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	12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
INDEPENDENCE VILLAGE OF GREENWOOD	2339 S STATE ROAD 135 GREENWOOD, IN 46143

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: December 5 and 6, 2023 Facility number: 005722 Residential Census: 77 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed December 8, 2023.	R 0000	The submission of the Plan of Correction does not indicate an admission by Independence Village of Greenwood 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 Greenwood. 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. The Community respectfully requests consideration for a desk review. Karen Yarnell Rumple, HFA	
R 0148 Bldg. 00	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Karen Yarnell Rumple	Administrator	12/20/2023

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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	(2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on observation, interview, and record review, the facility failed to ensure potentially hazardous materials were kept secure and behind locked doors to prevent resident's access to the materials for of 2 days during the survey. (Maintenance Office, Mechanical Closet) Findings include: 1. On 12/5/23 from 12:01 p.m. to 12:08 p.m., the following was observed: - At 12:01 p.m., the Maintenance Office (Office) located on the first floor near the secured memory care unit and between the fire control room and the staff lounge, was observed. The entrance door to the office was observed to not be closed. Inside the office the following was observed, multiple hand tools, electrical tools, maintenance tools and equipment, various spray cans, and bins that contained multiple nails and screws. No staff were visible in the office or in the immediate area. - At 12:05 p.m., the Maintenance Director was observed entering and exiting the Maintenance Office. When the Maintenance Director exited the Office, the door was observed to not be closed. No staff were visible in the office or in the immediate area.	R 0148	R 148 1 No residents were affected by the deficient practice. 2 The Community realizes that residents who are cognitively impaired had the potential to be affected by the deficient practice. 3 The Executive Director did an audit to identify all doors that were unlocked that should have been locked. All doors that were identified as unlocked and should have been locked are now locked with functioning locking mechanisms. The Maintenance Director and Maintenance Assistant have been re-educated on keeping the Maintenance Office door closed and locked when not in the office. (Please see exhibit "A"). In addition, all leaders and housekeepers were re-educated to the locked door Standard Operating Procedure. (Please see exhibits "B" and "C"). 4 The doors will be checked daily by the use of an Addendum to the 1440 walks done daily by	12/18/2023

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	- At 12:08 p.m., the Maintenance Director was observed re-entering the Maintenance Office through the opened door. During an interview at that time, the Maintenance Director indicated the Maintenance Office space "contained multiple maintenance type of hazardous supplies and equipment." The door was to be kept closed when staff were not in the area. The Maintenance Director was unsure if there was a facility policy regarding hazardous materials being kept in a secured location. During an interview on 12/6/23 at 12:45 p.m., the Administrator indicated potentially hazardous materials were to be kept secure behind locked doors.2. During observations on 12/5/23 from 10:15 a.m. until 10:30 a.m., observed a mechanical closet on the first floor, across from Room 125 to be unlocked and was easily opened. The mechanical closet stored an Aqua Therm water heater. No staff were visible in the area. During an interview at that time, the Administrator indicated the door should have been locked. On 12/5/23 at 12:30 p.m. to 12:33 p.m., observed a mechanical closet on the first floor, across from Room 125 to be unlocked and was easily opened. The mechanical closet stored an Aqua Therm water heater. No staff were visible in the area. On 12/6/23 at 8:20 a.m., the Director of Nursing provided a list of self-mobile cognitively impaired residents residing in the facility. A review of the document indicated there were 12 of 57 residents residing in the facility who were self-mobile and cognitively impaired. On 12/6/23 at 8:20 a.m., the Director of Nursing provided a policy titled Door Function and Safety		an assigned leader (Please see exhibit "D"). Any doors identified will be locked immediately. Any doors to be found with a non-locking or non-functional mechanism will be reported to the Executive Director. The Executive Director will inform the Maintenance Director and the maintenance Director will correct the issue.	

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	Prevention Maintenance, dated 1/26/23, and indicated it was the current policy being used by the facility. A review of the policy indicated, "...When performing the preventative maintenance, the following procedure will be followed: 4. Wellness director organizes care staff to immediately check all secured doors/gates. Unsecured doors/gates will be monitored until issues are resolved."			
R 0151 Bldg. 00	410 IAC 16.2-5-1.5(h) Sanitation & Safety Standards -Noncompliance (h) Any pet housed in a facility shall have periodic veterinary examinations and required immunizations. Based on observation, interview, and record review, the facility failed to ensure pets who resided in the facility had received the rabies vaccinations prior to its end date and that annual veterinary examinations were completed for 2 of 6 residents who housed pets in the facility. (Resident 67, Resident 93) Findings include: 1. On 12/6/23 at 10:45 a.m., the Administrator provided a list of residents who housed pets in the facility. The list indicated Resident 67 had a canine. On 12/6/23 at 11:35 a.m., Resident 67's canine vaccination record was reviewed. The document titled "Rabies Vaccination Certificate" indicated the canine's rabies vaccination was expired on 10/20/22. No other documentation was provided. The record lacked a current rabies vaccination certification and an annual veterinary examination	R 0151	1 No residents were affected by the deficient practice. 2 The Community realizes that all residents residing in Assisted Living could have had the potential to be affected by the deficient practice. 3 Resident # 67's dog was vaccinated on 12/19/2023. (Please see exhibit "E"). Resident # 93's dog was vaccinated on 12/18/2023 (Please see Exhibit "F"). In addition, all residents with dogs have signed the Small Pet Addendum. (Please see Exhibit "G"). 4 The Receptionist has developed a binder with a tickler system by month to ensure all dogs vaccinations are up to date and will remind families thirty days in advance of the needed vaccination. In addition, the Executive Director/designee will	12/19/2023

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	of the canine. During an observation on 12/6/23 at 12:02 p.m., Resident 67's canine was observed resting on the living room floor. During an interview at that time, Resident 67 indicated the canine was "past due" for the annual veterinarian examination and rabies vaccination. During an interview on 12/6/23 at 12:15 p.m., the Administrator indicated Resident 67's canine rabies vaccinations and annual veterinarian examinations documentation should have been updated. The documentation should have been readily accessible for review. 2. On 12/6/23 at 10:45 a.m., the Administrator provided a list of residents who had pets in the facility. The list indicated Resident 93 had a canine. On 12/6/23 at 10:46 a.m., Resident 93's clinical record was reviewed. The record lacked a current rabies vaccination certification and an annual veterinary examination of the canine. During an interview on 12/6/23 at 10:47 a.m., the Administrator indicated Resident 93's canine rabies vaccinations and annual veterinarian examinations documentation should have been current. The documentation should have been readily accessible for review. During an observation on 12/6/23 at 12:10 p.m., Resident 93's canine was heard barking loudly and was observed walking around in the apartment. During an interview at that time, Resident 93 indicated she was unsure when the canine's rabies vaccination and annual veterinary examination had been completed.		ensure that vaccination records are obtained and reviewed for an up to date vaccination, prior to the lease signing. No dogs without an updated vaccinations will be allowed to reside in the Community.	

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	On 12/6/23 at 11:55 a.m., the Administrator provided a copy of the Pet Policy - Unsecured Areas: Standard Operating Procedure, dated 4/5/21, and indicated it was the current policy in use by the facility. A review of the document indicated, "...all residents with pets residing within the community must submit an annual health record...the resident/responsible party agrees to register and immunize the pet in accordance with local laws and requirements..." On 12/6/23 at 3:00 p.m., a review of the Rabies Vaccination Requirements located at 345 IAC 1-5-2 indicated, "...all dogs...3 months of age and older must be vaccinated against rabies..."			