STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
INDEPENDENCE VILLAGE OF FISHERS SOUTH	9745 OLYMPIA DR FISHERS, IN 46038

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00443518 and IN00438521. Complaint IN00443518 - No deficiencies related to the allegations are cited. Complaint IN00438521 - No deficiencies related to the allegations are cited. Survey dates: September 26 and 27, 2024 Facility number: 002999 Residential Census: 79 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on October 2, 2024.	R 0000	The submission of the Plan of Correction does not indicate an admission by Independence Village of Fishers South that the findings and allegations contained herein are an accurate and true representation of the Quality of Care provided to the residents of Independence Village of Fishers South. The Community hereby maintains it is in substantial compliance with the requirements of participation for residential health care communities. To this end, the Plan of Correction shall serve as the Credible Allegation of Compliance with all State requirements governing the operations of this Community.	
R 0036 Bldg. 00	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency Based on interview and record review, the facility failed to timely inform the physician of a significant weight loss for 1 of 1 resident reviewed for behaviors (Resident 72). Findings include: The clinical record for Resident 72 was reviewed on 9/26/24 at 2:16 p.m. The diagnoses included, but were not limited to, dementia and depression. He was admitted to the facility on 6/24/24.	R 0036	1 The identified resident was affected by the deficient practice. Service plans were updated for identified resident. 2 The community realizes that all residents have the potential to be affected by the deficient practice. All residents will be reviewed for weight. changes per the Company's SOP and complete notification to the	11/01/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Christine N Bright	Executive Director	10/16/2024

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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	A service plan, created 6/24/24, indicated Resident 72 needed assistance with dining. The goal was for him to maintain his independence with dining. The interventions included he required reminders and cues for selecting and making meal choices, encouragement of food and fluids, and staff would report any changes in dining abilities. On 7/23/24, Resident 72's weight was recorded as 148 pounds and, on 8/3/24, his weight was recorded as 130.7 pounds. The clinical record did not contain documentation that a re-weight had been obtained, weekly weights were initiated, or that the physician had been informed of the weight loss. On 9/17/24, Resident 72's weight was recorded as 128.7 pounds. A Nutritional Assessment, dated 9/18/24, indicated Resident 72 had a significant weight change and had lost 18.3 pounds. He had a 12.4% weight loss in three months. His Body Mass Index (BMI) was under the recommended levels. During an interview on 9/27/24 at 9:50 a.m., the Wellness Director (WD) indicated she was unsure why a re-weight had not been completed after the, 8/3/24, weight had been done nor why weekly weights had not been initiated. The physician should have been notified of a weight gain or loss of three pounds or more. On 9/27/24 at 1:04 p.m., the Executive Director provided the Resident Weights Policy, last reviewed 10/17/23, which indicated, "...The purpose of the Resident Weight Policy is to recognize and respond to a resident's weight		residents Health Care provider, Emergency contact and follow up as per the SOP indicates. 3 Effective immediately, weights are to be entered into the resident's electronic chart on the day the weight is taken. During the 24 hour review the weight will be reviewed to identify weight changes that would need further follow-up according to the company SOP. Any resident that has been identified as having a Weight change of more than 3 lbs. Will be reviewed weekly to ensure that the SOP is being followed to prevent further weight changes with timely intervention. An in-service will be scheduled with in 30 days for all wellness staff regarding weight changes according to our company SOP. 4 Weekly conversations of any weight changes will be done during weekly collaboration review with Peers and PCP. Immediate action to be taken by staff if it is determined that there is potential impact to the resident to prevent any additional weight change and a detailed action plan will be put in place. All staff will be notified of the action plan with weekly review by the Executive Director.	

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	related to nutritional needs... If the resident has gained/ lost three pounds or more from the prior recorded weight, the weight should be repeated... If the re-weigh continues to reflect a gain/ loss of three pounds or more, the findings should be reported to the Healthcare provider and Wellness Leader and begin weekly weights x 4 [times 4] weeks...." 410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense			
R 0052 Bldg. 00	Based on interviews and record review, the facility failed to protect the residents' right to be free from sexual abuse by another resident for 1 of 2 residents reviewed for abuse. (Resident 38) Findings include: 1 a. The clinical record for Resident 38 was reviewed on 9/26/24 at 2:40 p.m. The diagnosis included, but were not limited to, dementia. A service plan, created 10/25/23, indicated Resident 38 was independent with communication. 1 b. The clinical record for Resident 72 was reviewed on 9/26/24 at 2:16 p.m. The diagnoses included, but were not limited to, dementia and depression. He was admitted to the facility on 6/24/24. A service plan, created 6/24/24, indicated Resident 72 had expressive behaviors of sexual inappropriateness towards staff. The goal was for him to accept redirection from staff when he made sexually inappropriate comments or touching of staff.	R 0052	1 The identified residents were affected by the deficient practice. Service plans were updated for identified residents. 2 The community realizes that all residents have the potential to be affected by the deficient practice. Action plans will be developed and implemented immediately to ensure no additional residents are not impacted by this deficiency. 1 An all staff in-service will be scheduled within 30 days regarding behavior monitoring and abuse. Any resident with combative behaviors will be placed on 1:1 until placement can be found at a behavioral health facility if recommended by PCP. Family will be required to provide the 1:1 care until placement can be arranged. 3 The Wellness Director and Executive Director will be notified	11/23/2024

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	Resident 38's Electronic Health Record (EHR) had a health status note, dated 8/26/24, as a late entry, for 8/25/24, which indicated a male resident had inappropriately touched Resident 38 while she was in the courtyard. Resident 38 was sitting in a patio chair and had dozed off when she was awakened by a male resident who had placed his hand between her legs and moved his hand toward her stomach. Resident 38 had kicked and yelled at the male resident. The male resident was removed from the area. Resident 72's EHR contained a behavior expression note, dated 8/25/24, that indicated Resident 72 had inappropriately touched a female resident while she was napping in the courtyard. The female resident indicated she was woken up by Resident 72 touching her in-between her legs and moving his hand upward. Resident 72 was separated from the female resident immediately. During an interview on 9/27/24 at 2:02 p.m., Certified Nursing Assistant (CNA) 3 indicated she had worked, on 8/25/24, when the incident between Resident 38 and 72 had occurred. Resident 38 was sitting in the sun and had fallen asleep in her chair. Resident 72 had also been in the courtyard. CNA 3 had been assisting another resident inside of the building and entered the courtyard to see Resident 72 standing over Resident 38. Resident 38 was yelling at Resident 72. CNA 3 had separated them, and Resident 38 had told CNA 3 that Resident 72 had touched her "private area". CNA 3 had separated the residents and informed the Qualified Medication Aide (QMA) about the incident as soon as it happened. Resident 72 had a history of inappropriately touching staff but had not touched another resident inappropriately until		immediately of any allegations of resident-to-resident abuse. The WD and ED will notify the physician and family to immediately begin 1:1 care prior to placement at a behavioral health facility. The Wellness Director will review the 24-hour report for any reported allegations and email this report to the Regional Wellness Director and the Executive Director who will address any abuse reports. This will be monitored daily and copies will be placed in the community binder and reviewed weekly during the Collaboration meeting with Peers and PCP.	

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	then. On 9/26/24 at 2:34 p.m., the Executive Director provided the Abuse, Neglect, or Exploitation policy, last reviewed 6/7/23, which read "...Definitions...Abuse - Harm or threatened harm to an adult's health or welfare caused by another person...Abuse, neglect, or exploitation of any resident will not be tolerated...."			
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency Based on observation, interview, and record review, the facility failed to ensure the kitchen flooring, walls, and ceiling vents were clean. This had a potential to affect 79 of 79 residents that resided in the facility. Findings include: A kitchen tour was conducted with the Executive Chef on 9/26/24 at 10:12 a.m. An observation was made of the dishwasher area walls, flooring, and ceiling vents. The walls behind the dishwasher and sink area had a yellow substance splatter down the walls and flooring and had a black substance along the back wall. The ceiling vent in that area had a gray substance in between the vent tracks. After, the stove and fryer area were observed with a yellow substance splattered down the walls behind the stove area, and the flooring had a black substance along the back wall to the drain area. The above ceiling vent in between the food preparation area, and the refrigerator and freezer had a gray substance in between the vent tracks. An observation was made of the kitchen with	R 0273	1 No residents were identified or affected by this deficient practice. 2 The community realizes that all residents have the potential to be affected by the deficient practice. 3 The culinary staff will immediately start a cleaning regimen which will be lead by the Executive Chef. The cleaning regimen will include but is not limited to, cleaning of all walls, floors and vents on a day-to-day basis. This will also include the cleaning of all appliances, shelves, coolers and refrigerators, and prep areas. The initial cleaning will be completed by 10/8/2024 and after this will be an ongoing process. 4 The Executive Chef will implement a new checklist system for all Culinary staff to ensure all requirements are met. This checklist will include all areas of cleaning, the staff member who is responsible for completing that	11/11/2024

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	Executive Chef on 9/27/24 at 10:56 a.m. The kitchen was observed with the walls of the dishwasher area, and the stove and fryer area with a yellow substance splatter down the walls, and the flooring in both areas had a black substance. The ceiling vents had a gray substance in between the vent tracks. An interview was conducted with the Executive Chef on 9/27/24 at 11:05 a.m. He indicated all the ceiling vents in the kitchen area were cleaned by the maintenance department. He had not seen him clean the vents for a while. The fryer last week had over flown and splattered on the walls and down the floor to the drain. The culinary staff has been working on getting the spillage cleaned up. Recently, culinary staffing has improved. He would address the cleanliness of the flooring and walls of the kitchen. A "Culinary Cleaning Schedule" policy was provided by the Executive Director on 9/27/24 at 3:53 p.m. It indicated, "...The purpose of the Culinary Cleaning Schedule is to provide a process and resource tool for the culinary team to maintain safety and sanitation standards in the kitchen...A weekly special tasks...Saturdays. clean and polish back wall of cook line...pull out all equipment and clean floors underneath...."		task, and at what point during the shift this will be completed. The culinary leaders will be responsible for making sure the checklists are completed and holding those accountable that are not completing the checklists. Staff will be educated on the importance of the cleaning process and the impact it has on the day to day care of our residents. The Executive Director will continuously monitor the checklists to support the culinary leadership.	
R 9999 Bldg. 00	3.1-14 Personnel (k) There shall be an organized ongoing inservice education and training program planned in advance for all personnel. This training shall include, but not be limited to, the following: (1) Residents' rights. (2) Prevention and control of infection.	R 9999	1 No residents were identified or affected by this deficient practice. 2 The community realizes that all residents have the potential to be affected by the deficient practice.	11/11/2024

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	(3) Fire prevention. (4) Safety and accident prevention. (5) Needs of specialized populations served. (6) Care of cognitively impaired residents. (l) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel as follows. The nursing personnel, this shall include at least twelve (12) hours of inservice per calendar year and six (6) hours of inservice per calendar year for nonnursing personnel. (u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method, (5 TU PPD), administered by person having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually		3 As of the date of the visit the leadership staff have implemented a new onboarding process to ensure all state requirements are met for new staff. All leaders will be involved in the onboarding process and follow through with the completion of all required documentation and both steps of the tuberculosis testing. All employees working in the Memory care unit will receive all required training as outlined in the state guidelines. 4 All leaders will verify that all employees files are completed per the state guidelines prior to the employee being added to the schedule. The Executive Director will also ensure that all files have been completed and a monthly audit will be completed using random employee files. If files are found to not be completed then the employee will be pulled from the schedule until all requirements are met.	

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	thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. (3) The facility shall maintain a health record of each employee that includes: (A) a report of the preemployment physical examination. (u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This state rule was not met as evidenced by: Based on interview and record review, the facility failed to ensure a new staff person received the second step tuberculin skin test and six hours of dementia training prior to working on a dementia unit for 1 of 5 employee files reviewed. ((Certified Nursing Assistant (CNA) 2)) The new employee personal file for CNA 2 was provided by the Executive Director on 9/27/24 at 10:00 a.m. It indicated CNA 2 had started employment on 8/20/24. It did not indicate a second step tuberculin skin test had been completed. The dementia training completion			

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	documentation indicated CNA 2 had completed 3.5 hours of dementia training. The nursing and CNA worked schedule was provided by the Executive Director on 9/26/24 at 11:45 a.m. It indicated CNA 2 had worked on the dementia unit on 9/23/24 and 9/28/24. An interview was conducted with the Executive Director and the Wellness Director (WD) on 9/27/24 at 11:48 a.m. She indicated the second step tuberculin skin test was missed. The WD indicated by error, CNA 2 had worked on the dementia unit prior to completing the required six hours of dementia training. A "Tuberculosis Infection Control" policy was provided by the Executive Director on 9/27/24 at 3:53 p.m. It indicated, "...A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the mantoux method... unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employee the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step...."			