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	04/26/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00429183. Complaint IN00429183 - State deficiencies related to the allegations are cited at R0039. Survey dates: April 25 and 26, 2024. Facility number: 003902 Residential Census: 82 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on May 8, 2024.	R 0000	ATT: Brenda BurokerDirector of Division Long Term Care2 North Meridian StreetIndianapolis, Indiana 46204 Re: State Residential Licensure with Complaint Survey Independence Village of Avon 182 S County Road 550 E Avon, IN 46123 Dear Ms. Buroker, On April 25, 2024, a State Residential Licensure with Complaint (IN00429183) Survey 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. Please consider this letter and Plan of Correction to be the facility's credible allegation of compliance. 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 May 26th, 2024. Please feel free to call me with any further questions at 317-745-2766. Respectfully submitted, Romeo Behl Independence Village of Avon 182 S County Road 550 E Avon, IN 46123	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Romeo Behl	Executive Director	05/17/2024

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.

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	04/26/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0039 Bldg. 00	410 IAC 16.2-5-1.2(n) Residents' Rights- Deficiency (n) Residents may, throughout the period of their stay, voice grievances to the facility staff or to an outside representative of their choice, recommend changes in policy and procedure, and receive reasonable responses to their requests without fear of reprisal or interference. Based on observation, interview, and record review, the facility failed to ensure residents were free from misappropriation of their property and failed to ensure an effective in-service/education program for grievances was in place for all staff to prevent the potential failed reporting and investigation for 2 of 3 residents reviewed for misappropriation (Residents B and E). Findings include: On 4/25/24 at 11:27 a.m., Resident B was observed in her apartment. She utilized a rollator walker from her bedroom to the living room and took a seat on her couch. Her apartment was observed to be cluttered with personal items and collectible figurines. Resident B indicated, during the recent refurbishing of the facility, she had several pieces of personal property that went missing. She was most upset about a necklace that had two sizable diamonds in it which had been a gift from her youngest son. Other pieces of jewelry were gone as well as a mint condition purple Princess Diana TY bear, and a collectible cat-figure wall clock. She discussed her grievance with the Maintenance Director and reported the stolen items. They both suspected it may have been a construction member when they were remodeling her apartment. She indicated she reported the missing items to both the Maintenance Director and the Executive Director (ED) but had been told,	R 0039	**R039 Resident s rights and non-compliance** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***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.*** ***1)Immediate actions taken for those residents identified:*** Resident B and E were interviewed by ED for her missing items and reports and grievances were filled for all missing items as per facility policy. ***2)How the facility identified other residents:*** Any resident residing in the facility had the potential to be affected. All residents were interviewed by Department heads for any missing	05/26/2024

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	04/26/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	there was nothing they could do about it. During an interview on 4/26/24 at 10:35 a.m., the Maintenance Director indicated he remembered Resident B complained about several items that went missing during the reconstruction. When asked what she reported stolen, the Maintenance Director indicated a diamond necklace, a TY collectible, and a wall clock. When asked what staff should do when there were told about stolen property, he indicated he always advised them to fill out a grievance and he would report to the ED for investigation. He could not remember if he reported the incident or not. When asked if any other residents had personal items that turned up missing, the Maintenance Director indicated Resident E reported she had several pieces of jewelry that went missing. During an interview on 4/26/24 at 11:20 a.m., Resident E indicated she had jewelry and money stolen. One day, she could not recall, when she had gotten $200 from the bank. She placed half of the money in one coin purse, and the other half in a second coin purse. Resident E indicated she always locked her door when she left the apartment. The money was in her purse left in her apartment. She believed a staff member had stolen it when she was out of her apartment for activities or meals. At the beginning of the year, her grandchildren came for a visit and she had planned to pass down some family heirloom jewelry to her granddaughters for a Christmas present. When she went to get her rings from their place in her bedroom dresser drawer, the jewelry was gone. She reported the theft to the Maintenance Director and the ED. During an interview on 4/26/24 at 10:42 a.m., the ED indicated anytime a staff member was told by a		items. Grievance and reports were filed as per facility policy. Residents were encouraged to notify facility staff immediately about any missing items. **3)Measures put into place/ System changes:** In-service provided to all staff on abuse, neglect and misappropriation of property and to notify ED immediately. ED/Designee will interview 3 resident 3 times weekly x 4 weeks, then 2 residents 2 times weekly x 4 weeks and then 1 resident 1 time weekly for 1 months for any missing items and reports and grievances will be filled as facility policy. **4)How the corrective actions will be monitored:** ED/Designee will be responsible for this plan of correction and Audit findings will be presented to the department heads meeting once a month x 6 months. The results of these audits will be reviewed in Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. **5) Date of compliance: 5.26.24**	

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	04/26/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resident they believed personal items had been stolen or misplaced, the staff member should either fill out a grievance for the resident or assist them to fill one out, and immediately report the incident to the ED. The ED indicated she did recall Resident E's money being stolen, but did not know that she had also reported jewelry missing. The ED had not been notified of Resident B's missing items either. On 4/26/24 at 12:37 p.m., the ED provided a copy of the reportable incident #162 related to Resident E's missing money. Along with the reportable was an in-service sign-in sheet. The ED indicated she conducted an in-service on abuse/neglect and grievances, for all nursing staff. When asked if other staff were also in-serviced on the facility's procedure for reporting abuse/neglect and grievances, the ED indicated no. The ED indicated she should have provided the in-service for all staff. On 4/25/24 at 3:37 p.m., the ED provided a copy of the current facility policy titled, "Abuse, Neglect, or Exploitation," reviewed 6/2023. The policy indicated, "Exploitation- misuse of an adult's funds, property or personal dignity ... by another person ... employees are to immediately report any witnessed or suspected incidents of abuse, neglect or exploitation to the supervisor on duty and the Wellness Director or designee. For the purposes of this policy, "immediately" means as soon as possible, but will not exceed twenty-four (24) hours after the incident ...." This citation relates to Complaint IN00429183.			
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation			

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	04/26/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility.			
	Based on observation, interview, and record review, the facility failed to ensure a resident's (Resident B) medical record was accurate and a true reflection of her ability to self-administration of medications for 1 of 3 residents reviewed for falls. Findings include: On 4/25/24 at 11:27 a.m., Resident B was observed in her apartment. She utilized a rollator walker from her bedroom to the living room and took a seat on her couch. Her apartment was observed to be cluttered with personal items and collectible figurines. Various items were observed on the floor and throughout the apartment. When asked if she had a hard time ambulating around the clutter, Resident B indicated, "that's what I get for being a collector." She indicated she had one fall, a few weeks prior, she tripped over something she didn't see on the kitchen floor. She indicated she did not sustain any injuries. The nurse had come initially to check her out, but that was it. Next to her seat on the couch, was a pre-set pill box, topical creams and bottles of eye drops. A plastic bag of 4 additional pill boxes was observed on the	R 0216	**R216 Evaluation and non-compliance** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***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.*** ***1)Immediate actions taken for those residents identified:*** Resident B will be reassessed by WD for self-administration and for properly storing medications by 05/19/2024. ***2)How the facility identified other residents:***	05/26/2024

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	04/26/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	seat of the couch next to her. When asked about her medications, Resident B indicated she set up and administered all her own medications and explained what they were. Her medications also included topical anti-fungal and eye drops for dry eyes. She indicated she kept lots of pill boxes pre-set so she always had some available. She could not recall when she set them, and the boxes and bags were not labeled. When asked if she always kept her door locked if she left the apartment, she indicated most of the time, but sometimes if she had a bout of irritable bowel syndrome, she would leave it unlocked so she could get back into the apartment in a hurry. Further, there was two clear plastic containers. The first container was observed to have original and individually packaged tablets both blue and clear in color. The second container had more than 20 tablets, both blue and clear, which had been removed from their original packaging. When asked about these medications, Resident B indicated, she kept a stash of already opened bowel medications because sometimes she needed to get to them quickly. The container of unopened tablets, she kept to open and refill her second container of unsealed medications. On 5/25/24 at 1:10 p.m., Resident B's medical record was reviewed. She had diagnoses which included, but were not limited to, epilepsy and recurrent seizures, high blood pressure, and urinary incontinence. Resident B had current physician's order which included, but not limited to the following: a. Artificial Tears with instructions to instill 2 drops in both eyes four times a day. b. Ketoconazole Cream (an antifungal medication) with instructions to apply topically twice a day to		Any resident residing in the facility had the potential to be affected. All residents who self-administer their meds will be reassessed by WD/AWD for self-administration and properly storing medication. **3)Measures put into place/ System changes:** Inservice provided to the Licensed nurses on self-administration assessments. WD/Designee will assess 3 residents 3 times weekly x 4 weeks, then 2 residents 2 times weekly x 4 weeks and then 1 resident 1 time weekly for 1 month for self-administration and educate them on storing the meds to ensure compliance. **4)How the corrective actions will be monitored:** ED/Designee will be responsible for this plan of correction and Audit findings will be presented to the department heads meeting once a month x 6 months. The results of these audits will be reviewed in Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. **5) Date of compliance: 5/26/24**	

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	04/26/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	affected areas. The most recent Medication Self-Administration Evaluation was dated 2/6/24. The assessment indicated, "Resident desired to self-administer on certain medications," but the specific medications were not documented. For special situations, both eye drops, and topical medications were marked as, "Not Applicable." The assessment indicated Resident B met compliance and kept all her medications in a locked container. During an interview on 4/25/24 at 4:15 p.m., the Wellness Director (WD) indicated, Residents who were able to self-administer their medications needed to keep their medications secured in lock boxes in their rooms. Residents were permitted to pre-set medications, but they also needed to be kept secured and they should always lock their apartment doors when they were not home. When asked about the accuracy of Resident B's assessment, the WD indicated it should be a true and accurate reflection of the resident's physician orders. On 4/25/24 at 4:15 p.m., the WD provided a copy of current facility policy titled, "Medication-Resident Self Administration," reviewed 6/2022. The policy indicated, " ...The Wellness Director of Designee will review the Self-Administration of Medication Evaluation with the resident to evaluate their ability to safely administer and store their own medications ... All medications must be secured in a locked storage container including medications requiring refrigeration ... All medications, over-the-counter medications, dietary supplements, or treatments must remain in the original container with legible label. Pill boxes are not permitted unless State Licensing expressly authorizes use of pill boxes ...."			

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	04/26/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.			
	Based on observation, interview, and record review, the facility failed to ensure a resident (Resident B) received monitoring and/or supervision after she sustained a fall for 1 of 3 residents reviewed for falls. Findings include:	R 0217	**R217 Evaluation-Deficiency** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not***	05/26/2024

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	04/26/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 4/25/24 at 11:27 a.m., Resident B was observed in her apartment. She utilized a rollator walker from her bedroom to the living room and took a seat on her couch. Her apartment was observed to be cluttered with personal items and collectible figurines. Various items were observed on the floor and throughout the apartment. When asked if she had a hard time ambulating around the clutter, Resident B indicated, "that's what I get for being a collector." She indicated she had one fall, a few weeks prior, she tripped over something that she didn't see on the kitchen floor. She indicated she did not sustain any injuries. The nurse had come initially to check her out, but that was it. On 5/25/24 at 1:10 p.m., Resident B's medical record was reviewed. She had diagnoses which included, but were not limited to, epilepsy and recurrent seizures, high blood pressure, and urinary incontinence. A nursing progress note, dated 2/4/24 at 4:16 p.m., indicated Resident B had been found on the floor in her kitchen. Resident B told the staff she had bent down to pick something up but forgot to lock the walker and it rolled away and caused her to fall. She indicated she did not hit her head, and the nurse took a set of vital signs which were within normal limits. The fall was unwitnessed, and the record lacked documentation that neurological assessments had been completed. The record lacked documentation of any further fall follow-up, assessment and/or interventions. The record lacked documentation of physical therapy and/or gait analysis arrangements as specified in the facility's policy below.		***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.*** ***1)Immediate actions taken for those residents identified:*** Resident B chart was reviewed for accuracy and a new 6 month fall risk assessment was completed that reflects high risk of falls. ***2)How the facility identified other residents:*** Any resident residing in the facility had the potential to be affected. All falls from last 30 days were reviewed to make sure that all falls follow up, interventions that include physical therapy and/or gait analysis are completed. Licensed nurses will be in serviced on completion and assessing fall to ensure all fall follow up, interventions that include physical therapy and/or gait analysis are completed. **3)Measures put into place/ System changes:** WD/Designee will review any new falls 3 times weekly x 4 weeks, then 2 times weekly x 4 weeks and then 1 time weekly for 1 month to ensure that all falls follow up, interventions that include physical therapy and/or gait analysis are completed.	

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	04/26/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A 6 month Fall Risk assessment, dated 2/6/24 (two days after her fall), indicated, "no." Resident B had no history of falling, but was at high risk for falls. During an interview on 4/25/24 at 4:10 p.m., the Wellness Director (WD) indicated if a resident had an unwitnessed fall, staff should immediately ensure the resident was safe and had no injuries then make the required notifications. Staff should complete more frequent checks and fall follow which would include neurological checks to ensure the resident's continued safety and that no delayed injuries were evident. Staff should also complete a post fall assessment and let management know so that assessment and/or interventions would be discussed/provided. On 4/25/24 at 4:10 p.m., the WD provided a copy of current facility policy titled, "Resident Forms," reviewed 3/2023. The policy indicated, "The purpose of the Residents Falls policy is to provide guidelines for evaluating a resident after a fall and to assist staff in identifying causes of fall ... staff complete the post fall documentation. The incident is recorded on the incident log with the post fall interventions. Medical intervention, physical therapy and or gait analysis is arranged when residents remain a significant risk for falls ...."		**4)How the corrective actions will be monitored:** WD/Designee will be responsible for this plan of correction and Audit findings will be presented to the department heads' meeting once a month x 6 months. The results of these audits will be reviewed in Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. **5) Date of compliance: 5.26.24**	
R 0242 Bldg. 00	410 IAC 16.2-5-4(e)(2) Health Services - Offense (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			

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	04/26/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	clinical record. Based on record review and interview, the facility failed to ensure residents, who required the use of high-risk medications, were observed/monitored for undesirable effects of those medications and the facility failed to provide medically appropriate diagnoses for the use of black box (when serious adverse reactions or special problems occur, particularly those that may lead to death or serious injury) medications for 3 of 3 residents reviewed for adverse effects (Residents 20, 9, and 12). Findings include: 1. On 4/25/24 at 1:30 p.m., a comprehensive record review was completed for Resident 20. He had diagnoses which included, but were not limited to, dementia, adult failure to thrive (syndrome of weight loss, decreased appetite and poor nutrition, and inactivity, often accompanied by dehydration, depressive symptoms, impaired immune function, and low cholesterol), major depressive disorder, atrial fibrillation (a type of abnormal heartbeat), and gastro-esophageal reflux disease (GERD) (occurs when stomach acid repeatedly flows back into the tube connecting the mouth and stomach). He had a current physician's order for risperidone (an atypical antipsychotic medication with a black box warning and used to treat schizophrenia, bipolar disorder, or irritability associated with autistic disorder), 0.25 mg (milligrams) two times daily for adult failure to thrive. The record lacked documentation of medication monitoring. 2. On 4/25/24 at 2:00 p.m., a comprehensive record	R 0242	**R242 Health Serviced offense.** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***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.*** ***1)Immediate actions taken for those residents identified:*** Resident 20,9 and 12 orders and dx were reviewed for accuracy. New orders for monitoring side effects from antipsychotic medication with black box warning were added in MAR.MD was notified. ***2)How the facility identified other residents:*** Any resident residing in the facility had the potential to be affected. All residents on antipsychotic medication were reviewed and new orders for monitoring side effects from antipsychotic medication with black box warning were added in MAR. Licensed nurses were in serviced on monitoring antipsychotic medications.	05/26/2024

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	04/26/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	review was completed for Resident 9. She had the following diagnoses which included, but were not limited to, unspecified dementia with behavioral disturbances, anxiety disorder, age-related physical debility, major depression, chronic kidney disease, hypothyroidism (the thyroid gland cannot make enough thyroid hormone to keep the body running normally), anemia, and hypertension. She had the following orders for medications with black box warnings and without any monitoring for adverse effects related to the use of these medications. Lorazepam concentrate 2mg/ml (an antianxiety medication) take 0.25 ml every 4 hours as needed for anxiety, lorazepam 0.5 mg take 1 tablet two times daily for anxiety, lorazepam 1 mg take 1 tablet 45 minutes prior to showers as needed for anxiety, Mirtazapine (an antidepressant) 15 mg take 1 tablet every night at bedtime for antidepressants, risperidone 0.5 mg take 1 tablet two times daily for antipsychotics, and trazodone (an antidepressant) 50 mg take 1 tablet at bedtime for insomnia. The record lacked documentation of medication monitoring. 3. On 4/26/24 at 9:30 a.m., a comprehensive record review was completed for Resident 12. She had the following diagnoses which included, but were not limited to, unspecified dementia with behavioral disturbance, type 2 diabetes mellitus, and dermatitis (a skin condition). She had the following orders for medications. Sertraline 50 mg (an antidepressant) take 1 tablet daily for depression, trazodone 50 mg give "one-half" tablet by mouth every 12 hours as needed for antidepressants, and trazodone 50 mg		**3)Measures put into place/ System changes:** WD/Designee will review 3 residents 3 times weekly x 4 weeks, then 2 residents 2 times weekly x 4 weeks and then1 resident 1 time weekly for 1 month that also include new admission to ensure that all antipsychotic medications have side effect monitoring in place. **4)How the corrective actions will be monitored:** ED/Designee will be responsible for this plan of correction and Audit findings will be presented to the department heads' meeting once a month x 6 months. The results of these audits will be reviewed in Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. **5) Date of compliance: 5/26/24**	

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	04/26/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	take 1 tablet by mouth at bedtime for antidepressants. The record lacked documentation of medication monitoring. A policy titled, "Medication Orders," dated 9/22/22, was provided by the ED (Executive Director) on 4/26/24 at 11:24 a.m. It indicated, " ...All medications must contain medication name, dosage, route and frequency. Indications for use must be included in PRN (as needed) medication orders ...."			
R 0300 Bldg. 00	410 IAC 16.2-5-6(c)(4) Pharmaceutical Services - Deficiency (4) Over-the-counter medications, prescription drugs, and biologicals used in the facility must be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date. Based on observation and interview, the facility failed to ensure over the counter (OTC) medications and prescription medications were appropriately labeled and dated after they were opened, and failed to ensure expired medication were removed from the medication carts and medication storage refrigerators for 9 of 24 residents reviewed for medication labeling and storage (Residents 10, 11, 12, 21, 13, 14, 15, 9, and 16). Findings include: On 4/25/24 at 11:00 a.m., an observation of the medication cart and refrigerator was completed with Qualified Medication Aide, (QMA) 53 present.	R 0300	**R300 pharmaceutical Services** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***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.*** ***1)Immediate actions taken for***	05/26/2024

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	04/26/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	1. Resident 10 had a bottle of refresh eye drops (used for dry eyes) in the medication cart that was undated. 2. Resident 11 had glargine-yfgn in the cart with a date of 3/3/24. The glargine-yfgn had no name or directions, just a room number. The pen was expired. She had a pen of humalog insulin in the medication cart with no label. The humalog insulin was opened on 3/24/24 and was expired. She had a bottle of lorazepam 2mg/ml (used to treat anxiety) in the medication room refrigerator that was not dated when it was opened. 3. Resident 12 had a pen of lantus insulin in the medication cart with no label. It was opened 3/9/34 and was expired. 4. Resident 21 had two boxes of Slow Fe (an iron supplement) in the medication cart with only the name and date. She had a bottle of refresh eye drops in the medication cart with no date to indicate when it was opened. 5. Resident 13 had a bottle of stool softener 8.6 mg (milligrams) (used for constipation) with no label on the bottle. She also had a bottle of vitamin D3 (a supplement) with no label on the bottle. 6. Resident 14 had a bottle of aspirin 81 mg in the medication cart with no label on the bottle. 7. Resident 15 had a bottle of lorazepam 2 mg/ml (mg/milliliter) in the medication room refrigerator with no date on the bottle when opened. 8. Resident 9 had a bottle of lorazepam 2 mg/ml in the medication room refrigerator with no date to indicate when opened.		***those residents identified:*** Resident 10,11,12,21,13,14,15,9 and 16 medications were ordered dated and labeled as per policy. ***2)How the facility identified other residents:*** Any resident residing in the facility had the potential to be affected. Medication carts audits were completed by WD/Designee to ensure all medications are labeled and dated per policy. Licensed nurses and QMA's educated on med storage, labelling medication and date medication as per policy. **3)Measures put into place/ System changes:** WD/Designee will Audit meds carts 1 times weekly x 4 weeks, then 1 times weekly x every 2 weeks and then 1 time monthly for 1 month to ensure all medications are accurately label and dated as per facility policy. **4)How the corrective actions will be monitored:** ED/Designee will be responsible for this plan of correction and Audit findings will be presented to the department heads' meeting once a month x 6 months. The results of these audits will be reviewed in Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months.	

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	04/26/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	9. Resident 16 had a bottle of lorazepam 2 mg/ml in the medication room refrigerator with no date to indicate when opened. In the top drawer of the medication cart there were external creams, Diflucan (used for yeast infections), bacitracin cream (used to treat infections), and bio freeze (used as a topical gel to relieve pain). These medications were stored with inhalers and eye drops. On 4/25/24 at 11:20 a.m. during an interview with QMA 53, she took notes regarding the findings and indicated she would correct the labeling of OTC medications. A policy titled, "Medication Storage," was provided by the ED (Executive Director) on 4/26/24 at 11:25 a.m. It indicated, " ...Over the counter medications must be labeled with pharmacy printed label and no 'stock meds' are allowed for multi resident use. Drugs for external use shall be clearly marked as such and shall be stored separately from other medications. All discontinued and expired meds are to be removed and destroyed .... multi-dose vials with a revised expiration date once the multi-dose vial is opened or punctured. Nurses are not permitted to administer any medication from a multi-dose vial that is beyond the 28-day expiration date ...." A policy titled, "Medication Labels" was provided by the ED on 4/26/24 at 11:31 a.m. It indicated, " ...multi-dose vials are to be discarded 28 days after the first use unless the manufacturer specifies otherwise (shorter or longer). All stored medication must be labeled with the expiration date (the last dose that the product is to be used). The manufacturer's expiration date is based on the		**5) Date of compliance: 5/26/24**	

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	04/26/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	fact that the product has not been opened ...."			
R 0306 Bldg. 00	410 IAC 16.2-5-6(g)(1-9) Pharmaceutical Services - Noncompliance (g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information: (1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of. (6) The method of disposition. (7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug. (9) The signature of a witness, if any, to the disposal of the drug. Based on interview and record review, the facility failed to ensure resident medications were destroyed upon the removal of the resident from the facility for 1 of 2 residents reviewed for closed records (Resident D). Findings include: On 4/25/24 at 1:00 p.m., Resident D's closed medical record was reviewed. Resident D was a memory care resident who had diagnoses which included, but were not limited to, unspecified dementia, major depressive disorder, and Type 2 diabetes. Resident D was removed from the facility on 2/5/24 by her power of attorney (POA) and	R 0306	**R306 pharmaceutical Services-noncompliance** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***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.***	05/26/2024

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	04/26/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	transferred to another facility. Resident D's record review did not provide documentation regarding the disposition of her medications. During an interview on 4/26/24 at 11:56 a.m., The Wellness Director (WD) indicated Resident D's controlled substance medications had not been destroyed and would not be destroyed until the end of April. The WD indicated she was aware of missing documentation from Resident D's chart and the late disposal of the Resident's controlled substances. The controlled medications included: a. morphine (a narcotic pain reliever), a schedule II narcotic and b. lorazepam (a benzodiazepine used for anxiety), a schedule IV-controlled substance On 4/26/24 at 11:26 a.m., the ED provided a copy of the current standard operating procedure titled, "Medication Destruction/Disposal," last updated on 12/4/2023. The document indicated, " ...Controlled substances are to be destroyed within 72 hours of discontinuation of the medication or death of the resident...Document the destruction and disposal of medication(s) on the Drug Destruction/Disposition Log or pharmacy online form, print and place copy in the Drug Destruction/Disposition Binder ...."		***1)Immediate actions taken for those residents identified:*** Resident D no longer resides in the building. ***2)How the facility identified other residents:*** Any resident residing in the facility had the potential to be affected. WD, AWD and Licensed nurses were reeducated on policy and procedure of medication disposal within 72 hours of discontinuation of medication and death of the resident and will be in clinical records and shall include name of resident, strength, prescription number, reason, amount, date, method of disposal, signature of person disposing and witness signature. **3)Measures put into place/ System changes:** WD/Designee will Audit 3 residents 1 times weekly x 4 weeks, then 2 residents 1-time weekly x 4 weeks and then 1 resident 1-time weekly 1 month to ensure all medications are accurately disposed as per facility policy. **4)How the corrective actions will be monitored:** ED/Designee will be responsible for this plan of correction and Audit findings will be presented to the department heads' meeting once a month x 6 months. The results of these audits will be reviewed in Meeting monthly for 6 months or until 100% compliance	

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	04/26/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			is achieved x3 consecutive months. **5) Date of compliance: 5.26.24**	
R 0354 Bldg. 00	410 IAC 16.2-5-8.1(g)(1-7) Clinical Records - Noncompliance (g) A transfer form shall include the following: (1) Identification data. (2) Name of the transferring institution. (3) Name of the receiving institution and date of transfer. (4) Resident ' s personal property when transferred to an acute care facility. (5) Nurses ' notes relating to the resident ' s: (A) functional abilities and physical limitations; (B) nursing care; (C) medications; (D) treatment; and (E) current diet and condition on transfer. (6) Diagnosis. (7) Date of chest x-ray and skin test for tuberculosis.			
	Based on interview and record review, the facility failed to ensure transfer documentation was created for 1 of 2 residents reviewed for closed records (Resident D). Findings include: On 4/25/24 at 1:00 p.m., Resident D's closed medical record was reviewed. Resident D was a memory care resident who had diagnoses which included, but were not limited to, unspecified dementia, major depressive disorder, and Type 2 diabetes.	R 0354	**R354 clinical records-noncompliance** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***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***	05/26/2024

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	04/26/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident D was removed from the facility on 2/5/24 by her power of attorney (POA) and transferred to another facility. Resident D's record review did not provide any documentation regarding her removal from the facility or transfer information. During an interview on 4/26/24 at 9:15 a.m., the Wellness Director (WD) indicated all residents should have documentation regarding transfers or discharges included in their chart. The WD indicated Resident D should have documentation regarding her removal from the facility and transfer to another long-term care facility. The WD indicated she was aware of missing documentation from Resident D's chart. On 4/25/24 at 3:37 p.m., the WD provided a copy of the current standard operating procedure titled, "Resident Discharge for Indiana," last updated on 1/24/2023. The document indicated, "...When a transfer or discharge of a resident is proposed, whether intrafacility or interfacility, provision for continuity of care shall be provided by the facility ... The facility must, on a form prescribed by the department, do the following: (A) The reason for the transfer or discharge. (B) The effective date of the transfer or discharge. (C) The location to which the resident is transferred or discharged ...."		***plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** ***1)Immediate actions taken for those residents identified:*** Resident D no longer resides in the building. ***2)How the facility identified other residents:*** Any resident residing in the facility had the potential to be affected. WD reeducated all licensed nurses on discharging resident and documentation. **3)Measures put into place/ System changes:** WD/Designee will Audit all discharges 3 times weekly x 4 weeks, then 2 x weekly for 4 weeks and then 1 time weekly 1 month to ensure all discharges are completed accurately and documented as per policy. **4)How the corrective actions will be monitored:** ED/Designee will be responsible for this plan of correction and Audit findings will be presented to the department heads' meeting once a month x 6 months. The results of these audits will be reviewed in Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. **5) Date of compliance: 5.26.24**	

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	04/26/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE