STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 11/21/2023	
	PROVIDER OR SUPPLIER	OF ZIONSVILLE EAST		11755	ADDRESS, CITY, STATE, ZIP COD N MICHIGAN RD /ILLE, IN 46077		
(X4) ID PREFIX TAG R 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
Bldg. 00	Investigation of Coron October 5, 2023  Complaint IN00418 deficiencies related R0052, R0090, and Survey dates: Nove Facility number: 01  Census: 70  These State Resider accordance with 41	8114 - Not corrected. State to the allegations are cited at R0214.  mber 21, 2023  2263	R 00	000	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution this plan of correction does a constitute admission or agreement by the provider of the truth of the facts alleged conclusions set forth in the statement of deficiencies. The plan of correction is prepare and/or executed solely becaut it is required by the provision of federal and state law.	of n of not f or he d use	
R 0052 Bldg. 00	(1) sexual abuse; (2) physical abuse (3) mental abuse; (4) corporal punish (5) neglect; and (6) involuntary sed Based on interview failed to assess, doc investigations of reallegations for 4 of (Residents F, L, M, Findings include:	- Offense e the right to be free from: e; hment; clusion. and record review, the facility hument, and conduct thorough sident to resident abuse 5 residents reviewed for abuse	R 00	052	R052 Residents right -offense This Plan of Correction is the center's credible allegation of compliance.  Preparation and/or execution this plan of correction does in	e of n of	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

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 disclodays 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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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLETED
			B. WI	NG		11/21/2023
				CTREET	ADDRESS SITY STATE ZID COD	
NAME OF P	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD N MICHIGAN RD	
ואוסבסבא		OF ZIONSVILLE EAST				
INDEPEN	NDENCE VILLAGE	OF ZIONSVILLE EAST		ZIONS	VILLE, IN 46077	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	at 2:15 p.m. A late	entry progress notes created			constitute admission or	
	by the Memory Car	re Director (MCD) on 11/10/23			agreement by the provider o	of .
	at 8:35 a.m., effecti	ve date 11/9/23 at 4:00 a.m.,			the truth of the facts alleged	or
	indicated it was rep	orted to the MCD Resident F			conclusions set forth in the	
	had hit Resident L in the stomach as she was				statement of deficiencies. T	The
	walking by him in the activity room. A certified				plan of correction is prepare	ed
	nursing assistant (CNA) and qualified medication				and/or executed solely beca	use
	aide (QMA) had wi	tnessed the incident and			it is required by the provisio	ns
	separated the reside	ents to prevent further			of federal and state law.	
	behaviors. Resident	F was removed from the				
	room.				1)Immediate actions taken f	for
					those residents identified:	
	Diagnoses on Resident F's profile included, but					
	were not limited to, dementia without behavioral				Resident G, L, F and M resid	
		ed brain functions such as			in the building and their orde	
		dgement with no disorders			and service plans have been	1
		ggression, paranoid delusions,			reviewed and updated.	
	hallucinations, etc.)	<b>.</b>				
					2)How the facility identified	
		lacked documentation for			other residents:	
		de, but not limited to,				
		sident representative,			Any resident residing in the	
		(ED), and Wellness Director			facility had the potential to b	
	were notified of the				affected. Audit completed or	۱
		assessed for injuries to			all residents with new	
	include vital signs.				behaviors to ensure that	.
		monitored after the incident			service plan has been updat	ed.
	for psychosocial ha					
	_	p of resident to resident			3)Measures put into place/	
		le root cause of altercation,			System changes:	
	and measures to pre	event future altercations.				
	A T4	F14: 4-4- 1.0/10/22			Inservice and education	_
		ss Evaluation, dated 9/10/23,			provided to all staff on abuse	e,
	indicated Resident				residents rights, dignity,	
		required 1 caregiver assistance			identifying new behaviors, a	
		esident was not independent			report to DON/ED immediate	riy
		d required staff assistance of 1,			for any pertinent events.	
		r mobility included a walker or			Only staff that	
		ident was not independent			Only staff that can enter not	
	with cognitive and	psychosocial function. The			in to the EMAR system are the	ne

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPL	ETED
			B. W	ING		11/21/	2023
				_	_		
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
					N MICHIGAN RD		
INDEPE	NDENCE VILLAGE	OF ZIONSVILLE EAST		ZIONS	VILLE, IN 46077		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDERIC DI ANI OF CORRECTIONI		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	.16	DATE
	cognition/behaviora	al service plan indicated a			head nurse/Wellness Directo	r.	
	focus on behaviors,	a goal to not act out in a way			Memory Care Directors will r	10	
	that was harmful to	self or others, and			longer have access to		
	interventions to monitor/check and report				documenting. All wellness		
	changes from baseline behaviors to nurse.				staff and team members are	to	
					report any resident to reside		
	During an interview	v on 11/21/23 at 4:45 p.m., the			altercations to WD and ED n		
	Wellness Director indicated Resident F had hit				matter what, 24/7.		
		23. The Wellness Nurse had			Newly adapted system for		
	not been aware of the	he incident until this week			proper documentation has		
	when she was revie	wing Resident F's chart			been developed with the Nur	'se	
	regarding the reside	ent to resident abuse incident			On Call team that supports of		
	1	n 11/17/23. The Wellness			community. For all incidents		
	Director indicated s	she had been on the secured			that need a nurse to assess		
	memory care unit n	nultiple times since 11/9/23, and			during regular business hou	rs	
	I -	formed by any other staff			or while on call, our Wellnes		
		ness Director had then informed			Director will visually assess		
	the Executive Direc	etor (ED) of the 11/9/23 incident			and update all appropriate		
	and he indicated he	had no knowledge of the			entities. Our QMAs will call t	he	
	incident either. To l	her knowledge a formal			Nurse On Call line and will		
	investigation was n	ot initiated, witness			video/telehealth to the nurse	's	
	statements were no	t obtained, and the Memory			on call to assess and get		
	Care Director had n	not reported the incident to the			instructions only when our o	wn	
		residents to be assessed. The			nurse is not available.		
	Memory Care Direc	ctor had received abuse training			Documentation of the root		
	and was aware abus	se was to be reported			cause of incident, who was		
	immediately so abu	se could be state reported			notified, resident assessed f	or	
	within two (2) hour	rs.			injuries, new orders received	t	
					will be updated by Nurse On		
	An All Staff Meetin	ng, dated 10/19/23, presented			Call outside normal business	s	
	by the Wellness Dir	rector, indicated 25			hours and will be documented	ed	
	documented signatu	ares of having received the			by Administrative Nurse and	/or	
	education to include	e abuse and resident rights.			Wellness Director(WD)/DON		
	The Memory Care	Director signature was not on			during normal business hou	rs.	
	the document.				All Fall/Incident follow up wi	II	
					be executed and documente	d	
	1b. Resident L's rec	cord was reviewed on 11/21/23			by Admin Nurse or WD.		
	at 2:36 p.m. Diagn	oses on Resident L's profile					
	included, but were	not limited to, Alzheimer's			4)How the corrective actions	s	
		e disease that destroys	1		will be monitored:		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 11/21/2023	
	ROVIDER OR SUPPLIER	OF ZIONSVILLE EAST	11755	ADDRESS, CITY, STATE, ZIP COD N MICHIGAN RD VILLE, IN 46077	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
TAG	memory and other i and dementia with be (impaired brain fundand judgement with aggression, paranoid etc.).  The resident record Resident L to include a. Progress notes had describing the resident F.  b. The physician, re Executive Director were notified of the c. The resident was include vital signs. d. The resident was for psychosocial had e. Nursing follow up altercation to include and measures to preduce the condition of the	mportant mental functions), behavioral disturbance ctions such as memory loss disorders such as agitation, d delusions, hallucinations, lacked documentation for de, but not limited to, d been documented ent being abused by Resident sident representative, (ED), and Wellness Director incident. assessed for injuries to monitored after the incident rm. p of resident to resident le root cause of altercation, event future altercations.  Rating Scale (BCRS), dated age 6, indicated severe	TAG	The Wellness Director will review 24 hour incident rep every morning and follow u with Administrative Nurse regarding falls/incidents an new orders. Documentation reviews will be completed bi-weekly by WD.  5) Date of compliance: 12/20/2023	ort p
	Resident F up and c	hoke him maybe 4-5 seconds			

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
			B. WING	<u></u>	11/21/2023
			CTREET	ADDRESS CITY STATE ZIR COD	<u> </u>
NAME OF I	PROVIDER OR SUPPLIEF	R		ADDRESS, CITY, STATE, ZIP COD	
INDEDE	NDENCE VIII ACE	OF ZIONOVII I F FACT		N MICHIGAN RD	
INDEPE	NDENCE VILLAGE	OF ZIONSVILLE EAST	ZIONS	VILLE, IN 46077	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	before staff broke is	t up. Resident G went back to			
	his seat and Reside	nt F escorted out of the dining			
	area. Resident F wa	as sent out for psych			
		ggression, and Resident G			
	carried on about his	s day.			
		ord was reviewed on 11/21/23 at			
		es on Resident F's profile			
		not limited to, dementia			
		disturbance (impaired brain			
		nemory 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				
		ed Resident F had been sitting			
	-	ining room with several other			
		picked up one of his eating			
	_	it Resident G. Resident G then			
		and walk around the table			
		ound Resident F's neck and put			
	_	oke hold telling him not to throw			
		aff immediately separated the			
		psychiatric (psych) nurse			
		ras notified, and she			
		n-house psych hospital stay for			
	medication adjustm				
	A progress notes fo	or Resident F, dated 11/17/23 at			
		d the resident had been picked			
	-	sport and taken for admission			
	to nearby city psycl				
		-			
	Resident F's service	e plan lacked documentation			
	the resident had bel	haviors to include physical			
	aggression towards	other residents.			
	During an interview	v on 11/21/23 at 2:56 p.m., the			
	Wellness Director i	indicated, the administrative			
	nurse with the help	of a corporate nurse had been			

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	OF CORRECTION	IDENTIFICATION NUMBER	r í	UILDING	00	COMPL 11/21	ETED
	ROVIDER OR SUPPLIER	OF ZIONSVILLE EAST		11755	ADDRESS, CITY, STATE, ZIP COD N MICHIGAN RD /ILLE, IN 46077		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE
TAG	responsible for asse processing physicia. Wellness Nurse was resident service plant. B. Resident G's reco 3:30 p.m. Diagnose included, but were resident without behavioral of the service of the service of the service of the service of the tabutensils and threw in the front of his shirt and got up from the he put his arm arour Staff immediately thresidents. Resident of the tabutensils and threw in the front of his shirt and got up from the he put his arm arour Staff immediately thresidents. Resident of the message left for the The resident record Resident G to include a. The ED, and Welthe incident. d. The resident was include vital signs. e. The resident was for psychosocial hard. Nursing follow up altercation to include and measures to president to the service of the service	ssments, care plans, and n's (MD) orders. The s in the process of re-doing all as.  ord was reviewed on 11/21/23 at es on Resident G's profile not limited to, dementia disturbance.  or Resident G, dated 11/17/23 at the resident was seated at the vaiting for his meal to be ident F who was seated on the le, picked up one of his eating that Resident G, hitting him on the Resident G became upset table and walked around and and Resident F's neck in a hold. The separated the two G did not complaint of being MD was notified, and a daughter.  lacked documentation for de, but not limited to, lness Director were notified of assessed for injuries to monitored after the incident		TAG			DATE
		age 5, indicated moderate					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 11/21/2023	
	PROVIDER OR SUPPLIE	R OF ZIONSVILLE EAST	11755	ADDRESS, CITY, STATE, ZIP COD N MICHIGAN RD VILLE, IN 46077	•
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT	DBE COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPRODE	DATE
	A service plan, date	ed 11/9/23, indicated focus:			
	_	ill make appropriate decisions			
		d environment with assistance.			
		lent requires assistance with			
		occasional confusion, deficits			
		wandering. Care staff will report			
	any changes in abil	ity to reason.			
	3 An Indiana State	e Department of Health Survey			
		ort, dated 11/5/23 at 11:45 p.m.,			
		M had been sitting in the			
		ng, when Resident L approached			
	her, grabbed her face, and told her to "shut up".				
	An Indiana State Department of Health Survey				
		day follow-up report, dated			
		I new medications were ordered			
	for Resident L and	behaviors have subsided and a			
	calmer demeanor h	ad been present.			
	a Resident I's reco	ord was reviewed on 11/21/23 at			
		es on Resident L's profile			
		not limited to, Alzheimer's			
		ntia with behavioral			
	disturbance.	oona rorar			
	The resident record	l lacked documentation for			
	Resident L to inclu	de, but not limited to,			
		nts had been obtained.			
		s assessed for injuries to			
	include vital signs.				
		up of resident to resident			
		de root cause of altercation,			
	and measures to pr	event future altercations.			
	During an interview	w on 11/21/23 at 4:54 p.m., the			
	_	indicated, Resident L's service			
		apdated after the resident to			
	_	there were no witness			
	statements obtained				

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	COM	E SURVEY PLETED 21/2023
	PROVIDER OR SUPPLIER	OF ZIONSVILLE EAST	11755	ADDRESS, CITY, STATE, ZIP CO N MICHIGAN RD VILLE, IN 46077	OD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE GCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	at 3:25 p.m. Diagno	oses on Resident M's profile not limited to, severe vascular				
	progress notes had	lacked documentation been documented describing bused by Resident L.				
		Rating Scale (BCRS), dated age 6, indicated severe				
	behaviors, goal: res that is harmful to so	sident M, dated 9/12/23, focus: sident will not act out in a way elf or others, intervention: report changes from baseline				
	and Wellness Direct continued education	v on 11/21/23 at 6:25pm, the ED etor indicated despite in with the staff, the abuse eing followed by all staff.				
	provided an Abuse, policy, last reviewe policy was the one	p.m., the Wellness Director Neglect, or Exploitation at 6/7/23, and indicated the currently being used by the indicated, "Abuse, neglect, or				
	All allegations, sus abuse, neglect, or e investigatedInitia residenta. If the r	resident will not be tolerated. picions, and incidents of xploitation will be promptly al Response: 1. Protect the resident is injured, immediate ken to treat the residentA				
	supervisor should p residentc. The re be notified of the in	perform an initial check on the sident's responsible party will acident, and the resident's aEmployees are to				

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	COM	E SURVEY PLETED 1/2023
INDEPEN	PROVIDER OR SUPPLIER	OF ZIONSVILLE EAST	11755	ADDRESS, CITY, STATE, ZIP C N MICHIGAN RD VILLE, IN 46077	OD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	incidents of abuse, a supervisor on duty a designee. For the purimmediately means not exceed twenty-fincident or discover the resident's chart aresident's ROM [rand body check, vital signification will be contained and the reprovided An investigation will be contained to the accuse written statements of the accused, and ear of the investigation, the information gath the allegation or susual meaning the appropriate licer and registries in accountlined in the state Incident/Accident of the investigation. This State tag relates the deficiency was failed to implement to prevent recurrence.	es to Complaint IN00418114.  cited on 10/5/23. The facility a systemic plan of correction ce.				
R 0090 Bldg. 00	(g) The administration overall management responsibilities of include, but are not (1) Informing the control of	3(g)(1-6) d Management - Deficiency ator is responsible for the ent of the facility. The the administrator shall of limited to, the following: division within twenty-four oming aware of an unusual				

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	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION ND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 B. WING			COMP	(X3) DATE SURVEY COMPLETED 11/21/2023		
	PROVIDER OR SUPPLIE	R OF ZIONSVILLE EAST		11755 I	ADDRESS, CITY, STATE, ZIP COD N MICHIGAN RD /ILLE, IN 46077		
(X4) ID PREFIX	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	P	ID REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION
TAG	occurrence that of welfare, safety, of unusual occurrence included a written report of electronic mail to twenty-four (24) if occurrences included (A) epidemic outly (B) poisonings; (C) fires; or (D) major accided if the division care be made to the epublished by the (2) Promptly arrathe provision of nursing care or or requested by the representative.  (3) Obtaining direct admission of an inversion of an invers	ints. Innot be reached, a call shall mergency telephone number division. Inging for or assisting with nedical, dental, podiatry, or ther health care services as resident or resident's legal actor approval prior to the individual under eighteen (18) in adult facility. Facility maintains, on the furster record of actual time facts the: Ill name; and furs worked during the past ins. Insults of the most recent the facility conducted by any plan of correction in correction in the facility, and any eys. The results must be innation in the facility in a facesible to residents and a		TAG			DATE

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	` ′		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	
			B. Wl	NG		11/21	/2023
NAME OF P	PROVIDER OR SUPPLIE	R		STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
					N MICHIGAN RD		
INDEPEN	NDENCE VILLAGE	OF ZIONSVILLE EAST		ZIONS	VILLE, IN 46077		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	•	ection to any member of the					
	public upon reque		D 0	200			10/00/000
		and record review, the facility	R 0	)90	R090- Administration and		12/20/2023
	_	e and timely and accurately			Management		
	-	esident abuse within 2 hours,					
	-	in 5 days for 2 of 5 residents			This Blancat Commention is 44	ı	
	reviewed for abuse	e (Residents F and L).			This Plan of Correction is the		
	Findings include,			center's credible allegati compliance.		of	
	1. A late entry pros	te entry progress notes created by the			Preparation and/or execution	on of	
	Memory Care Director (MCD) on 11/10/23 at 8:35				this plan of correction does		
	a.m., effective date 11/9/23 at 4:00 a.m., indicated it				constitute admission or		
	was reported to the MCD Resident F had hit				agreement by the provider of	of	
	-	tomach as she was walking by			the truth of the facts alleged		
		room. A certified nursing			conclusions set forth in the		
		nd qualified medication aide			statement of deficiencies. 1	The .	
		sed the incident and separated			plan of correction is prepare	ed	
	the residents to pre	event further behaviors.			and/or executed solely beca		
	Resident F was ren	noved from the room.			it is required by the provision		
					of federal and state law.		
	The facility failed	to submit a state reportable					
	incident report, or	a 5-day follow up report.			1)Immediate actions taken	for	
	_	_			those residents identified:		
	During an interview	w on 11/21/23 at 4:45 p.m., the					
	Wellness Director	indicated, Resident F had hit			Resident F and L reside in t	:he	
	Resident L on 11/9	0/23. The Wellness Nurse had			building and their orders an	d	
	not been aware of	the incident until this week			service plans have been		
	when she was revie	ewing Resident F's chart			reviewed and updated.		
		ent to resident abuse incident					
		on 11/17/23. The Memory Care			2)How the facility identified	1	
		we a nursing certification. The			other residents:		
	-	ector had been interviewed and					
		not reported the 11/9/23			Any resident residing in the	•	
		nd no response. The Wellness			facility had the potential to b		
	Director indicated, she had been on the secured				affected. Audit completed or	n	
	-	multiple times since 11/9/23, and			all residents with new		
	she had not been informed by any other staff				behaviors to ensure that		
		ness Director had then informed			service plan has been updat	ted.	
	the Executive Dire	ctor (ED) of the 11/9/23 incident,					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPL	ETED
			B. W	ING	<del>_</del>	11/21/	2023
				_			
NAME OF F	PROVIDER OR SUPPLIEF	R			ADDRESS, CITY, STATE, ZIP COD		
					N MICHIGAN RD		
INDEPEN	NDENCE VILLAGE	OF ZIONSVILLE EAST		ZIONS	VILLE, IN 46077		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	and he indicated he	had no knowledge of the			3)Measures put into place/		
	incident either. To	her knowledge a formal			System changes:		
	investigation was n	ot initiated, witness					
	statements were no	t obtained, and the Memory			Only staff that can enter not	es	
		not reported the incident to the			in to the EMAR system are th		
		residents to be assessed. The			head nurse/Wellness Directo		
	_	ctor had received abuse training			Memory Care Directors will r		
	1	se was to be reported			longer have access to	-	
		use could be state reported			documenting. All wellness		
	within two (2) hour	•			staff and team members are	to	
	(=)				report any resident to reside		
	Long-Term Care A	buse and Incident Reporting			altercations to WD and ED no		
	_	2/8/22, indicated, "Abuse is the			matter what, 24/7.		
	1	injury, unreasonable			Newly adapted system for		
		idation, or punishment with			proper documentation has		
		narm, pain, or mental anguish			been developed with the Nur	·co	
		cludes, but not limited to,			On Call team that supports of		
	1 -	unching, biting, and kicking			community. For all incidents		
		(g) The administrator is			that need a nurse to assess	•	
		overall management of the			during regular business hou	re	
	_	asibilities of the administrator			or while on call, our Wellnes		
		re not limited to the following:			Director will visually assess	3	
		ivision within twenty-four (24)			and update all appropriate		
		aware of an unusual			entities. Our QMAs will call t	ho	
		ectly threatens the welfare,			Nurse On Call line and will	iie	
		a residentStaff treatment of			video/telehealth to the nurse	'e	
	1	facility must ensure that all			on call to assess and get	· 3	
		nvolving mistreatment, neglect,			instructions only when our o	w.n	
	_	injuries of unknown source,			nurse is not available.	/ <b>V V</b> I I	
	_	on of resident property, are			Documentation of the root		
		ely to the administrator of the					
	1 -	fficials in accordance with state			cause of incident, who was	or	
	_				notified, resident assessed f		
		shed procedures, including to			injuries, new orders received		
		d certification agency. (d) The			will be updated by Nurse On		
	1	evidence that all alleged			Call outside normal business		
		bughly investigated and must			hours and will be documented	-	
		ential abuse while the			by Administrative Nurse and	/or	
		progress. (e) The results of the			Wellness Director(WD)/DON		
	investigation must				during normal business hou		
	administrator or the	e administrator's designated			All Fall/Incident follow up wil	ll .	

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 11/21/2023
	PROVIDER OR SUPPLIEF	OF ZIONSVILLE EAST	11755	ADDRESS, CITY, STATE, ZIP COD N MICHIGAN RD SVILLE, IN 46077	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRODEFICIENCY)	DBE COMPLETION DATE
	representative and to other officials in accordance with state lawwithin five (5) working days of the incident"			be executed and docume by Admin Nurse or WD.	ented
	The deficiency was	es to Complaint IN00418114. cited on 10/5/23. The facility a systemic plan of correction		The Executive Director of report to the division, all resident-to-resident abus within 24 hours of incide Access Indiana or paper site is down once informs staff or Wellness Director Executive Director will resinput documentation from EMAR system to report information as accurately received. Investigation we conducted by the Execut Director or Wellness Director/Designee if Execut Director is on vacation of indisposed. Follow up to division will be entered we 5 days of initial report.  4) How the corrective act will be monitored:  The Executive Director  5) Date of compliance:	se nt via form if ed by r. The eview m y as vill be citive cutive r o the vithin
R 0214	410 IAC 16.2-5-2( Evaluation - Defic	•			
Bldg. 00	(a) An evaluation each resident sha admission and sh	of the individual needs of Il be initiated prior to all be updated at least upon a known substantial			

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED		
			B. W	B. WING 11			11/21/2023	
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF PROVIDER OR SUPPLIER					N MICHIGAN RD			
	NDENCE VILLAGE	OF ZIONSVILLE EAST	•	ZIONS	VILLE, IN 46077			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECT ACTION SHOW			(X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCE		DATE	
	change in the resident 's condition, or more often at the resident 's or facility 's request.							
		shall evaluate the nursing						
	needs of the resid	_						
		and record review, the facility	R 0	214	R214 Personnel		12/20/2023	
		ely and timely assess, treat,					12,20,2023	
		sonalize the service plan for						
		nd after resident to resident			This Plan of Correction is the	he		
	abuse for 4 of 5 res	idents reviewed for resident			center's credible allegation	of		
	abuse (F, L, M, and	1 G).			compliance.			
	Findings include,			Preparation and/or exect		on of		
					this plan of correction does	not		
		eord was reviewed on 11/21/23			constitute admission or			
		oses on Resident F's profile	_		agreement by the provider of			
		not limited to, dementia			the truth of the facts alleged or			
		disturbance (impaired brain			conclusions set forth in the			
		nemory loss and judgement	statement of deficiencies. The					
		ders such as agitation, aggression, sions, hallucinations, etc.).			plan of correction is prepare			
	paranoid delusions,	, namucinations, etc.).			and/or executed solely beca			
	A late entry progre	ss notes created by the			it is required by the provision of federal and state law.	oris		
		ctor (MCD) on 11/10/23 at 8:35			or rederar and state law.			
	1	11/9/23 at 4:00 a.m., indicated it			1)Immediate actions taken	for		
	· ·	MCD Resident F had hit			those residents identified:			
	_	tomach as she was walking by						
		room. A certified nursing			Resident F, L, M and G resident	de		
		d qualified medication aide			in the building and their ord			
		sed the incident and separated			and service plans have beer			
	the residents to pre-	vent further behaviors.			reviewed and updated.			
	Resident F was ren	noved from the room.						
					2)How the facility identified	1		
		lacked documentation for			other residents:			
		de, but not limited to,						
	_	ip of resident to resident			Any resident residing in the			
		de root cause of altercation,			facility had the potential to b			
		event future altercations.			affected. Audit completed or	n		
	b. The service plan	was updated.			all residents with new			
	Duning and interm	or an 11/21/22 at 4:45 41 -			behaviors to ensure that			
	During an interview	v on 11/21/23 at 4:45 p.m., the			service plan has been updat	ea.		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	a. Building <u>00</u>		00	COMPL	ETED
			B. W	B. WING 11/21/2023			/2023
		ı		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			N MICHIGAN RD		
INIDEDEN	NDENCE VII I AGE	OF ZIONSVILLE EAST			VILLE, IN 46077		
IINDEFEI	NDLINGE VILLAGE	OI ZIONOVILLE EAGT	_	ZIONS	· · · · · · · · · · · · · · · · · · ·		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI			COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ndicated, Resident F had hit					
		/23. The Wellness Nurse had			3)Measures put into place/		
		he incident until this week			System changes:		
		ewing Resident F's chart					
		ent to resident abuse incident			Administrative nurse who w		
	that had occurred o	n 11/17/23.			put in charge of documentin	g	
					follow ups has been		
		v on 11/21/23 at 4:52 p.m., the			terminated. All resident to		
		ndicated, Resident F's service			resident altercations including	ng	
	_	ipdated regarding behaviors			root cause and service plan		
		d 11/17/23 abuse incidents. The			updates will be completed by	-	
	administrative nurse had been responsible for				Wellness Director or Design	ee	
	updating service plans, and this had not been				to prevent recurrence.		
	done.						
	11 D '1 (T)	1 11/21/22			4)How the corrective action	S	
		cord was reviewed on 11/21/23			will be monitored:		
		oses on Resident L's profile					
	l '	not limited to, Alzheimer's			The Wellness Director will	4	
		e disease that destroys			review 24 hour incident repo		
	1	important mental functions), behavioral disturbance			every morning and follow up with Administrative Nurse	•	
		ections such as memory loss				i	
		n disorders such as agitation,			regarding falls/incidents and new orders. Documentation	l	
	1	d delusions, hallucinations,			reviews will be completed		
	etc.).	d delusions, nandemations,			-		
	- C.C. j.				bi-weekly by WD.		
	The resident record	lacked documentation for			5) Date of compliance:		
		de, but not limited to,			bate of compliance.		
		up of resident to resident			12/20/2023		
		de root cause of altercation,			12,20,2020		
	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:						
		th services through the psych					
		and report changes from					
	baseline behaviors	-					
	2a. An Indiana Stat	e Department of Health Survey					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. B	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 11/21/2023		
NAME OF PROVIDER OR SUPPLIER INDEPENDENCE VILLAGE OF ZIONSVILLE EAST			STREET ADDRESS, CITY, STATE, ZIP COD 11755 N MICHIGAN RD ZIONSVILLE, IN 46077					
P	(4) ID REFIX 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 indicated at the start tossed/threw a uten got up, went around around Resident F's Resident F up and obefore staff broke in his seat and Resident area. Resident F was evaluation for his a carried on about his A progress notes for 12:08 p.m., indicate at the table in the direction of the proceeded to get up and put his arm around him in a sort of chothings at people. State two residents. The practitioner (NP) we recommended an in medication adjustment of the proceeded to get up and put his arm around him in a sort of chothings at people. State two residents. The practitioner (NP) we recommended an in medication adjustment of the progress notes for 5:08 p.m., indicated up by hospital transit to nearby city psycle. Resident F's services the resident had bel aggression towards. During an interview Wellness Director in nurse with the help responsible for asset	ort, dated 11/17/23 at 11:40 a.m., at of lunch, Resident F sil at Resident G. Resident G. It the table, and put his arm at throat and started to rough schoke him maybe 4-5 seconds at up. Resident G went back to at up. Resident G went back at up. The went of the dining at the went of the went of the went of the went of the went went went of the went went went went went went went wen					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
			B. WING		11/21/2023	
		<u>I</u>	STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹		N MICHIGAN RD		
INDEPEN	NDENCE VILLAGE	OF ZIONSVILLE EAST		VILLE, IN 46077		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI			
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE	
	Wellness Nurse was in the process of re-doing all					
	resident service pla	ns.				
	2b. Resident G's rea	cord was reviewed on 11/21/23				
		oses on Resident G's profile				
		not limited to, dementia				
	without behavioral					
		or Resident G, dated 11/17/23 at				
	-	d the resident was seated at the				
	-	vaiting for his meal to be				
		sident F who was seated on the				
		ole, picked up one of his eating				
		t at Resident G, hitting him on				
		t. Resident G became upset				
		e table and walked around and nd Resident F's neck in a hold.				
	-	hen separated the two				
	_	G did not complaint of being				
		MD was notified, and a				
	message left for the					
	-	-				
		lacked documentation for				
		de, but not limited to,				
	-	p of resident to resident de root cause of altercation,				
		event future altercations.				
	b. The service plan					
	s. The service plan	apanton				
	Resident G's servic	e plan lacked documentation				
	the resident had bel	haviors to include physical				
	aggression towards	other residents.				
	-	ed 11/9/23, indicated focus:				
		ill make appropriate decisions				
		l environment with assistance.				
		ent requires assistance with				
		occasional confusion, deficits				
		wandering. Care staff will report				
	any changes in abil	ny to reason.		Í.		

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 11/21/2023				
NAME OF PROVIDER OR SUPPLIER INDEPENDENCE VILLAGE OF ZIONSVILLE EAST			11755	STREET ADDRESS, CITY, STATE, ZIP COD 11755 N MICHIGAN RD ZIONSVILLE, IN 46077					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY)	CTION (X5) ULD BE PROPRIATE  COMPLETIC DATE	ON			
	Report System report indicated Resident common area cryin her, grabbed her factor An Indiana State D Report System 5 - 6 11/11/23, indicated	e Department of Health Survey ort, dated 11/5/23 at 11:45 p.m., M had been sitting in the g, when Resident L approached ce, and told her to "shut up".  epartment of Health Survey day follow-up report, dated new medications were ordered behaviors have subsided and a ad been present.							
	2:36 p.m. Diagnos	was reviewed on 11/21/23 at es on Resident L's profile not limited to, Alzheimer's tia with behavioral							
	Resident L to inclu a. Nursing follow u altercation to include	lacked documentation for de, but not limited to, up of resident to resident de root cause of altercation, event future altercations.  was updated.							
	Wellness Director i	v on 11/21/23 at 4:54 p.m., the indicated, Resident L's service updated after the resident to there were no witness d.							
	at 3:25 p.m. Diagno	oses on Resident M's profile not limited to, severe vascular							
	Resident M to inclu	lacked documentation for ade, but not limited to, ad been documented							

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· ′		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. Bl	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 11/21/2023	
NAME OF PROVIDER OR SUPPLIER INDEPENDENCE VILLAGE OF ZIONSVILLE EAST				11755	ADDRESS, CITY, STATE, ZIP COD N MICHIGAN RD /ILLE, IN 46077		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION			ID PROVIDER'S PLAN OF CORRECTIC PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)			(X5) COMPLETION DATE
	L. b. The service plan A care plan for Res behaviors, goal: res that is harmful to s monitor/check and behaviors to nurse. Cross Reference Re This State tag relat The deficiency was	sident M, dated 9/12/23, focus: sident will not act out in a way elf or others, intervention: report changes from baseline 0052.  ses to Complaint IN00418114. secited on 10/5/23. The facility that a systemic plan of correction					

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