STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
INDEPENDENCE VILLAGE OF ZIONSVILLE EAST	11755 N MICHIGAN RD ZIONSVILLE, IN 46077

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R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00408170, IN00414011, IN00415294, and IN00418114. Complaint IN00408170 - No deficiencies related to the allegations are cited. Complaint IN00414011 - No deficiencies related to the allegations are cited. Complaint IN00415294 - No deficiencies related to the allegations are cited. Complaint IN00418114 - State deficiencies related to the allegations are cited at R0052, R0090, R0117, and R0214. Survey dates: October 3, 4, and 5, 2023 Facility number: 012263 Residential Census: 76 These state residential findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on October 12, 2023.	R 0000		
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion.			

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

Bradley Miller | Executive Director | 11/07/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Based on observation, interview, and record review, the facility failed to assess, document, and conduct thorough investigations of resident to resident abuse allegations for 4 of 5 residents reviewed for abuse (Residents C, D, J, F, and K). Findings include, 1. An Indiana State Department of Health Survey Report System report, dated 9/25/23 at 6:21 a.m., indicated on 9/24/23 at 9:01 p.m., Resident C was in his room and Resident D went into Resident C's room and started yelling and striking Resident C. Staff could not get Resident D to leave the room and police were called. Residents were separated, no injuries noted. Staff will be retrained on deescalating situations. An Indiana State Department of Health Survey Report System 5 - day follow-up report, dated 10/3/23, indicated no injuries reported or seen. Resident D was not the aggressor (he was not involved in the incident). Resident J had gone into Resident C's room and started hitting him. Resident J was sent to the emergency room (ER) and had been moved out by his wife. Resident D was recovering from the incident, and the care plan continued. On 10/4/23 at 2:30 p.m., Resident C was observed in the main lounge of the secured memory care unit sitting in his wheelchair (wc) among peers watching television (TV). The resident was relaxed, calm, and quiet. Certified Nursing Assistant (CNA) 7 indicated, Resident C could stand and pivot to transfer with assistance, and once in a wc "was on the move" everywhere. Resident could get combative during care if he did not understand what was expected of him and	R 0052	**R052 Residents right -offense** ***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** ***1)Immediate actions taken for those residents identified:*** Resident C, D, F and K reside in the building and their orders and service plans have been reviewed and updated. Resident J has moved out and has not been back to community since the incident. ***2)How the facility identified other residents:*** Any resident residing in the facility had the potential to be affected. Audit completed on all residents with new behaviors to ensure that service plan has been updated. **3)Measures put into place/ System changes:** Inservice and education provided to all staff on abuse, residents rights, dignity, identifying new behaviors, and report to DON/ED immediately for any pertinent events. Newly adapted system for proper	11/17/2023

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	staff kept repeating themselves, but otherwise had no behaviors. On 10/4/23 at 3:35 p.m., Resident C was observed in the main lounge of the secured memory care unit sitting in his wc among peers watching TV. His right arm and hand were observed to have a 3 inch (in) by (x) 3 in padded dressing on top of his right wrist, back of hand, down onto forefinger, with dark discoloration observed on hand and thumb around the dressing. Another 3 in x 3 in padded dressing was observed on top of the upper right forearm near the bend of his arm, scabbed skin observed around the dressing. Neither dressing was dated or initialed with information of when or who had placed the dressing. 1a. Resident C's record was reviewed on 10/4/23 at 11:34 a.m. Diagnoses on Resident C's profile included, but were not limited to, left sided hemiplegia or hemiplegia (paralysis) following a cerebral infarction (stroke), dementia without behavioral disturbance, and need for assistance with personal care. A progress notes for Resident C, dated 9/25/23 at 12:44 a.m., resident returned from the emergency room with no new orders noted. A progress notes for Resident C, dated 9/28/23 at 4:22 p.m., indicated resident seen by a home health agency for skin tears to right arm, with dressing to right arm skin tears changed. The nurse practitioner (NP) was to send orders for home health services. Hospital discharge instructions, dated 9/24/23 at 11:31 p.m., indicated primary diagnosis skin tear of right forearm without complication. Additional		documentation has been developed with the Nurse On Call team that supports our community. For all incidents that need a nurse to assess, our QMAs will call the Nurse On Call line and will video/telehealth to the nurse's on call to assess and instruct. Documentation of the root cause of incident, who was notified, resident assessed for injuries, new orders received will be updated by Nurse On Call outside normal business hours and will be documented by Administrative Nurse and/or Wellness Director(WD)/DON during normal business hours. All Fall/Incident follow up will be executed and documented by Admin Nurse or WD. **4)How the corrective actions will be monitored:** The Wellness Director will review 24 hour incident report every morning and follow up with Administrative Nurse regarding falls/incidents and new orders. Documentation reviews will be completed bi-weekly by WD. **5) Date of compliance:** 11/17/2023	

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	instructions: the steri-strip bandages applied on the wound should be left on until they fall off (typically 1-2 weeks). These may get briefly wet with bathing but should not be soaked for any period of time. You do not need to apply any type of ointment or medication to these wounds. If any dressing is placed over the wound, it should be a non-adherent material that will not stick to the bandages. I recommend leaving the current bandage on for a few days. A Medication Administration Record (MAR) for Resident C, dated September 2023, indicated no documentation the resident had been treated for wounds to his right arm and hand. Qualified Medication Aide (QMA) 8 indicated there were no physician's orders to treat the skin tears on Resident C's right arm and hand, and she was not sure who was monitoring or treating his wounds or changing his dressings, but he did go out at times. The resident record lacked documentation for Resident C to include, but not limited to, a. The resident was involved in a resident to resident altercation on 9/24/23. b. The physician, resident representative, Executive Director (ED), and Wellness Director were notified of the incident. c. The resident was assessed for injuries to include vital signs. d. The resident was monitored after the incident for psychosocial harm. e. The resident had large skin tears and bruising to his left arm and hand sustained from another resident, or a description of the wounds. f. Orders were obtained to the send the resident to the ER for evaluation, and reason for order. g. An ER report with details to include time of arrival, reason for ER visit, treatment provided			

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	while in the ER, and discharge orders. h. Timely physician's orders to utilize home health care services for wound management. i. Physician's orders for wound care to the right arm and hand. j. Nursing follow up of resident to resident altercation to include wound healing, root cause of altercation, and measures to prevent future altercations. j. The service plan was not updated. A Brief Cognitive Rating Scale (BCRS) score of 7 indicated very severe cognitive decline. An Interim Wellness Evaluation, dated 9/9/23, indicated Resident C could not transfer independently, and required 1 caregiver assistance for transfers. Overall skin condition normal. The resident was not independent with cognitive and psychosocial function. A care plan for Resident C, dated 8/9/23, indicated he had behaviors. The goal was for the resident to not act out in a way that was harmful to self or others. The intervention was for monitor/check and report changes from baseline behaviors to the nurse. 1b. Resident J's record was reviewed on 10/4/23 at 11:09 a.m. Resident J was admitted to the facility on 9/18/23 with diagnoses to include, but were not limited to, Alzheimer's disease, and mild dementia with behavioral disturbances. A Brief Cognitive Rating Scale (BCRS) score of 7 indicated very severe cognitive decline. An Interim Wellness Evaluation - pre move-in, dated 9/15/23, indicated Resident J was independent with transfers and ambulation, he did			

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	not use assistive devices. The resident did not need escort within the facility to meals, activities, internal events, or programming. Resident J was not independent with cognitive and psychosocial function. No demonstration of behaviors. A progress notes, dated 9/20/23 at 3:24 a.m., indicated Resident J entered another resident's room and refused to leave. He was being uncooperative with staff, yelling at staff, combative physically and verbally. Resident J had no prn (as needed) interventions. Staff were unable to redirect Resident J at this time, so were advised to remove the resident assigned to room for safety and allow Resident J to exit room on his own accord for redirection. Will continue to monitor. The resident record lacked documentation for Resident J to include, but not limited to, a. The resident was involved in a resident to resident altercation on 9/24/23, and root cause of the incident. b. The physician, resident representative, ED, and Wellness Director were notified of the incident. c. The resident was assessed for injuries to include vital signs. d. Orders were obtained to the send the resident to the ER for evaluation, and reason for order. e. The resident did not return to the facility from the ER, and disposition. A care plan for Resident J, dated 9/18/23, indicated he had behaviors. The goal was for the resident to not act out in a way that was harmful to self or others. The intervention was for orientation: resident wandered aimlessly or in undirected fashion without definable or obtainable purpose, i.e., looking for visitors who were not coming, or relatives who may be			

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	deceased. Not a disturbance to others. A Nurse Triage Phone Call Template, dated 9/24/23 at 8:55 p.m., indicated the triage nurse LPN 15 had been notified by QMA 16 of a resident to resident altercation between Residents C and J. The QMA was informed to call the Wellness Nurse. A Nurse Triage Phone Call Template, dated 9/25/23 at 12:39 a.m., indicated the triage nurse LPN 15 had been notified by QMA 12 that Resident C returned from the ER with no new orders noted. LPN 15 indicated, documentation in the electronic medical record of resident return with no new orders noted. During an interview on 10/4/23 at 12:42 p.m., Resident J's spouse indicated, he had been admitted to the facility from home for a respite stay as the spouse needed a rest. The resident could not do for himself, he had a long history of pacing and was constantly on the move, and he had been physically aggressive with her such as pushing her when he was redirected. Resident J had been placed on medications in the past for treatment of behaviors such as inappropriate laughter, but she felt the medications made his sick and discontinued them. The resident had run off from home several times both day and during the night, but with the help of neighbors, the fire department, and an ankle bracelet, he was always found. Spouse indicated after admission to the facility the resident paced up and down the halls daily, and even when she visited he would not sit for more than 5 minutes at a time. On 10/20/23, two (2) days after his admission, the spouse was told Resident J had been found sleeping in a female resident's bed and scared the lady and she ran into the bathroom and locked her door until staff			

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	came, but she doubted the story. In her opinion, the facility did not have enough staff monitoring the resident. On 9/24/23, the day of discharge, the spouse was called and told Resident J had gone into a male resident's room and beaten him up. She did not doubt he hit someone but doubted the "beat up" story. Resident J's spouse indicated, she was told Resident C had been hit in the face and had scratches on his face. Upon arrival to the facility, the spouse observed 2 ambulances, cop cars and the fire department. Resident J was currently in a geriatric psych ward, a recommendation from the hospital. During an interview on 10/4/23 at 2:46 p.m., QMA 8 indicated, she had been in charge of the secured memory care unit the night of the altercation between Resident C and Resident J. She was not sure where the information came from that Resident D had been in Resident C's room, but that information was inaccurate. QMA 8 indicated, Resident J had not been going into his assigned room since admission, and was observed to walk continuously, and go in and out of other residents' rooms. Resident J lived across the hallway from Resident C. On 9/24/23 around 10:00 p.m. while an aide was doing rounds, the aide could hear Resident C repeatedly yelling for help. There had been 2 aides working on the unit, one went to Resident C's room and the other went to find QMA 8. When all 3 staff members entered Resident C's room, Resident J was observed to be half naked with just underwear on, was trying to get Resident C out of the bed and was yelling it was his room. Resident J was observed to be kicking Resident C and pulling on his right arm and hand which resulted in a large skin tear on his forearm. QMA 8 indicated she could not remember Resident J hitting Resident C, or if Resident C had scratches on his face. Staff were			

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	unable to get Resident J to leave Resident C's room as he was hitting and kicking staff and throwing things in the room, so police were called, and they came. Both residents had been sent to ER for evaluation and treatment. Resident C later returned to the facility, but Resident J never came back. A few days before the altercation on 9/24/23, Resident J had been in a female resident's room while she was in the activity room. When she returned to her room and found Resident J in her bed she was upset. During an interview on 10/4/23 at 2:46 p.m., QMA 8 indicated, when incidents such as the resident to resident altercation happened, it was her responsibility to call the Wellness Director, lead QMA or triage nurse, and they were responsible for documenting situations and vital signs, and letting staff know when to complete follow up documentation. QMA 8 indicated, she was not responsible for documenting the incident between Resident C and Resident J, she called the Wellness Director and the night QMA documented the altercation had happened. During an interview on 10/5/23 at 10:33 a.m., QMA 10 indicated she called the triage nurse for any incident or if a resident became ill, gave the triage nurse vital signs, and the triage nurse took it from there. The triage nurses worked from home. Triage nurse notes were being documented on the word of a staff member on site, not because the triage nurse assessed the resident. There was supposed to be a triage binder in the nurse's station for the QMA to document vital signs. 2. An Indiana State Department of Health Survey Report System report, dated 7/24/23, indicated, the ED was informed on 6/16/23 at 10:01 a.m., Resident K yelled at and physically shook Resident F at the			

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	dining room table during breakfast. Resident K stated she was irritated by the whistling sound Resident F as making. Resident K was offered to sit at another table, and she refused. Immediate action taken: Resident K went out to smoke. Preventative action taken: Resident K reminded she could not yell or touch other residents. 2a. Resident K's record was reviewed on 10/5/23 at 2:45 p.m. Diagnoses on Resident K's profile included, but were not limited to, mild cognitive impairment and anxiety. A progress notes, dated 6/16/23 at 9:53 a.m., indicated Resident K went up to Resident F, got into her face and yelled "shut up", while banging her hand on the table and then physically shook her. The ED, administrative nurse, and family were notified of the incident. A progress notes, dated 6/16/23 at 10:33 a.m., indicated it was reported to the writer Resident K yelled and physically shook another resident at the dining table during breakfast. Resident K stated she was irritated by the whistling sound the other resident was making. Resident was offered to sit at another table, resident refused. Resident educated to not yell and put hands on other residents. Resident voiced understanding. Power of Attorney (POA) and ED notified. Will continue to observe resident on her behaviors. The resident record lacked documentation for Resident K to include, but not limited to, a. The resident was assessed for injuries to include vital signs. b. The physician was notified of the incident. d. The resident was monitored after the incident for psychosocial harm. d. The service plan was not updated.			

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	An Interim Wellness Evaluation, dated 6/6/23, indicated, Resident K was independent with transfers, ambulated without a mobility device, and was independent with dining. She did not need an escort within the facility to meals, activities, internal events, and programming. Resident K was independent with cognitive and psychosocial function, and demonstrated anxious, disruptive, or obsessive behavior requiring additional attention (easily redirected). A care plan for Resident K, dated 4/6/23, indicated she had behaviors. The goal was for staff to be able to identify factors that helped to prevent and/or minimize inappropriate behaviors. The intervention indicated, monitor and check the resident, and report changes from baseline behaviors to the nurse. 2b. Resident F's record was reviewed on 10/5/23 at 2:25 p.m. Diagnoses on Resident F's profiled included, but were not limited to, dementia without behavioral disturbance. A progress notes, dated 6/16/23 at 9:59 a.m., Resident F was in the dining room at breakfast whistling, and Resident K got upset about her whistling. Resident K got into Resident F's face and told her to shut up while banging on the table, and the proceeded to physically shake her. The ED, administrative nurse, and POA's for both residents were notified. A progress notes, dated 6/16/23 at 10:47 a.m., indicated it was reported to the writer that Resident F was whistling at the dining table that morning at breakfast and Resident K was annoyed by the whistling sound. Resident K yelled and shook Resident F. When the writer approached			

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	Resident F she continued to whistle. The resident denies pain and no distress was noted. Resident F was taken to her room. The daughter and ED were made aware. The resident record lacked documentation for Resident F to include, but not limited to, a. The resident was assessed for injuries to include vital signs. b. The physician was notified of the incident. d. The resident was monitored after the incident for psychosocial harm. d. The service plan was not updated. An Interim Wellness Evaluation, dated 4/19/23, indicated, Resident F required assistance for transfers, was not independent with ambulation, used a wheelchair, and needed an escort within the facility to meals, activities, internal events, and programming. The resident was independent with dining. Resident F was not independent with cognitive and psychosocial function, and she did not demonstrate being anxious, disruptive, or obsessive behavior requiring additional attention. A care plan for Resident F, dated 8/10/23, indicated the resident had behaviors. The care plan lacked documentation of a goal. The intervention indicated, report changes from baseline behaviors to the nurse. During an interview on 10/5/23 at 3:19 p.m., the Wellness Director indicated, after the resident to resident altercation between Resident C and Resident J, she had written out a timeline of events, but the information had not been documented in either resident's chart, and the information was not available in their medical records. Her understanding was that when there was no nurse in the facility, there was a 24/7 nurse			

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	triage line, and that nurse was responsible for assessing and documenting the situation. The administrative charge nurse LPN 9 had been on call 9/24/23 and it had been her responsibility to document the altercation between Residents C and J, document when Resident C returned from the ER, and process new orders from the hospital discharge summary. The psych nurse was responsible for psychosocial documentation, and the Wellness Nurse was responsible for updating service/care plans. Orders for Resident C to be seen by home health services for wound care were not found in the resident record. The Wellness Nurse acknowledged the appropriate documentation was not in the resident's chart. The Wellness Nurse indicated, it was her responsibility to assure residents were assessed, documentation was completed, and treatment was rendered as needed. On 10/5/23 at 6:00 p.m., the Wellness Director provided an Abuse, Neglect, or Exploitation policy, last reviewed 6/7/23, and indicated the policy was the one currently being used by the facility. The policy indicated, "Abuse, neglect, or exploitation of any resident will not be tolerated. All allegations, suspicions, and incidents of abuse, neglect, or exploitation will be promptly investigated ...Initial Response: 1. Protect the resident ...a. If the resident is injured, immediate action should be taken to treat the resident ...A supervisor should perform an initial check on the resident ...c. The resident's responsible party will be notified of the incident, and the resident's attending physician ...Employees are to immediately report any witnessed or suspected incidents of abuse, neglect, or exploitation to the supervisor on duty and the Wellness Director or designee. For the purposes of this policy, immediately means as soon as possible, but will			

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		A. BUILDING 00 B. WING	10/06/2023

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	not exceed twenty-four [24] hours after the incident or discovery of injury ...Documentation in the resident's chart should include results of resident's ROM [range of motion], results of the body check, vital signs, notification of the physician and the responsible party, treatment provided ... An investigation of the allegation or suspicion will be completed timely but not later than 14 days after the incident...Interview the resident, the accused, the witnesses ...Obtain written statements from the resident, if possible, the accused, and each witness ... After completion of the investigation, the community will analyze the information gathered and determine whether the allegation or suspicion is substantiated ...Results of the investigation will be reported to the appropriate licensing agencies, other officials, and registries in accordance with the law and as outlined in the state specific Resident Incident/Accident Reporting policy ..." This State tag relates to Complaint IN00418114.			
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks;			

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	(B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request			
	Based on interview and record review, the facility failed to investigate, and timely and accurately report resident to resident abuse within 2 hours, and follow up within 5 days, for 4 of 5 residents reviewed for abuse (Residents C ,D, J, F, and K). Findings include,	R 0090	**R090- Administration and Management** ***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of***	11/17/2023

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	1. An Indiana State Department of Health Survey Report System report, dated 9/25/23 at 6:21 a.m., indicated on 9/24/23 at 9:01 p.m., Resident C was in his room and Resident D went into Resident C's room and started yelling and striking Resident C. Staff could not get Resident D to leave the room and police were called. Residents were separated, no injuries noted. Staff will be retrained on deescalating situations. An Indiana State Department of Health Survey Report System 5 - day follow-up report, dated 10/3/23, indicated no injuries reported or seen. Resident D was not the aggressor (he was not involved in the incident). Resident J had gone into Resident C's room and started hitting him. Resident J was sent to the emergency room (ER) and had been moved out by his wife. Resident D was recovering from the incident, and the care plan continued. The state reportable incident reports failed to document Resident C as having been sent to the emergency room for treatment related wounds resulting from being attacked by Resident J, and the 5 day follow up report was submitted late. 2. An Indiana State Department of Health Survey Report System report, dated 7/24/23, indicated, the ED was informed on 6/16/23 at 10:01 a.m., Resident K yelled at and physically shook Resident F at the dining room table during breakfast. Resident K stated she was irritated by the whistling sound Resident F as making. Resident K was offered to sit at another table, and she refused. Immediate action taken: Resident K went out to smoke. Preventative action taken: Resident K reminded she could not yell or touch other residents.		***this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** ***1)Immediate actions taken for those residents identified:*** Resident C, D, F and K reside in the building and their orders and service plans have been reviewed and updated. Resident J has moved out and has not been back to community since the incident. ***2)How the facility identified other residents:*** Any resident residing in the facility had the potential to be affected. Audit completed on all residents with new behaviors to ensure that service plan has been updated. **3)Measures put into place/ System changes:** Inservice and education provided to all staff on abuse, residents rights, dignity, identifying new behaviors, and report to DON/ED immediately for any pertinent events. Newly adapted system for proper documentation has been developed with the Nurse on Call team that supports our community. For all incidents that need a nurse to assess, our QMAs will call the Nurse on Call	

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	The state reportable incident report and 5-day follow up report were submitted in excess of 5 weeks late. A Wellness Meeting sign-in log, dated 9/20/23, indicated documentation staff had received education related to abuse, neglect, exploitation, and resident rights. No documentation provided during the survey related to staff re-education on deescalating situations per information on the state reportable incident form. Follow up investigation documentation to include resident assessment for injury, notification to responsible parties including the resident representative and physician, investigation conclusion with root cause and preventative measures, and witness statements were not provided during the survey. During a phone interview with the Executive Director (ED) on 10/6/23 at 2:25 p.m., he indicated the resident to resident abuse between Residents C and J happened on a Sunday right before he was leaving on vacation the next morning. He reported the information on Monday morning at 5:30 a.m. to the state by information given to him by voicemail and text before leaving, the Wellness Nurse then did the follow up while he was gone. An on-call triage nurse Licensed Practical Nurse (LPN 15 took the call about the incident. The ED indicated, the facility was staffed with Qualified Medication Aides (QMA's) around the clock, so there were about 6 triage nurses routinely on call, most were from Indiana and 1 from Ohio. He had just found out the triage nurses were not going to be responsible for taking abuse information and documenting. Education on deescalating		line and will video/telehealth to the nurses on call to assess and instruct. Documentation of the root cause of incident, who was notified, resident assessed for injuries, new orders received will be updated by Nurse on Call outside normal business hours and will be documented by Administrative Nurse and/or Wellness Director (WD)/DON during normal business hours. All Fall/Incident follow up will be executed and documented by Admin Nurse or WD. The Executive Director will report to the division, all resident-to-resident abuse within 2 hours of incident via Access Indiana or paper form if site is down. The Executive Director will review input documentation from EMAR system to report information as accurately as received. Investigation will be conducted by the Executive Director or Wellness Director/Designee if Executive Director is on vacation or indisposed. Follow up to the division will be entered within 5 days of initial report. **4)How the corrective actions will be monitored:** The Executive Director **5) Date of compliance:** 11/17/2023	

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	residents had not been done yet, scheduled for next week. Indicated it was his responsibility to timely report incidents including abuse to the appropriate entities and to assure the information was correct. Long-Term Care Abuse and Incident Reporting Policy, effective 12/8/22, indicated, "Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish ...Physical abuse includes, but not limited to, hitting, slapping, punching, biting, and kicking ....1. State Rules ...(g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident...Staff treatment of residents ...(c) The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property, are reported immediately to the administrator of the facility and other officials in accordance with state law through established procedures, including to the state survey and certification agency. (d) The facility must have evidence that all alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in progress. (e) The results of the investigation must be reported to the administrator or the administrator's designated representative and to other officials in accordance with state law ...within five (5) working days of the incident ..." Cross Reference R0052.			

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	This State tag relates to Complaint IN00418114.			
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review, the facility failed to ensure a resident received appropriate assessment and follow up after resident to resident abuse with injuries for 1 of 5 residents reviewed for abuse (Residents C and J). Findings include: During an interview on 10/4/23 at 2:46 p.m., QMA 8 indicated, she had been in charge of the secured	R 0117	**R117 Personnel** ***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or***	11/17/2023

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	memory care unit the night of the incident between Resident C and Resident J. She was not sure where the information came from that Resident D had been in Resident C's room, but that information was inaccurate. QMA 8 indicated, Resident J had not been going into his assigned room since admission, and was observed to walk continuously, and go in and out of other residents' rooms. Resident J lived across the hallway from Resident C. On 9/24/23 around 10:00 p.m. while an aide was doing rounds, the aide could hear Resident C repeatedly yelling for help. There had been 2 aides working on the unit, one went to Resident C's room and the other went to find QMA 8. When all 3 staff members entered Resident C's room, Resident J was observed to be half naked with just underwear on, was trying to get Resident C out of the bed and was yelling it was his room. Resident J was observed to be kicking Resident C and pulling on his right arm and hand which resulted in a large skin tear on his forearm. QMA 8 indicated she could not remember Resident J hitting Resident C, or if Resident C had scratches on his face. Staff were unable to get Resident J to leave Resident C's room as he was hitting and kicking staff and throwing things in the room, so police were called, and they came. Both residents had been sent to ER for evaluation and treatment. Resident C later returned to the facility, but Resident J never came back. A few days before the altercation on 9/24/23, Resident J had been in a female resident's room while she was in the activity room. When she returned to her room and found Resident J in her bed she was upset. On 10/4/23 at 3:35 p.m., Resident C was observed in the main lounge of the secured memory care unit sitting in his wc among peers watching TV. His right arm and hand were observed to have a 3		***conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** ***1)Immediate actions taken for those residents identified:*** Resident C, D, F and K reside in the building and their orders and service plans have been reviewed and updated. Resident J has moved out and has not been back to community since the incident. ***2)How the facility identified other residents:*** Any resident residing in the facility had the potential to be affected. Audit completed on all residents with new behaviors to ensure that service plan has been updated. **3)Measures put into place/ System changes:** Inservice and education provided to all staff on abuse, residents rights, dignity, identifying new behaviors, and report to DON/ED immediately for any pertinent events. Newly adapted system for proper documentation has been developed with the Nurse On Call team that supports our community. For all incidents that need a nurse to assess, our QMAs will call the Nurse On Call line and will video/telehealth to the nurse's on call to assess and instruct. Documentation of the root cause	

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	inch (in) by (x) 3 in padded dressing on top of his right wrist, back of hand, down onto forefinger, with dark discoloration observed on hand and thumb around the dressing. Another 3 in x 3 in padded dressing was observed on top of the upper right forearm near the bend of his arm, scabbed skin observed around the dressing. Neither dressing was dated or initialed with information of when or who had placed the dressing. Resident C's record was reviewed on 10/4/23 at 11:34 a.m. Diagnoses on Resident C's profile included, but were not limited to, left sided hemiplegia or hemiplegia (paralysis) following a cerebral infarction (stroke), dementia without behavioral disturbance, and need for assistance with personal care. A progress notes for Resident C, dated 9/25/23 at 12:44 a.m., resident returned from the emergency room with no new orders noted. A progress notes for Resident C, dated 9/28/23 at 4:22 p.m., indicated resident seen by a home health agency for skin tears to right arm, with dressing to right arm skin tears changed. The nurse practitioner (NP) was to send orders for home health services. Hospital discharge instructions, dated 9/24/23 at 11:31 p.m., indicated primary diagnosis skin tear of right forearm without complication. "Additional instructions: the steri-strip bandages applied on the wound should be left on until they fall off (typically 1-2 weeks). These may get briefly wet with bathing but should not be soaked for any period of time. You do not need to apply any type of ointment or medication to these wounds. If any dressing is placed over the wound, it should be a		of incident, who was notified, resident assessed for injuries, new orders received will be updated by Nurse On Call outside normal business hours and will be documented by Administrative Nurse and/or Wellness Director(WD)/DON during normal business hours. All Fall/Incident follow up will be executed and documented by Admin Nurse or WD. **4)How the corrective actions will be monitored:** The Wellness Director will review 24 hour incident report every morning and follow up with Administrative Nurse regarding falls/incidents and new orders. Documentation reviews will be completed bi-weekly by WD. **5) Date of compliance:** 11/17/2023	

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	non-adherent material that will not stick to the bandages. I recommend leaving the current bandage on for a few days." A Medication Administration Record (MAR) for Resident C, dated September 2023, indicated no documentation the resident had been treated for wounds to his right arm and hand. Qualified Medication Aide (QMA) 8 indicated there were no physicians' orders to treat the skin tears on Resident C's right arm and hand, and she was not sure who was monitoring or treating his wounds or changing his dressings, but he did go out at times. The resident record lacked documentation for Resident C to include, but not limited to, a. The resident was involved in a resident to resident abuse on 9/24/23. b. The resident was assessed for injuries to include vital signs. c. The resident had large skin tears and bruising to his left arm and hand sustained from another resident, or a description of the wounds. f. Orders were obtained to the send the resident to the ER for evaluation, and reason for order. g. An ER report with details to include time of arrival, reason for ER visit, treatment provided while in the ER, and discharge orders. h. Timely physician's orders to utilize home health care services for wound management. i. Physician's orders for wound care to the right arm and hand. j. Nursing follow up of resident to resident abuse to include wound healing. j. The service plan was not updated. During an interview on 10/5/23 at 11:42 a.m., with Licensed Practical Nurse (LPN) 9 indicated, Resident C's chart lacked documentation from the			

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	ER physician regarding arrival to ER, assessment upon arrival to ER, or diagnoses/reasoning for visit. During an interview on 10/5/23 at 10:52 a.m., Licensed Practical Nurse (LPN) 9 indicated upon review of Resident C's medical record, there was no documentation regarding resident to resident abuse on 9/24/23, the resident had been sent to the emergency room (ER), the resident returned to the facility, or that Resident C had injuries. LPN 9 indicated a triage nurse had been notified of the incident, and she was supposed to have documented in the electronic medical record (EMR). LPN 9 indicated she had observed Resident C to have wounds the morning after the incident and had dressed his wounds, and then called home health for orders regarding the wounds. The Nurse Practitioner (NP) had seen Resident C on 9/28/23 and given orders to have home health care for the new injuries. The home health agency has seen the resident for prior skin tears, so no paperwork was needed to have the resident seen. On 10/5/23 at 11:42 a.m., LPN 9 provided a handwritten note written on a legal pad, without a header to indicated name of company being represented, with illegible signatures, and indicated these were notes from a home health nurse alleged to be caring for Resident C's arm wounds. Documentation included, a. "9/29 new skin tears - right arm proximal and distal. Wound care performed. I'll come 2 x/week [2 times per week]." b. "10/2/23 wound care performed to right arm and right hand skin tears. 100% granulation tissue [red, bumpy tissue in the wound bed as the wound heals] present. Orders: clean with wound cleaner. Apply Medihoney [used to treat acute			

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	and chronic wounds] then xeroform [non-adherent dressing for wounds with low drainage] then foam dressing 2 x/week." c. "10/5/23 wounds are epithelized today. Discontinue wound care-areas open to air. NP [nurse practitioner] notified. (?) will come once a week next week to re-check, then discipline dc [discontinue]. PT to continue." An initial encounter report, dated 10/3/23, indicated resident being admitted to (agency name) to establish services. Home health referral made on 9/29/23 related to wound care to right arm. Resident record lacked documentation wound care was provided to the resident's arm from 9/24 when seen in the ER until 9/29 when a home health referral was made, or official home health documentation of wound care until 10/3/23 when the resident's home health services were established. On 5/23 at 3:19 p.m., the Wellness Nurse provided a When to Call the Triage Line document, undated, and indicated the document was the current guideline used by the facility. The document indicated, "When to call the triage line ...if it is determined by the triage nurse that a resident to be sent out to the hospital the triage line nurse will contact the family member and Wellness Nurse to advise. When to call the Wellness Nurse ...resident exhibiting combative or high-risk behaviors and not able to be redirected or reapproached ...resident to resident altercation or incident ..." On 5/23 at 3:19 p.m., the Wellness Nurse provided an Assisted Living Lead QMA document, undated, and indicated the document was the			

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	current guideline used by the facility. The document indicated, "Call nurse triage line for all incidents on AL [assisted living] or MC [memory care], such as falls injuries, altercations ..." The document indicated the phone numbers of the nurse triage line and the Wellness Director. A Qualified Medication Aide (QMA) Job Description, undated, indicated, "QMA will perform medication and treatment administrations according to MAR/TAR [medication administration record/treatment administration record], assist residents with person care needs under the supervision of a licensed nurse, and supervise Certified Nurse Aide staff as required ...Key Responsibilities ...perform treatments within the scope of practice .... observe, record, and report observations ...." During an interview on 10/4/23 at 2:46 p.m., QMA 8 indicated, when incidents such as the resident to resident abuse happened, it was her responsibility to call the Wellness Director, lead QMA or triage nurse, and they were responsible for documenting situations and vital signs, and letting staff know when to complete follow up documentation. QMA 8 indicated, she was not responsible for documenting the incident between Resident C and Resident J, she called the Wellness Director and the night QMA documented the altercation had happened. During an interview on 10/5/23 at 10:28 a.m., QMA 6 indicated the facility staffed a Licensed Practical Nurse (LPN) to work the day shift Monday through Friday. LPN 9 was the administrative charge nurse, and it was her responsibility to write physician's orders, order resident medications, and follow-up resident incidents. There was no nurse on duty on the evening shifts or weekends,			

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	so staff called a triage nurse. QMA 6 indicated she could not answer to how the resident would be assessed when the triage nurse was not in the facility. To her knowledge, triage progress notes were being documented on the word of a staff member working on site, not because the triage nurse assessed the resident. It was the responsibility of the triage nurse to fill out an initial incident report as needed, and then LPN 9 would complete the follow up when she was in the facility. QMA 6 indicated if she had an incident such as a fall or skin tear, she would call the triage nurse but also put a progress note in the electronic medical record (EMR). During an interview on 10/5/23 at 10:33 a.m., QMA 10 indicated she called the triage nurse for any incident or if a resident became ill, gave the triage nurse vital signs, and the triage nurse took it from there. The triage nurses worked from home. Triage nurse notes were being documented on the word of a staff member on site. The triage nurse did not assess the resident. There was supposed to be a triage binder in the nurse's station for the QMA to document vital signs. During an interview on 10/5/23 at 10:46 a.m., LPN 9 indicated she was the administrative charge nurse. Her job was to write resident orders, do resident admission paperwork, and generally make sure resident charts were in order. There were no nurses staffed in the facility off hours or on weekends, there were triage nurses. If a resident had a fall or incident off hours, the QMA would call the triage nurse to report the incident and get instructions from the triage nurse on what to do. If there was no nurse in the facility to assess residents, the triage nurse gathered information from the QMA. The triage nurse then charted incidents off secondhand information from a			

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	QMA (who was not qualified to complete an assessment on a resident) not by what the triage nurse saw or assessed firsthand. The triage nurse charted resident information in the EMR. If a resident had wounds, the wounds were assessed and documented by the home health nurse or hospice services. During an interview on 10/5/23 at 3:19 p.m., the Wellness Director indicated, it was her understanding that the facility was staffed with QMA's on evening, night, and weekend shifts. When there was no nurse in the facility, the QMA was to call the 24/7 nurse triage line, and it was the responsibility of the triage nurse to assess situations such as resident to resident abuse and document. Some of the triage nurses had been in the building, but not all, and they did not know the residents well. The Wellness Nurse indicated, it was ultimately her responsible for assuring residents were assessed, documentation completed, and treatment rendered as needed. Cross Reference R0052. This State tag relates to Complaint IN00418114.			
R 0214 Bldg. 00	410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on observation, interview and record review, the facility failed to appropriately and timely assess, treat, document, and personalize	R 0214	**R117 Personnel** ***This Plan of Correction is the***	11/17/2023

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	the service plan for wounds obtained during resident to resident abuse for 1 of 5 residents reviewed for resident abuse (Residents C). Findings include, An Indiana State Department of Health Survey Report System report, dated 9/25/23 at 6:21 a.m., indicated on 9/24/23 at 9:01 p.m., Resident C was in his room and Resident D went into Resident C's room and started yelling and striking Resident C. Staff could not get Resident D to leave the room and police were called. Residents were separated, no injuries noted. Staff will be retrained on deescalating situations. An Indiana State Department of Health Survey Report System 5 - day follow-up report, dated 10/3/23, indicated no injuries reported or seen. Resident D was not the aggressor (he was not involved in the incident). Resident J had gone into Resident C's room and started hitting him. Resident J was sent to the emergency room (ER) and had been moved out by his wife. Resident D was recovering from the incident, and the care plan continued. On 10/4/23 at 3:35 p.m., Resident C was observed in the main lounge of the secured memory care unit sitting in his wc among peers watching TV. His right arm and hand were observed to have a 3 inch (in) by (x) 3 in padded dressing on top of his right wrist, back of hand, down onto forefinger, with dark discoloration observed on hand and thumb around the dressing. Another 3 in x 3 in padded dressing was observed on top of the upper right forearm near the bend of his arm, scabbed skin observed around the dressing. Neither dressing was dated or initialed with information of when or who had placed the		***center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** ***1)Immediate actions taken for those residents identified:*** Resident C, D, F and K reside in the building and their orders and service plans have been reviewed and updated. Resident J has moved out and has not been back to community since the incident. ***2)How the facility identified other residents:*** Any resident residing in the facility had the potential to be affected. Audit completed on all residents with new behaviors to ensure that service plan has been updated. **3)Measures put into place/ System changes:** Inservice and education provided to all staff on abuse, residents rights, dignity, identifying new behaviors, and report to DON/ED immediately for any pertinent events. Newly adapted system for proper documentation has been developed with the Nurse On Call team that supports our	

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	dressing. Resident C's record was reviewed on 10/4/23 at 11:34 a.m. Diagnoses on Resident C's profile included, but were not limited to, left sided hemiplegia or hemiplegia (paralysis) following a cerebral infarction (stroke), dementia without behavioral disturbance, and need for assistance with personal care. A progress notes for Resident C, dated 9/25/23 at 12:44 a.m., resident returned from the emergency room with no new orders noted. A progress notes for Resident C, dated 9/28/23 at 4:22 p.m., indicated resident seen by a home health agency for skin tears to right arm, with dressing to right arm skin tears changed. The nurse practitioner (NP) was to send orders for home health services. Hospital discharge instructions, dated 9/24/23 at 11:31 p.m., indicated primary diagnosis skin tear of right forearm without complication. "Additional instructions: the steri-strip bandages applied on the wound should be left on until they fall off (typically 1-2 weeks). These may get briefly wet with bathing but should not be soaked for any period of time. You do not need to apply any type of ointment or medication to these wounds. If any dressing is placed over the wound, it should be a non-adherent material that will not stick to the bandages. I recommend leaving the current bandage on for a few days." A Medication Administration Record (MAR) for Resident C, dated September 2023, indicated no documentation the resident had been treated for wounds to his right arm and hand. Qualified Medication Aide (QMA) 8 indicated there were no		community. For all incidents that need a nurse to assess, our QMAs will call the Nurse On Call line and will video/telehealth to the nurse's on call to assess and instruct. Documentation of the root cause of incident, who was notified, resident assessed for injuries, new orders received will be updated by Nurse On Call outside normal business hours and will be documented by Administrative Nurse and/or Wellness Director(WD)/DON during normal business hours. All Fall/Incident follow up will be executed and documented by Admin Nurse or WD. **4)How the corrective actions will be monitored:** The Wellness Director will review 24 hour incident report every morning and follow up with Administrative Nurse regarding falls/incidents and new orders. Documentation reviews will be completed bi-weekly by WD. **5) Date of compliance:** 11/17/2023	

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	physician's orders to treat the skin tears on Resident C's right arm and hand, and she was not sure who was monitoring or treating his wounds or changing his dressings, but he did go out at times. The resident record lacked documentation for Resident C to include, but not limited to, a. The resident was involved in a resident to resident altercation on 9/24/23. b. The resident was assessed for injuries to include vital signs. c. The resident had large skin tears and bruising to his left arm and hand sustained from another resident, or a description of the wounds. f. Orders were obtained to the send the resident to the ER for evaluation, and reason for order. g. An ER report with details to include time of arrival, reason for ER visit, treatment provided while in the ER, and discharge orders. h. Timely physician's orders to utilize home health care services for wound management. i. Physician's orders for wound care to the right arm and hand. j. Nursing follow up of resident to resident altercation to include wound healing. j. The service plan was not updated. During an interview on 10/5/23 at 11:42 a.m., with Licensed Practical Nurse (LPN) 9 indicated Resident C's chart lacked documentation from the ER physician regarding arrival to ER, assessment upon arrival to ER, or diagnoses/reasoning for visit. During an interview on 10/5/23 at 10:52 a.m., Licensed Practical Nurse (LPN) 9 indicated upon review of Resident C's medical record, there was no documentation regarding resident to resident abuse on 9/24/23, the resident had been sent to			

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	the emergency room (ER), the resident returned to the facility, or that Resident C had injuries. LPN 9 indicated, a triage nurse had been notified of the incident, and she was supposed to have documented in the electronic medical record (EMR). LPN 9 indicated, she had observed Resident C to have wounds the morning after the incident and had dressed his wounds, and then called home health for orders regarding the wounds. The Nurse Practitioner (NP) had seen Resident C on 9/28/23 and given orders to have home health care for the new injuries. The home health agency has seen the resident for prior skin tears, so no paperwork was needed to have the resident seen. On 10/5/23 at 11:42 a.m., Jackie LPN provided a handwritten note written on a legal pad, without a header to indicated name of company being represented, with illegible signatures, and indicated these were notes from a home health nurse alleged to be caring for Resident C's arm wounds. Documentation included, a. "9/29 new skin tears - right arm proximal and distal. Wound care performed. I'll come 2 x/week [2 times per week]." b. "10/2/23 wound care performed to right arm and right hand skin tears. 100% granulation tissue [red, bumpy tissue in the wound bed as the wound heals] present. Orders: clean with wound cleaner. Apply Medihoney [used to treat acute and chronic wounds] then xeroform [non-adherent dressing for wounds with low drainage] then foam dressing 2 x/week." c. "10/5/23 wounds are epithelized today. Discontinue wound care-areas open to air. NP [nurse practitioner] notified. (?) will come once a week next week to re-check, then discipline dc [discontinue]. PT to continue."			

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	An initial encounter report, dated 10/3/23, indicated resident being admitted to (agency name) to establish services. Home health referral made on 9/29/23 related to wound care to right arm. Resident record lacked documentation wound care was provided to the resident's arm from 9/24 when seen in the ER until 9/29 when a home health referral was made, or official home health documentation of wound care including a description with measurements of the wounds until 10/3/23 when the resident home health services were established. Cross Reference R0052. This State tag relates to Complaint IN00418114.			