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	09/19/2024

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

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R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00434279, IN00435806, IN00442138, and IN00442472. Complaint IN00434279 - No deficiencies related to the allegations are cited. Complaint IN00435806 - No deficiencies related to the allegations are cited. Complaint IN00442138 - State deficiencies related to the allegations are cited at R0053. Complaint IN00442472 - State deficiencies related to the allegations are cited at R0217. Survey dates: September 19, 2024 Facility number: 003902 Residential Census: 84 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on October 3, 2024.	R 0000	ATT: Brenda Buroker Director of Division Long Term Care 2 North Meridian Street Indianapolis, Indiana 46204 Re: Complaint Survey Independence Village of Avon 182 S County Road 550 E Avon, IN 46123 Dear Ms. Buroker, On September 19, 2024, a Complaint (IN00434279, IN00435806, IN00442138, IN00442472) Survey was conducted by the Indiana State Department of Health with **Survey Event ID SWP711**. 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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			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 November 9, 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	
R 0053 Bldg. 00	410 IAC 16.2-5-1.2(w) Residents' Rights - Deficiency Based on observation, interview, and record review, the facility failed to ensure a resident was	R 0053	**R053 Resident s rights - Deficiency**	11/09/2024

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	free from verbal abuse for 1 of 3 residents reviewed for abuse. Findings include: On 9/19/24 at 10:30 a.m., Resident B was observed and interviewed. Upon approach to her apartment, there was a sign posted that her apartment was under 24-hour video surveillance. Resident B was seated in a recliner chair with her legs elevated. She was dressed, neat and clean. Resident B agreed to a confidential interview and allowed the door to be closed. Throughout the interview, Resident B was very quiet, and reluctant to discuss her nursing treatment. Resident B indicated there had been an incident, but she did not want to talk about the incident. She was afraid that she would get in trouble, and they would take it out on her and be mean to her. Resident B indicated she would be living there for a while and was worried if she complained she would not be treated "right." During an interview on 9/19/24 at 11:30 a.m., Resident B's daughter indicated she had received a call from the facility to inform her Resident B had fallen. Resident B had Parkinson's and she fell often. A few days later when she received a voicemail recording that had been left on her nephew's phone. Apparently, Resident B had tried to call him while she was on the floor, and the phone went to voicemail which captured the verbal altercation between Resident B and two staff members. The daughter indicated Resident B sounded confused and upset, and the "brash" tone used by the aides were unhelpful and only escalated the situation. The daughter applauded the facility for having a diverse staff but indicated with the diversity came language and cultural barriers that made it hard for Resident B and other		**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 was interviewed by ED for any abuse/neglect. No abuse or neglect was reported by resident at this time. Resident was encouraged to report any abuse or neglect immediately and how to file grievances 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 abuse. Grievance and reports were filed as per facility policy. Residents were encouraged to notify facility staff immediately about any abuse. **3)Measures put into place/ System changes:** In Service provided to all staff on	

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	residents to understand the staff. The staff often spoke with heavy accents and spoke too fast which frustrated Resident B, and in turn frustrated the staff that Resident B couldn't understand. When the family listened to the voicemail, they were upset that the staff seemed to make the whole situation worse by not talking slower or using a kinder tone. When the daughter spoke with Resident B about what happened, Resident B indicated, that the aide just started tugging on her to get her off the floor, which was why Resident B had slapped her on the arm, and then the aide started yelling at her and waved her arms around upset with Resident B. Instead of escalating situations, staff were supposed to be trained to be patient and de-escalate situations. On a voicemail, recorded 8/25/24 at 7:27 p.m., the following could be heard: Resident B: "Help me!" Qualified Medication Aide (QMA) 27: "We are trying to help you!" Resident B: "Help me!" QMA 27: "Sit up!" [speaks but words are undetermined as the phone was shuffled] " ...we are going to the bathroom." Resident B: "I've been to the bathroom twice. I don't need to go again." QMA 27: "Ok, come and sit down on your chair!" The phone was shuffled and undetermined noises were head, then QMA 27's voice was heard louder at a yell, "why are you being like this now?!" Resident B: "You're not the one sitting on the floor are you? You act like you're hurt." QMA 28: "She acts like she's hurt?" QMA 27: [some words undetermined] "You hurt me, a slap on the arm, that hurt. Why are you doing that? What is your fear?" Resident B: "I'm going to call 911."		abuse, neglect and misappropriation of property and to notify ED immediately. The ED/Designee will interview 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 any abuse 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: 11.9.24**	

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	QMA 27 answered a phone call: "Hello? We are trying to get her up she is sitting on the floor down by her chair." QMA 27 and QMA 28: "She is acting confused." Resident B: "Help me, they are trying to force me." Nurse 30:"Can I talk to her or is she going to be able to listen?" Resident B: "Hello?" Nurse 30: "Hello, [Resident B]? Hi, my name is [Nurse 30] I'm the nurse, the girls there are just trying to help you get off the floor, will you let them help you get you up?" Resident B: "They weren't trying to help me get up. They were trying to force me to stay down." Nurse 30: "Oh, well, um they're going to help you get up now ok?" Resident B: "I'm up, I'm up." QMA 27: "You are not up, you are sitting down!" The message ends. On 9/19/24 at 11:45 a.m., Resident B's medical record was reviewed. She had diagnoses which included, but were not limited to, Parkinson's disease (a degenerative disorder of the central nervous system that affects movement, often including tremors) and depressive episodes. The Saint Louis University Mental Status Exam (SLUMS, is a brief screening assessment used to detect cognitive impairment) assessment, dated 5/6/24, indicated Resident B scored 24 out of 30 which indicated only mild cognitive impairment. A Service Conference Summary, dated 10/23/23, indicated Resident B didn't want to press her call pendant for help, especially during the weekends because she doesn't want to bother the staff. "Aides and QMAs are not pleasant during weekends."			

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	A nursing progress note, dated 8/25/24 at 7:24 p.m., indicated Resident B had an " ...unwitnessed fall, resident alerted staff with pendant, staff found resident sitting on her bottom in her living area, resident lost her balance while trying to ambulate to the bathroom with use of walker, she denies hitting her head, no apparent injuries noted at this time, resident denies pain initially ... post fall monitoring for injury/pain/change in condition, resident was resistant to allow staff to assist her off the floor, she became verbally aggressive with staff, she was assisted up off the floor after speaking with this writer ...." A nursing progress note, dated 8/29/24 at 11:56 a.m., indicated, the writer spoke with the resident about incident on 8/25/24 with staff members QMA 28 and QMA 27. Resident B had fallen and was found on the floor by QMA 27. QMA 28 was called to alert triage nurse about fall. Staff attempted to get resident off of the floor and Resident B became verbally abusive and actually hit one of the staff members. Resident B stated that she smacked staff member QMA 28 and pushed her. Resident B also stated that she didn't know why they were in her room and did not want help getting off the floor. Triage Nurse 30 advised the resident to let staff help her off the floor. Staff then two-person transferred her from the floor and tried to assist her to the bedroom. A third staff member was called to assist. Resident continued to be verbally aggressive to staff. Resident B stated she had a long day, and she did not like the QMA 28. She did not like how staff tried to get her off the floor or how they spoke to her. Writer let resident know that the situation would be investigated and staff would be in-serviced on customer service, resident approach, and transfer methods to better service her and other residents.			

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	On 9/19/24 at 2:35 p.m., the Executive Director (ED) provided a copy of the facilities investigation. The investigation lacked documentation of other Resident interviews to determine if this was an isolated incident and/or if other residents had experienced similar situations. The investigation included a Corrective Action Form, dated 8/29/24, which indicated QMA 27 had been suspended for suspicion of improper conduct, "Resident stated QMA 27 was verbally aggressive towards her. Sent recording to family." An in-service was provided on 8/29/24 for all staff but lacked QMA 27's signature for her attendance. During an interview on 9/19/24 at 2:34 p.m., the Director of Nursing (DON) indicated QMA 27 still worked at the facility and other staff had complained about her not wanting to work and complaining about her workload. The DON indicated she had spoken with several staff members to remind them not to speak together in their own language around Residents, and when they spoke to resident to speak slower, with a calmer tone and give time for the Resident's to understand and respond. On 9/19/24 at 2:34 p.m., the ED provided a copy of current, but undated facility policy titled, "Residents' Rights." The policy indicated, " ...Residents have the right to a dignified existence ... Residents have the right to exercise any or all of the enumerated rights without: restraint, interference, coercion, discrimination or threat of reprisal ... Residents have the right to be treated with consideration, respect and recognition of their dignity and individuality ... Residents have the right to be free from verbal abuse ...."			

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	On 9/19/24 at 2:34 p.m., the ED provided a copy of current facility policy titled, "Abuse, Neglect or Exploitation," reviewed 6/7/23. The policy indicated, " ...an investigation of the allegation or suspicion will be completed timely but not later than 14 days after the incident ... interview the resident, the accused, and witnesses ... if there are no direct witnesses, then interviews should be expanded ...." This citation relates to Complaint IN00442138.			
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency Based on observation, interview, and record review, the facility failed to provide neurological assessments on residents who had unwitnessed falls with dementia and did not send residents to the hospital for evaluation as their policy states for 2 of 4 residents reviewed (Resident E and G). Findings include: 1. On 9/19/24 at 11:30 a.m., a record review was completed for Resident E. He had the following diagnoses which included, but not limited to, dementia, osteoarthritis, insomnia, and essential hypertension. A progress note, dated 6/17/24 at 12:34 a.m., indicated resident was found on the floor near a doorway laying on his back. There was no apparent injury noted. Three people assisted resident to his wheelchair. Hospice was made aware of the fall. He was not transported to the hospital for evaluation. The document and resident's medical record lacked documentation that No neurological checks were conducted.	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 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 E no longer reside in the community. Resident G chart was reviewed for accuracy and a new 6 month fall risk assessment was completed that reflects high risk of falls.	11/09/2024

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	A progress note, dated 6/15/24 at 11:17 p.m., indicated resident was found lying on the floor in front of his recliner. No new apparent injuries were noted, and he was assisted by three people back to his chair. Hospice was notified. He was not transported to the hospital for evaluation. The document and resident's medical record lacked documentation that No neurological assessments were conducted. A progress note, dated 6/11/24 at 7:02 p.m., indicated resident was found sitting on the floor with his head against a table. He had redness noted to the backside of his head. He was assisted back to his chair. His catheter bag was so full of urine that it leaked on to the floor. He had two different shoes on. Hospice was notified. He did not go to the hospital for evaluation. The document and resident's medical record lacked documentation that No neurological assessments were conducted. A progress noted, dated 6/9/24 at 3:48 a.m., indicated resident was found on the floor at his bedside. He was assisted to his recliner. There was no evidence that resident hit his head during the fall. Hospice was notified. He was not sent to the hospital for evaluation. The document and resident's medical record lacked documentation that No neurological assessments were conducted. Resident E had a service plan. It indicated he was at risk for falls. The goal was to reduce the chance of falls with the community and an intervention included to remind him to use his walker and rest when feeling weak or when staff noticed tremors. 2. On 9/19/24 at 1:35 p.m., Resident G was		***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 that include sending resident to hospital for evaluation are completed if applicable, interventions that include physical therapy and/or gait analysis are completed. Licensed nurses will be in service 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 that include sending resident to hospital for evaluation are completed if applicable, interventions that include physical therapy and/or gait analysis are completed. **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	

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	observed walking in the hallway with a walker. His forehead and both eyes were bruised. He has visible bruising to his arms. He was unable to recall how he obtained the bruising. On 9/19/24 at 1:55 p.m., a record review was conducted for Resident G. He had the following diagnoses which included but were not limited to dementia, major depressive disorder, anxiety, and muscle weakness. A progress note, dated 9/17/24 at 4:55 p.m., indicated resident had tripped on his door strip and fell. He was noted to have a hematoma (A pool of mostly clotted blood that forms in an organ, tissue, or body space) about 1 inch in diameter to his left eyebrow, a cut on his left cheek near the eye and a skin tear to his left thumb and right thumb. Hospice was notified and an ice pack was placed to his hematoma. He was not sent to the hospital. The document and resident's medical record lacked documentation that neurological checks were not initiated. Resident G had a service plan for falls. The goal indicated resident would participate with fall prevention measures to reduce risk of fall occurrence. An intervention included education: remind resident to use assistive device, remind to use call light, encourage exercise for strength/balance, increase hydration, and ensure proper footwear/clothing, etc. During an interview on 9/19/24 at 12:00 p.m., the Wellness Director (WD) indicated they do not do neurological assessments on residents because they were an assisted living, and they sent residents who fall to the hospital for evaluation. A policy titled "Resident Falls" was provided by		months or until 100% compliance is achieved x3 consecutive months. **5) Date of compliance: 11.9.24**	

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	the WD on 9/19/24 at 3:05 p.m., It indicated, " ...For an individual who has fallen and has a trauma resulting in deformity, exhibit any change in level of consciousness, received obvious head or significant trauma, the Wellness Leader of Caregivers will summon Emergency Medical Services (911) ...The healthcare provider is contacted for further instructions if the head was not involved in the fall and the resident is able to move all extremities. Caregivers provide appropriate care and frequent checks. Any change in status is reported to the WD, the staff, with the healthcare provider's guidance, will follow up on any fall with associated injury until the resident is stable and delayed complication such as a late fracture of subdural hematoma have been ruled out or resolved ...." This citation relates to Complaint IN00442472.			