed him away. They were separated and verbal redirection was provided.<br><br>The note lacked documentation the physician had been notified.<br><br>f. On 7/3/22 at 1:45 p.m., Resident C got into an | | | |

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| | altercation with a peer over a cane.<br><br>The record lacked follow up, intervention and physician notification.<br><br>g. On 9/4/22 at 7:48 p.m., Resident C was aggressive toward staff and residents. He threatened to use silverware on another resident. He was redirected and "educated."<br><br>The record lacked documentation of follow up and physician notification. The record lacked documentation of the type of "education" provided and/or how effective it was for Resident C at his level of baseline confusion.<br><br>h. On 2/23/23 at 11:05 a.m., Resident C attacked a female resident, apparently unprovoked, while in the main activity room. Before staff could intervene, Resident C hit her 5 or 6 times in the face and head. "It was not known what triggered the incident."<br><br>i. On 4/7/23 at 2:26 a.m., Resident C walked up to another resident, unprovoked, and began to hit him in the face. Although there was evidence of physician notification, no new orders, or increased supervision/monitoring was implemented.<br><br>j. On 5/17/23 at 8:58 a.m., Resident C grabbed a female resident. She was started and screamed for him to get off of her. Staff intervene and Resident C indicated, he "wanted to play with her ... she liked it."<br><br>The record lacked documentation of follow up and physician notification.<br><br>An in-patient psychiatric discharge summary | | | |

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| | dated 4/24/23 indicated, " ...the patient was assessed onsite at [name of psychiatric hospital]. The patient recently returned back to Independence Village last week following an inpatient stay for punching another resident. The facility reports the on 4/6/23 patient struck another resident in the face with a closed fist ... the facility has not been able to redirect the patient to prevent the physical aggression ..." the discharge summary indicated his primary mental health diagnosis was, "Psychotic disorder with delusions."<br><br>Resident C's record lacked update or revision to include his new diagnosis as indicated in his Psychiatric discharge summary.<br><br>Resident C's service plans lacked updates or revision to include services provided, or interventions necessary to prevent Resident C from making continued unprovoked attacks against his peers.<br><br>Resident C had a service plan which was initiated on 2/13/23 which only addressed his history of wandering into other resident's rooms. Intervention for this service plan included, but were not limited to, "Monitor whereabouts every hour," "Behaviors: Known triggers for resisting care are (SPECIFY [which was not revised to specify]). The resistive behave is de-escalated by (SPECIFY [which had not been revised to specify]).<br><br>The record lacked documentation of hourly whereabout checks.<br><br>During an interview on 7/21/23 at 11:30 a.m., the Wellness Director, she indicated, hourly whereabout checks were not something that was | | | |

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| | documented, but served as a reminder for staff to check on Resident C more frequently. When asked about what the difference was from routine monitoring/supervision for residents on the MC unit v. additional hourly whereabout checks, the WD indicated they were the same.<br><br>A2. On 7/19/23 at 2:30 p.m., Resident C's medical record was reviewed. Resident C resided on the secured Memory Care Unit (MC) and had diagnoses which included, but were not limited to, dementia (a degenerative brain disorder that effects memory) with behavioral disturbance and diabetes mellitus (a blood sugar disorder).<br><br>A behavior not dated, 4/27/22 at 6:59 p.m., indicated, Resident C was agitated when the nurse administered a tuberculosis skin test. He became verbally abusive and threatened the staff with violence. He wandered around the unit aimlessly and did not respond to verbal redirection. He entered another resident's apartment and urinated on the other resident's bed.<br><br>The behavior note lacked documentation of physician notification for intrusive wandering and abusive language.<br><br>The behavior note lacked documentation of person-centered interventions to redirect or prevent further incidents.<br><br>A behavior note dated, 4/27/22 at 9:05 p.m., indicated, Resident C became physically combative when the nurse attempted to administer his evening insulin injection. Resident C attempted to punch and kick the nurse, and used more abusive and threatening language, "I'm going to F------ shoot you!" In order to administer Resident C's insulin, "two additional staff | | | |

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| | members were required to hold resident in place to administer insulin." After his insulin was administered, he continued to wander around the unit, attempted to open locked doors and enter other resident's apartments.<br><br>The behavior note lacked documentation of physician notification for his attempt to refuse his medication, aggressive behavior and continued intrusive wandering.<br><br>The behavior note lacked documentation of person-centered interventions to redirect or prevent further incidents.<br><br>Resident C's most recent Service Plans were reviewed and lacked revision to include documentation related to his refusal of medication and aggressive behavior towards staff.<br><br>During an interview on 7/20/23 at 11:23 a.m., Charge Nurse 8 indicated every resident had the right to refuse their medication at any time. If a resident had a hard time understanding or was too agitated to administer the insulin at that time, then staff should attempt to reapproach, or ask another nurse to attempt to administer his insulin. If the resident still refused, then they should never be forced or held against their will to administer. The staff should also let the physician know about the refusal and see if there should be any new orders.<br><br>During an interview on 7/21/23 at 11:30 a.m., the Wellness Director, indicated residents had the right to refuse medications, even residents on the MC unit. If redirection or reapproach did not work, then staff should notify her and the doctor.<br><br>On 7/21/23 at 1:20 p.m., the Wellness Director provided a copy of the Residency Agreement. | | | |

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| | The agreement indicated, " ...ix. Protection- The community will take reasonable action to ensure the health, safety, and well-being of a Resident as indicated in the Resident's Individualized Service Plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial and personal exploitation while on the premises, while under the supervision of the Community or an employee of the Community ...."<br><br>On 7/20/23 at 1:30 p.m., the Executive Director (ED) provided a copy of current, but undated facility policy titled, "Cellular Phone Usage." The policy indicated, "the use of personal cellular phones for calls, texting, emails, social media, etc. is strictly prohibited. Person phones are NEVER to be used or visible in resident areas or when working with residents. A3. An Indiana State Department of Health Survey Report System report, dated 7/05/23 at 5:15 p.m., indicated staff reported to the Executive Director (ED) that Resident F got upset at Resident G and made a contact, as she switched water in the bowl for ducks in the courtyard after Resident F had poured orange juice into it. Residents were immediately separated by staff members and notification made. Vital signs and skin assessments were checked on both resident. Preventative interventions included, both residents would be followed up for any emotional distress, both were seen by psych services with no new orders. Service plans were reviewed and updated.<br><br>a. During the initial tour, on 7/19/23 at 11:37 a.m., Resident F was observed in his apartment with his significant other and 2 cats. Resident F indicated they had moved into the facility about 4 months ago and he had no concerns with the staff or other residents. | | | |

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| | A typed note provided by the ED, with a typed signature and date of 7/8/23, indicated, "Follow up done with Resident F on 7/6/23, 7/7/23, and 7/8/23. No emotional distress was observed or voiced by the resident. Resident voiced no concerns or observed any concerns."<br><br>Resident F's record was reviewed on 7/19/23 at 1:30 p.m. Diagnoses on Resident F's profile included, but were not limited to, mild cognitive impairment of uncertain or unknown etiology, and type 2 diabetes mellitus (chronic condition where the body either doesn't produce enough insulin, or it resists insulin).<br><br>An Interim Wellness Evaluation, completed on 6/16/23, indicated the resident was independent with cognitive and psychosocial function. The assessment section for cognitive/behavioral care plan was left blank.<br><br>A vital signs assessment, completed on 7/5/23, indicated Resident F had a physical altercation with a female resident in the courtyard about ducks. Blood Pressure 130 / 88 (normal 133/69), temperature 98.3 Fahrenheit (°F) (normal 98.6), pulse 86 (normal 60 - 100 beats per minute), and respiration 17 (normal 12-18 per minute).<br><br>A progress notes, dated 7/5/23 at 3:45 p.m., indicated Resident F allegedly struck a female resident (Resident G) in the right side of face with open hand due to an argument over ducks in the courtyard. It was reported also that the female resident removed herself immediately from the situation and alerted staff about the incident while Resident F went back to his apartment.<br><br>A progress notes, dated 7/5/23 at 5:30 p.m., | | | |

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| | indicate a deputy sheriff came to talk to both Resident F and Resident G.<br><br>A progress notes, dated 7/7/23 at 11:08 a.m., Resident F stated he did not make contact with a female resident, stated "I don't remember even doing that I know [Resident G's name] thinks she's in charge of everything we are moving out next month!" Writer educated resident on not using physical violence with anyone, resident stated he understood.<br><br>Plan of Care, dated 3/1/23, indicated Resident F was alert and oriented. There was no care plan related to documentation of behaviors.<br><br>The follow up investigation lacked documentation like-residents in assisted living, had been interviewed or assessed for potential injury, or that staff working or resident representatives visiting on the date of the incident had been interviewed. Resident records lacked documentation resident was seen by psych services or that care plans were updated as documented on the state follow up reports.<br><br>b. During the initial tour on 7/19/23 at 11:17 a.m., Resident G was observed in her apartment with her cat. Resident G indicated, recently male Resident F had slapped her across the right side of her face when she dumped a cake pan used for watering the ducks when Resident F put orange drink and soda into it. She explained to Resident F the ducks would not drink it, and this upset him. Another unidentified resident had observed the incident and called for staff. A dietary person came out and stood between them as Resident F drew back his fist and indicated he was going to hit her again. Resident G did not think Resident F was confused, she just thought he could be mean. | | | |

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| | Resident G indicated Resident F had lied to police and said he had not hit her. Resident G indicated about 20 people saw the incident. Staff had assessed her for injury, called the police who took a statement and basically said it was her word against the male resident as there was no evidence and did nothing.<br><br>A typed note provided by the ED, with a typed signature and date of 7/8/23, indicated, "Follow up done with Resident G on 7/6/23, 7/7/23, and 7/8/23. No emotional distress was observed or voiced by the resident. Resident voiced no concerns or observed any concerns."<br><br>Resident G's record was reviewed on 7/20/23 at 9:40 a.m. Diagnoses on Resident G's profile included but were not limited to cerebral infarction (stroke), and dorsalgia (physical discomfort occurring anywhere on the spine or back).<br><br>A vital signs assessment, completed on 7/5/23, indicated Resident G was sitting with ladies and playing cards, denied any further pain from incident, will continue to observe. Blood Pressure 129/81, temperature 97.0 °F, pulse 96, and respiration 24.<br><br>A progress notes, dated 7/5/23 at 1:42 p.m., indicated Resident G was in the ED's office and stated male Resident F had struck her in the right side of face with open hand due to an argument over ducks in the courtyard. She had removed herself immediately from situation and alerted staff of the incident, and Resident F had left the area and went back to his apartment. Assessment done, Resident G had no bruising to right side of face, resident stated that "I am just sore" and staff to continue to follow up with resident. | | | |

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| | A progress notes, dated 7/5/23 at 5:30 p.m., a deputy sheriff came to talk to both parties involved.<br><br>A late progress note created on 7/19/23 at 10:46 a.m. by LPN 8, effective date 7/7/23 at 10:37 a.m., indicated no sign of trauma to any areas. Resident voiced no complaints of pain or discomfort.<br><br>Resident record lacked documentation of resident follow up assessment for injury or timely follow up for psychosocial harm after being struck in the face by a male resident during an altercation on 7/5/23. No documentation of a psych physician consult as documented on the state reportable incident, or update to the resident service plan.<br><br>During an interview on 7/19/23 at 12:08 p.m., Licensed Practical Nurse (LPN) 8 indicated he had been aware of Resident F hitting Resident G. The incident was caused by Resident G telling Resident F he should not be putting orange drink in the duck water pan outside and she dumped it, made him upset.<br><br>During an interview on 7/19/23 at 11:34 a.m., LPN 8 indicated Resident F and Resident G had not been sent to the ER for evaluation as they had not been injured during the altercation. When there was resident to resident abuse in the facility, staff were to assessment the residents for injury to include taking their vital signs and observe for injury and psychosocial distress for 72 hours, this information was to be documented in the resident progress notes and vital sign section of the electronic medical record (EMR). If a resident was seen by psych services, a note was kept in the hard chart. Resident F hitting a peer should have been documented in his service plan. Service plans were reviewed every 6 months and updated | | | |

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| | with significant changes.<br><br>During an interview on 7/21/23 at 11:51 a.m., the ED and Wellness Director indicated they were aware of the incident between Resident F and Resident G. Resident G had dumped a duck water pan when Resident F had poured orange drink into the pan. Resident G indicated when she stood up Resident F had slapped her in the face. Neither resident had been seen by psych services since the incident on 7/5/23. The Wellness Director acknowledged there was not consistent documentation of 72 hour follow up having been completed for any resident incident.<br><br>On 7/20/23 at 1:30 p.m., the ED provided a Resident -to- Resident Contact policy, last reviewed 12/20/21, and indicated the policy was the one currently being used by the facility. The policy indicated, "1. Community staff will monitor residents for inappropriate behavior towards other residents, family members, visitors, or to the staff. Occurrences of such incidents shall be promptly reported to the Wellness Director and to the Executive Director. 2. If two residents are involved in an altercation, staff will: a. Separate the residents, and institute measures to calm the situation. b. Identify what happened ...c. Notify each resident's representative and physician ...d. Review the events with Wellness Leader and possible measures to try and prevent additional incidents. e. Consult attending physician to identify treatable conditions. f. Make any necessary changes in the care plan approaches to any or all of the involved individuals. g. If after carefully evaluating the situation, it is determined that any of the residents involved may need a change in their care needs, a care conference and evaluation should be initiated. h. Report incidents, findings, and corrective measures to appropriate | | | |

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| | agencies as outlined in community's abuse reporting policy ...<br><br>B. Resident M's record was reviewed on 7/20/23 at 2:15 p.m. Resident M was admitted to the facility on 6/6/23 with diagnoses to included, but were not limited to, dementia, repeated falls, difficulty walking, age-related physical debility, and late-onset cerebellar ataxia (sudden inability to coordinate muscle movement due to disease or injury to the cerebellum (part of the brain at the back of the skull)).<br><br>During an interview on 7/20/23 at 2:45 p.m., the Resident M's friend indicated Resident M had moved into the secured memory care unit of the facility on 6/6/23. Up until that time the resident was ambulating with a rollator walker independently and had lived in an independent care facility with caregiver oversight. On Wednesday 6/7/23 Resident M fell in the hallway outside her room. Resident M's friend was notified and came in that day to find the resident sitting on the couch in her room. The resident was observed to be in severe pain when attempts were made by staff to get the resident up off the couch, so staff stood her up and put her into a wheelchair to move her to the bed. The next day on Thursday 6/8/23 a mobile x-ray of the resident's hip was ordered, but not obtained until the evening of Friday 6/9/23. The resident was diagnosed with a fracture of the right femur (thigh bone). No further follow up was initiated or completed by staff over the weekend. Staff were observed multiple times transferring the resident to and from the wheelchair and to and from the bed by standing her up, even though the resident was expressing severe pain. Staff told Resident M's friend it was hard to get Resident M up on her feet to get her dressed and get her moving, did | | | |

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| | not think they knew she had a fracture. On Sunday 6/11/23 Resident M's friend observed Resident M up in the wheelchair and her hip looked swollen, so Resident M's friend asked Resident M to be sent to the hospital. The resident was transferred, where she underwent hip surgery on Monday 6/12/23. Resident M's friend indicated, she was sure Resident M was gotten up daily into a wheelchair for meals, she was surprised the hip was not attended to immediately.<br><br>Confidential interviews were conducted during the survey and indicated the following:<br>a. Resident M had a fall with injury to her hip and staff made her walk on it for several days.<br>b. Resident M's medical issues were ignored, and the resident did not receive treatment for four days.<br>c. Nursing staff and management were aware of Resident M's fall and fracture. The aides were standing the resident up and transferring her into a wheelchair daily on her injured leg and taking her to the dining room for 5 days before receiving treatment. The resident was in pain when stood and could not walk. Not sure if the aides had been made aware the resident had a fractured leg. Licensed Practical Nurse (LPN) 8 had assessed the resident after she fell and said she was "fine."<br><br>A fall risk assessment, dated 6/6/23, score of 41.0 indicated moderate risk for falling.<br><br>A medication administration record, dated June 2023, indicated pain levels of 7/10 on 6/8/23, and 2/10 on 6/9/23. The resident record lacked documentation pain levels had been documented daily after the fall on 6/7/23 until discharge.<br><br>A physician's order for pain medication, dated | | | |

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| | 6/8/23, indicated acetaminophen (analgesic) 325 mg give 2 tablets by mouth every 4 hours as needed for pain. One (1) dose of acetaminophen was documented as administered on 6/10/23 at 10:19 a.m., for a pain level of 7/10. Resident record lacked documentation pain medication was administered for daily documentation of pain after the fall on 6/7/23.<br><br>A progress notes for Resident M, dated 6/7/23 at 9:03 p.m., indicated the resident fell that morning. Since after the fall resident complaint of right leg pain, nurse was notified. Family visited during the evening and staff continue to monitor.<br><br>A progress notes for Resident M, dated 6/8/23 at 2:40 p.m., resident had a fall yesterday, still has pain on her leg. The pain level is 7/10, she was going to get a new script for pain medicine.<br><br>A progress notes for Resident M, dated 6/8/23 at 8:38 p.m., indicated resident still complaints of pain to right leg, but came out to socialize with other residents. Nurse Practitioner (NP) ordered an x-ray for her leg. Staff will continue to observe.<br><br>A progress notes, for Resident M, dated 6/11/23 at 4:50 a.m., per family resident wanting resident to go to the hospital for fracture.<br><br>A progress notes, dated 6/11/23 at 5:00 a.m., resident transported to local hospital via ambulance per family request.<br><br>A progress notes, dated 6/11/23 at 1:00 p.m., writer spoke with power of attorney (POA), and she would like the fracture taken care of as soon as possible. QMA calling to see what next steps is.<br><br>The resident record lacked documentation of a | | | |

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| | service plan related to history of falling.<br><br>The resident fall with fracture was not reported to the appropriate agencies for follow up according to policy.<br><br>During an interview on 7/21/23 at 12:00 p.m., the Wellness Director indicated, Resident M was only in the facility a short time, she had no care record that gave staff direction on how to do her care. The resident had admitted from an independent care facility with a care giver and ambulated with a rollator walker. The Wellness Director was out of the facility during the week the resident was admitted and fell. LPN 8 who acted as her ADON had taken care of the situation, and informed her on Friday 6/9/23, she did not come into the facility to manage the incident. The Wellness Director indicated she did not know if the staff were standing the resident but knew they were putting her into a wheelchair.<br><br>During an interview on 7/21/23 at 10:53 a.m., Qualified Medication Aide (QMA) 21 indicated she frequently worked on the secured memory care unit. She had only 1 encounter with Resident M when she administered her medications, she had no knowledge of the resident having a fractured hip. The staff had gotten the resident up and out of bed to dress her, she was put into a wheelchair and brought out to the dining room.<br><br>During an interview on 7/21/23 at 12:05 p.m., the ED indicated, she had not been working in the facility at the time of the resident's fall with fracture to state report the incident, the facility had been in between ED's at that time.<br><br>A fax to the ED from the Regional Operations/Wellness Director, dated 7/21/23, | | | |

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| | indicated "From 5/25/23 - 6/12/23 there was no ED license on the community. It was being covered by [an ED at a sister facility] regarding any ED coverage needed. We were within the regulatory guidance for adding the current ED's license to the community."<br><br>During the exit conference on 7/21/23 at 2:00 p.m., the WD indicated she had not reported the fall with fracture the covering ED at the time as that person was on vacation out of state.<br><br>This State tag relates to Complaint IN00412406. | | | |
| R 0063<br><br>Bldg. 00 | 410 IAC 16.2-5-1.2(gg)<br>Residents' Rights- Noncompliance<br>(gg) Residents have the right to individual expression through retention of personal clothing and belongings as space permits unless to do so would infringe upon the rights of others or would create a health or safety hazard.<br>Based on observation, interview, and record review, the facility failed to ensure the safety of residents in the Assisted Living facility by ensuring a resident who displayed physical abuse against another resident did not keep a pocketknife in his apartment or carry a pocketknife on his person while in the facility for 1 of 6 residents reviewed for abuse (Resident F).<br><br>Findings include:<br><br>On 7/20/23 at 11:15 a.m., Resident F was observed in his apartment, ambulating independently with a steady gait. Resident F indicated, he had a pocketknife he used when woodworking, but no longer carried it in the facility. He also kept his carpentry tools in his apartment. | R 0063 | **R063 Residents' right Non-Compliance**<br>***1)Immediate actions taken for those residents identified:***<br>Resident F doesn't carry pocketknife or any other weapon in the facility.<br>***2)How the facility identified other residents:***<br>Any resident residing in the facility was at risk of being affected adversely. Re-education provided to all residents in the community on residential agreement section referring to community policy on weapons, knives, firearms, and explosive materials. Residents directed to give any such items to | 09/07/2023 |

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| | Resident F's record was reviewed on 7/19/23 at 1:30 p.m. Diagnoses on Resident F's profile included, but were not limited to, mild cognitive impairment of uncertain or unknown etiology, and type 2 diabetes mellitus (chronic condition where the body either doesn't produce enough insulin, or it resists insulin).<br><br>A progress notes, dated 7/5/23 at 3:45 p.m., indicated Resident F allegedly struck a female resident on the right side of her face with open hand due to an argument over ducks in the courtyard.<br><br>Cross Reference R0052.<br><br>A progress notes, dated 7/6/23 at 1:30 p.m., indicated writer and Executive Director (ED) went to resident's apartment to speak with him on concerns from others that he had a pocketknife on his belt that he wore at times. When resident answered the door, he was polite and soft spoken, resident showed a utility knife to writer and ED and stated, "I have worn it before, but I won't anymore, and I will get rid of it." ED re-educated resident on no weapons allowed on premise, resident then signed the education from the lease on weapons and stated, "I'm moving at the end of the month, you guys can't even take care of ducks, let alone people!" Resident redirected and writer and ED exited apartment.<br><br>The resident record lacked documentation staff followed up with resident to assure he had gotten rid of the knife.<br><br>During an interview on 7/19/23 at 11:34 a.m., LPN 8 indicated he was the charge nurse. The resident had tools, bikes, and plants outside in courtyard. LPN 8 indicated he thought Resident F was | | their families and/or community management for safe keeping and assurance of resident safety throughout duration of such residents residing in the community.<br>Education provided to all staff on policy not to carry weapons, knives, firearms, or explosives in the community and report it to DON/ED immediately.<br>**3)Measures put into place/ System changes:**<br>All residents and families/POA's are being re-educated via newsletters, in which re-education/reminders will be provided via monthly newsletters but at a quarterly minimum. Residents will also be re-educated about this policy at monthly Resident Council Meetings in which said information will be provided once per quarter at minimum. Education for staff will be provided upon hire and semi-annually at all staff meetings.<br>**4)How the corrective actions will be monitored:**<br>All residents and staff are reminded and encouraged to say something if they see something.<br>5)Date of Compliance:<br>September 7th, 2023 | |

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| | | A. BUILDING 00<br>B. WING | 07/21/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| INDEPENDENCE VILLAGE OF AVON | 182 S COUNTY ROAD 550 E<br>AVON, IN 46123 |

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| | independent, living in his own apartment, and was allowed to have knives if he wanted to include a pocketknife.<br><br>A Resident Agreement for Resident F, dated 2/28/23, indicated, "Weapons are not allowed in the community or on community property. This includes, but is not limited to firearms, knives, explosive materials, and collectible or antique weapons.<br><br>This State tag relates to Complaint IN00412406. | | | |
| R 0090<br><br>Bldg. 00 | 410 IAC 16.2-5-1.3(g)(1-6)<br>Administration and Management - Deficiency<br>(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:<br>(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:<br>(A) epidemic outbreaks;<br>(B)poisonings;<br>(C) fires; or<br>(D) major accidents.<br>If the division cannot be reached, a call shall be made to the emergency telephone number published by the division.<br>(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 | | | |

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| | representative.<br>(3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility.<br>(4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the:<br>(A) employee's full name; and<br>(B) dates and hours worked during the past twelve (12) months.<br>(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.<br>(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 interview and record review, the facility failed to ensure abuse, injuries of unknown origin, and falls with significant injury were reported to the state licensing agency as facility reported incidents for 3 of 6 residents reviewed for incidents (Residents C, M, and F).<br><br>Findings include:<br><br>1a. On 7/19/23 at 2:30 p.m., Resident C's medical record was reviewed. Resident C resided on the secured Memory Care Unit (MC) and had diagnoses which included, but were not limited to, dementia (a degenerative brain disorder that effects memory) with behavioral disturbance and diabetes mellitus (a blood sugar disorder). | R 0090 | **R090 Administration and management**<br>***1)Immediate actions taken for those residents identified:***<br>Resident C resides in community and his nail and thumb has healed. Resident F doesn't carry pocketknife or any other weapon in the facility.<br>Resident M no longer resides in the facility.<br>Resident F resides in the facility and his back fracture has been healing.<br>Inservice and education provided to all staff on reporting abuse and any unusual incidents to ED /DON | 09/07/2023 |

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| | A nursing progress note dated, 1/15/23 at 2:20 p.m., indicated, an unidentified Qualified Medication Aid (QMA) reported Resident C's thumb was bruised and swollen, due to his nail bed being cut too low and he was a diabetic. The nurse attempted to notify both the Medical Doctor (MD) and Nurse Practitioner (NP), but was unable to reach them, and left a voicemail requesting an evaluation and possibly an antibiotic to treat the thumb.<br><br>A physician progress note, dated 1/19/23 (4 days later), indicated Resident C was being seen for follow-up to an injury of his right thumb. " ...It appears patient had nail clippers and cut his nails slightly too deep into the nail bed. Patient was found subsequently to have swelling and bruising to his right thumb ... thumb has remained red, swollen and bruised for about a week ...." The physician ordered a course of antibiotics to treat for cellulitis.<br><br>A physician progress note, dated 2/16/23, indicated, Resident C's thumb continued to be swollen. " ...facility reports concern due to swelling of his thumb still being present. Order an Xray of the right thumb."<br><br>A nursing progress note, dated 2/18/23 at 1:55 p.m., indicated the results of the Xray had been received and revealed an acute fracture of the 1st distal phalanx (thumb).<br><br>1b. A nursing progress note, dated 5/7/22 at 4:04 a.m., indicated, Resident C was noted to wander throughout the night. Around 3:20 a.m., he was not found in his room or any of the common areas. Upon a search of other resident's rooms, Resident C was found in a female resident's room. He was laying on top of her in bed with his shirt and | | /MD and POA immediately and ED /DON will report it to appropriate agencies in a timely manner.<br>Inservice provided to all licensed nurses on fall precautions, change in condition, completion of follow up, and to notify MD, POA, and WD of any incidents and/or changes in condition immediately.<br>All alert and oriented residents were educated to notify charge nurse/DON immediately of any falls in or outside of facility.<br>***2)How the facility identified other residents:***<br>***Audit completed by DON/Designee to review any falls, unusual incidents from last 30 days to verify accuracy of documentation and to notify agencies.***<br>**3)Measures put into place/ System changes:**<br>DON/Designee will provide copies of all X-ray results to ED and ED will report all unusual occurrences to the Division accordingly, along with providing Gateway access to the on-call Executive Director and Regional Wellness Director to ensure continual reporting of any reportable incidents in lieu of vacations and vacancies.<br>**4)How the corrective actions will be monitored:**<br>DON/Designee will provide copies of all X-ray results to ED and ED will report all unusual occurrences to the Division accordingly, along | |

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| | shoes off. He was redirected to his room.<br><br>1c. A nursing progress note, dated 5/17/23 at 8:58 a.m., indicated Resident C grabbed a female resident. She was started and screamed for him to get off of her. Staff intervened and Resident C indicated, he wanted to "play with her ... she liked it."<br><br>During an interview on 7/21/23 at 11:30 a.m., the Executive Director (ED) indicated she provided all state reportable incidents related to Resident C that were available via the Gateway. She indicated she could not find a record of report or investigation for the above incidents, and indicated, although she was not the ED at the time the incidents occurred, she would have reported and investigated.<br><br>On 7/21/23 at 9:05 a.m., the Wellness Director provided a copy of current facility policy titled, "Resident - to - Resident Contact," revised 12/20/21. The policy indicated, " ...Report incidents, findings, and corrective measures to appropriate agencies as outlined in our community's abuse reporting policy ..."<br>Long-Term Care Abuse and Incident Reporting Policy, effective 12/8/22, indicated, "Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish ...Physical abuse includes, but not limited to, hitting, slapping, punching, biting, and kicking ....1. State Rules ...(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, | | with providing Gateway access to the on-call Executive Director and Regional Wellness Director to ensure continual reporting of any reportable incidents in lieu of vacations and vacancies.<br>**5)Date of compliance: September 7th, 2023** | |

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| | safety, or health of a resident...Staff treatment of residents ...(c) The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property, are reported immediately to the administrator of the facility and other officials in accordance with state law through established procedures, including to the state survey and certification agency. (d) The facility must have evidence that all alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in progress. (e) The results of the investigation must be reported to the administrator or the administrator's designated representative and to other officials in accordance with state law ...within five (5) working days of the incident ...Staff to resident abuse: all allegations of staff to resident abuse must be reported. Staff may receive allegations from any source, including other staff, residents, family members, or other health care providers...."2. Resident M's record was reviewed on 7/20/23 at 2:15 p.m. Resident M was admitted to the facility on 6/6/23 with diagnoses to included, but were not limited to, dementia, repeated falls, difficulty walking, age-related physical debility, and late-onset cerebellar ataxia (sudden inability to coordinate muscle movement due to disease or injury to the cerebellum (part of the brain at the back of the skull).<br><br>During an interview on 7/20/23 at 2:45 p.m., a resident's friend indicated Resident M had moved into the secured memory care unit of the facility on 6/6/23. Up until that time the resident was ambulating with a rollator walker independently and had lived in an independent care facility with caregiver oversight. On Wednesday 6/7/23 Resident M fell in the hallway outside her room. | | | |

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| | The resident's friend was notified and came in that day to find the resident sitting on couch in her room. The resident was observed to be in severe pain when attempts were made by staff to get the resident up off the couch, so staff stood her up and put her into a wheelchair to move her to the bed. The next day on Thursday 6/8/23 a mobile x-ray of the resident's hip was ordered, but not obtained until the evening of Friday 6/9/23. The resident was diagnosed with a fracture of the right femur (thigh bone). No further follow up was initiated or completed by staff over the weekend. Staff were observed multiple times transferring the resident to and from the wheelchair and to and from the bed by standing her up, even though the resident was expressing severe pain. Staff told the resident's friend it was hard to get Resident M up on her feet to get dressed and get her moving. The resident's friend did not think staff knew the resident had a fracture. On Sunday 6/11/23 the resident's friend observed Resident M up in a wheelchair and her hip looked swollen. The resident's friend asked she be sent to the hospital, and the resident was transferred, where she underwent hip surgery on Monday 6/12/23. The resident's friend indicated she was sure Resident M was gotten up daily into a wheelchair for meals, and she was surprised the hip was not attended to immediately.<br><br>A progress notes for Resident M, dated 6/7/23 at 9:03 p.m., indicated the resident fell that morning. Since after the fall resident complaint of right leg pain, nurse was notified. Family visited during the evening and staff continue to monitor.<br><br>A progress notes, for Resident M, dated 6/11/23 at 4:50 a.m., per family resident wanting resident to go to the hospital for fracture. | | | |

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| | A progress notes, dated 6/11/23 at 5:00 a.m., resident transported to local hospital via ambulance per family request.<br><br>A progress notes, dated 6/11/23 at 1:00 p.m., writer spoke with power of attorney (POA), and she would like the fracture taken care of as soon as possible. QMA was calling to verify next steps.<br><br>The resident fall with fracture was not reported to the appropriate agencies for follow up according to policy.<br><br>During an interview on 7/21/23 at 12:00 p.m., the Wellness Director indicated, Resident M was only in the facility a short time. She was out of the facility during the week the resident was admitted and fell. LPN 8 who acted as her ADON had taken care of the situation, and informed her on Friday 6/9/23, she did not come into the facility to manage the incident. The Wellness Director indicated she did not know if the staff were standing the resident but knew they were putting her into a wheelchair.<br><br>During an interview on 7/21/23 at 12:05 p.m., the ED indicated, she had not been working in the facility at the time of the resident's fall with fracture to state report the incident, the facility had been in between ED's at that time.<br><br>A fax to the ED from the Regional Operations/Wellness Director, dated 7/21/23, indicated "From 5/25/23 - 6/12/23 there was no ED license on the community. It was being covered by [an ED at a sister facility] regarding any ED coverage needed. We were within the regulatory guidance for adding the current ED's license to the community." | | | |

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| | During the exit conference on 7/21/23 at 2:00 p.m., the Wellness Director indicated she had not reported the fall with fracture. The covering ED at the time as that person was on vacation out of state.<br><br>3. On 7/20/23 at 11:15 a.m., Resident F was observed in his apartment, ambulating independently with a steady gait. Resident F indicated, a few weeks ago he fell while out at a friend's house helping to build a support on a back porch. While stepping onto the supports he fell and hurt his back. He had asked the staff to send him to the emergency room (ER) due to back pain and was diagnosed with fractures in his back. Resident F indicated his back had hurt bad and he "was stoved up" for a few days. The resident presented a bottle of pain medication he was prescribed while in the ER, with a label that read hydrocodone (narcotic pain medication) 10/325 milligrams (mg) give 1-2 tablets by mouth every 6 hours as needed for 7 days. Resident F indicated, the hydrocodone made him "drunk", in a daze, caused him to vomit, and he had not taken them since.<br><br>Resident F's record was reviewed on 7/19/23 at 1:30 p.m. Diagnoses on Resident F's profile included, but were not limited to, mild cognitive impairment of uncertain or unknown etiology, and type 2 diabetes mellitus (chronic condition where the body either doesn't produce enough insulin, or it resists insulin).<br><br>A fall assessment, completed on 6/16/23, a score of 16, indicated low risk for falling.<br><br>A progress notes for Resident F, dated 6/27/23 at 9:20 p.m., indicated resident reported that he fell yesterday, and he needed to go to the hospital | | | |

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| | that he was not feeling good. Resident was sent to the hospital.<br><br>A progress notes for Resident F, dated 6/28/23 at 8:10 a.m., indicated, resident returned to facility via ambulance around 3:19 a.m. Resident able to walk and aware of surroundings. Staff will continue to monitor.<br><br>A progress notes for Resident F, dated 6/29/23 at 10:32 p.m., indicated resident readmitted. Vital signs stable, speech clear, resting in bed without signs or symptoms of distress noted.<br><br>Resident record lacked documentation of identified fracture of transverse process of lumbar vertebra identified at hospital on 6/27/23. Facility failed to provide copy of x-ray per request during survey.<br><br>An ER record for Resident F, dated 6/27/23, indicated reason for visit, fall. Diagnosis closed fracture of transvers process of lumbar vertebra. Follow up with primary care physician later this week for revaluation and any continued or recurrent symptoms as discussed.<br><br>After visit summary by Resident F's attending physician, dated 6/30/23, indicated resident seen for following issues: history of vertebral fracture, type 2 diabetes mellitus with stage 3 chronic kidney disease ...Stop taking Hydrocodone-acetaminophen (Norco) 10-325 mg tablet.<br><br>Resident record lacked documentation the resident had a fall with fracture.<br><br>The resident fall with fracture was not reported to the appropriate agencies for follow up according | | | |

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| | to policy.<br><br>During an interview on 7/19/23 at 11:34 a.m., Licensed Practical Nurse (LPN) 8 indicated he was the charge nurse. He was not aware Resident F had fallen or had a fractured back. If he'd known there was a fractured back, he would have done an incident report, told the ED, notified the primary care physician, and resident POA/representative. Resident F having a fall with fracture should have been documented in the resident service plan. Service plans were reviewed every 6 months and updated with significant changes.<br><br>On 7/21/23 at 11:15 a.m., the Wellness Director left note, indicated the facility did not have a copy of Resident F's back CT-scan, it was not sent from the hospital.<br><br>During an interview on 7/21/23 at 11:51 a.m., the Wellness Director indicated, Resident F came back from hospital and did not inform staff. She was not aware of resident telling staff he had a back fracture. Facility had no copy of the resident's CT scan of the back. The resident was offered therapy, but he refused. LPN 8 told her the fracture was old, she did not follow up. The ED indicated she was not aware of the resident's back fracture until the day prior during the survey. Normally the ED would have reported any fracture to the appropriate agencies.<br><br>On 7/20/23 at 1:30 p.m., the ED provided a Resident Incident/Accident Reporting policy, last reviewed 1/20/23, and indicated the policy was the one currently being used by the facility. The policy indicated, "Purpose: A Resident Incident/Accident Report is completed whenever there is a need to explain/investigate an | | | |

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| | unwitnessed injury or unexplained event to include but not limited to bruises, skin tears, fall with injury, hospital treatment ...Procedure: 1. When the incident occurs, staff informs the supervisor on duty. 2. Supervisor on duty to notify Wellness Director on call, if incident is an unusual occurrence. 3. Resident Incident/Accident Report is completed by staff prior to leaving from their shift ... 8. Upon completion of Incident/Accident Report, staff is to document, in resident's chart, a brief summary of the incident ...forward to their Wellness Director upon completion. 9. Wellness Director[s] review Incident/Accident Report and documentation and performs follow-up as indicated. Any change in service plan or follow-up action is documented ...Types of injuries reportable under state rules ...1. Abuse: The willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish ...8. Injuries of unknown source: Required to report examples include but are not limited to following: a. Injures whose origin is unobserved/unexplained ...9. Injuries sustained while a resident was physically restrained. 10. Major accidents: required to report examples include but are not limited to: a. All fractures...."<br><br>This State tag relates to Complaints IN00412406 and IN00413370. | | | |
| R 0117<br><br>Bldg. 00 | 410 IAC 16.2-5-1.4(b)<br>Personnel - Deficiency<br>(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 | | | |

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| | | A. BUILDING 00<br>B. WING | 07/21/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| INDEPENDENCE VILLAGE OF AVON | 182 S COUNTY ROAD 550 E<br>AVON, IN 46123 |

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| | 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.<br>Based on interview and record review, the facility failed to ensure residents received appropriate assessment and follow up after potential head injuries due to the lack of staffing available to complete assessments for 3 of 3 residents reviewed for accidents (Residents C, N, and P).<br><br>Findings include:<br><br>On 7/19/23 at 2:30 p.m., Resident C's medical record was reviewed. Resident C resided on the secured Memory Care Unit (MC) and had diagnoses which included but were not limited to dementia (a degenerative brain disorder that effects memory) with behavioral disturbance and diabetes mellitus (a blood sugar disorder).<br><br>A nursing progress note, dated, 2/23/23 at 11:05 a.m., Resident C attacked a female resident (Resident N), apparently unprovoked, while in the main activity room. Before staff could intervene, Resident C hit Resident N 5 or 6 times in the face | R 0117 | **R117 Personal Deficiency**<br><br>**The facility requests paper compliance for this citation.**<br>***This Plan of Correction is the center's credible allegation of compliance.***<br>***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.***<br>***1)Immediate actions taken for those residents identified:***<br>Resident F, N and P continue to reside in the community. | 09/07/2023 |

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| | and head. "It was not known what triggered the incident."<br><br>On 7/21/23 at 1:15 p.m., Resident N's record was briefly reviewed, and lacked documentation of follow up neurological assessments after being hit in the head several times.<br><br>A nursing progress note, dated 4/7/23 at 2:26 a.m., indicated Resident C walked up to another resident, (Resident P) unprovoked, and began to hit him in the face. Although there was evidence of physician notification, no new orders, or increased supervision/monitoring was implemented.<br><br>On 7/21/23 at 1:15 p.m., Resident P's record was briefly reviewed, and lacked documentation of follow up neurological assessments after being hit in the face.<br><br>A nursing progress note, dated 7/6/23 at 10:30 a.m., indicated, Resident C got into an altercation with a peer and was pushed. Resident C lost his balance and fell. He landed sideways and indicated his back, head, and ear hurt. He was sent to the hospital.<br><br>The record indicated he returned later that day with no new orders.<br><br>The record lacked documentation of continued neurological assessments upon his return.<br><br>During an interview on 7/21/23 at 11:00 a.m., the Wellness Director indicated neurological assessments were not completed. The facility only practiced up to the scope of a Qualified Medication Aide (QMA), and because QMAs could not complete assessments, neurological | | In-service provided to all nursing staff regarding unwitnessed falls and to notify DON/Designee, physician, and POA immediately. In-service also provided on resident returning from Hospital, etc. for the goal of identifying new orders, identify and intervene if resident is found to have decided to keep said medications on their person and to notify DON/Designee, physician, and POA immediately. Return from Hospital checklist implemented accordingly. Resident F service plan reviewed and updated by DON.<br>***2)How the facility identified other residents:***<br>Any resident residing in the facility was at risk of being adversely affected. Audit completed on all residents' charts for the goal of identifying/capture any residents with unidentified history of behaviors and to assure said residents service plan has been updated accurately.<br>**3)Measures put into place/ System changes:**<br>In-service and education will be provided to all nursing staff to notify DON/Designee/charge nurse/POA/Physician immediately regarding any change in condition, self-med possession, and to transfer resident to ER immediately if needed. DON/Designee will update Service plan when change occurs. | |

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| | checks had not been conducted. The Wellness Director indicated since the facility was only Assisted Living, it would be up to the residents to report to the nurse if they felt they had residual effects from a potential fall or head injury. The resident was responsible for seeking treatment from the nurse. The Wellness Director indicated they only provided basic monitoring for 72 hours and vital signs as needed, but no neurological assessments for Memory Care residents who may not be able to verbalize lingering symptoms.<br><br>On 7/21/23 at 1:02 p.m., the Wellness Director provided a copy of an e-mail from a regional clinical support staff. The email indicated, "We do not have a Standard of Practice to cover this, as we follow Indiana state regulation regarding resident care and the involvement of skilled nursing services as needed."<br><br>This State tag relates to Complaints IN00412406 and IN00413370. | | Don/designee will review 3 resident charts one time weekly for 4 weeks, 2 resident charts one time weekly for 4 weeks, and lastly one resident chart one time weekly for 4 weeks to ensure all falls and behaviors have been documented accurately and service plan has been updated.<br>**4)How the corrective actions will be monitored:**<br>Don/Designee will be responsible for this plan of correction and Audit findings will be presented to the QAA Committee monthly x 6 months. The results of these audits will also be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is identified x3 consecutive months. The QA Committee will identify any trends and/or patterns and will make recommendations to revise the plan of correction as indicated.<br><br>**5) Date of compliance:** 9/7/2023 | |
| R 0214<br><br>Bldg. 00 | 410 IAC 16.2-5-2(a)<br>Evaluation - Deficiency<br>(a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. | | | |

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| | Based on observation, interview, and record review, the facility failed to ensure personalized service plan agreements were maintained for 1 of 6 residents reviewed for behaviors (Resident C).<br><br>Findings include:<br><br>On 7/20/23 from 11:54 a.m., until 12:19 p.m., Resident C was observed during a lunch observation. He was seated at a table with 3 other male residents. One Resident required total assistance to eat his lunch, and Resident C was observed to become frustrated that the other resident received 1 on 1 (1:1) attention/assistance and was served dessert before he was. Certified Nurse Aide (CNA) 18, who assisted the tablemate, assured Resident C he had been treated equally, but Resident C indicated, "he gets more than me." Resident C stood up and left the table. He was observed to have only one shoe on, and the other remained under the table.<br><br>On 7/20/23 at 1:00 p.m., an unscheduled activity was started in the activity lounge. Staff paused a movie that was playing and began to bounce balloons around and encouraged the residents to gently bat the balloons back and forth.<br><br>On 7/20/23 at 1:06 p.m., Resident C got up from the dining room table and entered the activity area. His pants were observed to sag. CNA 20 brought a belt into the activity lounge and attempted to assist Resident C to put the belt on. Resident C became agitated and raised his fist to the aid. CNA 20 left him alone and he sat in a chair. Resident C remained frustrated and confused. He indicated, as he pointed to the activity, "what's going on? It's not fair doing this playing. I don't want them to cheat him." | R 0214 | **R214 Evaluation Deficiency**<br>***1)Immediate actions taken for those residents identified:***<br>Resident C service plan was reviewed and updated by DON.<br>***2)How the facility identified other residents:***<br>Any resident residing in the facility was at risk of being adversely affected. Audit completed on all resident charts for the goal of identifying behaviors and service plans have been updated.<br>**3)Measures put into place/ System changes:**<br>In-service and education will be provided to all nursing staff on how to deescalate residents' behavior and Dementia training.<br>Alert charting initiated. (Copies Attached)<br>Weekly census and service plan review will occur during weekly wellness meetings. Meetings to include ED, DON, ADON, RCS, NP, Therapy, MCD and various care team members to differ week to week. Re-education provided to WD on Service Plan SOP. (Attached)<br>**4)How the corrective actions will be monitored:**<br>Don/Designee will be responsible for this plan of correction and Audit findings will be presented to the QAA Committee monthly x 6 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance | 09/07/2023 |

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| | On 7/19/23 at 2:30 p.m., Resident C's medical record was reviewed.<br><br>Resident C resided on the secured Memory Care Unit (MC) and had diagnoses which included but were not limited to dementia (a degenerative brain disorder that effects memory) with behavioral disturbance. He admitted to the facility on 4/11/23 from an in-patient psychiatric unit.<br><br>A corresponding summary of present illness from the psychiatric unit, dated 2/26/23, indicated Resident C had resided in a previous secured memory care unit but began to display behaviors ... "pushed a female staff member when she tried to redirect him while he was trying to pursue a fellow female resident. Staff reports that patient is possessive over items, such as his jeans and furniture. Staff reports that when a fellow resident sits on furniture patient will become upset and make a fist at them, showing aggression ...."<br><br>Resident C's record review revealed repeated, unprovoked, aggressive verbal and physical threats, as well as physical attacks against his peers and staff.<br><br>Cross reference R0052.<br><br>Resident C had a service plan which was initiated on 2/13/23 which only addressed his history of wandering into other resident's rooms. Intervention for this service plan included, but were not limited to, "Monitor whereabouts every hour," "Behaviors: Known triggers for resisting care are (SPECIFY [which was not revised to specify]). The resistive behave is de-escalated by (SPECIFY [which had not been revised to specify]). | | is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.<br><br>**5) Date of compliance:** 9/7/2023 | |

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| | Resident C's service plans lacked updates or revision to include services provided, for his refusal of medication and failed to make revision or implement new interventions as necessary to prevent Resident C from making continued unprovoked attacks against his peers.<br><br>The record lacked documentation of hourly whereabout checks.<br><br>During an interview on 7/21/23 at 11:00 a.m., the Wellness Director indicated Service Plans were to be individualized to each residents. They were completed upon admission and at least every 6 months after that. However, Service Plans should also be revised as needed with resident change of condition.<br><br>This State tag relates to Complaints IN00412406 and IN00413370. | | | |
| R 0242<br><br>Bldg. 00 | 410 IAC 16.2-5-4(e)(2)<br>Health Services - Offense<br>(2) The resident shall be observed for effects of medications. Documentation of any undesirable effects shall be contained in the clinical record. The physician shall be notified immediately if undesirable effects occur, and such notification shall be documented in the clinical record.<br>Based on observation, interview, and record review, the facility failed to assess, document, and monitor for the effects of diabetic medications for 1 of 1 resident with orders for 3 hyperglycemic (high blood sugar) medications (Resident F).<br><br>Findings include,<br><br>On 7/20/23 at 11:15 a.m., Resident F was observed in his apartment, ambulating independently with a | R 0242 | **R242 Health Services offense**<br><br>**The facility requests paper compliance for this citation.**<br>***This Plan of Correction is the center's credible allegation of compliance.***<br>***Preparation and/or execution of this plan of correction does not constitute admission or*** | 09/07/2023 |

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| | steady gait. Resident F indicated staff administered his medications in his apartment. He was not currently being monitored for his blood sugar levels by staff sticking his finger, but he was now taking 3 medications and they probably needed to.<br><br>Resident F's record was reviewed on 7/19/23 at 1:30 p.m. Diagnoses on Resident F's profile included, but were not limited to, mild cognitive impairment of uncertain or unknown etiology, and type 2 diabetes mellitus (chronic condition where the body either doesn't produce enough insulin, or it resists insulin).<br><br>A physician's order, dated 6/5/23, indicated Pioglitazone (Actos) 15 milligram (mg) tablet, take 1 tablet by mouth every day for diabetes mellitus type 2.<br><br>A physician's order, dated 6/30/23, indicated glimepiride (Amaryl) 2 mg tablet, take 1 table by mouth twice daily for diabetes mellitus type 2.<br><br>A physician's order, dated 7/4/23, indicated metformin (Glucophage) 500 mg ER (extended release), take 2 tablets (1000 mg) by mouth twice daily with meals for diabetes mellitus type 2).<br><br>Resident record lacked physician's order to monitor blood sugars and or parameters for when to notify the physician.<br><br>A progress notes, dated 6/30/23 at 3:05 p.m., indicated, while doing 72 hours checkup for his vital signs (no reason given), the resident's blood sugar level was 530. The writer was unable to reach the doctor by phone, so printed out the paper and sent it with the resident to a doctor's appointment on this date. | | ***agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.***<br>***1)Immediate actions taken for those residents identified:***<br>Resident F all medications were reviewed by DON and education provided to Licensed nurses and QMA to record BS and notify MD, POA and DON with any changes .<br>***2)How the facility identified other residents:***<br>Any resident residing in the community was at risk of being adversely affected. Audit completed on all residents with Diabetes to ensure all diabetic orders are accurate and service plans are updated.<br>**3)Measures put into place/ System changes:**<br>Don/designee will review 3 resident charts one time weekly for 4 weeks, 2 resident charts one time weekly for 4 weeks, and lastly one resident chart one time weekly for 4 weeks to ensure all diabetic orders are accurate and service plans have been updated.<br>**4)How the corrective actions will be monitored:**<br>Don/Designee will be responsible for this plan of correction and Audit findings will be presented to the QAA Committee monthly x 6 | |

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| | A progress notes, dated 6/30/23 at 5:15 p.m., new order from the primary care provider for glimepiride 2 mg tablet by mouth twice daily, and metformin 500 mg give 2 tablets by mouth twice daily at 2:00 a.m. and 2:00 p.m.<br><br>Blood sugar monitoring in the resident medical record, dated 2023, indicated documentation twice to include,<br>a. On 6/30/2023 at 1:21 p.m., 530.0 mg/dl (milligrams per deciliter) (normal fasting blood sugar level 126 mg/ml or lower if diabetic).<br>b. On 6/30/2023 at 10:01 p.m., 321.0 mg/dl.<br><br>A service plan for Resident F, dated 6/16/23, indicated the focus was medications. The goal was for the resident to be supported to take all medications safely and as ordered. Interventions indicated the residents' medications were staff managed. The resident needed help with medications due to cognitive loss.<br><br>Resident record lacked a service plan regarding hyperglycemia/type 2 diabetes mellitus after elevated blood sugar readings of 530 mg/dl.<br><br>During an interview on 7/21/23 at 10:30 a.m., the Wellness Director indicated there was no record of the resident blood sugar readings having been monitored. The staff did not monitor his blood sugars, the resident gave his own medications, and he was only on one oral hyperglycemic medications.<br><br>On 7/20/23 at 2:15 p.m. the Executive Director (ED) provided a Diabetes Hyperglycemia policy, last reviewed 10/17/22, and indicated the policy was the one currently being used by the facility. The policy indicated, "The purpose of the diabetes | | months. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.<br><br>**5) Date of compliance:** 9/7/2023 | |

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| | hyperglycemia guidelines is for staff to be able to assist residents with diabetes hyperglycemia symptoms and associated health problems in order to reduce resident's hospitalizations and improve or maintain his or her quality of life ...Procedure: 1. Obtain physician's orders for glucose monitoring, diabetic medications, or sliding scale/long acting insulin as needed. 2. Monitor resident's glucose levels as ordered by physician. 3. Administer all diabetic medications, oral or insulin as ordered. 4. Observe for signs/symptoms of hyperglycemia, a. loss of appetite, b. nausea or vomiting, c. fruity, acetone breath, d. deep, rapid breathing, e. drowsiness/restlessness, f. abdominal pain, g. coma. 5. Contact healthcare provider for glucose levels that exceed ordered parameters. 6. If conditions worsen, contact Wellness Leader and call 911 ...."<br><br>This State tag relates to Complaint IN00412406. | | | |