STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey and Investigation of Complaints IN00390169 and IN00389737 . This visit included a State Residential Licensure Survey. Complaint IN00390169 - Substantiated. Federal/State deficiencies related to the allegations are cited at F686 and F694. Complaint IN00389737 - Unsubstantiated due to lack of evidence. Survey dates: September 20, 21, 22, 23, 26, 27, and 28, 2022 Facility number: 000189 Provider number: 155292 AIM number: 100267330 Census Bed Type: SNF/NF: 114 Residential: 50 Total: 164 Census Payor Type: Medicare: 10 Medicaid: 66 Other: 38 Total: 114 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 3, 2022	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a Recertification and State Licensure survey on September 20, 2022. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
F 0550 SS=D	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
Bldg. 00	§483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	required under this subpart. Based on observation, interview, and record review, the facility failed to promote dignity by not assuring cognitively impaired residents were fully dressed when in the common area for 2 of 3 residents reviewed for dignity (Resident 50 and 264). Findings include: 1. The clinical record for Resident 50 was reviewed on 9/21/22 at 2:07 p.m. The Resident's diagnosis included, but were not limited to, Alzheimer's disease and cognitive communication deficit. A care plan, initiated on 6/25/2018, indicated she needed assistance with ADL (Activities of Daily Living) care due to her Alzheimer's disease. The goal was for her to improve her current functional status and the approaches included, but were not limited to, assist her with dressing, grooming and hygiene as needed, initiated 6/25/2018. A Quarterly MDS (Minimum Data Set) Assessment, completed 8/1/2022, indicated she needed extensive assistance with dressing and had short- and long-term memory deficits. She had severely impaired decision making and was rarely or never able to make herself understood. Resident 50 was continuously observed on 9/23/22 from 9:27 a.m. through 10:38 a.m. At 9:27 a.m., She was sitting in the dining room wearing a thin hospital gown. Her back was exposed, and she had nothing on her legs. She was at the dining room table, sitting in her wheelchair, eating breakfast with a clothing protector in place. When she finished eating breakfast, her clothing	F 0550	p="" role="heading" aria-level="1" paraid="1297489563" paraeid="{77efe298-d2fb-4942-9ed4-afba41508483}{248}">F550 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident 50 was dressed and staffing caring for her were immediately educated on dignity Resident 264's clothing was retrieved from his assisted living apartment and was dressed. Staff on unit were immediately educated on dignity. p="" paraid="128862181" paraeid="{13a157f3-4b2c-4551-a057-b14a1c30efea}{31}">How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by this deficient practice. All staff re-educated on dignity utilizing Resident Rights policy. A daily rounding tool reviewing dignity to be utilized by Care Companions/Department Managers. What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur? ul="" role="list" All staff re-educated on dignity utilizing Resident Rights policy. A daily rounding tool reviewing Residents Rights including dignity	11/04/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	protector was removed and CNA (Certified Nursing Assistant) 4 assisted her to the hallway and placed her in front of the nurse's station. She had oatmeal on her hospital gown and nothing covering her legs or back. She continued to sit in front of the nursing station. As she sat in the hallway, a visitor passed by and greeted her, CNA 4 passed by and spoke with her many times, QMA 2 was working on the computer behind the desk, and the CC (Cottage Coordinator) spoke with her. At 10:48 a.m., CNA 4 spoke with her and told her it was time for her to get ready for the day and took her into her room. During an interview on 9/23/22 at 10:48 a.m., CNA 4 indicated that Resident 50 was gotten up and into her chair for breakfast by the night shift staff. She was not on the "get up list" so the night shift staff did not dress her and get her ready for the day, just into her wheelchair so that she could eat breakfast. She had not refused care. 2. The clinical record for Resident 264 was reviewed on 9/21/22 3:12 p.m. The Resident's diagnosis included, but were not limited to, dementia and weakness. He was admitted to the facility on 9/19/22. A care plan, initiated on 9/19/22, indicated he needed assistance with ADL care related to falls and dementia. On 9/26/22 at 10:57 a.m., Resident 264 was observed sitting in a wheelchair in the hallway by his room. He was wearing a hospital gown and socks. On 9/26/22 at 3:26 P.M., Resident 264 was observed sitting at the nurse's station in his		to be utilized by Care Companions/Department Managers. How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The POC QAPI Tool will be utilized by ED/designee weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	wheelchair dressed in a hospital gown. His back and left thigh were exposed. During an interview on 9/26/22 at 3:26 p.m., QMA (Qualified Medication Aide) 2 indicated he did not have any clothing to dress him in. He was recently admitted, and he had an apartment in the adjoining assisted living facility. All of the clothing he had available in the nursing facility were in the laundry. During an interview on 9/26/22 at 3:34 p.m., Laundry Aide 33 indicated Resident 264 did not have any clean clothing ready to be returned to him. It normally took 2 days from when the clothing came to the facility laundry for it to be returned to the resident's closets. She was not aware that he did not have any clothing available to wear. During an interview on 9/26/22 at 3:43 p.m., QMA 34 indicated that Resident 264 had an apartment in the assisted living and had clothing available in his apartment closet. During an interview on 9/26/22 at 3:49 p.m., the Social Services Assistant indicated that the normal procedure was when residents were admitted from the adjoining assisted living facility their family was called to bring clothing over to the nursing facility. If the family was unavailable to bring the clothing, then housekeeping was called to bring clothing from their assisted living apartment for them to use in the nursing facility. During an interview on 9/23/22 at 11:03 a.m. the Director of Nursing indicated she would expect that resident's would be dressed to go to the dining room or common areas.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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 3/26/22 at 3:46 p.m., the Director of Nursing provided the current Resident Rights Policy which read "...Resident Rights. You have the right to a dignified existence, self- determination, and communication with and access to the persons and services inside and outside the facility...Receive the services and/ or items included in the plan of care..." 3.1-3(t)			
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, interview, and record review, the facility failed to ensure a resident was determined clinically appropriate by the Interdisciplinary team (IDT) to self-administer medications for 1 of 1 residents observed with medications left at bedside during a random observation. (Resident 8) Findings include: The clinical record for Resident 8 was reviewed on 9/23/22 at 2:22 p.m. Resident 8's diagnoses included, but not limited to, diverticulosis, chronic kidney disease, major depressive disorder, and dementia. Resident 8's clinical record did not contain a Self Administration of Medication Assessment nor a physician's order specifying the resident's ability to self-administer medications. Resident 8's quarterly MDS (minimum data set) dated 9/9/22 indicated, Resident 8 was cognitively intact.	F 0554	p="" role="heading" aria-level="1" paraid="1548957163" paraeid="{13a157f3-4b2c-4551-a057-b14a1c30efea}{119}"> p="" role="heading" aria-level="1" paraid="1548957163" paraeid="{13a157f3-4b2c-4551-a057-b14a1c30efea}{119}">F554 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?¿ Medications were removed from Resident 8's bedside. p="" paraid="348992940" paraeid="{13a157f3-4b2c-4551-a057-b14a1c30efea}{152}">How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?¿ All residents have the potential to be affected by this	11/04/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	During an interview with with Resident 8 on 9/23/22 at 10:12 a.m., an observation of Resident 8's bedside table and night stand occurred. On Resident 8's bedside table, was a clear plastic cup which contained an unidentified medication and on the night stand were two tubes of medication labeled Ketoconazole. Resident 8 stated, the pill in the medication cup was his Protonix. An interview with LPN (Licensed Practical Nurse) 3 on 9/23/22 at 10:27 p.m. indicated, Resident 8 should not have medications left at bedside. A Self Administration of Medications policy was received on 9/23/22 at 12:42 p.m. from DON (Director of Nursing). The policy indicated, "Procedure...If a resident desires to participated in self-administration, the Interdisciplinary Team will assess the competence of the resident to participate by completing the 'Self-Administration of Medication Assessment' observation. A physician order will be obtained specifying the resident's ability to self-administer medications and, if necessary, listing which medications will be included in the self-administration plan." 3.1-11(a)		deficient practice. Licensed nurses and QMAs educated on self of medications policy All residents were reviewed to ensure medications were not left at bedside for residents who are not approved to ¿ p="" paraid="951864294" paraeid="{13a157f3-4b2c-4551-a057-b14a1c30efea}{194}">What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur?¿ Licensed nurses and QMAs educated on self of medications policy A daily rounding tool reviewing Residents Rights including medication left at bedside to be utilized by Care Companions/Department Managers. p="" paraid="1039509160" paraeid="{13a157f3-4b2c-4551-a057-b14a1c30efea}{236}">How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?¿ The POC QAPI Tool will be utilized by ED/designee weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance p="" paraid="1039509160"	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
			paraeid="{13a157f3-4b2c-4551-a057-b14a1c30efea}{236}">	
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation, interview, and record review, the facility failed to assure a call light was within reach of a resident for 1 of 2 residents reviewed for call lights in reach (Resident 18). Findings include: The clinical record for Resident 18 was reviewed on 9/21/22 at 10:51 a.m. The Resident's diagnosis included, but were not limited to, hemiplegia (partial paralysis) of the left side and hypertension. An Annual MDS (Minimum Data Set) Assessment, completed 6/27/22, indicated she was usually able to make herself understood and to understand others. On 9/21/22 at 10:51 a.m., Resident 18 was observed laying in her bed. Her call light was hanging on top of a feeding pump that was adjacent to her bed. On 9/26/22 at 2:44 p.m., Resident 18 was observed laying in her bed. Her soft touch call light was in the upper left-hand corner of her bed. She indicated she did not know where her call light	F 0558	F558 p="" paraid="1546043198" paraeid="{91cc3176-30e1-4acb-8a42-d8444c57746a}{13}">What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Call light clip added to Resident 18's call light. Call light clipped in reach of resident. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice All resident rooms were checked for call lights to ensure placement and function by Care Companion team/Department Managers. ul="" role="list" All staff re-educated regarding call lights placement and function. What measures will be put into place or what systemic changes make to ensure that the deficient	11/04/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	was and that she used her right hand when she needed to use it. On 9/27/22 at 2:35 p.m., Resident 18 was observed with the Maintenance Director. She was laying in her bed. She indicated her call light was laying on her left arm where she could reach it. During an interview on 9/27/22 at 2:38 p.m., the Maintenance Director indicated that call lights should always be placed within reach of the residents. 3.1-3(v)(1)		practice does not recur? DNS/Designee will conduct an in-service with all staff regarding Call lights for residents. A daily rounding tool including call light placement to be utilized by Care Companions/Department managers. p="" paraid="1872432155" paraeid="{91cc3176-30e1-4acb-8a42-d8444c57746a}{87}"> How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	
F 0584 SS=D Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. Based on observation, interview, and record review, the facility failed to provide a clean, sanitary, and homelike environment by not maintaining walls in good repair and in clean condition for 5 of 8 residents reviewed for environmental concerns (Residents 20, 25, 48, 49, and 52) and failed to provide clean linen for 1 of 1 residents reviewed for catheter care. (Resident 25)	F 0584	F584 p="" paraid="175588153" paraeid="{91cc3176-30e1-4acb-8a42-d8444c57746a}{117}">What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Bathroom of residents 25 and 84(not48)	11/04/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	Findings include: 1 a. On 9/20/22 at 2:00 p.m., Residents 25 and 48's room was observed. The bathroom had gouges in the drywall and scuff marks on the bathroom wall. On 9/26/22 at 2:34 p.m., Residents 25 and 48's room was observed. The gouges and scuff marks on the bathroom wall continued to be present. On 9/27/22 at 2:42 p.m., Residents 25 and 48's room was observed with the MS (Maintenance Supervisor). He indicated that the wall in the bathroom was in need of repair and that he had not been informed of the gouges and scuff marks. 1 b. On 9/21/22 at 9:37 a.m., Residents 29 and 49's room was observed. There were gouges and scrapes on the bathroom wall, and a hole in the wall of the bathroom, just above the cove base, which was approximately 5 inches by 2 inches. On 9/26/22 at 2:38 p.m., Resident 29 and 49's bathroom was observed. The gouges and scrapes on the bathroom wall and the hole in the wall continued to be present. On 9/27/22 at 2:45 p.m., Resident 29 and 49's bathroom was observed with the MS. He indicated he had not been made aware of the scrapes and the hole in the bathroom wall. 1 c. On 9/21/22 at 11:32 a.m., Resident 52's room was observed. There were nail holes and a yellow- brownish substance on the wall in back of his television. On 9/26/22 at 2:42 p.m., Resident 52's room was observed. The nail holes and yellow-brownish		patched and painted Bathroom of residents 29 and 49 patched and painted Resident 52's wall was and nail holes were patched and painted. Resident 25's linen was replaced. p="" paraid="656548203" paraeid="{91cc3176-30e1-4acb-8a42-d8444c57746a}{179}">How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice Director has conducted facility audit to determine where repairs need to be made and has initiated repairs accordingly ED/Designee will conduct an all staff related to including proper work order procedure What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur? ul="" role="list" ED/Designee will conduct an all staff related to including proper work order procedure The ED will make weekly rounds with the Maintenance Director through all rooms throughout facility to ensure the deficient practice does not recur. How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The POC QAPI Tool will be utilized by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	substance continued to be present on the wall. During an interview on 9/26/22 at 2:42 p.m., Resident 52 indicated the substance had been on the wall had been there for quite a while. He was not sure what it was. On 9/27/22 at 2:38 p.m., Resident 52's room was observed with the MS. He indicated he had not been made aware of the nail holes or the substance on the wall and that it needed repaired and repainted.2. The clinical record for Resident 25 was reviewed on 9/20/22 at 2:00 p.m. The diagnosis for Resident 25 included, but was not limited to, cerebral infraction (stroke). A Significant change MDS (Minimum Data Set) Assessment dated 7/10/22 indicated Resident 25 was moderately cognitive impaired. She was total dependent of 2 staff persons for bed mobility. A care plan dated 6/6/22 indicated "Resident requires assistance with ADLs [Activities of Daily Living]...Approach: Assist with dressing, grooming, hygiene as needed..." An observation was made of catheter care for Resident 25 with Certified Nursing Assistant (CNA)12 and CNA 16 on 9/23/22 at 10:31 a.m. Resident 25 was observed in bed lying on her back. CNA 12 had removed the resident's brief. The inside nor the outside of the brief was observed soiled. During the care, CNA 12 had turned the resident on her left side. The resident's sheet she was lying on was observed with a basketball size stained area that was underneath the buttocks. The area was dry and black-brown and red in color. The resident had a dressing over her sacrum that was dated 9/23/22. CNA 12 indicated at that time the dressing was dry and		ED/designee weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	attached. There was no observation of wound drainage. CNA 12 had removed the soiled sheets and replaced with clean linen. CNA 12 indicated she believed the soiled area was from wound drainage. When the wound dressing was changed by the nurse it was not noticed the bed sheet had gotten soiled. An interview was conducted with CNA 11 at 9/23/22 at 11:43 a.m. She indicated she was Resident 25's cna that day. The wound dressing had been changed on night shift. She had started her shift at 8:00 a.m., and had turned the resident at around 9:00 a.m. CNA 11 had not noticed the resident's bed sheet was soiled. 3.1-19(f)(5)			
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility	F 0610	p="" role="heading" aria-level="1"	11/04/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	failed to provide evidence of a thoroughly investigated reportable incident for 1 of 2 reportable incidents reviewed. (Resident 25 and 265) Findings include: The clinical record for Resident 25 was reviewed on 9/23/22 at 2:00 p.m. The diagnosis for Resident 25 included, but was not limited to, cerebral infraction (stroke). The clinical record for Resident 265 was reviewed on 9/23/22 at 2:45 p.m. The diagnosis for Resident 265 included, but was not limited to, depression. The resident had discharged on 8/25/22. A reportable incident was provided by the Director of Nursing (DON) on 9/22/22 at 1:36 p.m. It indicated the facility had reported an incident that had occurred on 7/4/22 to the Indiana Department of Health. The residents involved were Residents' 25 and 265. The brief description indicated, "...Reported by a staff member that an undisclosed amount medication was unable to be located this morning during count...Follow up:...7/12/22 Audit complete on all narcotics with no additional findings. (Name of Nurse) [License Practical Nurse (LPN) 14]... suspended pending investigation...IMPD [Indianapolis Metropolitan Police Department] notified of missing medications. The alleged nurse did not comply with investigation. All medications were immediately replaced at facility expense. Resident's did not miss any medications..." The completed investigation was provided by the DON on 9/22/22. It included the following documentation:		paraid="1098094627" paraeid="{0b126c64-51c2-4917-aed9-0c5abbebf8fc}{19}">F610 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 265 and 25 no longer reside in facility Resident's 265 and 25 never missed medications and were assessed and had no pain concerns. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? ul="" role="list" All residents receiving narcotic medication have the potential to be affected by the alleged deficient practice Regional Director of Clinical Services will conduct an with Executive Director and Director of Nursing Services related to Investigation of Alleged Violations including having evidence of thorough investigations What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur? Regional Director of Clinical Services will conduct an with Executive Director and Director of Nursing Services related to Investigation of Alleged Violations including having evidence of thorough investigations All Diversion investigation files will be reviewed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	The incident report that was provided to the Indiana Department of Health, An email from the IMPD dated 7/5/22 indicated the online report was successfully received, and A statement written by the DON indicated "On July 5th, 2022, I texted the nurse [LPN 14] and asked her to call me ASAP [as soon as possible]. [LPN 14] returned the call, and I asked what she knew about missing narcotic sheets. She stated that she new nothing about missing narcotic sheet, she went on to say that she had given all meds. I explained that we had an allegation of missing narcotics and or narcotic sheets and that I needed her to write a statement for me and submit to a drug test immediately. [LPN 14] confirmed that she would write and send me a statement and go drug test that afternoon. I never received a statement and to my knowledge no drug test was submitted. [LPN 14] would not answer or return subsequent calls regarding the matter. I called and informed [name of agency nursing] that she worked with of the allegations and told them she could not return to the building. I also filed a police report..." There were no other documentation including staff statements in the completed investigation file. An interview was conducted with the DON on 9/26/22 at 10:38 a.m. She indicated Qualified Medication Aide (QMA) 15 had reported tramadol and oxycodone medications that included the controlled substance record sheets were missing for Resident 25 and 265. The medications for Resident 25 and 265 were located in the medication cart in the locked narcotic storage box. The controlled substance records were located at		by Regional Director of Clinical Services to ensure thorough investigation x 6 months p="" paraid="1230880554" paraeid="{0b126c64-51c2-4917-aed9-0c5abbebf8fc}{121}">How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The POC QAPI Tool will be utilized by ED/designee weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	the nurse's station. The DON was unable to find a written statement from QMA 15. LPN 14 was not compliant with providing a written statement. An interview was conducted with QMA 15 on 9/267/22 at 2:46 p.m. She indicated she had counted the narcotics in the 100 unit medication cart with LPN 14 at 10:00 p.m., on 7/3/22 at the end of her shift. The narcotic box contained narcotics for current and discharged residents. When she returned the next morning, 7/4/22, she did not count the narcotics on the medication cart with LPN 14. She had counted with another staff person. The narcotic medications in the box for the discharged residents that were there the evening before were not there in the morning. She believed the medications were oxycodones. There should be 2 nurses to dispose of narcotic medications. That night, there were not enough nurses to do that. She immediately reported to the weekend supervisor and the DON the narcotics were missing. She can not recall if she had written a statement of the occurrence nor had she heard the missing medications were located. A statement by QMA 24 was provided by the DON on 9/27/22 at 12:59 p.m. The statement was not included in the file. QMA 24 indicated, "I worked July 3rd on a double shift, evening-night. I counted the cart on 100 hall with LPN 14 from evening shift to night and the count was correct. I then counted the cart when I left in the morning with QMA 15 and again the count was correct..." The abuse policy was provided by the Executive Director on 9/29/22 at 3:08 p.m. It indicated, "...Misappropriation of Resident Funds or Property - Deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's property or money without the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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's consent...Investigation: The Executive Director is the designated individual responsible for coordinating all efforts in the investigation of abuse allegations, and for assuring that all policies and procedures are followed. In the absence of the Executive Director, this responsibility will be delegated to the Director of Nursing Services....11. The investigation will include: Facts and observations by involved employees, Facts and observations by witnessing employees,..Facts and observations from others who might have pertinent information, Facts and observations by the supervisor or individual whom the initial report was made,..Analyze the occurrence to determine root cause, and what changes are needed to prevent further occurrences. Based on the root cause, determine if care provisions will be changed..." 3.1-28(d)			
F 0622 SS=D Bldg. 00	483.15(c)(1)(i)(ii)(2)(i)-(iii) Transfer and Discharge Requirements §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.			
	Based on interview and record review, the facility failed to provide a transfer form to the receiving facility for 1 of 1 resident reviewed for hospitalization. (Resident 115) Findings include: The clinical record for Resident 115 was reviewed on 9/26/22 at 9:00 a.m. The diagnosis for Resident 115 included, but was not limited to, acute kidney failure. The resident was admitted on 8/3/22 and	F 0622	F622 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? ul="" role="list" Resident 115 no longer resides at the facility How will you identify other residents having the potential to be affected by the same deficient	11/04/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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 the hospital on 8/7/22. A progress note dated 8/10/22. It indicated, "Unable to obtain life story from patients admission on 8/3/22 until she left on hospital leave on 8/7/22." Resident 115's medical record did not contain a transfer form nor progress note the resident was transferred to the hospital. An interview was conducted with the Director of Nursing (DON) on 9/26/22 at 2:58 p.m. The DON indicated Resident 115 had a fall, and the resident's family wanted her to be sent to the hospital for evaluation. A transfer form and progress note should have been completed in the medical record. She was unable to find a transfer form that had been completed and sent with the resident when she was transferred to the hospital. A Resident Change of Condition policy was provided by the DON on 9/26/22 at 3:12 p.m. It indicated "...f. Document resident change of condition and response in the medical record. Documentation will include time and family/physician response..." A Hospital Discharge/Transfer policy was provided by the DON on 9/26/22 at 3:12 p.m. It indicated "...Procedure...Nursing will complete an Emergency transfer observation and attach copies of the following information from the resident medical record:...CCD (Continuity of Care Document) Medication list and last administration, Diagnosis codes, Allergies, Most recent Vital signs, Advanced directive, vaccination records, advanced directives form as applicable, Comprehensive Care Plan, Pertinent labs, notice of transfer/discharge, bed hold policy,		practice and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice DNS/Designee will conduct an with licensed nurses on hospital discharge/transfer policy. What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur? ul="" role="list" DNS/Designee will conduct an with licensed nurses on hospital discharge/transfer policy. DNS/Designee to review documentation of all residents who are transferred to hospital on the following business day. How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director ul="" role="list" If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	Nursing notes/social services notes pertinent to behavior issues maybe warranted for psychiatric hospitalizations..." 3.1-12(a)(3)(4)(A)(5)			
F 0677 SS=E Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview, and record review, the facility failed to provide the necessary services to maintain good grooming, oral care, personal hygiene, and providing timely assistance with dressing in street clothes for residents who are unable to carry out activities of daily living for 5 of 6 residents reviewed for activities of daily living (ADL) (Residents 21, 42, 49, 50, and 54) and 1 of 1 residents reviewed for tube feeding (Resident 25). Findings include: 1. The clinical record for Resident 21 was reviewed on 9/23/22 at 12:10 p.m. Resident 21's diagnoses included, but not limited to, Alzheimer's disease, muscle weakness, abnormalities of gait and mobility, repeated falls, and anxiety disorder. Resident 21's annual MDS (minimum data set) dated 6/29/22 indicated, Resident 21 required extensive assistance of one person for bed mobility and dressing; extensive assistance of 2 persons for transfers and toileting; and was totally dependant on one person for bathing. Resident 21's care plan dated 7/9/21 indicated,	F 0677	p="" role="heading" aria-level="1" paraid="433538120" paraeid="{0b126c64-51c2-4917-aed9-0c5abbebf8fc}{252}"> p="" role="heading" aria-level="1" paraid="433538120" paraeid="{0b126c64-51c2-4917-aed9-0c5abbebf8fc}{252}">F677 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident 21, 42, 54, 25, 49, and 50 received necessary ADL care. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? ul="" role="list" All residents who require ADL care have the potential to be affected by the alleged deficient practice All residents were observed to ensure were well groomed, oral care was provided, personal hygiene was provided by each	11/04/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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 21 required assistance with ADLs including bed mobility, transfers, eating and toileting. Interventions included, but not limited to, assist with ambulation as needed, assist with bathing as needed, assist with dressing/grooming/hygiene as needed, and assist with oral care at least two times daily. Another care plan dated 7/9/21 indicated, Resident 21 required assistance and/or monitoring a.m./p.m. cares including bathing, dressing, hair combing and oral care. Observations of Resident 21 were conducted on the following dates and times: - 9/21/22 at 10:43, Resident in bed with hospital gown on, hair was unkempt, feet were visibly dry. - 9/22/22 at 9:26 a.m., Resident's feet were visibly dry, hair was disheveled, and resident wore a hospital gown. - 9/22/22 at 3:38 p.m., Resident in bed with hospital gown on and hair was disheveled. - 9/23/22 at 10:10 a.m., A continuous observation of Resident 21 was initiated in bed with hospital gown on and hair was disheveled. - 9/23/22 at 12:24 p.m., the continuous observation of Resident 21 ended; Resident 21 remained in bed with hospital gown on a hair remained disheveled. The shower schedule for the 400 hallway was received on 9/23/22 at 3 p.m. It indicated, Resident 21 was to receive showers/complete bed baths on Wednesday and Saturday mornings. Resident 21's shower sheets for the months of August and September 2022 were received from DON (Director of Nursing) on 9/26/22 at 10:39 a.m. Only 5 shower sheets were located and they indicated, Resident 21 received a bath on 8/10/22 and 9/7/22.		resident care companion. All nursing staff re-educated on AM care and shower schedule What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur? All nursing staff re-educated on AM care and shower schedule The shower schedule and documentation will be reviewed daily in clinical ul="" role="list" A daily rounding tool including resident hygiene to be utilized by Care Companions/Department managers to ensure good grooming and personal hygiene. How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance ul="" role="list"	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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 21's point of care (POC) history for baths for the months of August and September 2022 were received from DON on 9/26/22 at 10:39 a.m. The POC for baths indicated, Resident 21 received a complete bed bath on 8/4/22 and no showers were recorded. The POC indicated partial bed baths for the following dates: 8/2, 8/9, 8/10, 8/15, 8/18, 8/23. 8/24, 8/26, 8/29, 8/31, 9/7, 9/8, 9/9, 9/10, 9/12, 9/13, 9/14, 9/16, 9/17, 9/18, 9/19, 9/20, 9/23, and 9/24. Resident 21 did not receive 2 showers/complete bed baths per week for the time frame reviewed. An interview with DON conducted on 9/26/22 at 11:57 a.m. indicated, a partial bed bath can be triggered when incontinent care was provided. 2. An interview with Resident 42 conducted on 9/22/22 at 9:12 a.m. indicated, he has had to "run them down" in order to get a staff member to assist him with shaving his facial hair. He stated, they don't offer to shave his beard and he normally doesn't have a beard and doesn't want the beard now. He indicated, he had spoke to the CNA (certified nursing assistant) about getting shaved today. An observation of Resident 42 on 9/22/22 at 3:38 p.m. was made. At the time, he still had a full beard and did not appear to have been shaved. An interview with Resident 42 was conducted on 9/23/22 at 10:06 a.m. He indicated, no one had come to assist him with shaving yesterday. He stated, "I have to beg them, one person will say I'll do it later and they don't come back. Another will say, I'm not your aide. I even asked the doctor one time and she said she would get someone, but no one came. This goes on so long that now I have			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	to go to dialysis looking all shaggy." The clinical record for Resident 42 was reviewed on 9/26/22 at 11:14 a.m. Resident 42's diagnoses included, but not limited to, adult failure to thrive, major depressive disorder, vascular dementia, muscle weakness, emphysema, age related physical debility and seizures. Resident 42's quarterly MDS dated 7/25/22 indicated, he is cognitively intact and requires limited assistance of one person for bed mobility, transfers, and dressing; supervision and set up for personal hygiene; and physical assistance in part of one person for bathing. Resident 42's care plan dated 1/28/22 indicated he requires assistance with ADLs. Interventions included, but not limited to, assist with bathing as needed and assist with dressing/grooming/hygiene as needed. The shower schedule for the 400 hallway was received on 9/23/22 at 3 p.m. It indicated, Resident 42 was to receive showers/complete bed baths on Monday and Thursday nights. Resident 42's shower sheets for the months of August and September 2022 were received from DON (Director of Nursing). Only 4 shower sheets for Resident 42 were located and they indicated the following: on 9/26/22 at 10:39 a.m. They indicated: on 8/11/22, he refused a shower; on 9/2/22, the shower sheet did not indicate a shower or bed bath was given; on 9/14/22 and 9/22/22, he refused his showers. Resident 42's POCs for baths for the months of August and September 2022 were received from DON on 9/26/22 at 10:39 a.m. They indicated a			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	partial bed bath was given on the following dates: 8/15, 8/18, 8/23, 8/24, 8/25, 8/26, 8/29, 8/31, 9/6, 9/7, 9/8, 9/10, 9/14, 9/16, 9/17, 9/18, 9/19, 9/20, 9/21, 9/22, 9/23, and 9/24. One shower was recorded on 8/20 and no complete bed baths were recorded. Resident 42 did not receive twice weekly showers/complete bed baths for the time frame reviewed. 3. An interview with Resident 54 was conducted on 9/21/22 at 11:45 a.m. He indicated, the staff doesn't offer to assist him with baths. He stated, he preferred showers, but "unless you grab a person and say to them, I need a shower today, it doesn't happen". He further indicated, the staff say they are short staffed as the reason they can't get showers done. Resident 54's clinical record was reviewed on 9/23/22 at 11:07 a.m. Resident 54's diagnoses included, but not limited to, right above the knee amputation, diabetes mellitus, neuropathy, indwelling urinary catheter, multiple left foot arterial ulcers, and muscle weakness. Resident 54's quarterly MDS dated 7/27/2022 indicated, he was cognitively intact, requires limited assistance of one person for transfers, dressing, and toileting; extensive assistance of one person for personal hygiene and was totally dependent on one person for bathing. Resident 54's admission MDS 12/30/20 indicated, it was "very important" to him to chose between a tub bath, a shower and a bed bath. Resident 54's care plan dated 12/24/20 indicated, he requires assistance with ADLs including bed mobility, transfers, eating and toileting.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	Interventions included, but not limited to, offer showers two times per week and assistance of two persons with transfers and a slide board as needed to get up to wheelchair. The 400 hallway shower schedule was received on 9/23/22 at 3:00 p.m. indicated, Resident 54's shower days were Wednesdays and Saturday nights. Resident 54's shower sheets for the months of August and September 2022 were received from DON (Director of Nursing). DON located only one shower sheet for the resident and it was dated 9/15/22. The shower sheet had only the residents name, CNA signature, and charge nurses signature on it. Resident 54's POCs for baths for the months of August and September 2022 were received from DON on 9/26/22 at 10:39 a.m. They indicated, one shower was given on 8/20; one completed bed bath given on 9/1/22; and partial bed baths were given on the following dates: 8/9, 8/12, 8/15, 8/23, 8/24, 8/25, 8/26, 8/31, 9/5, 9/6, 9/7, 9/8, 9/9, 9/10, 9/12, 9/12, 9/13, 9/14, 9/15, 9/16, 9/17, 9/18, 9/20, 9/21, 9/23, and 9/24. Resident 54 did not receive twice weekly showers/complete bed baths for the time frame reviewed.4. The clinical record for Resident 25 was reviewed on 9/20/22 at 2:00 p.m. The diagnosis for Resident 25 included, but was not limited to, cerebral infraction (stroke). A care plan dated 6/6/22 indicated "Resident requires assistance with ADLs [Activities of Daily Living]...Approach: Assist with dressing, grooming, hygiene as needed...Assist with oral care at least two times daily..."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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 medical provider note dated 9/1/22 indicated Resident 25 was "NPO" (nothing by mouth) and was to receive tube feedings.

An observation was made of Resident 25 in bed on 09/20/22 at 2:02 p.m. The resident's lips were observed to be chapped.

An observation was made of Resident 25 on 9/23/22 at 9:38 a.m. The resident's lips were observed to be brown, chapped and peeling.

During catheter care on 9/23/22 at 10:31 a.m., with Certified Nursing Assistant (CNA) 12 and CNA 16 an observation was made of Resident 25. The resident's lips were brown, chapped and peeling. CNA 12 and 16 was not observed providing oral care to the resident at that time.

An observation was made of Resident 25 with CNA 11 on 9/23/22 at 11:43 a.m. The resident was observed in bed with brown, dry, peeling lips. CNA 11 indicated she was the CNA assigned to Resident 25. She does not provide oral care on residents that are NPO. The nurses do that. The residents that can eat by mouth are provided oral care by the CNAs in the mornings.

An observation was made of Resident 25 with License Practical Nurse (LPN) 3 on 9/23/22 at 12:34 p.m. The resident's lips were observed to be brown, chapped, and peeling. LPN 3 indicated at that time, the residents lips were dry. The cna staff are to provide oral care to residents regardless if he or she was NPO or eat by mouth. LPN 3 was unable to find swabs in resident's room to provide oral care, but she would address.

5. The clinical record for Resident 49 was reviewed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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 9/21/22 at 2:00 p.m. The diagnosis for Resident 49 included, but was not limited to, Parkinson's disease. A Quarterly MDS (Minimum Data Set) Assessment dated 7/31/22 indicated Resident 49 was cognitively intact. A care plan dated 10/18/18 indicated Resident 49 "...requires assistance with ADLs...Approach:..Assist with bathing as needed per resident preference. Offer showers two times per week, partial bath in between. An observation was made of Resident 49 on 9/21/22 at 9:30 a.m. Resident 49 was observed with white-grey hair growth above her top lip and on her chin. An interview was conducted with Resident 49 on 9/21/22 at 9:33 p.m. She indicated staff provide bed baths not showers. She was suppose to receive 2 showers a week, but does not receive. She would like showers and shaved. Observations were made of Resident 49 on 9/23/22 at 3:05 p.m., and 9/26/22 at 11:26 a.m. The resident was observed with white-grey hair strands growth on her top lip and chin. An interview was conducted with Certified Nursing Assistant (CNA) 12 and 13 on 9/26/22 at 11:31 a.m. CNA 12 indicated she was the assigned CNA providing care to Resident 49 that day. CNA 12 and 13 indicated shaving was provided daily to residents. CNA 12 would shave the resident that day. A shower schedule and August and September 2022 shower sheets for Resident 49 was provided			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	by the Director of Nursing on 9/23/22 at 3:00 p.m. It indicated Resident 49 was to receive showers Wednesdays and Saturdays in the p.m. The shower schedule indicated "...Please file your shower sheets daily, make sure they are dated and signed. If your resident refuses a shower; notify the nurse. Attempt the shower 3 times. Have your resident sign the shower sheet as refusal with a witness please. The August 2022 shower sheets for Resident 49 indicated the following days resident refused shower: 8/3/22 - refused shower - there was no resident, cna or nurse signature, 8/13/22 - refused shower - there was no resident, cna or nurse signature, The September 2022 shower sheets for Resident 49 indicated the following days the resident refused showers: 9/3/22 - refused shower - bed bath given - there was no resident signature, 9/7/22 - "bed bath given at res [resident] request" - there was no resident signature6. The clinical record for Resident 50 was reviewed on 9/21/22 at 2:07 p.m. The Resident's diagnosis included, but were not limited to, Alzheimer's disease and cognitive communication deficit. A care plan, initiated on 6/25/2018, indicated she needed assistance with ADL (Activities of Daily Living) care due to her Alzheimer's disease. The goal was for her to improve her current functional status and the approaches included, but were not limited to, assist her with dressing, grooming and hygiene as needed, initiated 6/25/2018.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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 Quarterly MDS (Minimum Data Set) Assessment, completed 8/1/2022, indicated she needed extensive assistance with dressing and had short- and long-term memory deficits. She had severely impaired decision making and was rarely or never able to make herself understood.

Resident 50 was continuously observed on 9/23/22 from 9:27 a.m. through 10:38 a.m. At 9:27 a.m., She was sitting in the dining room with wearing a thin hospital gown. Her back was exposed, and she had nothing on her legs. She was at the dining room table, sitting in her wheelchair, eating breakfast with a clothing protector in place. When she finished eating breakfast, her clothing protector was removed and CNA (Certified Nursing Assistant) 4 assisted her to the hallway and placed her in front of the nurse's station. She had oatmeal on her hospital gown and nothing covering her legs or back. She continued to sit in front of the nursing station. As she sat in the hallway, a visitor passed by and greeted her, CNA 4 passed by and spoke with her many times, QMA 2 was working on the computer behind the desk, and the CC (Cottage Coordinator) spoke with her. At 10:48 a.m., CNA 4 spoke with her and told her it was time for her to get ready for the day and took her into her room.

During an interview on 9/23/22 at 10:48 a.m., CNA 4 indicated that Resident 50 was gotten up and into her chair for breakfast by the night shift staff. She was not on the "get up list" so the night shift staff did not dress her and get her ready for the day, just into her wheelchair so that she could eat breakfast. She had not refused care.

During an interview on 9/23/22 at 11:03 a.m. the Director of Nursing indicated she would expect

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	that resident's would be dressed to go to the dining room. An interview was conducted with the Director of Nursing on 9/23/22 at 3:02 p.m. She indicated the facility does not have an ADL policy. An A.M. Care procedure was provided by the Director of Nursing on 9/23/22 at 3:02 p.m. It indicated, "...7. Assist resident with oral hygiene,...8. Shave resident, is needed..." 3.1-38(a)(3) 3.1-38(b)(2) 3.1- 38(b)(4)			
F 0684 SS=E Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation and interview, the facility failed to ensure residents who are bedfast or chairfast have their body position changed every 2 hours as ordered for 3 of 3 residents reviewed for positioning/mobility (Residents 18, 21, and 22); failed to timely schedule a neurology appointment and administer medications, as ordered, by the physician for 1 of 1 residents reviewed for ADL decline and 3 of 6 residents reviewed for unnecessary medications (Residents 50, 95, 171, and 263).	F 0684	F684 p="" paraid="359409567" paraeid="{573f4374-cd3e-4425-b01c-1c70df1fa72c}{125}">What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Staff caring for Residents 18, 21, 22 were immediately educated on turning and repositioning Resident 95 no longer resides at facility Resident	11/04/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	Findings include: 1. A continuous observation of 400 unit was initiated on 9/23/22 at 10:10 a.m. The continuous observation period ended at 12:24 p.m. During the continuous observation, Residents 18, 21 and 22 were not turned in the 2 hour period and were in the same position for over 2 hours. a. Resident 18's clinical record was reviewed on 9/23/22 at 9:39 a.m. Resident 18's diagnoses included, but not limited to, hemiparesis(muscle weakness or partial paralysis on one side of body) of left side, chronic obstructive pulmonary disease, aphasia (language disorder that affects a person's ability to communicate), and anxiety disorder. Resident 18's annual MDS (minimum data set) dated 6/27/22 indicated, she was totally dependent on the assistance of two persons for bed mobility, toileting, transfers, and bathing; and totally dependent on the assistance of one person for dressing and personal hygiene. Resident 18's care plan dated 1/27/21 indicated, she preferred to stay in bed per her choice and would occasionally get up in the Broda chair. The interventions included, but not limited to, use body surround pillow when in bed, can use cervical collar and wedge cushion when body surround pillow was unavailable, encourage resident to get out of bed once a week, encourage her to turn and reposition every 2 hours or as needed. Resident 18's care plan dated 10/9/18 indicated, she was at risk for skin breakdown and the interventions included, but not limited to, utilize pillows under elbows, shoulders, and hips for positioning/offloading while in bed, encourage resident to turn and reposition at least every 2		50 has neurology appointment scheduled Resident 171 and 263 receiving all current medications per order p="" paraid="643999772" paraeid="{573f4374-cd3e-4425-b01c-1c70df1fa72c}{185}">How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice Full audit of medication administration to be completed by DNS/Designee. Full audit of appointment orders to be completed by DNS/Designee to ensure scheduled. DNS/Designee will conduct an with all nursing on staff on medication administration, skin management policy, appointment process. p="" paraid="1392044581" paraeid="{573f4374-cd3e-4425-b01c-1c70df1fa72c}{245}">What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur? DNS/Designee will conduct an with all nursing on staff on medication administration, skin management policy, appointment process. A daily rounding tool including turning and repositioning to be utilized by Care Companions/Department managers. Appointment schedules reviewed daily in clinical Medication	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	hours and elevate heels while in bed. A physician's order dated 3/28/19 indicated, for Resident 18 to be turned and repositioned every 2 hours. During the time of the continuous observation, Resident 18 was observed, lying on her back in her bed, no surround pillow or wedge was in use, no cervical collar was on, her head was tilted to the right side and her heels were not elevated. Resident 18 had not been repositioned during the 2 hour observation. b. The clinical record for Resident 21 was reviewed on 9/23/22 at 12:10 p.m. Resident 21's diagnoses included, but not limited to, Alzheimer's disease, muscle weakness, abnormalities of gait and mobility, repeated falls, and anxiety disorder. Resident 21's annual MDS (minimum data set) dated 6/29/22 indicated, Resident 21 required extensive assistance of one person for bed mobility and dressing; extensive assistance of 2 persons for transfers and toileting; and was totally dependant on one person for bathing. Resident 21's care plan dated 7/9/21 indicated, Resident 21 required assistance with ADLs including bed mobility, transfers, eating and toileting. Interventions included, but not limited to, provide assistance of one person for bed mobility. She also was at risk for skin breakdown due to very limited mobility and interventions included, but not limited to, encourage the resident to turn and reposition at least every 2 hours and to provide assistance as needed. During the time of the continuous observation, Resident 21 was observed to be lying on her back		Administration report to be run daily in clinical meeting p="" paraid="107394254" paraeid="{9c910b87-5f67-4112-9826-53cf2e33710b}{40}"> How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	in her bed watching television. Resident 21 was still in the same position when the continuous observation ended. c. The clinical record for Resident 22 was reviewed on 9/23/22 at 2:36 p.m. Resident 22's diagnoses included, but not limited to, Alzheimer's disease, psychotic disorder with delusions, hallucinations, cognitive communication deficit, tremors, and muscle weakness. Resident 22's quarterly MDS dated 5/17/22 indicated, she was severely cognitively impaired, required extensive assistance of two person for bed mobility and transfers. Resident 22's care plan 3/5/18 indicated, she was at risk for further skin breakdown and the interventions included, but not limited to, encourage resident to turn and reposition at least every two hours and provide assistance as needed. During the continuous observation, Resident 22 was seated in her Broda chair at the end of the 400 hallway and in a common area which was visible from down the hall; her eyes were closed and the chair was upright; she remained in the same position during the observation. She had not been assisted with changing her position in the chair nor was her weight ever shifted in the chair during the observation period. An interview with DON (Director of Nursing) was conducted on 9/23/22 at 12:34 p.m. She indicated, she was unable to located an ADL policy.2. The clinical record for Resident 50 was reviewed on 9/21/22 at 2:07 p.m. The Resident's diagnosis included, but were not limited to, Alzheimer's disease and cognitive communication deficit.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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 Quarterly MDS (Minimum Data Set) Assessment, completed 8/1/2022, indicated she needed extensive assistance with dressing and had short- and long-term memory deficits. She had severely impaired decision making and was rarely or never able to make herself understood.

A progress note, dated 6/29/22, indicated that the staff were assisting Resident 50 to the dining area when she made a "jerking" movement and fell down onto her buttocks.

A physician's order, dated 6/29/22, indicated she was to be referred to neurology due to frequent falls.

A physician's order, dated 7/1/22, indicated she was to be referred to a specific neurology clinic.

A progress noted, dated 7/1/22 at 1:26 p.m., indicated an attempt to make Resident 50 a neurology appointment had been done. The clinic had requested paperwork and the physician's order to be faxed to them. The fax had been completed and the neurology office was to call back with an appointment date.

During an interview on 9/22/22 at 2:06 p.m., CNA (Certified Nursing Assistant) 6 indicated that Resident 50 had been declining in her ability to walk for about 2 months. She could still walk short distances but continued to have "jerking" movements which made her fall. She also had "jerking" movements when she was sitting in her wheelchair. She was being seen by therapy who walked with her.

During an interview on 9/22/22 at 2:27 p.m., the Therapy Director indicated Resident 50 was on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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

case load. In therapy she had been walking about 40 feet with assistance. Resident 50 still had "jerking" movements while she was walking. She recalled that an appointment with a neurologist had been discussed several months ago but was unsure if it had been scheduled.

During an interview on 9/23/22 at 2:34 p.m., LPN (Licensed Practical Nurse) 3 indicated that when she received a physician's order for a referral to an outside physician, she would normally call the outside physician and attempt to set up the appointment. If they wanted items faxed, she would do so. If she had not gotten a follow up call about an appointment time, then she would follow up with the outside physician's office in about a week or so.

During an interview on 9/26/22 at 9:45 a.m., the Director of Nursing indicated that Resident 50 had not yet been seen by the neurologist.

3. The clinical record for Resident 263 was reviewed on 9/21/22 at 10:48 a.m. The Resident's diagnosis included, but were not limited to, dementia and Parkinson's disease. He was admitted to the facility on 9/9/22.

An Admission MDS (Minimum Data Set) Assessment, completed 9/15/22, indicated he had moderately impaired cognition.

Physician's orders, dated 9/9/22, indicated he was to receive acetaminophen (Tylenol) 500 mg (milligram) tablet three times daily, carbidopa - levodopa (Parkinson's medication) tablet 25-100 mg tablet three times a day and gabapentin (nerve pain medication) 300 mg capsule twice a day.

The September 2022 MAR (Medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	Administration Record) indicated he had not received the acetaminophen, carbidopa- levodopa, or gabapentin on 9/9/22 and 9/10/22 due to them being unavailable. During an interview on 9/26/22 at 2:01 p.m., the Registered Pharmacist indicated Resident 263's medications were dispensed on 9/9/22 and that the facility should have received the medications in the early morning of 9/10/22. During an interview on 9/26/22 at 2:18 p.m., the Director of Nursing indicated Resident 263's medication should have been at the facility by the morning of 9/10/22 and should have been administer as ordered. If had been unavailable the emergency drug kit could have been utilized. 4. The clinical record for Resident 95 was reviewed on 9/21/22 at 10:50 a.m. The diagnoses included, but were not limited to, diabetes mellitus. The 8/28/22 diabetes care plan indicated she was at risk for adverse effects of hyperglycemia or hyoglycemia related to use of glucose lowering medication and/or diagnosis of diabetes mellitus. An approach was for her to receive her medications as ordered, effective 8/28/22. An interview was conducted with Resident 95 on 9/21/22 at 11:00 a.m. She indicated she did not get her insulin as scheduled. When she mentioned it to staff, they acted like she was bothering them. She would rate medication administration a 3 on a scale of 1 to 10. "It's not up to par. That's the way I feel." The physician's orders indicated to administer 5 units of 100 unit/ml insulin glargine-insulin pen at bedtime, effective 9/12/22.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	The September, 2022 MAR (medication administration record) indicated she did not receive her insulin on the following dates: 9/13/22, 9/14/22, 9/15/22, 9/16/22, 9/17/22, 9/23/22, and 9/25/22. An interview was conducted with Resident 95 on 9/27/22 at 1:24 p.m. She indicated when she didn't receive her insulin, she felt nauseous and shaky. An interview was conducted with UM (Unit Manager) 7 on 9/27/22 at 1:26 p.m. She reviewed Resident 95's clinical record and indicated it was probably a QMA (Qualified Medication Aide) on the cart, who couldn't administer insulin, making the nurse responsible for administration, and perhaps the nurse just forgot to sign off on the MAR. 5. The clinical record for Resident 171 was reviewed on 9/27/22 at 1:38 p.m. The diagnoses included, but were not limited to, history of right femur fracture, depression, acute kidney failure, and hypertension. She was admitted to the facility on 9/19/22 The physician's orders indicated to administer 30 mg of enoxaparin subcutaneously every day, effective 9/19/22; a 20 mg tablet of Lasix once a day, effective 9/19/22; a 60 mg tablet of Nifedipine once a day, effective 9/19/22; and a 25 mg tablet of Zoloft once a day, effective 9/19/22. The September, 2022 MAR (medication administration record) indicated the Enoxaparin, Lasix, Zoloft, and Nifedipine were not administered on 9/20/22 due to the medications being unavailable.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	An interview was conducted with UM (Unit Manager) 7 on 9/26/22 at 3:04 p.m. She indicated one of the issues they were having was that sometimes pharmacy did not deliver on time and when they did, night shift nursing staff would put them in the medication room and the day shift nursing staff couldn't find them. "My understanding is that's the biggest thing." Sometimes when a medication was unavailable, pharmacy would say it was because they needed clarification. Sometimes if it was a QMA (Qualified Medication Aide) administering medications, they wouldn't call the pharmacy to clarify what the hold was or why the medication was unavailable. She'd been educating nursing staff on finding the medication and calling the pharmacy, and it was getting better. The Medication Shortages/Unavailable Medications policy was provided by the RDCS (Regional Director of Clinical Services) on 9/26/22 at 10:03 a.m. It read, "Upon discovery that facility has an inadequate supply of a medication to administer to a resident, facility staff should immediately initiate action to obtain the medication from the pharmacy." The Insulin Pen Administration policy was provided by the DON (Director of Nursing) on 9/27/22 at 2:23 p.m. The final step was to document pertinent information. The Medication Pass Procedure policy was provided by the DON on 9/27/22 at 2:23 p.m. The first step in the procedure was for medications to be administered within 60 minutes before and/or after time ordered. Step 16 was for the administration to be recorded on the MAR or TAR (treatment administration record) after given.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	3.1-25(b)(3) 3.1-37(b) 3.1-38(b)(6)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to provide care, consistent with professional standards of practice, to prevent a stage II pressure ulcer from developing and failed to administer Vitamin C and Zinc, as ordered, to 2 of 2 residents reviewed for pressure ulcers. (Resident 18 and Resident B) Findings include: 1. A continuous observation of 400 unit was initiated on 9/23/22 at 10:10 a.m. The continuous observation period ended at 12:24 p.m. During the continuous observation, Residents 18 was not turned in the 2 hour period and was in the same position for over 2 hours. During the time of the continuous observation, Resident 18 was observed, lying on her back in her bed, no	F 0686	F686 p="" paraid="2146540555" paraeid="{9c910b87-5f67-4112-9826-53cf2e33710b}{81}">What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident B no longer resides in Resident 18 is receiving all medications as ordered. Care plan reviewed to ensure all preventative interventions are in place. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the	11/04/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	surround pillow or wedge was in use, no cervical collar was on, her head was tilted to the right side and her heels were not elevated. An observation was conducted on 9/26/22 at 10:11 a.m. of Resident 18 lying in bed flat on her back. Resident 18's clinical record was reviewed on 9/23/22 at 9:39 a.m. Resident 18's diagnoses included, but not limited to, hemiparesis(muscle weakness or partial paralysis on one side of body) of left side, chronic obstructive pulmonary disease, aphasia (language disorder that affects a person's ability to communicate), and anxiety disorder. Resident 18's annual MDS (minimum data set) dated 6/27/22 indicated, she was totally dependent on the assistance of two persons for bed mobility, toileting, transfers, and bathing; and totally dependent on the assistance of one person for dressing and personal hygiene. Resident 18's care plan dated 1/27/21 indicated, she preferred to stay in bed per her choice and would occasionally get up in the Broda chair. The interventions included, but not limited to, use body surround pillow when in bed, can use cervical collar, and wedge cushion when body surround pillow was unavailable, encourage resident to get out of bed once a week, encourage her to turn and reposition every 2 hours or as needed and to perform weekly and as needed skin checks.. Resident 18's care plan dated 10/9/18 indicated, she was at risk for skin breakdown and the interventions included, but not limited to, utilize pillows under elbows, shoulders, and hips for positioning/offloading while in bed, encourage resident to turn and reposition at least every 2		potential to be affected by the alleged deficient practice ul="" role="list" Full audit of medication administration to be completed by DNS/Designee. DNS/Designee will conduct an with all licensed nurses and QMAs on medication administration. DNS/Designee will conduct an with all nursing staff on skin management policy. What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur? ul="" role="list" The DNS/designee will review the previous day medication administration records daily in clinical meeting Weekly skin assessments to be reviewed daily in clinical for compliance DNS/Designee will conduct an with all licensed nurses and QMAs on medication administration DNS/Designee will conduct an with all nursing staff on skin management policy. p="" paraid="976325994" paraeid="{9c910b87-5f67-4112-9826-53cf2e33710b}{243}">How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter with results reported to the Quality Assurance and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	hours and elevate heels while in bed and assess and document skin condition weekly and as needed. A care plan for behavioral symptoms dated 11/11/21 indicated she refuses care and interventions included, but not limited to, reapproach and try a different care giver. A physician's order dated 3/28/19 indicated, for Resident 18 to be turned and repositioned every 2 hours. A physician's order dated 10/30/19 indicated, to document weekly skin assessments on Wednesdays. A physician's order dated 3/7/19 indicated, for a wedge cushion to be used in bed for pressure relief. Resident 18's weekly skin assessments for June, July, August, and September 2022 were provided by RDCS (Regional Director of Clinical Services) on 9/23/22 at 3:37 p.m. Resident 18 had weekly skin assessments completed on the following dates: 6/16, 6/30, 7/28, 8/18, 9/18 and 9/22. Resident 18's weekly skin assessments were not completed weekly, as ordered, during June through September 2022. A New Skin Event for Resident 18 dated 9/18/22 at 8:44 p.m. indicated, she had a new wound on her left buttock. The measurement of the wound was 2 cm(centimeters) in length, 5 cm wide, and less than 0.1 cm in depth. The wound description indicated, it was an open area that was red and beefy in color. A Wound Management Report dated 9/19/22 at 2:44 p.m. indicated, the left buttock wound was not present on admission, measured 3 cm by 4.6		Performance Improvement Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	cm and 0.1 cm in depth. The wound was staged as a stage II pressure wound. An IDT (interdisciplinary team) note dated 9/22/2022 at 11:35 a.m. indicated, the new wound was a pressure ulcer to left buttocks. An interview with LPN (licensed practical nurse) 3 was conducted on 9/26/22 at 10:03 a.m. She indicated, Resident 18 was totally dependent for bathing, repositioning and turning. When asked if Resident 18 had a wedge cushion in her room, she replied, "I'll have to get one for her". A Skin Management policy was received on 9/23/22 at 3:37 p.m. from RDCS. The policy indicated, "Procedure For Wound Prevention...3. Interventions to prevent wounds from developing and/or promote healing will be initiated based upon the individual's risk factors to include but not limited to the following...Redistribute pressure (such as repositioning, protecting and/or offloading heels, etc.)...4. Residents identified at risk for pressure ulcer/injury and those with pressure ulcer/injury will have an individualized care plan developed with specific risk factors and contributing factors including preventative measures...7. Facility skin sweeps (head-to-toe-assessment) are conducted monthly to assess all residents' skin conditions and to ensure appropriate preventative measures are in place.2. The clinical record for Resident B was reviewed on 9/22/22 at 1:45 p.m. The diagnoses included, but were not limited to: chronic kidney disease, heart failure and pressure ulcers. The 2/8/22 impaired skin integrity care plan, last revised 4/6/22, indicated she had pressure ulcers to her sacrum, left hip, and right hip.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	The 3/22/22 wound care provider note indicated she had an unstageable pressure ulcer on her sacrum, an unstageable pressure ulcer on her left trochanter (hip,) and a stage 3 pressure ulcer on her right trochanter. The plan section of the note read, "MVI [multivitamin infusion] with minerals daily, Vit [Vitamin] C, 500 mg po [by mouth] BID [twice daily,] Zinc sulfate, 220 mg daily." The physician's orders indicated to administer the Vitamin C twice daily, starting 3/23/22 and the Zinc Sulfate once a day, starting 3/23/22. The March, 2022 MAR (medication administration administration record) indicated the Vitamin C was unavailable once on 3/28/22 and on hold once on 3/25/22 and once on 3/28/22. The Zinc Sulfate was on hold on 3/25/22 and 3/28/22. An interview was conducted with the RDCS (Regional Director of Clinical Services) on 9/26/22 at 10:03 a.m. She indicated she didn't have any information as to why the Vitamin C and Zinc were unavailable or on hold. She didn't know whether the staff overlooked them or they weren't in the building for administration. The Skin Management Program policy was provided by the RDCS on 9/23/22 at 9:50 a.m. It read, "It is the policy of [name of facility] to ensure that each resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	This Federal Tag relates to complaint IN00390169. 3.1-40 3.1-40(a)(2)			
F 0689 SS=E Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to assure hot water temperatures were at safe levels, at point of use, with the potential to affect 15 cognitively impaired and ambulatory residents of the 91 residents who reside in the 200, 300, and 400 halls at the facility. Findings include: On 9/20/22 at 1:45 p.m. the water in 2 random rooms on the dementia unit was observed to be hot to touch. During an interview on 9/20/22 at 2:02 p.m., the ED (Executive Director) indicated the water temperatures should not be over 120 degrees Fahrenheit. During an interview on 9/20/22 at 2:02 p.m., CNA (Certified Nursing Assistant) 5 indicated she had noticed the hot water had been hot occasional	F 0689	F689 p="" paraid="265412392" paraeid="{b4417952-e97e-458c-a90c-8816dd8c57a3}{23}">What corrective action(s) will be accomplished for those residents found to have been affected by deficient practice: Water heater mixing replaced for halls 200, 300 and 400. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken: Any resident resides halls 200, 300 and 400 have the potential to be affected by the alleged deficient practice. ul="" role="list" An audit will be completed of water temperatures on halls 200,	11/04/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	and that the temperatures of the hot water varied. On 9/20/22 at 2:05 p.m., the water heater was observed with the MS (Maintenance Supervisor). He indicated the water temperatures at the mixing valve was running at 130 degrees Fahrenheit. He had fixed a water leak in the pipes around 45 minutes ago and that may be why the water was running hot. He randomly checked hot water temperatures from the bathroom faucets weekly to monitor temperatures. On 9/20/22 at 2:11 p.m., the MS was observed randomly checking bathroom sink hot water temperatures as follows: room 304- 130 degrees Fahrenheit, room 311- 129 degrees Fahrenheit, room 205- 127 degrees Fahrenheit, room 215- 126 degrees Fahrenheit, room 401- 129 degrees Fahrenheit, and room 411- 127 degrees Fahrenheit. During an interview on 9/20/22 at 2:35 p.m., the MS indicated he randomly checked the hot water temperatures from the bathroom faucets weekly and logged the results. He was unsure if they had been completed weekly during the weeks he was not in the building. On 9/20/22 at 3:20 p.m., the MS provided the hot water temperate monitoring logs which indicated the temperatures (in degrees Fahrenheit) at point of use, were as follows: 8/12/22- 100 hall -120, 200 hall -118, 300 hall- 116, 400 hall -118 (no specific rooms identified), 8/16/22- 100 hall- 119, 200 hall-117, 300 hall -118 (no specific rooms identified), 8/22/22- room 106 -119, room 200 -118, room 306-119,		300 and 400. All staff will be in-serviced on water temperature guidelines, notification and work orders by Maintenance Director or Designee. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur: All staff will be in-serviced on water temperature guidelines, notification and work orders by Maintenance Director or Designee. ul="" role="list" Maintenance Director/Designee will check water temperatures weekly to ensure water temperatures are between 100-120 How will the corrective action(s) be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place: POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	9/1/22- room 107- 119, room 200- 118, room 308- 117, and 9/8/22- room 107- 117, room 200- 116, room 310- 118, and room 401- 118. There were no logs provided for 9/9/22 through 9/20/22. During an interview on 9/27/22 at 2:23 p.m., the Director of Nursing indicated there were 15 cognitively impaired and ambulatory residents residing at the facility. On 9/20/22 at 3:20 p.m., the MS provided the Test Water Temperatures procedure which read "...1. Ensure patient room water temperatures are between 105 and 115 Fahrenheit (or as specified by state requirements) ...Indiana- 100 to 120.... Test temperature in shower areas...test temperatures at the mixing valve...Check resident rooms at the end of each wind on a rotating basis...Record results in the water temperature log 1. note any discrepancies 2. Adjust water heater settings as required 3. Retest as necessary..." 3.1-45(a)(1)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.			
	Based on interview and record review, the facility failed to ensure staff provided catheter care, monitored of outputs and timely obtained a culture and sensitivity urinalysis (C & S UA) as ordered for 1 of 1 residents reviewed for catheter. (Resident 25) Findings include: The clinical record for Resident 25 was reviewed on 9/23/22 at 2:00 p.m. The diagnosis for Resident 25 included, but was not limited to, cerebral infraction (stroke). A care plan dated 9/8/22 for Resident 25 indicated "...Problem: Resident requires an indwelling	F 0690	p="" role="heading" aria-level="1" paraid="1388584635" paraeid="{b4417952-e97e-458c-a90c-8816dd8c57a3}{161}"> p="" role="heading" aria-level="1" paraid="1388584635" paraeid="{b4417952-e97e-458c-a90c-8816dd8c57a3}{161}">F 690 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident 25 had Urinalysis Culture and Sensitivity and was treated for UTI per MD order. Urine output is being	11/04/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	urinary catheter R/T [related to] Neurogenic bladder..Approach:...obtain labs as ordered...provide assistance with catheter care...Staff to record urinary output in mL [milliliters]..." A medical provider note dated 9/1/22 indicated "...reason discolored cloudy urine....Her urine has become cloudy and discolored...11. Discolored urine - check UA C & S..." A physician order dated 6/6/22 indicated staff was to record output every shift and provide catheter care. A physician order dated 9/1/22 indicated staff was to obtain a C & S UA for Resident 25. The August 2022 Treatment Administration Record indicated the following days catheter care was not provided and outputs were not recorded as ordered: 8/4/22 - 7:00 a.m. - 3:00 p.m., 8/7/22 - 7:00 a.m. - 3:00 p.m., and 3:00 p.m. - 11:00 p.m., 8/12/22 - 3:00 p.m. - 11:00 p.m., 8/14/22 - 3:00 p.m. - 11:00 p.m., 8/16/22 - 3:00 p.m. - 11:00 p.m., 8/27/22 - 7:00 a.m. - 3:00 p.m., 8/28/22 - 7:00 a.m. - 3:00 p.m., and 8/29/22 - 3:00 p.m. - 11:00 p.m. The September 2022 Treatment Administration Record indicated the following days catheter care was not provided and outputs were not recorded as ordered: 9/2/22 - 7:00 a.m. - 3:00 p.m., 9/5/22 - 11:00 p.m. - 7:00 a.m.,		monitored per order. p="" paraid="1989924175" paraeid="{b4417952-e97e-458c-a90c-8816dd8c57a3}{201}">How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents with foley catheters have the potential to be affected by the alleged deficient practice DNS/Designee will conduct an in-service with all nursing staff on Urinalysis Collection and documentation of urine outputs for residents with foley catheters. DNS/Designee ensured all other residents with was monitored per physician order. What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur? ul="" role="list" DNS/Designee will conduct an in-service with all nursing staff on Urinalysis Collection and documentation of urine outputs for residents with foley catheters. Lab orders and results to be audited daily in clinical Urine output documentation for residents with foley catheters to be reviewed daily in clinical How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? POC QAPI Tool will be utilized weekly x 4 weeks,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	9/7/22 - 11:00 p.m. - 7:00 a.m., 9/9/22 - 11:00 p.m. - 7:00 a.m., 9/11/22 - 3:00 p.m. - 11:00 p.m., 9/13/22 - 11:00 p.m. - 7:00 a.m., 9/14/22 - 3:00 p.m. - 11:00 p.m., 9/17/22 - 3:00 p.m. - 11:00 p.m., 9/21/22 - 7:00 a.m. - 3:00 p.m., A UA collected on 9/8/22 with a final report on 9/10/22 indicated Resident 25 was abnormal. A medical provider note dated 9/9/22 indicated "...reason: bacteriuria....Her urine is dark with sediment. A urinalysis was done with is abnormal. Urine culture pending at this time. A physician order dated 9/12/22 indicated Resident was to receive 875 milligrams-125 milligrams of amoxicillin. An interview was conducted with the Director of Nursing on 9/26/22 at 3:25 p.m. She indicated she was unable to locate any other documented outputs or catheter care that had been provided for Resident 25. The 9/1/22 order to obtain a UA for Resident 25 was missed. 3.1-41(a)(2)		monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director ul="" role="list" If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance ul="" role="list"	
F 0694 SS=D Bldg. 00	483.25(h) Parenteral/IV Fluids § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. Based on interview and record review, the facility failed to ensure assessment, flushing, and	F 0694	F694 What corrective action(s) will be	11/04/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	dressing change to a resident's PICC (peripherally inserted central catheter) for 1 of 1 resident reviewed for death. (Resident B) Findings include: The clinical record for Resident B was reviewed on 9/22/22 at 1:45 p.m. The diagnoses included, but were not limited to: chronic kidney disease, heart failure and pressure ulcers. The 2/1/22, 1:20 p.m. nurse's note read, "POA [power of attorney] notified of new orders. midline placed at this time. res had low grade fever of 99.1. cont [continues] to be lethargic with poor po [by mouth] intake. np [nurse practitioner] here and updated on labs and ua [urinalysis.] will cont to observe." The physician's orders read, "PICC: Change Midline dressing 24 hours after insertion. Nurse to measure (in centimeters) the PICC catheter length (from insertion site to catheter hub) AND nurse to measure upper arm circumference (10 cm above antecubital fossa). Once a day," effective 2/2/22; "PICC: Nurse to initial every shift PICC/Midline site free of warmth, redness or swelling," starting 2/1/22 and ending 2/10/22; "Pre-Filled Normal Saline (sodium chloride 0.9%) syringe; 0.9%; amt [amount:] 10 mL; injection Special Instructions: Flush each lumen of mid line to maintain patency Every Shift," starting 2/1/22 and ending 2/10/22; "PICC: Change Midline dressing every 7 days with transparent dressing. Nurse to measure (in centimeters) the PICC catheter length (from insertion site to catheter hub) AND nurse to ensure upper arm circumference (10 cm above antecubital fossa). Once a day every 7 days," starting 2/8/22 and ending 2/10/22.		accomplished for those residents found to have been affected by the deficient practice?¿¿ ul="" role="list" Resident B no longer resides in ¿ How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?¿¿ All residents receiving intravenous therapy have the potential to be affected by the alleged deficient practice¿ Audit completed of all residents receiving intravenous therapy to ensure all necessary orders were in place, flushes and dressing changes are occurring.¿¿ ul="" role="list" DNS/Designee will conduct an with all Licensed nursing staff on PICC Management Guidelines Policy¿¿ ¿ What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur?¿ DNS/Designee will conduct an with all Licensed nursing staff on PICC Management Guidelines Policy¿ ¿ DNS/Designee to verify IV/PICC care orders are in place when new order for an intravenous line is received.¿¿ p="" paraid="1349888734" paraeid="{d84f1bb9-79e3-4efe-a414-e965b85f0621}{167}">¿ How be monitored to ensure the deficient practice will not recur, i.e., what	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	The 2/10/22, 1:10 p.m. nurse's note read, "res [resident] resting in bed at this time.... also noted swelling to rue [right upper extremity.] notified np and received new orders to remove picc line d/t [due to] swelling. np to review recent labs to see if another iv [intravenous] needs placed. vitals remain wnl [within normal limits.] dtr [daughter] updated on all new orders and res current condition...." The 2/10/22, 1:40 p.m. nurse's note read, "This nurse removed residents PICC per MD orders. Resident tolerated it without incident. No noted bleeding, bandage applied. Tip intact. will continue to monitor the site and notify MD of any changes." The physician's orders indicated to establish IV midline or PICC line for IVF [intravenous fluids] administration, starting 2/11/22 and ending 2/22/22. There were no orders to change the midline dressing 24 hours after insertion; to assess the site for warmth, redness or swelling; to flush the midline; or to change the dressing every 7 days. An interview was conducted with Family Member 8 on 9/27/22 at 5:01 p.m. She indicated she had a video call with Resident B, noticed her PICC line was infiltrated [occurs when catheter goes through or comes out of the vein, allowing IV fluid to leak into surrounding tissue, which may cause pain, swelling, etc] and had to call the facility to inform the staff. An interview was conducted with the RDCS (Regional Director of Clinical Services) on 9/26/22 at 10:03 a.m. She indicated she was able to locate a progress note referencing an assessment of her second PICC, but no other verification of		quality assurance program will be put into place?¿¿ POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	assessment, flushing, or dressing changes, as there were no orders for these after the 2/11/22 PICC was placed. The Peripherally Inserted Central Catheter Management Guidelines was provided by the RDCS on 9/26/22 at 10:03 a.m. It read, "Procedure Steps: ...5. Dressing and securement device is to be changed every 7 days or PRN [as needed] using sterile technique (see procedure for Central Line Dressing Change). If gauze is placed during insertion, change dressing and securement device in 24 hours....7. If ordered by prescriber an unused catheter should be flushed at least daily with 3 mls of Heparin flush solution. 8. PICC insertion site should be assessed every shift for signs of redness, edema, pain, drainage or venous cord (red or hard outline of vein tracing upward on arm)." This Federal Tag relates to complaint IN00390169. 3.1-47(a)(2)			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on interview and record review, the facility failed to administer a resident's medication, as ordered, to 1 of 1 resident reviewed for dialysis. (Resident 175) Findings include:	F 0698	p="" role="heading" aria-level="1" paraid="1069369182" paraeid="{d84f1bb9-79e3-4efe-a414-e965b85f0621}{205}">F698 What corrective action(s) will be accomplished for those residents found to have been affected by the	11/04/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	The clinical record for Resident 175 was reviewed on 9/22/22 at 10:16 a.m. The diagnoses included, but were not limited to, end stage renal disease. He was readmitted to the facility on 9/13/22 from the hospital. The 6/9/22 dialysis care plan indicated the goal was for him to have no complications related to hemodialysis with an approach to provide treatment as ordered. The physician's orders indicated he was to receive dialysis treatments on Tuesdays, Thursdays and Saturdays at his dialysis with a chair time of 11:00 a.m. They indicated to administer an 800 mg tablet of Renagel (medication used to control phosphorus levels in people with chronic kidney disease who are on dialysis) 3 times daily with meals, effective 9/13/22. The September, 2022 MAR (medication administration record) indicated he was not administered the Renagel tablets 3 times daily between 9/14/22 and 9/26/22. The reasons for not administering were that the medication was unavailable for 26 of the administrations and on hold for 4 of the administrations. On 9/26/22 at 2:33 p.m., the dialysis logs were provided by the Unit Secretary of Resident 175's dialysis provider. They indicated he did not go to dialysis on 9/8/22, 9/15/22, and 9/22/22. An interview was conducted with UM (Unit Manager) 7 on 9/26/22 at 3:04 p.m. She indicated she was unaware the Renagel tablets were not being administered. He refused dialysis often, but there was no documentation to support that. There was a transportation issue on 9/8/22, because he just returned from the hospital and the		deficient practice? Resident 175 is receiving all medication as ordered. Care plan reviewed and updated to reflect refusals of treatment including but not limited to dialysis. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? ul="" role="list" All residents receiving hemodialysis have the potential to be affected by the alleged deficiency. Full audit of medication administration to be completed by DNS/Designee. DNS/Designee will conduct an with all licensed nurses and QMAs on medication administration. What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur? ul="" role="list" The DNS/designee will review the previous day medication administration records daily in clinical meeting DNS/Designee will conduct an with all licensed nurses and QMAs on medication administration How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	facility forgot to set up transportation upon return. Once they realized there was no transportation, she called the transportation provider, who informed her their system still showed him as being at the hospital. She then set up transportation for later that day, as his dialysis provider agreed to him coming, so long as he was there by 1:00 p.m. Then Resident 175 refused to go at 1:00 p.m., but there was no documentation to support that either. An interview was conducted with the DON (Director of Nursing) on 9/27/22 at 10:02 a.m. She indicated the Renagel tablets were available in the emergency drug kit for administration. Many of his missed administrations were by agency staff. She spoke with a pharmacy technician who informed her they never received the order for Renagel tablets. It was not on his profile at the pharmacy, so they were going to redo his profile to ensure it was accurate. He never should have gone that long without the medication. The Dialysis Care policy was provided by the DON on 9/26/22 at 11:57 a.m. It read, "It is the policy of [name of facility] to ensure that residents requiring dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care, and the residents' goals and preferences." 3.1-37(a)		thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	
F 0740 SS=D Bldg. 00	483.40 Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. Based on interview and record review, the facility failed to monitor and track behaviors, timely initiate care plans and interventions for behavioral symptoms 1 of 1 resident reviewed for behaviors and for 1of 5 residents reviewed for unnecessary medications (Resident 17 and 263); and failed to administer a resident's psychotropic medication, as ordered and obtain a psychological evaluation, as ordered, for 1 of 1 resident reviewed for dialysis. (Resident 175). Findings include: 1. The clinical record for Resident 17 was reviewed on 9/21/22 at 12:06 p.m. The Resident's diagnosis included, but were not limited to, Aphasia (inability to speak) and vascular dementia. An Admission MDS (Minimum Data Set) Assessment, completed 7/1/22, indicated he had short- and long-term memory loss and moderately impaired decision-making skills. He did not refuse care and did not receive anti-psychotic medications. A progress note, dated 8/3/22, indicated that the SSD (Social Services Director) had reviewed a list of assisted livings with Resident 17, and he had picked the top facilities that he preferred. SSD had called the assisted living facilities and referred him.	F 0740	p="" role="heading" aria-level="1" paraid="1453806299" paraeid="{a1ae00c9-ca2c-447a-b787-e6b398e123f6}{89}"> p="" role="heading" aria-level="1" paraid="1453806299" paraeid="{a1ae00c9-ca2c-447a-b787-e6b398e123f6}{89}">F740 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident 17 and 263 behavioral care plans reviewed and updated. Behavior tracking initiated Resident 175 medications reviewed with provider. Medications being administered per order. Resident continues to be followed by psychiatrist. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? ul="" role="list" ALL residents with health concerns have the potential to be affected by the alleged deficient practice Audit completed of all residents with behavior health concerns to ensure behavior tracking is in	11/04/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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 progress note, dated 8/9/22 at 8:55 a.m., indicated that the SSD and Resident 17 had completed an assessment with the Central Indiana Counsel on Aging and the results would be sent to the assisted living facility. An IDT (Interdisciplinary Team) progress note, dated 8/10/22 at 8:45 a.m., indicated that on 8/9/22 Resident 17's brother had reported to the SSD that Resident 17 believed there is poison in his food and someone at the facility placed it there. The SSD had spoken with Resident 17 who confirmed he believed his food was being poisoned. The root cause of behavioral expressions was awaiting the results of a urinalysis to rule out a urinary tract infection. The preventative interventions related to the above root cause were to obtain labs as ordered and a psychiatric referral. A progress note, dated 8/10/22 at 9:02 a.m., indicated the SSD saw him while he was eating breakfast. He reported the eggs were runny, but everything else tasted fine. He had no concerns of poisoning and had finished most of his breakfast. A Nurse Practitioner's Encounter Summary-Progress note, dated 8/10/22, indicated he was seen for an altered mental status and weight loss. Labs had been obtained and were unremarkable. The staff had reported that he believed there was poison in his food and thus declined to eat. The Social Worker reports that he has lost 8 pounds since his admission to the facility. He will be seen by the psychiatrist. An Initial Psychiatric Evaluation, dated 8/11/22, indicated Resident 17 was not eating due to paranoia and had recent delusions with weight loss. His thought process was confused, and		place, and to ensure residents are receiving psychotropics as ordered, What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur? ED/Designee to attend Monthly Behavior Management Meeting to ensure behavior management program is in place. Regional Social Service Support to Social Service team on Behavior Management Program p="" paraid="1949787157" paraeid="{a1ae00c9-ca2c-447a-b787-e6b398e123f6}{203}"> How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance p="" paraid="1949787157" paraeid="{a1ae00c9-ca2c-447a-b787-e6b398e123f6}{203}">	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	confabulated. His thought content was delusional. A new diagnosis of psychotic disorder with delusions due to his stroke was added and he was started on Zyprexa (anti-psychotic medication). A progress note, dated 8/12/22 at 5:36 p.m., indicated he had refused his evening medication and refused to wake up. A progress note dated 8/19/22 at 2:28 a.m., indicated he had been moved to the dementia unit and was adjusting well to the room change. During an interview on 9/26/22 at 3:21 p.m., LPN 1 indicated Resident 17 had not displayed any behaviors. He was one of the higher functioning residents on the dementia unit. She had noticed no behavioral issues. During an interview on 9/27/22 at 4:17 p.m., the SSD and the Corporate Social Services Consultant indicated Resident 17 displayed behaviors such as urinating in inappropriate places. He had delusions that his food was being poisoned. There had been no behavior notes for him other than those charted on 8/9/22 and 8/10/22. They did not see where any non- pharmacological interventions had been tried prior to the Zyprexa being started. There were not care plans for delusional behaviors or for anti-psychotic medication use. 2. The clinical record for Resident 263 was reviewed on 9/21/22 at 10:48 a.m. The Resident's diagnosis included, but were not limited to, dementia and Parkinson's disease. He was admitted to the facility on 9/9/22. A progress note, dated 9/9/22 at 3:27 p.m.,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	indicated Resident 263 had arrived at the facility. He was alert and oriented x 3 (to person, place, and time). A progress note, dated 9/10/22 at 8:14 p.m., indicated he was alert and oriented to time, room and environment, place, and person. He was not displaying exit seeking behavior. A progress note, dated 9/11/22 at 4:55 p.m., indicated he was alert and oriented to person. He was not displaying exit seeking behaviors. An Elopement Risk Assessment, dated 9/13/22 at 8:24 a.m., indicated Resident 263 was not at risk for elopement. An Event Report, dated 9/15/22 at 8:16 a.m., indicated neuropsych testing had been ordered due to his risk for elopement and wandering. A Nurse Practitioner's Encounter Summary-Progress Note, dated 9/15/22, indicated Resident 263 had been seen due to being an elopement risk and wandering at night. An Admission MDS (Minimum Data Set) Assessment, completed 9/16/22, indicated he had moderately impaired cognition. A care plan, initiated 9/16/22, indicated Resident 263 was at risk for elopement due to wandering and asking to go home repeatedly. The goal was for him to remain safely in the facility. The approaches, initiated 9/16/22, were for him to reside on a secured unit, provide 1:1 attention and conversations as needed, and that all facility exits were secured. During an interview on 9/21/22 at 10:48 a.m.,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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 263 indicated he felt as though the nurses didn't listen to him when he spoke and didn't answer questions when he had them. His goal was to return home if he could. During an interview on 9/26/22 at 3:19 p.m., LPN (Licensed Practical Nurse) 1 indicated Resident 263 would "sundown" in the evenings. His confusion would get worse, and he would want to do things like pay his bill from dinner. He would accuse the staff of "cheating" him on his bills and money. On Saturday, 9/24/22, he had displayed agitation and it was very hard to redirect him. She had finally called his partner to talk with him and calm him down, which had been successful. She should have documented that in the clinical record. During an interview on 9/27/22 at 4:03 p.m., the Social Services Director and the Corporate Social Services Consultant indicated that the nursing staff communicated behavior through a progress behavior communication note. The IDT (Interdisciplinary Team) reviewed the behavior communication notes each morning during the morning meeting and would develop interventions, notify the appropriated parties, and made referrals as needed. The staff did not use flow sheets to track behaviors. Resident 263 had been moved to the dementia care unit due to wandering and exit seeking. There were no behavior communication notes in the medical record for Resident 263. On 9/27/22 at 10:02 a.m., the Director of Nursing provided the Behavior Management Policy, last revised 5/2019, which read "...Policy: It is the policy of ... to provide behavioral interventions for residents with problematic or distressing behaviors. Interventions provided are both			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	individualized and non-pharmacological and part of a supportive physical and psychosocial environment that is directed toward preventing, relieving and or accommodating a resident's distressed behavior. Procedure: 1. Care plans should be initiated for any behavioral issue that affects, or has the potential to affect, the resident or other residents. Care plans should also be initiated for the behavioral symptoms that relate to psychotropic medication use and its associated diagnosis. All residents who are taking ...antipsychotic...medication... are to a behavior monitoring program and corresponding care plan in order to assist in assessing the efficacy of both interventions and medication use...2. When behavior occurs, the staff communicates to the nurse what behavior occurred. The nurse records the behavior on the monitoring form, if the resident is being monitored for the behavior, including what interventions were attempted during the episode and whether or not they were effective. 3. The nurse may also record the behavior as a New/Worsening Behavior Event...4. The IDT review should be a discussion with the team as to the behavior event, and evaluation of interventions, presentation of new interventions if applicable and an assessment of any underlying causes of the distressed behavior..."3. The clinical record for Resident 175 was reviewed on 9/22/22 at 10:16 a.m. The diagnoses included, but were not limited to: end stage renal disease, anxiety, and bipolar disorder. He was readmitted to the facility on 9/13/22 from the hospital. The 6/24/22 behavior care plan indicated he had a diagnosis of anxiety disorder as exhibited by being in his room with his door closed, easily agitated with others ie: asking questions, and loud noise, etc, pacing and feeling restless. An approach was to provide medication as ordered.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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

The 6/24/22 care plan indicated the problem was Resident 175 had been deterined to be mentally ill per the PASRR (pre admission screening resident review) level 2 assessment with a diagnosis of bipolar disorder and anxiety disorder. An intervention was ongoing mental health services.

The physician's orders indicated he was to receive dialysis treatments on Tuesdays, Thursdays, and Saturdays at his dialysis provider with a chair time of 11:00 a.m. They indicated to administer a 1 mg tablet of haloperidol at bedtime, effective 6/8/22, due to a diagnosis of bipolar disorder; 25mg of trazodone twice daily, effective 6/9/22, due to a diagnosis of anxiety; and psychiatric/psychological services to evaluate and treat, effective 6/10/22, due to a diagnosis of bipolar disorder.

The 9/10/22 through 9/13/22 hospital notes read, "He has been chronically underdialyzed due to noncompliance with dialysis and signing off dialysis early."

An interview was conducted with the SSD (Social Services Director) on 9/26/22 at 11:25 a.m. She indicated they were currently sending someone with him to dialysis on Tuesdays and Thursdays to see what was going on with him there, because she was getting reports from the social worker at dialysis that once he got there, he was not staying in the chair. They were currently trying to discharge him to a facility that had in house dialysis.

An interview was conducted with the Unit Secretary of Resident 157's dialysis provider on 9/26/22 at 11:54 a.m. She indicated they were having "disciplinary" issues with Resident 157

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	while at dialysis. He wouldn't keep his mask up while there and was "smart alecky." He would come to dialysis, be on the machine, and then 2 minutes later ask to be taken off the machine. It happened quite often. They'd spoken to the facility about it, so they started sending someone with him to dialysis, who could sit with him, explain why he was there, and encourage him to stay on the machine. She was unsure what caused him to behave this way. About a month ago, he "stripped naked" in the parking lot. They asked him to pull up his mask, which he would, but as soon as she would turn her head, he'd pull it down again. The nurse then asked him to step outside until ready for treatment. When he was brought back inside, he was agitated, so they called facility to come get him. He then went into the parking lot and "started a show." She felt sorry for him. On 9/26/22 at 2:33 p.m., the July, August, and September, 2022 dialysis logs were provided by the Unit Secretary of Resident 175's dialysis provider. They indicated he was scheduled for 4 hours each treatment, but his average active hours receiving dialysis treatments was 2 hours and 2 minutes. The September, 2022 MAR (medication administration record) indicated he did not receive his scheduled haloperidol on 9/6/22, 9/7/22, 9/8/22, or 9/9/22 due to the medication being unavailable. He did not receive his scheduled Trazodone once on 9/7/22, once on 9/16/22, and once on 9/17/22 due to the medication being unavailable, twice on 9/9/22 and once on 9/14/22 due to the medication being on hold. There was no information in the clinical record to indicate Resident 175 received a			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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

psychiatric/psychological evaluation since the 6/10/22 order to do so.

The 7/14/22 psyche note, written by Physician 15, read, "Attempted to see in psych eval [evaluation]...He is gone to dialysis so unable to see him today....Will attempt to see at next visit on 7/28/22.

An interview was conducted with UM (Unit Manager) 7 on 9/26/22 at 3:04 p.m. She indicated she was unsure as to why the Haloperidol was unavailable. One of the issues they were having was that sometimes pharmacy did not deliver on time and when they did, night shift nursing staff would put them in the medication room and the day shift nursing staff couldn't find them. "My understanding is that's the biggest thing." Sometimes when a medication was unavailable, pharmacy would say it was because they needed clarification. Sometimes if it was a QMA (Qualified Medication Aide) administering medications, they wouldn't call the pharmacy to clarify what the hold was or why the medication was unavailable. She'd been educating nursing staff on finding the medication and calling the pharmacy, and it was getting better. She somewhat recalled the Trazodone being unavailable, but couldn't recall the reason. She did not recall Resident 175 ever seeing psychiatric/psychological services while at the facility.

An interview was conducted with the SSD (Social Services Director) on 9/26/22 at 2:44 p.m. She indicated Physician 15 was their in house psyche provider. He came once a month and had an assistant who came twice monthly. Residents could be seen by either.

On 9/26/22 at 3:06 p.m., the SSD provided a list of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	dates on which Physician 15 was in the facility since Resident 175's 6/10/22 order to have a psychological/psychiatric evaluation. The dates were 6/16/22, 7/14/22, 7/28/22, 8/11/22, 9/1/22, and 9/15/22. On 9/26/22 at 3:06 p.m., the SSD provided the 9/26/22, 3:03 p.m. email from Physician 15 that read, "I was asked to see this resident for psych eval beginning with my 7/14/22 bimonthly visit to [name of facility.] On each occasion we reviewed his case in behavioral meetings but I have been unable to see him on that visit and subsequent 7/28, 8/11, 9/1, and 9/15 visits due to him being in hospital or at dialysis. I will attempt to see him when back in building on 9/29. Resident 175's clinical record indicated Resident 175 was not in the hospital on 9/15/22, and the September, 2022 dialysis logs provided by the Unit Secretary of Resident 175's dialysis provider indicated he was not at dialysis on 9/15/22. An interview was conducted with the DON (Director of Nursing) on 9/27/22 at 10:02 a.m. She indicated the Haloperidol was not given on 9/6/22 through 9/9/22, and it was all agency nursing staff responsible for administration. He should have received it. The Psychotropic Management policy was provided by the DON on 9/27/22 at 10:02 a.m. It read, "It is the policy of [name of facility] to ensure that a resident's psychotropic medication regimen helps promote the resident's highest practicable mental, physical and psychosocial well-being with person centered intervention and assessment. These medications are managed in collaboration with professional services and facility staff to include non pharmacological			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	interventions, assessment and reduction as applicable. Definition: A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: anti-psychotic; anti-depressant; anti-anxiety; and hypnotic." 3.1-43(a)(1) 3.1-37 3.1-37(a)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on interview and record review, the facility failed to ensure accurate and complete reconciliation of controlled medications for 1 of 2 reportable incidents reviewed. (Resident 25) Findings include: The clinical record for Resident 25 was reviewed on 9/23/22 at 2:00 p.m. The diagnosis for Resident 25 included, but was not limited to, cerebral infraction (stroke). A physician order dated 7/8/22 indicated Resident 25 was to receive 50 milligrams of tramadol every 6 hours for pain. The July 2022 Medication Administration Record for Resident 25 indicated she had received the 50 milligrams of tramadol every 6 hours from 7/8/22 at 6:00 p.m. through 7/31/22; except for 7/11/22 at 12:00 p.m., 7/15/22 at 6:00 p.m., and 7/16/22 at 6:00 a.m. The controlled substance record for 50 milligrams of tramadol to be given every 6 hours for Resident 25 indicated the following recorded dates, amounts given and remaining amounts: 7/10/22 - 10:00 p.m. - 1 tramadol pill medication given = 59 remaining tramadol medications, 7/11/22 - 12:00 a.m. - 1 tramadol pill medication given = 58 remaining tramadol medications - this	F 0755	F755 p="" paraid="771529031" paraeid="{a1ae00c9-ca2c-447a-b787-e6b398e123f6}{242}">What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident 25 no longer reside in facility never missed medications and were assessed and had no pain concerns. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? ul="" role="list" All residents receiving medications have the potential to be affected by the alleged deficient practice DNS/Designee will conduct an for all nurses and QMAs on Inventory Control of Controlled substances policy What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur? DNS/Designee will conduct an for all nurses and QMAs on Inventory Control of Controlled substances policy Unit Managers to conduct audit of controlled	11/04/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	information was crossed out with a written line through the documentation that was recorded, 7/11/22 - 6:00 a.m. - 1 tramadol pill medication given = 57 remaining tramadol medications - this information was crossed out with a written line through the documentation that was recorded, 7/12/22 - 12:00 a.m. - 1 tramadol pill medication given = 57 remaining tramadol medications - this information was crossed out with a written line through the documentation that was recorded, 7/12/22 - 6:00 a.m. - 1 tramadol pill medication given = 56 remaining tramadol medications - this information was crossed out with a written line through the documentation that was recorded, 7/12/22 - 12:00 p.m. - (unable to read amount given or remaining amount) - this information was crossed out with a written line through the documentation that was recorded and included a written documentation that indicated, "wrong sheet", Then the record indicated 59 tramadols remaining, 7/13/22 - 12:00 a.m. - 1 tramadol pill medication given = 58 remaining tramadol medications - this information was crossed out with a written line through the documentation that was recorded, 7/13/22 - 6:00 a.m. - 1 tramadol pill medication given = 57 remaining tramadol medications - this information was crossed out with a written line through the documentation that was recorded, 7/13/22 - 12:00 p.m. - 1 tramadol pill medication given = 58 remaining tramadol medications, no documented tramadols were given from 7/14/22 through 7/15/22, 7/16/22 - 12:00 a.m. - 1 tramadol pill medication given = 57 remaining tramadol medications, 7/16/22 - 6:00 a.m. - 1 tramadol pill medication given = 56 remaining tramadol medications, and 7/16/22 - documented "count corrected" 57 remaining tramadols		substances logs weekly p="" paraid="537395598" paraeid="{269451b0-c651-44fa-9006-b73e7a841d66}{77}">How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	An interview was conducted with the Director of Nursing on 9/28/22 at 9:54 am. She indicated she had spoken to Qualified Nursing Aide (QMA) 24 regarding the tramadol controlled substance record. QMA 24 had reported the 50 milligrams of tramadol had 2 controlled substance records that were being used by the staff to record the 50 milligrams of tramadol given and amounts remaining. She had combined the two substance records into 1 controlled substance record to be utilized and shredded the 2nd record. An Inventory Control of Controlled Substances policy was provided by the Director of Nursing on 9/28/22 at 11:02 a.m. It indicated "...1.2.3 The facility should routinely reconcile the number of dosages remaining in the package to the number of remaining doses recorded on the Controlled Substance Verification/Shift Count Sheet, to the medication administration record. 2. Facility should ensure that facility staff count all Schedule III-V controlled substances in accordance with facility policy and applicable law..." 3.1-25(b)(3)(e)(2)(3)			
F 0756 SS=D Bldg. 00	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. Based on interview and record review, the facility failed to timely act upon a pharmacist's recommendation on the monthly medication regimen review for 1 of 6 residents reviewed for unnecessary medications. (Resident 52) Findings include: The clinical record for Resident 52 was reviewed	F 0756	F756 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? ul="" role="list" Pharmacy recommendation reviewed with MD for resident 52 DNS/Designee to review with	11/04/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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 9/22/22 at 1:41 p.m. Resident 52's diagnoses included, but not limited to, multiple bilateral rib fractures, major depressive disorder, anxiety disorder, and chronic pain. Resident 52's current physician orders included, but not limited to, orders for the following pain medications: - Fentanyl (a narcotic pain medication) patch, 12 mcg/hr (micrograms per hour), transdermal (through the skin), once every 3 days. - Oxycodone (a narcotic pain medication), 5 mg (milligrams), every four hours as needed for moderate pain. A Pharmacy Consultation report dated 8/4/22 and received on 9/23/22 at 12:33 p.m. by DON (Director of Nursing) indicated, Resident 52 routinely received opioid analgesics (pain medication) such as Fentanyl. The recommendation was to initiate senna 8.6 mg 2 tablets once daily at bedtime while to continuing to monitor for signs and symptoms of constipation. The rationale for the recommendations listed was the use of a stimulant laxative was recommended to prevent opioid-related adverse effects such as, constipation and fecal impaction. The physician's response section of the report did not contain the physician's response and was not signed by the physician. An interview with DON conducted on 9/23/22 at 2:06 p.m. indicated, the pharmacy recommendation report had not been addressed by the physician yet related to the physician's response section being left blank and lacking the physician's signature. A Medication Regimen Review and Pharmacy Recommendations policy was received on 9/23/22		pharmacist regarding recommendations and notifying MD. All licensed nurses on pharmacist recommendation procedures. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. Pharmacist's recommendations were DNS/Designee to ensure all recommendations were followed up by the physician. ul="" role="list" DNS/Designee will conduct an in-service with all Licensed nurses on medication regimen review and pharmacy recommendations policy. What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur? DNS/Designee will conduct an in-service with all Licensed nurses on medication regimen review and pharmacy recommendations policy. Pharmacy recommendations will be reviewed by the DNS and the attending physician will be notified of recommendations. p="" paraid="728148442" paraeid="{269451b0-c651-44fa-9006-b73e7a841d66}{196}"> How be monitored to ensure the deficient	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	at 3:36 p.m. from RDCS (Regional Director of Clinical Services) indicated, "Medication Regimen Review...The Consultant Pharmacist recommendations will be reviewed by the Director of Nursing and the Attending Physician will be notified promptly of any recommendations needing immediate attention. Pharmacy recommendations should be reviewed with follow up by the physician within 30 days of the facility receiving. Once reviewed by the Physician the pharmacy recommendations will be filed in the resident's medical record. 3.1-25(i)		practice will not recur, i.e., what quality assurance program will be put into place? POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance p="" paraid="728148442" paraeid="{269451b0-c651-44fa-9006-b73e7a841d66}{196}"> p="" paraid="728148442" paraeid="{269451b0-c651-44fa-9006-b73e7a841d66}{196}">	
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.			
	Based on interview and record review, the facility failed to attempt non- pharmacological interventions prior to initiating an anti-psychotic medication for 1 of 1 resident reviewed for behaviors (Resident 17) Findings include: The clinical record for Resident 17 was reviewed	F 0758	F758 p paraid="1711302402" paraeid="{269451b0-c651-44fa-9006-b73e7a841d66}{232}" >What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	11/04/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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 9/21/22 at 12:06 p.m. The Resident's diagnosis included, but were not limited to, Aphasia (inability to speak) and vascular dementia. An Admission MDS (Minimum Data Set) Assessment, completed 7/1/22, indicated he had short- and long-term memory loss and moderately impaired decision-making skills. He did not refuse care and did not receive anti-psychotic medications. An IDT (Interdisciplinary Team) progress note, dated 8/10/22 at 8:45 a.m., indicated that on 8/9/22 Resident 17's brother had reported to the SSD that Resident 17 believed there is poison in his food and someone at the facility placed it there. The SSD had spoken with Resident 17 who confirmed he believed his food was being poisoned. The root cause of behavioral expressions was awaiting the results of a urinalysis to rule out a urinary tract infection. The preventative interventions related to the above root cause were to obtain labs as ordered and a psychiatric referral. A progress note, dated 8/10/22 at 9:02 a.m., indicated the SSD saw him while he was eating breakfast. He reported the eggs were runny, but everything else tasted fine. He had no concerns of poisoning and had finished most of his breakfast. A Nurse Practitioner's Encounter Summary-Progress note, dated 8/10/22, indicated he was seen for an altered mental status and weight loss. Labs had been obtained and were unremarkable. The staff had reported that he believed there was poison in his food and thus declined to eat. The Social Worker reports that he has lost 8 pounds since his admission to the facility. He will be seen by the psychiatrist.		Resident 17 behavioral care plans reviewed and updated. Behavior tracking initiated. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents with behavioral health concerns have the potential to be affected by the alleged deficient practice. ul class="BulletListStyle1 SCXW79555439 BCX0" role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verdana;" Audit completed of residents on anti-psychotic medications to ensure non-pharmacological interventions are in place. What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur? ED/Designee to attend Monthly Behavior Management Meeting to ensure that behavior management	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	An Initial Psychiatric Evaluation, dated 8/11/22, indicated Resident 17 was not eating due to paranoia and had recent delusions with weight loss. His thought process was confused, and confabulated. His thought content was delusional. A new diagnosis of psychotic disorder with delusions due to his stroke was added and he was started on Zyprexa (anti-psychotic medication). A progress note, dated 8/12/22 at 5:36 p.m., indicated he had refused his evening medication and refused to wake up. The August and September 2022 MAR (Medication Administration Record) indicated he had received Zyprexa 5 mg (milligram) once daily starting on 8/12/22 through 9/25/22, with the exception of 8/15, 8/15, 8/22, 8/30, and 9/18/22, when the medication had not been documented as given. During an interview on 9/27/22 at 4:17 p.m., the SSD and the Corporate Social Services Consultant indicated Resident 17 displayed behaviors such as urinating in inappropriate places. He had delusions that his food was being poisoned. There had been no behavior notes for him other than those charted on 8/9/22 and 8/10/22. They did not see where any non- pharmacological interventions had been tried prior to the Zyprexa being started. There were not care plans for delusional behaviors or for anti-psychotic medication use. On 9/27/22 at 10:02 a.m., the Director of Nursing provided the Psychotropic Management Policy, last revised 7/2022, which read "...2. Prior to initiating a psychotropic medication, an		program and psychotropic management policy is being followed. ul class="BulletListStyle1 SCXW79555439 BCX0" role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verdana;" Regional Social Service Support to in-service Social Service team on Behavior Management Program and psychotropic management policy. How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director ·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance p="" paraid="2088080627" paraeid="{f4c5b444-6653-4b43-9ce	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	assessment by the IDS prescriber will be made of the resident including other potential causes of the behavior: as well as non-pharmacological interventions that have been attempted. Symptoms and therapeutic goals must be clearly documented prior to initiating or increasing a psychotropic medication...4. For antipsychotic medications, diagnosis alone do not necessarily warrant the use [sic] these medications. Antipsychotic medications may be indicated if: a. behavioral symptoms present a danger to the resident or others: b. Expressions or indications of distress that are significant distress to the resident: c. Non-pharmacological approaches have been attempted but did not relieve the symptoms which are presenting a danger or significant distress...." 3.1-48(b)(1)		9-da0d689fefd9}{189}">	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals 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 when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview and record review, the facility failed to ensure medications stored in the medication carts were labeled with the residents' names, dated with open dates, not expired, and discharged residents' medications removed for 1 of 3 medications carts observed. (Resident 56, 68, 75, 174, 175, and 109) Findings include: 1. The clinical record for Resident 56 was reviewed on 9/23/22 at 2:00 p.m. The diagnosis for Resident 56 included, but was not limited to, type 2 diabetes mellitus. The resident was discharged on 9/16/22. 2. The clinical record for Resident 68 was reviewed on 9/23/22 at 2:05 p.m. The diagnosis for Resident 68 included, but was not limited to, cerumen (ear wax). 3. The clinical record for Resident 75 was reviewed on 9/23/22 at 2:15 p.m. The diagnosis for Resident 75 included, but was not limited to, type 2 diabetes mellitus. The resident discharged on 9/12/22. 4. The clinical record for Resident 109 was reviewed on 9/23/22 at 2:30 p.m. The diagnosis for Resident 109 included, but was not limited to, dependence of oxygen.	F 0761	p="" role="heading" aria-level="1" paraid="425624870" paraeid="{877c4606-fc04-4d65-aa96-c1ccce35050d}{86}"> p="" role="heading" aria-level="1" paraid="425624870" paraeid="{877c4606-fc04-4d65-aa96-c1ccce35050d}{86}">F761 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Medication cart was immediately audited and corrected by unit manager All licensed nurses and QMAs educated on medication storage policy ¿ How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? ul="" role="list" All residents have the potential to be affected by the alleged deficient practice DNS/Designee will conduct an with all Licensed nurses and QMAs on medication storage policy What measures will be put into place or what systemic changes make to ensure that the	11/04/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	5. The clinical record for Resident 174 was reviewed on 9/23/22 at 2:35 p.m. The diagnosis for Resident 174 included, but was not limited to, type 2 diabetes mellitus. 6. The clinical record for Resident 175 was reviewed on 9/23/22 at 2:40 p.m. The diagnosis for Resident 175 included, but was not limited to, type 1 diabetes mellitus. An observation was made of the 700 unit medication carts with License Practical Nurse (LPN) 27 and Registered Nurse (RN) 28 on 9/23/22 at 10:11 a.m. The medication cart was observed included, but was not limited to the following medications: 1 used lispro insulin pen - labeled with Resident 75's name, but no open date, 1 used lispro insulin pen - labeled with Resident 175's name, but no open date, 1 used glargine insulin pen - labeled with Resident 175's name with open date of 7/13/22, 1 used glargine insulin pen - labeled with Resident 56's name, but no open date, 1 used humalog 70/30 insulin pen - unlabeled with no name or open date, 1 opened bottle of lantaprost eye drops - labeled with Resident 174's name, but no open date, 1 opened bottle of nasal spray - labeled with Resident 109's name, but no open date, 1 opened bottle debrox ear drops - labeled with Resident 68's name, but no open date. During the observation, interviews were conducted with LPN 27 and RN 28 on 9/23/22 at 10:15 a.m. RN 28 indicated all medications stored in the medication cart should be labeled with residents' names and dated when the medications		deficient practice does not recur? DNS/Designee will conduct an with all Licensed nurses and QMAs on medication storage policy ul="" role="list" A daily rounding tool including medication storage to be utilized by nurse managers to ensure medications are appropriately labeled. How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance ul="" role="list"	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	were opened. All discharge residents' medications should be removed after they discharge. Residents' 56 and 75 had been discharged from the facility approximately a week ago. LPN 27 indicated Resident 175's glargine insulin pen with an open date of 7/13/22, had expired. The insulin was not to be used after 28 days. A Storage and Expiration of Medications policy was provided by the Director of Nursing on 9/23/22 at 3:36 p.m. It indicated "...4. Facility should ensure that medications and biological's that: (1) have an expired date on the label; (2) have been retained longer than recommended by manufacturer or supplier guidelines;...are stored separate from other medications until destroyed or returned to the pharmacy or supplier. 5. Once any medication or biological package is opened. Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the mediation has a shortened expiration date once opened. 5.1 Facility staff may record the calculated expiration date based on date opened on the medication container..." 3.1-25(j)(k)(6)			
F 0919 SS=D Bldg. 00	483.90(g)(2) Resident Call System §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities.	F 0919	p="" role="heading" aria-level="1"	11/04/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	Based on observation and interview, the facility failed to assure a bathroom call light was functional for 2 of 8 residents reviewed for environmental concerns (Resident 30 and 91). Findings include: On 9/20/22 at 2:53 p.m., Residents 30 and 91's room was observed. The call light in the bathroom was not functioning. Resident 91 indicated that the bathroom call light had not been working for at least 3 or 4 days. Maintenance was supposed to fix it but had not done it yet. On 9/26/22 at 2:23 p.m., Residents 30 and 91's room was observed. The call light in the bathroom was not functioning. Resident 30 indicated that it would not work when the string was pulled and that the staff were aware. On 9/27/22 at 2:28 p.m., Residents 30 and 91's room was observed with the Maintenance Supervisor. The Maintenance assistant was present in the bathroom working on the call light. The Maintenance Supervisor indicated he had been informed of the bathroom call light not functioning and had ordered replacement parts, which had arrived 2 days ago. They were fixing the call light. The facility did not provide a policy on functional call lights. 3.1-19(u)(2)		paraid="1459007371" paraeid="{877c4606-fc04-4d65-aa96-c1ccce35050d}{204}">F919 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Bathroom call lights for residents 30 and 91were repaired on 9/27/ How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by alleged deficient practice. ul="" role="list" All -service will be completed by Maintenance Director/Designee regarding reporting any call light concerns and completing work orders. All call lights were checked for functionality in each of the resident and by Director/Designee. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All staff will be completed by Maintenance Director/Designee regarding reporting any call light concerns and completing work orders. Maintenance Director/Designee to audit all call lights to ensure proper functioning. How the corrective action(s) will be monitored to ensure the deficient practice will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
			not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed ul="" role="list" POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. p="" role="heading" aria-level="1" paraid="1459007371" paraeid="{877c4606-fc04-4d65-aa96-c1ccce35050d}{204}"> ul="" role="list"	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: September 20, 21, 22, 23, 26, 27, and 28, 2022 Facility number: 000189 Residential Census: 50 These State Residential Findings are cited in accordance with 410 IAC 16.2-5.	R 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a Recertification and State	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	Quality review completed on October 3, 2022		Licensure survey on September 20, 2022. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
R 0047 Bldg. 00	410 IAC 16.2-5-1.2(r)(14-17) Residents' Rights - Deficiency (14) An intrafacility transfer can be made only if the transfer is necessary for: (A) medical reasons as judged by the attending physician; or (B) the welfare of the resident or other persons. (15) If an intrafacility transfer is required, the resident must be given notice at least two (2) days before relocation, except when: (A) the safety of individuals in the facility would be endangered; (B) the health of individuals in the facility would be endangered; (C) the resident ' s health improves sufficiently to allow a more immediate transfer; or (D) an immediate transfer is required by the resident ' s urgent medical needs. (16) The written notice of an intrafacility transfer must include the following: (A) Reasons for transfer. (B) Effective date of transfer. (C) Location to which the resident is to be transferred. (D) Name, address, and telephone number of the local and state long term care ombudsman.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	(E) For health facility residents with developmental disabilities or who are mentally ill, the mailing address and telephone number of the protection and advocacy services commission. (17) The resident has the right to relocate prior to the expiration of the two (2) days ' notice. Based on interview and record review, the facility failed to ensure a resident/resident representative was given a written notification of an intrafacility transfer at least two days before her relocation nor did the facility ensure a copy of the notice was in the resident's clinical record for 1 of 2 residents reviewed for transfer/discharge rights. (Resident 52) Findings include: The clinical record for Resident 52 was reviewed on 9/28/22 at 10:19 a.m. Resident 52's diagnoses included, but not limited to, cerebral infarction (stroke), dysphagia (difficulty in swallowing), and hypertension. A nursing note dated 7/01/2022 at 12:54 p.m. indicated, Resident 52 was discharged to a skilled nursing facility related to a decline in her physical condition. A Discharge to Other Facility dated 7/1/22 at 11:08 a.m. included, but not limited to, Resident 52's date of transfer was 7/1/22, listed the facility she was transferred to, address of where she was transferred from, length of stay at transferring facility, physician's name at time of transfer and indicated that physician would not be assuming care at the new facility, payment source, date of last bowel movement, reason for transfer, diagnosis at transfer, hearing impairment,	R 0047	R047 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident 52 no longer resides at the facility How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice DNS/Designee will conduct an with licensed nurses on hospital discharge/transfer policy. What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur? DNS/Designee will conduct an in-service with licensed nurses on utilization of discharge form when transferring to other facility. DNS/Designee to review documentation of all residents who are transferred to Other Facility on the following business day. How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into	11/04/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	incontinence status, activity tolerance limitations, potential for rehab, if she had an advanced directive, diet, hospice service, and COVID-19 vaccination status. It did not contain the local and state long term care ombudsman's name, address, and telephone number.		place? POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	
R 0187 Bldg. 00	410 IAC 16.2-5-1.6(k) Physical Plant Standards - Deficiency (k) Hot water temperature for all bathing and hand washing facilities shall be controlled by an automatic control valve. Water temperature at point of use must be maintained between one hundred (100) degrees Fahrenheit and one hundred twenty (120) degrees Fahrenheit. Based on observation, interview, and record review, the facility failed to ensure cognitive impaired residents had safe water temperatures of 120 degrees Fahrenheit or below for 3 of 6 resident's rooms observed during an environmental tour. (Resident's 35, 43 and 50) Findings include: 1. The clinical record for Resident 35 was reviewed on 9/28/22 at 2:45 p.m. The diagnoses for Resident 35 included, but were not limited to, Parkinson's and mild cognitive impairment. The 6/29/22 Brief Interview Mental Status (BIMS) Assessment indicated the resident was moderately cognitively impaired. 2. The clinical record for Resident 50 was reviewed	R 0187	R187 What corrective action(s) will be accomplished for those residents found to have been affected by deficient practice: Water heater mixing valve replaced for cottage 1. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken: Any resident resides on cottage 1 the potential to be affected by the alleged deficient practice. An audit will be completed of water temperatures on cottage 1. All staff will be in-serviced on water temperature guidelines, notification and work orders by	11/04/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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 9/28/22 at 2:47 p.m. The diagnosis for Resident 50 included, but was not limited to, dementia. The 5/26/22 Brief Interview Mental Status (BIMS) Assessment indicated the resident was severely cognitively impaired. 3. The clinical record for Resident 43 was reviewed on 9/28/22 at 2:50 p.m. The diagnosis for Resident 43 included, but was not limited to, vascular dementia. The 5/26/22 Brief Interview Mental Status (BIMS) Assessment indicated the resident was moderately cognitively impaired. On 9/20/22 at 1:45 p.m., the water in 2 random rooms on the long term care dementia unit was observed to be hot to touch. During an interview on 9/20/22 at 2:02 p.m., the ED (Executive Director) indicated the water temperatures should not be over 120 degrees Fahrenheit. An environmental tour was made with the Administrator on 9/28/22 at 2:04 p.m. During the tour, water temperatures were taken in random rooms that were located on the assisted living memory care unit. At that time, Resident 35 was observed in bed. The resident's bathroom sink water temperature was taken by the Administrator and was reading 130 degrees Fahrenheit. Further down the hall, the Administrator had taken Resident 50's bathroom sink water temperature. It was reading 125.8 degrees Fahrenheit. Then, Resident 43's bathroom sink water temperatures were also taken by the Administrator. It was reading 125.0 degrees Fahrenheit. The Administrator indicated at that time, he would		Maintenance Director or Designee. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur: All staff will be in-serviced on water temperature guidelines, notification and work orders by Maintenance Director or Designee. Maintenance Director/Designee will check water temperatures weekly to ensure water temperatures are between 100-120 How will the corrective action(s) be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place: POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	notify the Maintenance Supervisor (MS) to turn off the water and work to get the water temperatures down. "They are too hot." An interview was conducted with Qualified Medication Aide (QMA) 17 on 9/28/22 at 2:25 p.m. She indicated Resident 50 and 43 are ambulatory and Resident 43 uses the bathroom in her room. An interview was conducted with the MS on 9/28/22 at 3:20 p.m. He indicated he does weekly inspections of the water temperatures in the building. The temperatures are normally running between 116-118 degrees Fahrenheit. He checked the water temperatures on 9/23/22, in random rooms through out the facility. The water temperatures were fine. He would provide the temperature logs the last time Resident's 50, 43, and 35's rooms were checked. The temperature log dated 9/9/22 was provided by the ED on 9/28/22 at 3:59 p.m. The log did not indicate Resident 35, 43, 50's water temperatures in their rooms were checked on 9/8/22. An interview was conducted with the ED on 9/28/22 at 3:41 p.m. She indicated the water temperature policy was utilized for long term care and assisted living. On 9/20/22 at 3:20 p.m., the MS provided the Test Water Temperatures procedure which read "...1. Ensure patient room water temperatures are between 105 and 115 Fahrenheit (or as specified by state requirements) ...Indiana- 100 to 120.... Test temperature in shower areas...test temperatures at the mixing valve...Check resident rooms at the end of each wing on a rotating basis...Record results in the water temperature log			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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. note any discrepancies 2. Adjust water heater settings as required 3. Retest as necessary..."			
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on interview and record review, the facility failed to properly prevent and/or contain COVID-19 by not ensuring staff members were screened prior to entry to the facility for symptoms, test results, and exposure to COVID-19. This had the potential to effect 50 of 50 residents who reside in the Assisted Living facility. Findings include: The Assisted Living staffing schedule for 9/28/22 was received on 9/22/22 at 2:25 p.m. from ED (Executive Director). A copy of the facility's screening sheets for 9/28/22 were received from DON (Director of Nursing) on 9/28/22 at 1:21 p.m. The staffing schedule and screening sheets were cross referenced and found that two staff members working on the the Assisted Living had	R 0407	R407 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? This deficient practice is no longer in effect as we utilize the passive screening policy. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? DNS/Designee will conduct an in-service with all staff regarding updated covid 19 policy and procedures along with passive screening policy. What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur? DNS/Designee will conduct an in-service with all staff to review up to date covid 19 policy and	11/04/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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
	not completed their screening prior to entry to the facility. The two staff members were CNA (Certified Nursing Assistant) 2 and CNA 3. An interview with CNA 3 was conducted on 9/28/22 at 1:04 p.m. CNA 3 indicated, she thought she had screened upon entrance, but agreed the screening sheets did not contain her screening that morning. She indicated, she must have forgot complete the screening. An interview with CNA 2 was conducted on 9/28/22 at 1:16 p.m. CNA 2 indicated, she did not complete the screening that morning because she was running late. The Implementing Prevention Measures for COVID-19 policy was received on 9/28/22 at 2:45 p.m. from ED. The policy indicated, "Screening Screen all persons who enter the facility; (e.g. visitors, vendors and HCP [sic, Healthcare professionals] for signs and symptoms of COVID-19 (e.g. questions about and observations of signs or symptoms) and deny entry to those with COVID-19 diagnosis, signs or symptoms, or those who have close contact with someone with COVID-19 infection in the prior 10 days...The IP[sic, Infection Preventionist] shall ensure the screening processes are in place at all times."		procedures along with passive screening policy.How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	