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	11/21/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a Post Survey Revisit (PSR) to Investigation of Complaint IN00418114 completed on October 5, 2023. Complaint IN00418114 - Not corrected. State deficiencies related to the allegations are cited at R0052, R0090, and R0214. Survey dates: November 21, 2023 Facility number: 012263 Census: 70 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on December 7, 2023.	R 0000	***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.***	
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. Based on 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 F, L, M, and G). Findings include: 1a. Resident F's record was reviewed on 11/21/23	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***	12/20/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Bradley Miller	Executive Diirector	12/28/2023

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.

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	11/21/2023

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

(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 2:15 p.m. A late entry progress notes created by the Memory Care Director (MCD) on 11/10/23 at 8:35 a.m., effective date 11/9/23 at 4:00 a.m., indicated it was reported to the MCD Resident F had hit Resident L in the stomach as she was walking by him in the activity room. A certified nursing assistant (CNA) and qualified medication aide (QMA) had witnessed the incident and separated the residents to prevent further behaviors. Resident F was removed from the room. Diagnoses on Resident F's profile included, but were not limited to, dementia without behavioral disturbance (impaired brain functions such as memory loss and judgement with no disorders such as agitation, aggression, paranoid delusions, hallucinations, etc.). The resident record lacked documentation for Resident F to include, but not limited to, a. The physician, resident representative, Executive Director (ED), and Wellness Director were notified of the incident. b. The resident was assessed for injuries to include vital signs. c. The resident was monitored after the incident for psychosocial harm. d. Nursing follow up of resident to resident altercation to include root cause of altercation, and measures to prevent future altercations. An Interim Wellness Evaluation, dated 9/10/23, indicated Resident F could not transfer independently and required 1 caregiver assistance for transfers. The resident was not independent with ambulation and required staff assistance of 1, assistive devices for mobility included a walker or wheelchair. The resident was not independent with cognitive and psychosocial function. The		***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 G, L, F and M reside in the building and their orders and service plans have been reviewed and updated.** ***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.** **Only staff that can enter notes in to the EMAR system are the**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	11/21/2023

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

(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
	cognition/behavioral service plan indicated a focus on behaviors, a goal to not act out in a way that was harmful to self or others, and interventions to monitor/check and report changes from baseline behaviors to nurse. During an interview on 11/21/23 at 4:45 p.m., the Wellness Director indicated Resident F had hit Resident L on 11/9/23. The Wellness Nurse had not been aware of the incident until this week when she was reviewing Resident F's chart regarding the resident to resident abuse incident that had occurred on 11/17/23. The Wellness Director indicated she had been on the secured memory care unit multiple times since 11/9/23, and she had not been informed by any other staff member. The Wellness Director had then informed the Executive Director (ED) of the 11/9/23 incident and he indicated he had no knowledge of the incident either. To her knowledge a formal investigation was not initiated, witness statements were not obtained, and the Memory Care Director had not reported the incident to the triage nurse for the residents to be assessed. The Memory Care Director had received abuse training and was aware abuse was to be reported immediately so abuse could be state reported within two (2) hours. An All Staff Meeting, dated 10/19/23, presented by the Wellness Director, indicated 25 documented signatures of having received the education to include abuse and resident rights. The Memory Care Director signature was not on the document. 1b. Resident L's record was reviewed on 11/21/23 at 2:36 p.m. Diagnoses on Resident L's profile included, but were not limited to, Alzheimer's disease (progressive disease that destroys		**head nurse/Wellness Director. Memory Care Directors will no longer have access to documenting. All wellness staff and team members are to report any resident to resident altercations to WD and ED no matter what, 24/7.** **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 during regular business hours or while on call, our Wellness Director will visually assess and update all appropriate entities. Our QMAs will call the Nurse On Call line and will video/telehealth to the nurse's on call to assess and get instructions only when our own nurse is not available. 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:**	

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	11/21/2023

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

(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
	memory and other important mental functions), and dementia with behavioral disturbance (impaired brain functions such as memory loss and judgement with disorders such as agitation, aggression, paranoid delusions, hallucinations, etc.). The resident record lacked documentation for Resident L to include, but not limited to, a. Progress notes had been documented describing the resident being abused by Resident F. 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. Nursing follow up of resident to resident altercation to include root cause of altercation, and measures to prevent future altercations. A Brief Cognition Rating Scale (BCRS), dated 10/4/23, score of stage 6, indicated severe cognitive decline. A behavioral care plan, dated 8/7/23, indicated focus: behaviors, no goal, and interventions: receive mental health services through the psych NP, monitor/check and report changes from baseline behaviors to nurse. 2. An Indiana State Department of Health Survey Report System report, dated 11/17/23 at 11:40 a.m., indicated at the start of lunch, Resident F tossed/threw a utensil at Resident G. Resident G got up, went around the table, and put his arm around Resident F's throat and started to rough Resident F up and choke him maybe 4-5 seconds		**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:** **12/20/2023**	

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	11/21/2023

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

(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
	before staff broke it up. Resident G went back to his seat and Resident F escorted out of the dining area. Resident F was sent out for psych evaluation for his aggression, and Resident G carried on about his day. a. Resident F's record was reviewed on 11/21/23 at 2:15 p.m. Diagnoses on Resident F's profile included, but were not limited to, dementia without behavioral disturbance (impaired brain functions such as memory loss and judgement with no disorders such as agitation, aggression, paranoid delusions, hallucinations, etc.). A progress notes for Resident F, dated 11/17/23 at 12:08 p.m., indicated Resident F had been sitting at the table in the dining room with several other residents when he picked up one of his eating utensils and threw it Resident G. Resident G then proceeded to get up and walk around the table and put his arm around Resident F's neck and put him in a sort of choke hold telling him not to throw things at people. Staff immediately separated the two residents. The psychiatric (psych) nurse practitioner (NP) was notified, and she recommended an in-house psych hospital stay for medication adjustment. A progress notes for Resident F, dated 11/17/23 at 5:08 p.m., indicated the resident had been picked up by hospital transport and taken for admission to nearby city psych hospital. Resident F's service plan lacked documentation the resident had behaviors to include physical aggression towards other residents. During an interview on 11/21/23 at 2:56 p.m., the Wellness Director indicated, the administrative nurse with the help of a corporate nurse had been			

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	11/21/2023

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

(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
	responsible for assessments, care plans, and processing physician's (MD) orders. The Wellness Nurse was in the process of re-doing all resident service plans. b. Resident G's record was reviewed on 11/21/23 at 3:30 p.m. Diagnoses on Resident G's profile included, but were not limited to, dementia without behavioral disturbance. A progress notes for Resident G, dated 11/17/23 at 1:32 p.m., indicated the resident was seated at the dining room table waiting for his meal to be delivered when Resident F who was seated on the other side of the table, picked up one of his eating utensils and threw it at Resident G, hitting him on the front of his shirt. Resident G became upset and got up from the table and walked around and he put his arm around Resident F's neck in a hold. Staff immediately then separated the two residents. Resident G did not complaint of being hurt or injured. The MD was notified, and a message left for the daughter. The resident record lacked documentation for Resident G to include, but not limited to, a. The ED, and Wellness Director were notified of the incident. d. The resident was assessed for injuries to include vital signs. e. The resident was monitored after the incident for psychosocial harm. d. Nursing follow up of resident to resident altercation to include root cause of altercation, and measures to prevent future altercations. A Brief Cognition Rating Scale (BCRS), dated 11/9/23, score of stage 5, indicated moderate cognitive decline.			

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	11/21/2023

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

(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 service plan, dated 11/9/23, indicated focus: reasoning. Goal: Will make appropriate decisions about their care and environment with assistance. Interventions: resident requires assistance with redirection due to occasional confusion, deficits in judgement, and wandering. Care staff will report any changes in ability to reason. 3. An Indiana State Department of Health Survey Report System report, dated 11/5/23 at 11:45 p.m., indicated Resident M had been sitting in the common area crying, when Resident L approached her, grabbed her face, and told her to "shut up". An Indiana State Department of Health Survey Report System 5 - day follow-up report, dated 11/11/23, indicated new medications were ordered for Resident L and behaviors have subsided and a calmer demeanor had been present. a. Resident L's record was reviewed on 11/21/23 at 2:36 p.m. Diagnoses on Resident L's profile included, but were not limited to, Alzheimer's disease, and dementia with behavioral disturbance. The resident record lacked documentation for Resident L to include, but not limited to, a. Witness statements had been obtained. b. The resident was assessed for injuries to include vital signs. c. Nursing follow up of resident to resident altercation to include root cause of altercation, and measures to prevent future altercations. During an interview on 11/21/23 at 4:54 p.m., the Wellness Director indicated, Resident L's service plan had not been updated after the resident to resident abuse, and there were no witness statements obtained.			

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	11/21/2023

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

(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
	3b. Resident M's record was reviewed on 11/21/23 at 3:25 p.m. Diagnoses on Resident M's profile included, but were not limited to, severe vascular dementia. The resident record lacked documentation progress notes had been documented describing the resident being abused by Resident L. A Brief Cognition Rating Scale (BCRS), dated 9/13/23, score of stage 6, indicated severe cognitive decline. A care plan for Resident M, dated 9/12/23, focus: behaviors, goal: resident will not act out in a way that is harmful to self or others, intervention: monitor/check and report changes from baseline behaviors to nurse. During an interview on 11/21/23 at 6:25pm, the ED and Wellness Director indicated despite continued education with the staff, the abuse protocol was not being followed by all staff. 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			

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	11/21/2023

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

(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
	immediately report any witnessed or suspected incidents of abuse, neglect, or exploitation to the supervisor on duty and the Wellness Director or designee. For the purposes of this policy, immediately means as soon as possible, but will not exceed twenty-four [24] hours after the incident 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. The deficiency was cited on 10/5/23. The facility failed to implement a systemic plan of correction to prevent recurrence.			
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			

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	11/21/2023

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

(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
	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; (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			

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	11/21/2023

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

(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
	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 2 of 5 residents reviewed for abuse (Residents F and L). Findings include, 1. A late entry progress notes created by the Memory Care Director (MCD) on 11/10/23 at 8:35 a.m., effective date 11/9/23 at 4:00 a.m., indicated it was reported to the MCD Resident F had hit Resident L in the stomach as she was walking by him in the activity room. A certified nursing assistant (CNA) and qualified medication aide (QMA) had witnessed the incident and separated the residents to prevent further behaviors. Resident F was removed from the room. The facility failed to submit a state reportable incident report, or a 5-day follow up report. During an interview on 11/21/23 at 4:45 p.m., the Wellness Director indicated, Resident F had hit Resident L on 11/9/23. The Wellness Nurse had not been aware of the incident until this week when she was reviewing Resident F's chart regarding the resident to resident abuse incident that had occurred on 11/17/23. The Memory Care Director did not have a nursing certification. The Memory Care Director had been interviewed and asked why she had not reported the 11/9/23 incident and she had no response. The Wellness Director indicated, she had been on the secured memory care unit multiple times since 11/9/23, and she had not been informed by any other staff member. The Wellness Director had then informed the Executive Director (ED) of the 11/9/23 incident,	R 0090	**R090- Administration and Management** ***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 F and L reside in the building and their orders and service plans have been reviewed and updated.** ***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.**	12/20/2023

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	11/21/2023

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

(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 he indicated he had no knowledge of the incident either. To her knowledge a formal investigation was not initiated, witness statements were not obtained, and the Memory Care Director had not reported the incident to the triage nurse for the residents to be assessed. The Memory Care Director had received abuse training and was aware abuse was to be reported immediately so abuse could be state reported within two (2) hours. 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		**3)Measures put into place/ System changes:** **Only staff that can enter notes in to the EMAR system are the head nurse/Wellness Director. Memory Care Directors will no longer have access to documenting. All wellness staff and team members are to report any resident to resident altercations to WD and ED no matter what, 24/7.** **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 during regular business hours or while on call, our Wellness Director will visually assess and update all appropriate entities. Our QMAs will call the Nurse On Call line and will video/telehealth to the nurse's on call to assess and get instructions only when our own nurse is not available. 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**	

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	11/21/2023

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

(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
	representative and to other officials in accordance with state law ...within five (5) working days of the incident ...." Cross Reference R0052. This State tag relates to Complaint IN00418114. The deficiency was cited on 10/5/23. The facility failed to implement a systemic plan of correction to prevent recurrence.		**be executed and documented by Admin Nurse or WD.** **The Executive Director will report to the division, all resident-to-resident abuse within 24 hours of incident via Access Indiana or paper form if site is down once informed by staff or Wellness Director. 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:** **12/20/2023**	
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			

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	11/21/2023

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

(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
	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 interview and record review, the facility failed to appropriately and timely assess, treat, document, and personalize the service plan for behaviors before and after resident to resident abuse for 4 of 5 residents reviewed for resident abuse (F, L, M, and G). Findings include, 1a. Resident F's record was reviewed on 11/21/23 at 2:15 p.m. Diagnoses on Resident F's profile included, but were not limited to, dementia without behavioral disturbance (impaired brain functions such as memory loss and judgement with no disorders such as agitation, aggression, paranoid delusions, hallucinations, etc.). A late entry progress notes created by the Memory Care Director (MCD) on 11/10/23 at 8:35 a.m., effective date 11/9/23 at 4:00 a.m., indicated it was reported to the MCD Resident F had hit Resident L in the stomach as she was walking by him in the activity room. A certified nursing assistant (CNA) and qualified medication aide (QMA) had witnessed the incident and separated the residents to prevent further behaviors. Resident F was removed from the room. The resident record lacked documentation for Resident F to include, but not limited to, a. Nursing follow up of resident to resident altercation to include root cause of altercation, and measures to prevent future altercations. b. The service plan was updated. During an interview on 11/21/23 at 4:45 p.m., the	R 0214	**R214 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 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 F, L, M and G reside in the building and their orders and service plans have been reviewed and updated.** ***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.**	12/20/2023

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	11/21/2023

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

(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
	Wellness Director indicated, Resident F had hit Resident L on 11/9/23. The Wellness Nurse had not been aware of the incident until this week when she was reviewing Resident F's chart regarding the resident to resident abuse incident that had occurred on 11/17/23. During an interview on 11/21/23 at 4:52 p.m., the Wellness Director indicated, Resident F's service plan had not been updated regarding behaviors after the 11/923 and 11/17/23 abuse incidents. The administrative nurse had been responsible for updating service plans, and this had not been done. 1b. Resident L's record was reviewed on 11/21/23 at 2:36 p.m. Diagnoses on Resident L's profile included, but were not limited to, Alzheimer's disease (progressive disease that destroys memory and other important mental functions), and dementia with behavioral disturbance (impaired brain functions such as memory loss and judgement with disorders such as agitation, aggression, paranoid delusions, hallucinations, etc.). The resident record lacked documentation for Resident L to include, but not limited to, a. Nursing follow up of resident to resident altercation to include root cause of altercation, and measures to prevent future altercations. b. The service plan was updated. A behavioral care plan, dated 8/7/23, indicated focus: behaviors, no goal, and interventions: receive mental health services through the psych NP, monitor/check and report changes from baseline behaviors to nurse. 2a. An Indiana State Department of Health Survey		**3)Measures put into place/ System changes:** **Administrative nurse who was put in charge of documenting follow ups has been terminated. All resident to resident altercations including root cause and service plan updates will be completed by Wellness Director or Designee to prevent recurrence.** **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:** **12/20/2023**	

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	11/21/2023

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

(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
	Report System report, dated 11/17/23 at 11:40 a.m., indicated at the start of lunch, Resident F tossed/threw a utensil at Resident G. Resident G got up, went around the table, and put his arm around Resident F's throat and started to rough Resident F up and choke him maybe 4-5 seconds before staff broke it up. Resident G went back to his seat and Resident F escorted out of the dining area. Resident F was sent out for psych evaluation for his aggression, and Resident G carried on about his day. A progress notes for Resident F, dated 11/17/23 at 12:08 p.m., indicated Resident F had been sitting at the table in the dining room with several other residents when he picked up one of his eating utensils and threw it Resident G. Resident G then proceeded to get up and walk around the table and put his arm around Resident F's neck and put him in a sort of choke hold telling him not to throw things at people. Staff immediately separated the two residents. The psychiatric (psych) nurse practitioner (NP) was notified, and she recommended an in-house psych hospital stay for medication adjustment. A progress notes for Resident F, dated 11/17/23 at 5:08 p.m., indicated the resident had been picked up by hospital transport and taken for admission to nearby city psych hospital. Resident F's service plan lacked documentation the resident had behaviors to include physical aggression towards other residents. During an interview on 11/21/23 at 2:56 p.m., the Wellness Director indicated, the administrative nurse with the help of a corporate nurse had been responsible for assessments, care plans, and processing physician's (MD) orders. The			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	11/21/2023

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

(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
	Wellness Nurse was in the process of re-doing all resident service plans. 2b. Resident G's record was reviewed on 11/21/23 at 3:30 p.m. Diagnoses on Resident G's profile included, but were not limited to, dementia without behavioral disturbance. A progress notes for Resident G, dated 11/17/23 at 1:32 p.m., indicated the resident was seated at the dining room table waiting for his meal to be delivered when Resident F who was seated on the other side of the table, picked up one of his eating utensils and threw it at Resident G, hitting him on the front of his shirt. Resident G became upset and got up from the table and walked around and he put his arm around Resident F's neck in a hold. Staff immediately then separated the two residents. Resident G did not complaint of being hurt or injured. The MD was notified, and a message left for the daughter. The resident record lacked documentation for Resident G to include, but not limited to, a. Nursing follow up of resident to resident altercation to include root cause of altercation, and measures to prevent future altercations. b. The service plan was updated. Resident G's service plan lacked documentation the resident had behaviors to include physical aggression towards other residents. A service plan, dated 11/9/23, indicated focus: reasoning. Goal: Will make appropriate decisions about their care and environment with assistance. Interventions: resident requires assistance with redirection due to occasional confusion, deficits in judgement, and wandering. Care staff will report any changes in ability to reason.			

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	11/21/2023

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

(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
	3a. An Indiana State Department of Health Survey Report System report, dated 11/5/23 at 11:45 p.m., indicated Resident M had been sitting in the common area crying, when Resident L approached her, grabbed her face, and told her to "shut up". An Indiana State Department of Health Survey Report System 5 - day follow-up report, dated 11/11/23, indicated new medications were ordered for Resident L and behaviors have subsided and a calmer demeanor had been present. Resident L's record was reviewed on 11/21/23 at 2:36 p.m. Diagnoses on Resident L's profile included, but were not limited to, Alzheimer's disease, and dementia with behavioral disturbance. The resident record lacked documentation for Resident L to include, but not limited to, a. Nursing follow up of resident to resident altercation to include root cause of altercation, and measures to prevent future altercations. b. The service plan was updated. During an interview on 11/21/23 at 4:54 p.m., the Wellness Director indicated, Resident L's service plan had not been updated after the resident to resident abuse, and there were no witness statements obtained. 3b. Resident M's record was reviewed on 11/21/23 at 3:25 p.m. Diagnoses on Resident M's profile included, but were not limited to, severe vascular dementia. The resident record lacked documentation for Resident M to include, but not limited to, a. Progress notes had been documented			

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	11/21/2023

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

(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
	describing the resident being abused by Resident L. b. The service plan was updated. A care plan for Resident M, dated 9/12/23, focus: behaviors, goal: resident will not act out in a way that is harmful to self or others, intervention: monitor/check and report changes from baseline behaviors to nurse. Cross Reference R0052. This State tag relates to Complaint IN00418114. The deficiency was cited on 10/5/23. The facility failed to implement a systemic plan of correction to prevent recurrence.			