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	03/28/2023

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 Complaints IN00403574 and IN00404205. Complaint IN00403574 - Federal/state deficiencies related to the allegations are cited at F557. Complaint IN00404205 - No deficiencies related to the allegations are cited. Unrelated deficiencies cited. Survey dates: March 27 and 28, 2023 Facility number: 000189 Provider number: 155292 AIM number: 100267330 Census bed type: SNF/NF: 113 Residential: 46 Total: 159 Census payor type: Medicare: 16 Medicaid: 85 Other: 12 Total: 113 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 3, 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 March 28, 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.	
F 0557 SS=D Bldg. 00	483.10(e)(2) Respect, Dignity/Right to have Prsnl Property §483.10(e) Respect and Dignity.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Gina Couch	Executive Director	04/10/2023

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	03/28/2023

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 resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. Based on observation, interview, and record review, the facility failed to promote dignity by not assuring a resident's clothing didn't have the appearance of wetness and not assuring a resident with an indwelling catheter had a dignity bag for 2 of 5 residents reviewed for dignity. (Resident D and Resident F) Findings include: 1. The clinical record for Resident F was reviewed on 3/27/23 at 3:05 p.m. The diagnoses included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction, encephalopathy, muscle weakness, and spinal stenosis. An admission Minimum Data Set (MDS) assessment, dated 3/24/23, but not fully complete, indicated Resident F received extensive staff assistance for toileting, dressing, personal hygiene, and transfers. He was frequently incontinent of bowel and bladder. A care plan, dated 3/18/23, indicated Resident F required assistance with toileting due to incontinence. An approach was listed to assist with elimination. An activities of daily living (ADL) care plan, dated 3/18/23, indicated Resident F required assistance	F 0557	p role="heading" aria-level="1" paraid="1722459512" paraeid="{8453f3c9-677f-4bba-aeb b-12dbe9256c6d}{173}" >F557 (d) -Dignity What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident F was assisted with incontinent care and clothing was changed. ·Resident D catheter was placed in a dignity bag off the floor. p class="Paragraph SCXW125232909 BCX0" xml:lang="EN-US" paraid="2039590101" paraeid="{1b9665c8-d2a9-4c9c-b0 c4-a6de30956039}{188}" > How will you identify other residents having the potential to be affected by the same deficient	04/21/2023

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	03/28/2023

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
	with ADLs. The approaches were listed to assist of at least one with toileting and/or incontinent care as needed and assist with dressing/grooming/hygiene as needed. An observation conducted of Resident F, on 3/27/23 at 11:20 a.m., showed him sitting up in his wheelchair outside of his room with a visably wet spot to his hospital gown in the front part of his body. Resident F stated "I'm wet and I've been waiting for someone to come and help me". "My gown is wet". A staff member approached Resident F and he commented "where's all the help at"? "I need changed". "I got p--- on me". Resident F indicated he had been waiting "too long" for assistance in hygiene. An interview conducted with Resident F, on 3/28/23 at 10:23 a.m., indicated he was "very angry" in regards to 3/27/23 when he was incontinent and waited over 30 minutes for staff assistance. 2. The clinical record for Resident D was reviewed on 3/27/23 at 3:00 p.m. The diagnoses included, but was not limited to, chronic kidney disease, diabetes mellitus, dementia, muscle weakness, and retention of urine. An observation conducted on 3/27/23 at 11:00 a.m., noted Resident D's urinary catheter bag laying flat on the floor without a dignity bag. An observation conducted, on 3/27/23 at 2:03 p.m., of Resident D's urinary catheter bag laying flat on the floor without a dignity bag. A policy titled "Resident Rights", revised 11/16, was provided by Corporate Nurse 2 on 3/28/23 at 10:10 a.m. The policy indicated the following,		practice and what corrective action will be taken? All residents have the potential to be affected by this deficient practice. ·All residents with catheters were checked by DNS/designee to ensure bags are not touching floor and dignity bag placement ·DNS/Designee checked other residents to ensure clothing was clean and dry. No additional concerns were identified. ·All staff re-educated on dignity utilizing Resident Rights policy by DNS/Designee by 4/19/23. ·A daily rounding tool reviewing dignity to be utilized by Care Companions/Department Managers. What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur? ul class="BulletListStyle1	

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	03/28/2023

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
	"...All staff members recognize the rights of residents at all times and residents assume their responsibilities to enable personal dignity, well being, and proper delivery of care...." This Federal tag relates to Complaint IN00403574. 3.1-3(t)		SCXW125232909 BCX0" role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verdana;" All staff re-educated on dignity utilizing Resident Rights policy by DNS/Designee by 4/19/23. A daily rounding tool reviewing dignity to be utilized by Care Companions/Department Managers. How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The POC QAPI Tool will be utilized by ED/designee weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director ul class="BulletListStyle1 SCXW125232909 BCX0" role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible;	

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	03/28/2023

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
			cursor: text; font-family: verdana;" If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation, interview, and record review, the facility failed to ensure call lights were in reach for 2 of 5 residents reviewed for accommodation of needs. (Resident D and Resident H) Findings include: 1. The clinical record for Resident D was reviewed on 3/27/23 at 3:00 p.m. The diagnoses included, but was not limited to, chronic kidney disease, diabetes mellitus, dementia, muscle weakness, and retention of urine. An observation conducted on 3/27/23 at 11:00 a.m., noted Resident D's call light coiled up to the side rail and hanging downwards. Resident D attempted to reach his call light but was unable to do such during the observation. 2. The clinical record for Resident H was reviewed on 3/27/23 at 3:07 p.m. The diagnoses included, but were not limited to, encephalopathy, Parkinson's disease, and muscle weakness.	F 0558	p role="heading" aria-level="1" paraid="1322562537" paraeid="{1201070f-d8aa-45b9-9a8e-4c98a3834da0}{45}" >F558 D What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Call light clip added to Resident D and Resident H's call light. Call light clipped in reach of resident. 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 class="BulletListStyle1 SCXW167598390 BCX0"	04/21/2023

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	03/28/2023

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
	An observation conducted of Resident H, on 3/27/23 at 11:35 a.m., of her call light wrapped around the side rail and hanging down the side of the bed. She was up in her wheelchair and unable to reach the call light after she attempted during the observation. An observation conducted of Resident H, on 3/27/23 at 2:04 p.m., of her call light in the same position as prior and out of reach. An interview conducted with Corporate Nurse 2, on 3/28/23 at 10:12 a.m., indicated the expectations are for call lights to be in residents' reach. 3.1-3(v)(1)		role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verdana;" All residents have the potential to be affected by the alleged deficient practice All resident rooms were checked for call lights to ensure placement and function by Care Companion team/Department Managers. Call light clip added to all resident call lights to assist keeping call light in reach All staff re-educated regarding call lights placement and function by DNS/Designee by 4/19/23. A daily rounding tool reviewing call light in reach to be utilized by Care Companions/Department Managers. What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur? ul class="BulletListStyle1 SCXW167598390 BCX0" role="list" style="margin: 0px; padding: 0px; user-select: text;	

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	03/28/2023

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
			-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verdana;" Call light clip added to all resident call lights to assist keeping call light in reach All staff re-educated regarding call lights placement and function by DNS/Designee by 4/19/23. A daily rounding tool reviewing call light in reach to be utilized by Care Companions/Department Managers. How 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 Committee overseen by the Executive Director ul class="BulletListStyle1 SCXW167598390 BCX0" role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verdana;"	

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	03/28/2023

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
			If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health			

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	03/28/2023

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
	oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.			
	Based on interview and record review, the facility failed to ensure complete documentation of weekly skin assessments and the electronic medication administration records (EMARs) for 3 of 7 residents records reviewed. (Resident C, E,	F 0842	p role="heading" aria-level="1" paraid="1712837943" paraeid="{1201070f-d8aa-45b9-9a8e-4c98a3834da0}{161}" >F842 D	04/21/2023

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	03/28/2023

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 H) Findings include: 1. The clinical record for Resident C was reviewed on 3/27/23 at 12:23 p.m. The diagnoses included, but were not limited to, intestinal obstruction, cerebral infarction, muscle weakness, asthma, anxiety disorder, hypertension, and congestive heart failure. The February 2023 EMAR was reviewed and indicated the following holes: - Albuterol sulfate nebulizer treatment every 4 hours with 7 holes. 2. The clinical record for Resident E was reviewed on 3/27/23 at 3:02 p.m. The diagnoses included, but were not limited to, fracture of right fibula, diabetes mellitus, gout, congestive heart failure, atrial fibrillation, and spinal stenosis. A physician order, dated 2/24/23, indicated to conduct weekly skin assessments every Thursday. The EMAR for March of 2023 showed the weekly skin assessments to be conducted on 3/2/23, 3/9/23, 3/26/23, and 3/23/23 were left blank. A weekly skin observation was documented as being conducted on 3/9/23 and 3/16/23. No skin observations were documented as being completed on 3/2/23 and 3/23/23. 3. The clinical record for Resident H was reviewed on 3/27/23 at 3:07 p.m. The diagnoses included, but were not limited to, encephalopathy, Parkinson's disease, and muscle weakness.		What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Full house audit of administration compliance and weekly skin assessments completed by DNS and addressed as necessary 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 class="BulletListStyle1 SCXW253979729 BCX0" role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verdana;" All residents have the potential to be affected by the alleged deficient practice Full audit of nebulizer administration and weekly skin assessments completed by DNS/Designee. DNS/Designee will conduct an with all licensed nurses and QMAs on medication administration by 4/19/23.	

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	03/28/2023

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
	A physician order, dated 1/5/23, indicated to conduct a weekly skin assessment every Thursday. The EMAR for March of 2023 showed the weekly skin assessment for 3/23/23 was left blank. 3.1-50(a)(1) 3.1-50(a)(2)		DNS/Designee will conduct an with all nursing staff on skin management policy by 4/19/23. p paraid="1922719581" paraeid="{1201070f-d8aa-45b9-9a8e-4c98a3834da0}{244}" >What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur? The DNS/designee will review the previous day nebulizer administration records daily in clinical meeting ·Weekly skin assessments to be reviewed daily in clinical meeting for compliance ·DNS/Designee will conduct an with all licensed nurses and QMAs on medication administration by 4/19/23. ·DNS/Designee will conduct an with all nursing staff on skin management policy by 4/19/23. p paraid="437036718"	

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	03/28/2023

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
			paraeid="{08472391-5eb4-40e5-b1cc-91fce884139f}{37}" > How 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 with results 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	