STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	02/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Nursing Home Complaints IN00391300, IN00394673, IN00397247, IN00398169, IN00398408, IN00398923, IN00400811, IN00401490 and a COVID-19 Focused Infection Control Survey. This visit included the Investigation of Residential Complaint IN00395699. Complaint IN00391300 - Unsubstantiated due to lack of evidence. Complaint IN00394673 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00397247 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00398169 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00398408 - Unsubstantiated due to lack of evidence. Complaint IN00398923 - Substantiated. Federal/state deficiencies related to the allegations are cited at F755. Complaint IN00400811 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00401490 - Substantiated. Federal/state deficiencies related to the allegations are cited at F684. Survey dates: February 13, 14, and 15, 2023	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a Recertification and State Licensure survey on February 15, 2023. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Gina Couch	Executive Director	03/02/2023

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
	155292	A. BUILDING 00 B. WING	02/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Facility number: 000189 Provider number: 155292 AIM number: 100267330 Census bed type: SNF/NF: 123 Residential: 49 Total: 172 Census payor type: Medicare: 10 Medicaid: 83 Other: 30 Total: 123 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 15, 2023			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview, and record review, the facility failed to ensure bilateral boots were in place for a resident with an arterial ulcer (Resident H) for 1 of 3 residents reviewed for skin impairment. Findings include:	F 0684	p="" paraid="1781859794" paraeid="{478a9570-ce3b-4737-af87-53739882062e}{95}">F684 QOC What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Staff caring for	03/10/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	02/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The clinical record for Resident H was reviewed on 2/14/23 at 12:55 p.m. The diagnoses included, but were not limited to, fracture of right femur, acute embolism and thrombosis, peripheral vascular disease, and muscle weakness. A Significant Change in Status (MDS) minimum data set assessment, dated 1/31/23, indicated moderate cognitive impairment, extensive assistance with 2 staff for bed mobility, extensive assistance with one staff for dressing, and the presence of 2 venous and/or arterial ulcers. A physician order, dated 1/24/23, was noted for the use of Prevalon boots to bilateral feel except while bathing or bearing weight. A "Wound Management" tool, dated 1/31/23, indicated Resident H had an arterial ulcer to the left heel and the wound was still present as of 2/14/23. A care plan for skin impairment, revised 2/3/23, indicated Resident H had an arterial ulcer to the left heel. An approach was listed for a pressure reducing cushion in chair and a pressure reducing mattress on bed. An observation conducted of Resident H, on 2/13/23 at 11:58 a.m., noted her lying in bed with no Prevalon boots in place. There were 2 boots located on a nightstand in her room. Another observation of Resident H, on 2/13/23 at 3:10 p.m., noted her lying in bed with no Prevalon boots in place. There were 2 boots located on a nightstand in her room. The electronic treatment administration record		Resident H were immediately educated on arterial ulcer care plan intervention of bilateral boots Resident H no longer resides in facility How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? ul="" role="list" All residents with skin breakdown have the potential to be affected by the alleged deficient practice Full audit of skin care plan interventions to be completed by DNS/Designee. DNS/Designee will conduct an with all nursing on staff on skin management policy. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? DNS/Designee will conduct an with all nursing on staff on skin management policy. ul="" role="list" A daily rounding tool including skin care plan interventions to be utilized by Care Companions/Department managers. How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	02/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(ETAR) for February of 2023, noted the Prevalon boots signed off, as administered, on 2/13/23 for all shifts. There were no refusals documented for the month of February 2023, thus far. An interview conducted with the Director of Nursing (DON), on 2/14/23 at 1:57 p.m., indicated Resident H refuses to wear her Prevalon boots and it wasn't a surprise that the boots were not on her on 2/13/23. A policy titled "SKIN MANAGEMENT PROGRAM", revised 5/2022, was provided by the DON on 2/14/23 at 1:57 p.m. The policy indicated the following, "...PROCEDURE FOR ALTERATIONS IN SKIN INTEGRITY - PRESSURE AND NON-PRESSURE...2. Treatment order will be obtained from MD/NP [Medical Director/Nurse Practitioner]...6. A plan of care will be initiated to include resident specific risk factors and contributing factors with appropriate interventions implemented...." This Federal tag relates to Complaint IN00401490. 3.1-37(a)		reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	02/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on interview and record review, the facility failed to ensure a medication was obtained and administered for 1 of 3 residents reviewed for medication administration. (Resident G) Findings include: The clinical record for Resident G was reviewed on 2/13/23 at 2:32 p.m. The diagnoses included, but were not limited to, acute kidney failure, hepatic encephalopathy, cirrhosis of liver, ascites, emphysema, diabetes mellitus, and anemia. Resident G was admitted to the facility on 12/3/22. Discharge paperwork from the hospital indicated the following medication order, "...darbepoetin	F 0755	p="" paraid="1781859794" paraeid="{478a9570-ce3b-4737-af87-53739882062e}{95}">F755 Pharmacy /Procedures/Pharmacist/Records¿ What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? ul="" role="list" Nurses and QMA's educated on medication administration and new orders for non-controlled substances policy. Resident H no longer resides in facility How will you identify other	03/10/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	02/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	alfa 40 mCg/ mL [40 micrograms per milliliter] injectable solution [medication that causes the bone marrow to produce red blood cells]...1 Milliliter Subcutaneous...Every Tuesday at 6 PM [6:00 p.m.]...." A physician order, dated 12/3/22, indicated the following, "...Aranesp [darbepoetin alfa in polysorbat]...40mcg/0.4 mL...Injection...1 milliliter...Once A Day on Tue [Tuesday]...." The electronic medication administration record (EMAR) for December of 2022, indicated the Aranesp injection was not administered on 12/6/22 due to the medication being "on hold" and not signed off as administered on 12/13/22. The area on the EMAR was blank with no indication as to why it was not administered. An interview with the Director of Nursing (DON), on 2/14/23 at 1:57 p.m., indicated the pharmacy never sent the Aranesp injection because there were laboratory work that needed completed prior to administration. They were not completed, and the pharmacy faxed a clarification about the dosage. The DON indicated she called the pharmacy to inquire about the medication and the pharmacy staff indicated they never received a return fax, clarification, from the facility about Resident G's Aranesp injection. The medication was never sent to the facility for administration. A progress note, dated 12/15/22 at 9:31 a.m., indicated Resident G left the facility for a doctor's appointment and ended up going to the emergency room from the doctor's office. A hospital document, dated 12/16/22, indicated the following, "...upon reviewing patient's medication list, it was found that his list was		residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents receiving medications have the potential to be affected by the alleged deficient practice ul="" role="list" Full audit of medication administration to be completed by DNS/Designee. DNS/Designee will conduct an for all nurses and QMAs on new orders for non-controlled substances policy. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? DNS/Designee will conduct an for all nurses and QMAs on New orders for non-controlled substances policy Medication Administration report to be run daily in clinical meeting with follow-up on any missing medication. p="" paraid="1626374351" paraeid="{44034249-dd5e-484c-8321-047f3abc14ae}{122}"> How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	02/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	inaccurate, and that he had not been receiving his prescribed Aranesp...Furthermore, recent obtained outpatient labs (12/12) had displayed a Hgb [hemoglobin] 6.8 [Normal range for male: 13.8 to 17.2 grams per deciliter (g/dL)]...Assessment/Plan...5. Normocytic anemia due to blood loss...Acute on chronic normocytic anemia likely 2/2 [due to] blood loss, chronic disease/CKD [chronic kidney disease], and reportedly lacking Aranesp administration...1 unit PRBC [packed red blood cells] in the ED [emergency department]...." A policy titled "New orders for Non-Controlled Substances", revised 10/31/16, was provided by the DON on 2/14/23 at 1:57 p.m. The policy indicated the following, "...3. Facility should ensure all resident information is complete and accurate, has been reconciled and is verified by Physician/Prescriber before faxing or transmitting orders to the pharmacy...8. If the medication is needed before the next scheduled delivery and is not available in the Emergency Medication Supply, Facility staff should...8.1 Fax or transmit the order to the pharmacy...." This Federal tag relates to Complaint IN00398923. 3.1-25(a) 3.1-25(g)(2)		Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	
R 0000 Bldg. 00	This visit was for the Investigation of Residential Complaint IN00395699. The visit included the Investigation of Nursing Home Complaints IN00391300, IN00394673, IN00397247, IN00398169, IN00398408, IN00398923, IN00400811, IN00401490	R 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	02/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and a COVID-19 Focused Infection Control Survey. Complaint IN00395699 - Unsubstantiated due to lack of evidence. Survey date: February 13, 14 and 15, 2023 Facility number: 000189 Residential Census: 49 American Village was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00395699. Quality review completed on February 15, 2023		Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a Recertification and State Licensure survey on February 15, 2023. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	