This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00294091.

Compliant IN00294091-Substantiated. No deficiencies related to the allegations are cited.

Survey dates: May 8, 9, 10, 13, 14, and 15, 2019.

Facility number: 00189
Provider number: 155292
AIM number: 100267330

Census Bed Type:
SNF/NF: 132
Residential: 58
Total: 190

Census Payor Type:
Medicare: 23
Medicaid: 90
Other: 19
Total: 132

These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.

Quality review completed on May 24, 2019

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 May 15, 2019. 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.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determin other safeguards 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 disclosed 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.
### Summary Statement of Deficiencies

- **§483.10(a)(1)** A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.

- **§483.10(a)(2)** The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

- **§483.10(b)** Exercise of Rights.
  
  The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

- **§483.10(b)(1)** The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

- **§483.10(b)(2)** The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.

Based on observation, interview, and record review, the facility failed to treat a resident with dignity upon staff entrance into the room for 1 of 1 resident reviewed for dignity. (Resident 38)

#### Related Corrective Actions

1. For Resident 38, Care Plan for Impaired Vision was reviewed and approach was added for all staff to introduce themselves by name to Resident 38 and explain all
Findings include:

The clinical record for Resident 38 was reviewed on 5/8/19 at 12:30 p.m. The diagnoses for Resident 38 included, but were not limited to, malnutrition and failure to thrive. He was receiving hospice services in the facility.

The 10/5/18 impaired vision care plan indicated the goal was for Resident 38 to not experience negative consequences of his vision loss.

An interview was conducted with Family Member 2, Resident 38's wife, on 5/8/19 at 12:38 p.m. She indicated Resident 38 had poor vision, and it would be helpful if the staff would introduce themselves and tell them why they're in his room. She stated, "It would help him feel less alone. I've noticed they don't always do that."

An observation was made of Resident 38 on 5/15/19 at 10:28 a.m. CNA (Certified Nursing Assistant) 3 entered Resident 38's room without knocking, to answer his call light request. After entering, CNA 3 stated, "Yes, sir, how may I help you?" Resident 38 responded. CNA 3 informed Resident 38 she and another staff member were going to assist him with getting up shortly. CNA 3 did not introduce herself during this interaction.

An observation of Resident 38 was made with the DNS (Director of Nursing Services) on 5/15/19 at 10:43 a.m. The DNS entered Resident 38's room without knocking on the door.

An interview was conducted with Family Member 2 on 5/14/19 at 4:20 p.m. She indicated she'd spoken with staff previously, at care plan meetings, about introducing themselves to Resident 38, when entering his room. She stated, actions and activities for all interactions with Resident 38. Information and approach added to resident profile.

2. All residents have potential to be affected by deficiency. MDS nurse will review care plan for all residents identified with severely impaired vision by 6/5/19. Individual approach updated for care plans to include all staff to introduce themselves by name and explain all actions and activities for all interactions with identified individuals. Information and approach added to resident profiles.

3. CEC/designee will complete a facility wide in-service with all departments on resident rights policy specific to dignity and respectful interactions with residents. During the resident rights training for orientation of new hires, focus will be directed specifically on dignity and respectful interactions to include knocking prior to entering the room and staff explaining activity to be performed, to be completed by 6/10/2019.

4. Each resident will be assigned a care representative. The staff care representative/designee will conduct daily rounds to include: staff observations and resident interviews to ensure standards of dignity and respect are met for all residents on rounding tool. Rounds will be conducted on the
"He's pretty low maintenance. At this point, I think the status quo is okay. It would be nice, if they made it a general rule to do that."

The Resident Rights policy was provided by the DNS on 5/15/19 at 2:40 p.m. It read, "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."

3.1-3(a)

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 provide a resident with a touch pad call light, as ordered and ensure a resident's call light was easily accessible for 1 of 1 resident reviewed for dignity and 1 of 1 residents reviewed for position and mobility. (Residents 31 and 38)

Findings include:

1. The clinical record for Resident 38 was reviewed on 5/8/19 at 12:30 p.m. The diagnoses for Resident 38 included, but were not limited to, malnutrition and failure to thrive.

The 10/5/18 impaired vision care plan for Resident 38 indicated an intervention was to keep his call following schedule: Daily for 4 weeks, then weekly for 4 weeks, and monthly for 6 months with a goal/threshold of 95% compliance rate with all interactions. Director of Nursing/designee will assess data from rounding tools and present results during monthly QAPI meeting, overseen by Executive Director, to determine further actions, educational needs, and frequency of ongoing monitoring.

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F 0558
1. Resident 38 push call light was immediately replaced with flat panel call light at time of observation/notification. Resident 31 call light was immediately removed from the floor and placed within reach of resident at the time of observation/notification.

2. All residents have the potential to be affected by this deficiency. Facility wide audit will be completed by nursing managers/designee, each resident profile compared to room environment to ensure all devices are correct and in place, (to be completed by 6/5/19)
light in reach at all times.

The physician's orders for Resident 38 indicated a touch pad call light, effective 9/28/18.

An observation of Resident 38 was made on 5/13/19 at 3:40 p.m. He was sitting in his recliner in his room.

An observation of Resident 38 was made on 5/14/19 at 10:38 a.m. He was sitting in his recliner in his room.

An observation was made of Resident 38 on 5/15/19 at 10:28 a.m. He was sitting in his recliner, with his standard push button call light on his lap. Resident 38 attempted to press his call light by feeling for the cord, maneuvering his hand up the cord, and feeling around with his thumb for the small red button. Resident 38 pressed the side of the red button multiple times, but was unable to press the top of the red button to activate it. Resident 38 set the call light back down, and stopped attempting to activate it. A touch pad call light was observed on his bed on the other side of the room.

An observation was made and interview was conducted with Resident 38 and the DNS (Director of Nursing Services) on 5/15/19 at 10:43 a.m. Resident 38 was sitting in his recliner chair in his room. His call light was between his left leg and the side of his recliner chair. Resident 38 indicated his touch pad call light was easier to use, would like one, and asked if he was going to get one.

2. The clinical record for Resident 31 was reviewed on 5/9/19 at 9:00 a.m. The diagnosis for Resident 31 included, but was not limited to, hemiplegia and hemiparesis following...
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

**X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER**

**155292**

**X2) MULTIPLE CONSTRUCTION**

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**X3) DATE SURVEY COMPLETED**

05/15/2019

**NAME OF PROVIDER OR SUPPLIER**

AMERICAN VILLAGE

**STREET ADDRESS, CITY, STATE, ZIP CODE**

2026 E 54TH ST

INDIANAPOLIS, IN 46220

**SUMMARY STATEMENT OF DEFICIENCY**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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**PROVIDER'S PLAN OF CORRECTION**

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

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A nontraumatic subarachnoid hemorrhage affecting left non-dominant side.

The 2/18/19 quarterly MDS (Minimum Data Set) assessment indicated Resident 31 had a BIMS (brief interview for mental status) score that indicated she was cognitively impaired. Resident 31 had functional status of impairment on one side of her upper and lower extremities. She was extensive assistance with 2 person assistance for bed mobility and transfers. Resident 31 also needed extensive assistance with 1 staff person for personal hygiene and eating.

A care plan for Resident 31 dated 10/10/18, indicated "Resident requires assistance with ADLs (activities of daily living) including bed mobility, transfers, eating and toileting related to: subarachnoid hemorrhage/CVA (stroke),... left sided hemiparesis, left hand splint, dysarthria (motor speech disorder),...aphasia (inability to comprehend or formulate language), dysphasia (swallowing),...weakness,...abnormal posture, altered awareness of immediate physical environment...hx (history) of ...edema left side,...decreased ROM (range of motion) to left side,..."

An observation was made of Resident 31 on 5/9/19 at 10:13 a.m. Resident 31 was lying in bed. Resident 31’s call light was attached to the wall, and the cord ran against the length of the wall lying on the floor.

An observation was made of Resident 31 on 5/9/19 at 3:25 p.m. Resident 31 was lying in bed with the call light and bed remote positioned on the left side of her on the top left side of her bed.

An observation was made of Resident 31 on
5/13/19 at 9:44 a.m. Resident 31 was lying in bed with the call light attached to the wall lying on the floor.

An observation was made of Resident 31 in bed with the Assistant Director of Nursing Services (ADNS) on 5/13/19 at 10:04 a.m. The call light was observed attached to the wall lying on the floor.

At that time, the ADNS indicated the call light should be in reach to Resident 31. The ADNS then picked up the call light and placed it left side of Resident 31 on the bed.

3.1-3(v)(1)

483.10(f)(1)-(3)(8)
Self-Determination
§483.10(f) Self-determination.
The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.

§483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.

§483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.

§483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside
and outside the facility.

§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.

Based on observation, record review and interview, the facility failed to honor a resident's choice related to preferred method of getting weighed daily for 1 of 2 residents reviewed for choices. (Resident 104)

Finding includes:

On 5/8/19 at 12:21 p.m. an observation was made of resident 104 sitting in her wheelchair in the dining room. At that time, one other resident was in the dining room.

On 5/09/19 at 2:11 p.m., in an interview with resident 104 she stated, "I would rather get weighed on the machine instead of the chair because the chair hits me in all the wrong places." The resident indicated she has asked the "people wearing red" several times to be weighed in the machine but indicated her preference is not being considered. She stated, "after therapy, they sit me in the dining room by myself and no other residents are there. I have asked to go back to my room but they say no and its cold in the dining room and I just freeze".

The record for resident 104 was reviewed on 5/13/19 at 9:44 a.m. Diagnosis include, but were not limited to, hypertension, diverticulitis with perforation; acute kidney injury; left upper extremity DVT (deep vein thrombosis, a blood clot); Congestive Heart Failure (CHF) and breast cancer.

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<td>1. Resident 104 care plan immediately updated to include preference to be weighed in a hooyer lift/</td>
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<td>2. All residents have the potential to be affected by deficiency. Facility wide audit will be completed by care</td>
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<td>representatives/designee to ensure that current residents’ preferences are being met by resident and family interview, (to be completed by 6/8/19)</td>
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<td>3. CEC/designee will complete facility wide in-service for staff of all departments on honoring resident choices and preferences to be completed by 6/10/2019.</td>
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<td>4. Each resident will be assigned a care representative. The staff care representative will conduct daily rounds to include interview of resident to ensure choices and preferences are being met for all residents on rounding tool.</td>
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<td>Rounds will be conducted daily a week for 4 weeks, then weekly for 4 weeks, and monthly for 6 months with a goal/threshold of</td>
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The care plan dated, 4/19/2019, indicated resident is at risk for pain related to: muscle weakness, impaired range of motion of bilateral upper extremities and bilateral lower extremities. An intervention listed on 4/19/2019 indicated an approach was to assist with positioning to comfort.

On 5/14/19 at 3:15 p.m., an interview with UM 1 indicated she had not been made aware of residents choice on how to be weighed. She indicated that a residents choice of the method of getting weighed should be honored by all staff members. UM1 indicated that CNA's wear red scrubs and concluded that resident 104 is referencing the CNAs when saying "the people in red".

On 5/14/19 at 3:44 p.m. an interview with UM and resident 104, resident 104 indicated she was not happy with the way staff was weighing her. According to resident 104, the CNAs had been lifted with hoyer out of bed then placed in wheel chair and wheeled down to roll up scale but prefers to be weighed in the hoyer lift. UM 1 clarified that the resident could have been weighed by hoyer lift more easily rather than how the resident stated she was being weighed and did not need to be weighed in the chair vs the lift. The resident was a daily weight related to congestive heart failure.

An interview on 5/15/19 at 5:26 p.m. with DON indicated a resident's preference on manner of obtaining a daily weight are not part of the traditional resident preference profile that is completed upon admission.

3.1-3(u)(1)
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**NAME OF PROVIDER OR SUPPLIER**

AMERICAN VILLAGE

2026 E 54TH ST

INDIANAPOLIS, IN 46220

**SUMMARY STATEMENT OF DEFICIENCY**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

**PROVIDER'S PLAN OF CORRECTION**

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

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- §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.

- §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.

- §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).
  - (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.
  - (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.
  - (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.
  - (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.
  - (v) The facility is not relieved of its obligation
Based on interview and record review, the facility initiated CPR (Cardio Pulmonary Resuscitation) to a resident whose code status was DNR (Do Not Resuscitate) for 1 of 1 resident reviewed for death. (Resident 135)

Findings include:

- The clinical record for Resident 135 was reviewed on 5/13/19 at 10:51 a.m. The diagnoses for Resident 135 included, but were not limited to: chronic respiratory failure, end stage renal disease, heart failure, and failure to thrive. He was admitted to the facility on 2/20/19.

- The physician's orders for Resident 135 indicated his code status was a DNR, effective 2/20/19. An alert on the physician's orders read, "POST [Physician's Order for Scope of Treatment] FORM 2/13/18 DNR/COMFORT MEASURES/NO ARTIFICIAL NUTRITION: Revised 2/18/19."

- Resident 135's electronic health record contained 2 versions of the same 2/13/18, revised 2/18/19, POST form. Both versions indicated Resident 135 was DNR, comfort measures only, and no artificial nutrition. Both versions were signed by Resident 135. Only one of the versions was signed by the treating physician/NP (Nurse Practitioner.) The electronic health record indicated both versions were attached to the electronic health record on 2/21/19.

- The 2/21/19 care plan for Resident 135 read, "Resident/legal representative has formulated an
**Summary Statement of Deficiencies**

**Advanced Directive:** POST FORM: DNR, comfort measures, no artificial nutrition. The goal indicated on the care plan read, "Resident/legal representative preferences in regards to advanced directives will be honored."

The 2/25/19, 11:54 a.m. nurse's note read, "Writer spoke with wife, stated he told her that he was going to do all the refusals which has been noted today. Res [Resident] has refused all care today including dialysis and medication...told family that he was tired and wanted to go home. NP in facility updated of res recent changes and refusals."

The 2/25/19, 3:52 p.m. nurse's note read, "Res was noted by staff at 3:20 p.m., appeared to be without vitals. Unsigned dnr noted in the res file, cpr initiated, staff called 911 and medical power of attorney(wife). POA [Power of Attorney] stated he is to be dnr, so per poa cpr stopped. Death verified by 2 nurses, time of death 3:30 p.m. Wife is on her way at this time to facility." The original version of this note included a statement that read, "Upon further review of the chart, a signed copy of the DNR was located."

The 2/25/19, 4:15 p.m. nurse's note read, "Writer responded to CPR code alert; resident noted without pulse/respirations, resident lowered to floor from bed, CPR initiated x [times] 3 nurses. 911 dispatched. Staff member entered room and advised resident's representative (wife) provided verbal consent to stop CPR per his advanced directives."

An interview was conducted with the DNS (Director of Nursing Services) on 5/13/19 at 2:19 p.m. She indicated she thought SSA (Social Services Assistant) 4 saw the unsigned version of wide tracker in real time and monitor weekly for weeks for 6 months. with a goal of 100% compliance. Social Services Director will ensure 100% compliance and present findings from the tracker during monthly QAPI meeting to determine further actions, educational needs, and continued monitoring needs.
Resident 135's DNR in his record, so they started CPR, and stopped per Resident 135's wife's verbal request.

An interview was conducted with SSA 4 on 5/13/19 at 2:24 p.m. in the presence of the DNS. She indicated when she saw the POST Form was not signed, she took it to the nurse practitioner, who told her to have another POST form completed, but in the process, Resident 135 coded. She indicated, when Resident 135 first admitted, there was a POST form completely filled out, so she created the DNR care plan. Then, when she looked again, she saw the unsigned one, and did not see the signed one, but may have overlooked it.

The Physicians Order for Scope of Treatment policy was provided by the Administrator on 2/23/19 at 3:00 p.m. It read, "It is the policy of the facility that Physician Orders for Scope of Treatment (POST) forms will be honored and executed per the following guidelines as residents and/or legally recognized health care decision maker's desire....For residents admitting with an existing POST form: ...The POST will be honored during the initial comprehensive assessment period (14 days) even if the attending physician has not yet formally reviewed the form."

3.1-4(d)

483.10(i)(1)-(7)
Safe/Clean/Comfortable/Homelike Environment
§483.10(i) Safe Environment.
The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.
The facility must provide:

§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.

(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.

(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90(e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.

Based on observation, interview and record review the facility failed to ensure reasonable care for the protection of residents personal property from loss related to lack of reporting of missing items for Resident 95 and 336, concern/grievance forms for missing items were filled out. Resident 95 to have missing items.

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<td>For resident 95 and 336, concern/grievance forms for missing items were filled out. Resident 95 to have missing items</td>
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AMERICAN VILLAGE

STREET ADDRESS, CITY, STATE, ZIP CODE
2026 E 54TH ST
INDIANAPOLIS, IN 46220

NAME OF PROVIDER OR SUPPLIER

SUMMARY STATEMENT OF DEFICIENCY
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
clothing items for 2 of 3 residents reviewed for personal property. (Resident 95 and Resident 336)

Findings include:

1. An interview with resident 95, on 5/9/19 at 11:53 a.m. indicated, he had lost a striped shirt and a pair of jeans over a week ago. He had told his physical therapist (PT) a week ago that these items were missing. The PT went to the laundry room to look for the missing items but returned and told resident 95 that they could not locate them.

An interview with the Unit Manager (UM1) on 5/13/19 at 11:29 a.m. indicated, the proper procedure for reporting lost items is to staff to make her aware of what the missing items are, talk with the resident to ensure a proper description of missing items is obtained, create and distribute a written report of missing items, for tracking purposes, to the Laundry Supervisor. The Laundry Supervisor should then go through the lost and found. If the missing items are not found, the UM1 indicated, the missing item report would be given to the administrator. She indicated she was not aware of the missing items and that staff should have notified her by leaving a note, talking with her directly or following up with social services for resident 95. She indicated the reporting and investigation into lost personal items is handled in the same manner as a grievance.

An interview with the Laundry Supervisor (LS18) on 5/14/19 at 10:51 a.m. indicated her procedure for locating missing items is: once she receives the missing item report, she speaks to resident directly to get an accurate description of items. She then will go through items in the lost and replaced and Resident 336 missing items were located.

2. All residents have the potential to be affected by this deficiency. The IDT reviewed residents that have outstanding grievances related to missing items. Each resident in the facility will be assigned a care representative immediately who will visit their assigned residents daily. The staff care representatives will conduct interviews by 6/10/19 to determine if any residents currently have missing items. A new grievance will be generated for any outstanding missing items.

3. Care representatives will complete the interviews for their assigned residents by 6/10/19 to ensure 100% of residents have been audited for any current missing items. Should an item be suspected missing in the future, staff will follow grievance process and reference the personal property inventory to see what may be missing. Staff will be in-serviced by 6/10/19 on the grievance process. Activities Director will provide education monthly at Resident Council on who to contact and how to complete the grievance process should they have an item(s) missing. This education will be ongoing.

4. All grievances will be addressed in IDT meeting daily.
found area in laundry room. If not found, she passes the report to the administrator. She indicated its usually a 24 hour turn around time from the time she gets the information to locating the missing items.

An interview on the same day, at 2:55 p.m. with LS indicated resident 95's belongings have not been located as of yet but, she will continue to look for them.

On 05/14/19 at 4:05 p.m., an interview with DON indicated that a grievance form should have been filled out for missing items when resident 95 first stated he was missing personal property. DON indicated she was not aware of this issue but would look for a previously filed grievance form for resident 95.

The Administrator, interviewed on 5/14/19 at 4:13 p.m., indicated if a resident's personal property was not located the facility would reimburse for the missing items.

At the time of exit from facility, the DON had not provided a previously filed grievance form regarding resident 95's missing items.

2. During an interview with resident 336 on 5/09/19 at 11:23 a.m., she indicated she was missing a pair of jeans, a pair of underwear, a bra and a T-shirt and had informed her day shift nurse on 5/8/19. Resident 336 stated, "they took them before my name was placed in it."

On 5/13/19 at 11:29 a.m., an interview with UM1 indicated, she was not aware of resident 336's missing clothing and that staff should have notified her of this. The staff member who receives information of missing items from a

Grievances related to missing items will be monitored via QA Tools spreadsheet and reported back to facility during monthly QAPI meeting. 100% of grievances related to missing items will be resolved monthly, with the Executive Director/Administrator overseeing these resolutions. The monitoring and reporting during QAPI meeting will be ongoing.
resident should have notified the UM1 by leaving a note, talking with her directly or following up with social services. She indicated the reporting and investigation into lost personal items is handled in the same manner as a grievance.

An interview on 5/14/19 at 3:55 p.m. with the Laundry Manger (LM) stated, "I found her bra, underwear and a t-shirt she didn't even realize was missing. I put her name inside them so next time we will know who they belong to". She indicated she would continue to look for the remaining missing items.

On 05/14/19 at 4:05 p.m., an interview with DON indicated that a grievance form should have been filled out for missing items when resident 336 first stated she was missing personal property. DON indicated she was not aware of this issue prior to now.

The Resident Concerns and Grievances policy received 5/14/19 states, "...The intent of our policy is to have support each resident's right to voice grievances (e.g., complaints about treatment, care, management of funds, lost clothing, violation of rights, etc.) and to assure that after receiving a complaint/grievance, we actively seek a resolution and keep the resident appropriately apprised of our progress toward resolution...If a concern/grievance of any kind is noted, the Concern/Grievance form is used. The person receiving the concern completes Section I. The Concern/Grievance form is then referred to the Department Head for review and actions taken.

3.1-9
3.1-28(a)
<table>
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<tr>
<th>F 0637</th>
<th>06/10/2019</th>
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<td><strong>483.20(b)(2)(ii)</strong></td>
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<td>Comprehensive Assessment After Significant Chg</td>
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<td>§483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a &quot;significant change&quot; means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)</td>
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<td>Based on interview and record review, the facility failed to ensure a Significant Change MDS (Minimum Data Set) assessment was completed for 1 of 1 resident reviewed for hospice. (Resident 38)</td>
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<td>Findings include:</td>
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<td>The clinical record for Resident 38 was reviewed on 5/8/19 at 12:30 p.m. The diagnoses for Resident 38 included, but were not limited to, malnutrition and failure to thrive.</td>
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<td>An interview was conducted with Family Member 2, Resident 38's wife, on 5/8/19 at 12:41 p.m. She indicated Resident 38 was currently receiving hospice services.</td>
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<td>An interview was conducted with the LPN (Licensed Practical Nurse) 5 on 5/13/19 at 3:41 p.m. She indicated Resident 38 was currently receiving hospice services and referenced a hospice binder for him located at the nurse's station.</td>
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The physician’s orders for Resident 38 indicated a consult with hospice services, effective 3/28/19, and to admit to hospice services, effective 4/5/19.

The census portion of Resident 38’s electronic health record indicated his payer source changed to hospice effective 4/1/19.

The most recent MDS assessment completed for Resident 38 was a 2/20/19 Quarterly Assessment. No Significant Change MDS assessment was completed.

An interview was conducted with the MDS Coordinator on 5/13/19 at 3:45 p.m. She indicated a Significant Change MDS assessment should be completed for a resident going on or coming off of hospice. She indicated Resident 38 should have had one completed within 14 days of going on hospice.

3.1-31(d)(1)

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 administer a resident’s diabetes and depression medications as ordered, significant change documentation was opened, and date of completion.

4. MDS/designee will complete tracker in real time and monitor weekly for 6 months with a goal/threshold of 100% compliance rate. MDS/designee will assess data from tracker and present results during monthly QAPI meeting, overseen by Executive Director, to determine further actions, educational needs, and frequency of ongoing monitoring.

1. Resident 115 medications were restocked by pharmacy and administered as ordered. For the case of Resident 31 upon
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<tr>
<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCY</th>
<th>(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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<td>ensure the placement of pravalon boots, edema glove and ear protectors on a resident as ordered, and monitor a skin tear for healing for 1 of 5 residents reviewed for unnecessary medications, 1 of 1 resident reviewed for position and mobility, and 1 of 3 resident reviewed for skin conditions. (Residents 24, 31 and 115)</td>
<td>notification of deficiency, hand splint, edema glove, ear protectors, and pravalon boots were applied immediately. In the case of Resident 24, Wound Nurse immediately assessed scabbed area upon notification and MD was notified of existing scabbed area. New order given to monitor area for 72 hours for temperature and drainage, new order given to refer Resident 24 to dermatology services. Resident was seen by dermatology on 5/28/19 with no new orders.</td>
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<td>Findings include:</td>
<td>1. The clinical record for Resident 115 was reviewed on 5/14/19 at 12:33 p.m. The diagnoses for Resident 115 included, but were not limited to, diabetes and depression. The diabetes care plan for Resident 115 indicated to administer medications as ordered. The physician's orders for Resident 115 indicated to administer a 5 mg tablet of Tradjenta once daily, effective 6/7/19, and 90 mg of Duloxetine once daily, effective 4/16/19. The April, 2019 and May, 2019 MARs (medication administration records) indicated the Tradjenta was not administered on 4/30/19, 5/1/19, and 5/13/19, because the drug was unavailable. The May, 2019 MAR indicated the Duloxetine was not administered on 5/13/19, because the drug was unavailable. An interview was conducted with the DNS (Director of Nursing Services) on 5/15/19 at 9:36 a.m. She indicated she looked into why the above medications were unavailable on the above dates and concluded it was because the medications were not in their refill window, as insurance would not pay for additional doses sooner than the refill was due. The DNS called the facility pharmacy at notification of deficiency, hand splint, edema glove, ear protectors, and pravalon boots were applied immediately. In the case of Resident 24, Wound Nurse immediately assessed scabbed area upon notification and MD was notified of existing scabbed area. New order given to monitor area for 72 hours for temperature and drainage, new order given to refer Resident 24 to dermatology services. Resident was seen by dermatology on 5/28/19 with no new orders.</td>
<td>2. All residents on have potential to be affected by deficiency. Assistant Director of Nursing will conduct an audit for the previous 30 days for medications marked as not-available. Pharmacy will be contacted to restock any unavailable medications. Audit to be completed by 6/8/19 Care representatives/designee will conduct facility wide audit for profile interventions, resident profiles will be compared to room environment to ensure all devices and interventions are correct and in place. Audit to be completed by 6/5/19 Nursing managers/designee will complete facility wide skin sweeps for residents to assess any areas and determine ongoing monitoring and management per skin integrity policy. Audit to be completed by 6/8/19</td>
<td>3. CEC/designee will complete</td>
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**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**IDENTIFICATION NUMBER**

**MULTIPLE CONSTRUCTION**

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**DATE SURVEY COMPLETED**

05/15/2019

**NAME OF PROVIDER OR SUPPLIER**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

AMERICAN VILLAGE

2026 E 54TH ST

INDIANAPOLIS, IN 46220

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<tr>
<th>(X4) ID</th>
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A telephone interview was conducted with Pharmacy Technician 6 on 5/15/19 at 10:00 a.m., via speaker phone, in the presence of the DNS, Staff Development Coordinator, and Nurse Consultant. Pharmacy Technician 6 indicated they sent 14 tablets of Tradjenta to the facility for Resident 115 on 4/26/19, and another 14 tablets were sent out 5/6/19. Pharmacy Technician 6 indicated the facility should have had the medication available for administration on 4/30/19, 5/1/19, and 5/13/19. Pharmacy Technician 6 indicated, as far as the Duloxetine, the facility requested the wrong dose and should request the 30 mg and 60 mg capsules at the same time.

2. The clinical record for Resident 31 was reviewed on 5/9/19 at 9:00 a.m. The diagnosis for Resident 31 included, but was not limited to, hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting left non-dominant side.

The 2/18/19 quarterly MDS (Minimum Data Set) assessment indicated Resident 31 had a BIMS (brief interview for mental status) score that indicated she was cognitively impaired. Resident 31 had functional status of impairment on one side of her upper and lower extremities. She was extensive assistance with 2 person assistance for bed mobility and transfers. Resident 31 also needed extensive assistance with 1 staff person for personal hygiene and eating.

A care plan for Resident 31 dated 10/10/18, indicated "...Resident requires assistance with ADLs (activities of daily living) including bed mobility, transfers, eating and toileting related to: subarachnoid hemorrhage/CVA (stroke),... left
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|    |        |     | Sided hemiparesis, left hand splint, dysarthria  
(motor speech disorder), aphasia (inability to comprehend or formulate language), dysphasia (swallowing), weakness, abnormal posture, altered awareness of immediate physical environment...hx (history) of edema left side,...decreased ROM (range of motion) to left side,...   | Nurse/designee will use a weekly tracker for any resolved/healed existing areas over the past 30 days and ensure documentation of areas in weekly skin assessments.  
4. ADNS will compare report with Omnicare system and track any medication orders not processes correctly per facility process for 5 times per week for 4 weeks and monthly for 6 months.  
ADNS/designee will present results during monthly QAPI meeting, overseen by Executive Director, to determine further actions, educational needs, and frequency of ongoing monitoring.  
Each resident will be assigned a care representative. The staff care representative will conduct rounds to include profile interventions are in place for all residents on rounding tool. Rounds will be conducted daily 4 weeks, then weekly for 4 weeks, and monthly for 6 months with a goal/threshold of 95% compliance rate. Director of Nursing/designee will assess data from rounding tools and present results during monthly QAPI meeting, overseen by Executive Director, to determine further actions, educational needs, and frequency of ongoing monitoring.  
Wound Nurse/designee will conduct weekly audit of all skin assessments Audit will be conducted 5 times a week for 4  |    |    |    |
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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

5/1/19 - day shift - documented "not administered: drug/item unavailable",
5/1/19 - night shift - documented "not administered: drug/item unavailable",
5/2/19 - day shift - documented "not administered: drug/item unavailable",
5/2/19 - night shift - documented "not administered: drug/item unavailable",
5/3/19 - evening shift - documented "not administered: drug/item unavailable",
5/3/19 - night shift - documented "not administered: drug/item unavailable",
5/4/19 - day, evening, night shift - documented "not administered: drug/item unavailable",
5/5/19 - day shift - documented "not administered: drug/item unavailable",
5/6/19 - day, evening, night shift - documented "not administered: drug/item unavailable",
5/7/19 - day shift - documented "Not Administered: on Hold",
5/7/19 - evening and night shift - documented "not administered: drug/item unavailable",
5/8/19 - day shift - documented "not administered: drug/item unavailable",
5/9/19 - day, evening, night shift - documented "not administered: drug/item unavailable", and
5/10/19 - day shift - documented "not administered: drug/item unavailable",

An observation was made of Resident 31 on 5/9/19 at 10:13 a.m. She was lying in bed with her nasal cannula in her nose with oxygen running. She did not have ear protectors on her oxygen tubing and was not wearing her edema glove on her left hand or pravalon boots on her lower extremities.

An observation was made of Resident 31 on 5/9/19 at 3:25 p.m. She was lying in bed with oxygen tubing in her nose and running. She did
### Statement of Deficiencies and Plan of Correction

**Identification Number:** MULTIPLE CONSTRUCTION

**Date Survey Completed:** 05/15/2019

**Name of Provider or Supplier:** AMERICAN VILLAGE

**Street Address, City, State, Zip Code:** 2026 E 54TH ST, INDIANAPOLIS, IN 46220

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<tr>
<th>(X4) ID</th>
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<th>Summary Statement of Deficiency (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
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<td><strong>Resident 31</strong> was observed lying in bed with oxygen tubing in her nose and running. She was not wearing an ear protector on her oxygen tubing and she was not wearing an edema glove on her left hand. The staff had not been placing the boots on, because of the sore.</td>
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<td>An interview was conducted with Certified Nursing Assistant (CNA) 15 on 5/13/19 at 10:02 a.m. He indicated he was Resident 31's CNA, and Resident 31 wears a left hand splint when she gets up in her chair. She normally wears the pravalon boots, but has a sore. The staff had not been placing the boots on, because of the sore.</td>
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<td>An interview was conducted with the Assisted Director of Nursing Services (ADNS) on 5/13/19 at 3:53 p.m. She indicated she had completed an assessment on Resident 31, and there was no reason why she should not be wearing her pravalon boots. She also should have ear protectors on her oxygen tubing and her left edema glove on her left hand as ordered. ADNS indicated she had educated staff to document if Resident 31 refused to wear her pravalon boots and edema glove.</td>
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<td><strong>Resident 24</strong> was observed in the common area attending an activity. He had a scabbed area, red and brown in appearance, on his upper right forehead. There was no observation of ear protectors on her oxygen tubing, and she was not wearing edema glove on her left hand or pravalon boots on her lower extremities.</td>
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**Note:**
- Each corrective action should be cross-referenced to the appropriate deficiency.

---

**Event ID:** UTGY11  **Facility ID:** 000189  **Page:** 24 of 49
was no dressing present on the area.

The clinical record contained an event report dated 2/26/2019 at 6:10 p.m., indicating Resident 24 had a new skin tear on his forehead. The skin tear was originally noted on 2/24/2019, and measured 2 cm (centimeters) x 4.5 cm x 0.1 cm.

A nursing progress note dated 3/1/2019 at 1:40 p.m., indicated the abrasion remains to forehead and was being treated with bacitracin (ointment).

There was no further documentation about the skin tear in the clinical record. The clinical record did not contain a care plan about the scabbed area on his upper right forehead.

During an interview on 5/15/2019 at 10:20 a.m., LPN (Licensed Practical Nurse) 20 indicated that Resident 24 had received a skin tear on his forehead a couple of months ago. The area had been treated with bacitracin for a while, and now was a "crusty" area. It was being left open to the air.

During an interview on 5/15/2019 at 10:35 a.m., the DNS (Director of Nursing Services) indicated that on 3/7/2019 the skin tear area on his forehead was scabbed over and that scabs were not normally monitored for healing.

On 5/15/2019 at 10:51 a.m., RN (Registered Nurse) 21 was observed palpating (touching) the scabbed area on Resident 24's forehead. When she palpated the area, a pea sized amount of red and yellow drainage came out from under the scabbed area.

During an interview on 5/15/2019 at 10:51 a.m., RN 21 indicated the scabbed area measured 2 cm x 1.2
cm and that it had the appearance of dry eschar (dead tissue). She indicated the drainage was seropurulent (serum and pus) in appearance, and that the physician would be informed.

On 5/15/2019 at 11:50 a.m., the Staff Development Coordinator provided a copy of the Skin Management Program Policy dated 4/2018, which reads as follows: "Skin Management Program... Policy: it is the policy of American Senior Communities to ensure that each resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable....Procedure for Wound Prevention:....6. Any skin alteration noted by direct care givers during daily care and/ or shower days must be reported to the licensed nurse for further assessment, to include but not limited to bruises, open areas, redness, skin tears, blisters, and rashes. The licensed nurse is responsible for assessing all skin alterations by the direct caregivers on the shift reported. 7. Facility skin sweeps [head-to-toe-assessments] are conducted monthly to assess all residents' current skin conditions...”

3.1-37

483.25(d)(1)(2)
Free of Accident Hazards/Supervision/Devices
§483.25(d) Accidents.
The facility must ensure that -
§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and
§483.25(d)(2) Each resident receives
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<tr>
<td>F 0689</td>
<td>1. Upon notification, bottle of body wash was immediately removed from Resident 13’s room.</td>
<td>06/10/2019</td>
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<td>2. All residents on memory care units have potential to be affected by deficiency. A sweep of all memory care units was completed upon notification to ensure all hazardous materials were properly stored.</td>
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<td>3. CEC/designee will conduct facility wide in-service for all departments on storage of hazardous materials specific to memory care units, to be completed by 6/10/2019. During orientation training of new hires, storage of hazardous materials specific to memory care units will continue to be reinforced.</td>
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<td>4. Each resident will be assigned a care representative. The staff care representative will conduct daily rounds ensuring hazardous materials are stored properly for all residents on rounding tool. Rounds will be conducted daily 4 weeks, then weekly for 4 weeks, and monthly for 6 months with a goal/threshold of 95% compliance rate with all interactions. Director of Nursing/designee will assess data from rounding tools and present results during monthly QAPI meeting, overseen by Executive Director, to determine further actions, educational needs, and frequency of ongoing</td>
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**An observation was made of Resident 13's bathroom with License Practical Nurse (LPN) 22 on 5/8/19 at 1:21 p.m. A white bottle labeled shampoo and body wash was observed on the sink. LPN 22 indicated at that time the shampoo body wash should have been locked up.**

The Material Safety Data Sheet, dated 5/30/15, for fragrance shampoo and body wash observed was provided by the Administrator on 5/13/19 at 9:15 a.m. It indicated for first aid measures, "...Ingestion: Call a physician immediately. Rinse mouth thoroughly with water. Do no induce vomiting unless directed to do so by a physician..."

3.1-45(a)(1)

483.25(g)(4)(5)
Tube Feeding Mgmt/Restore Eating Skills
§483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-

§483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and

§483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to
aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.

Based on observation, interview, and record review, the facility failed to ensure G-tube dressing changed as ordered for 1 of 1 resident reviewed for tube feeding. (Resident 31)

Findings include:

The clinical record for Resident 31 was reviewed on 5/9/19 at 9:00 a.m. The diagnosis for Resident 31 included, but was not limited to, hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting left non-dominant side.

The 2/18/19 quarterly MDS (Minimum Data Set) assessment indicated Resident 31 had a BIMS (brief interview for mental status) score that indicated she was cognitively impaired. Resident 31 had functional status of impairment on one side of her upper and lower extremities. She was extensive assistance with 2 person assistance for bed mobility and transfers. Resident 31 also needed extensive assistance with 1 staff person for personal hygiene and eating.

A care plan for Resident 31 dated 2/28/19, indicated "...Resident at risk for complications related to enteral feeding. Approach... Cleanse around site as ordered..."

A physician order for Resident 31 dated 3/1/19, indicated staff was to "cleanse gtube (gastrostomy feeding tube) site with soap and water, pat dry, apply gauze qd (every day). Once a day. 10:00 p.m. - 6:00 a.m.""

An observation was made of Resident 31 on 5/13/19 at 9:44 a.m. She was lying in bed and her
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<tr>
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<td>g-tube site was exposed. The site was observed to have a white shredded and wadded gauze dressing covering the site. The gauze had a dark brown substance on the dressing with a piece of tape dated 5/10/19 written on the piece of tape.</td>
<td>1. Resident 84 BMP and Valproic Acid level was reordered and collected by laboratory services immediately. 2. All residents have the potential to be affected by this deficiency. Lab audit will be completed for</td>
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<td>An observation was made of Resident 31 with the Assistant Director of Nursing Services (ADNS) on 5/13/19 at 10:04 a.m. Resident 31 was lying in bed and an observation was made of Resident 31's g-tube site. The g-tube site did not have a gauze dressing applied to the site. The ADNS indicated at that time the site should have a gauze on the site. She had spoken with License Practical Nurse (LPN) 14, and he had removed the dressing. He had reported the dressing needed to be changed and was planning on replacing the dressing with a new gauze. The ADNS indicated the dressing should be changed daily.</td>
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3.1-44(a)(2) 483.50(a)(1)(i) Laboratory Services §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. Based on interview and record review the facility failed to assure that the facility provided laboratory testing as ordered by the physician for 1 of 5 residents reviewed for unnecessary medications (Resident 84). Findings include:
### Statement of Deficiencies and Plan of Correction

**Provider or Supplier Name:** American Village  
**Street Address:** 2026 E 54TH ST  
**City:** Indianapolis, IN 46220

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<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Summary Statement of Deficiency</th>
<th>Provider's Plan of Correction</th>
<th>Completion Date</th>
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<tbody>
<tr>
<td>F0812</td>
<td>SS=F</td>
<td>Bldg. 00</td>
<td>The clinical record for Resident 84 was reviewed on 5/13/2019 at 2:04 p.m. The diagnosis for Resident 84 included, but were not limited to, dementia and hypertension. The clinical record contained a physician's order dated 4/11/2018, indicating Resident 84 should have a complete blood count, complete metabolic panel, and a valporic acid level drawn by the laboratory in April, August, and December every year. The clinical record did not contain laboratory results from April 2019. During an interview on 5/13/2019 at 4:04 p.m., the DNS (Director of Nursing Services) indicated the laboratory had not done a complete blood count, complete metabolic panel, and a valporic acid level in April 2019, and that they should have been completed. 3.1-49(a) (b)</td>
<td>past 30 days to ensure all labs were collected and completed. Any outstanding labs will be ordered and collected to ensure updated compliance. Audit to be completed by 6/5/19. 3. CEC/designee will complete in-service for licensed nurses on timely collection of labs and documentation of laboratory services. Facility process change generated: Licensed nurses for each unit will provide laboratory services with log to sign for completion and presented to DNS/designee upon completion. Process to be initiated by 6/10/2019. 4. CEC/designee will review collection reports in clinical meetings and resolve any missed collections5 times a week for 4 weeks, then weekly for 4 weeks, and then monthly for 6 months with goal/threshold of 100% compliance rate. Laboratory services will be notified of missed collections and asked to re-collect samples. Missed collections will be put onto tracking log. CEC/designee will present results during monthly QAPI meeting, overseen by Executive Director, to determine further actions, educational needs, and frequency of ongoing monitoring.</td>
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</tbody>
</table>

**Event ID:** UTGY11  
**Facility ID:** 000189  
**If continuation sheet:** Page 31 of 49
§483.60(i) Food safety requirements.
The facility must -

§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.
   (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.
   (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.
   (iii) This provision does not preclude residents from consuming foods not procured by the facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.

Based on observation, record review, and interview, the facility failed to ensure food was stored and prepared under sanitary conditions related to: open and/or undated food in the cooler and freezer, not securely closing open bags of dried food for 150 of 154 residents residing at facility and ensuring the proper levels of chemical sanitation liquid used for the final rinse cycle of the dish machine for 60 residents residing on assisted living.

Findings include:

1. During the Brief Kitchen Sanitation Tour on 4/8/19 at 10:10 a.m. with Assistant Dietary Manager and Dietary Manager the following was observed in the main kitchen:
   - Exposed frozen peas, outdated chocolate, cups of chocolate and white milk, apple juice, orange sprinkles, juices, thickened water, beef base, orange drink and exposed brown rice were all discarded immediately. Dietary Manager examined all dry and wet storage areas to ensure no other food items were expired, uncovered, or stored improperly. The kitchen was thoroughly cleaned. The dishwasher was repaired.
   - All residents have the potential to be affected by this deficiency. The Dietary Manager and Assistant Dietary Manager

2. 06/10/2019
a. In the freezer there was a box of frozen peas, the plastic bag containing the pea was left open to air exposing the peas.

b. In the refrigerator there were 5 cups of milk on a cart. 3 cups of white milk and 2 cups of chocolate milk were not dated or labeled.

c. In the refrigerator were 8, four ounce cups of thickened apple juice, on a shelf, with a use by date of 3/6/18.

d. In the dry storage room, there was a bag of brown rice that was not securely closed leaving the contents open to air.

e. In the dry storage room, there was a bottle of orange sprinkles with no open date on product.

f. In the dry storage room, there was a bottle of multi-colored sprinkles with no open date on product.

2. During the Brief Kitchen Sanitation Tour on 4/8/19 at 10:10 a.m. with Dietary Manager the following was observed in the assisted living kitchen:

   a. The stove burner top was laden with caked up, black, lumpy grease.

   b. The dishwasher failed to dispense an adequate amount of liquid sanitizer to ensure proper sanitation of kitchen wares. The dishwasher went through an initial run to check the temperature of the wash and rinse cycle. The wash cycle read 100 degrees and the final rinse cycle read 125. The Dietary Manager (DM) indicated, at that time, the dishwasher used chemicals for final rinse will perform daily walk through of the dry and wet storage areas ensuring proper food storage and dating labeling of food. Daily cleaning tasks will also be required of dietary staff and checked off by Dietary Manager or Assistant Dietary Manager. These will begin immediately and be ongoing.

3. Dietary Manager in-serviced all dietary staff on food safety, proper labeling dating, proper food storage, kitchen sanitation, and recording dishwasher temps. Dietary Manager to monitor daily cleaning schedule which includes all components of the kitchen. Dietary Manager and Assistant Dietary Manager to use Daily Walk-thru Checklist to ensure compliance in the deficient areas. Labeling and Dating instructions were also added to every refrigerator and freezer in the kitchen and satellite locations. Dish machine will be monitored for proper functioning. Meal observation will be conducted by Assistant Dietary Manager to ensure proper dispensing of food.

4. Dietary Manager will monitor sanitation measures weekly for 13 weeks, then monthly ongoing. Threshold for sanitation should be 90% or greater. Assistant Dietary Manager and Dietary Manager will continue daily walk throughs with daily checklists indefinitely. Assistant
disinfection. A second run of the dishwasher was performed to test for adequate level of disinfection using the test strips supplied by the Dietary Manager. The test strip resulted with the color yellow. When compared to the reference color samples on the test strip bottle, did not match any of the reference colors on the test strip bottle. Two further attempts to test the final rinse cycle for adequate amount of final rinse sanitizer indicated an issue with the dishwasher. At that time, the DM indicated she would call for service on the dishwasher and the dishwasher would not be used until the issue was resolved. The dishwasher was not currently being used, however a rack of bottles, which were drying, was at the clean end of machine. DM indicated the bottles would be rewashed using the main kitchen's dishwasher.

On 5/9/19 at 9:18 a.m., a service detail report was received from DM stated, "Squeeze tube on sanitizer roller needed replaced. I put on new (sic) and now functioning properly (sic)".

c. In the refrigerator were 6 pitchers of assorted juices were dated "5/4-5/7",
d. An opened bottle of chocolate syrup, in the refrigerator, was dated "3/1-4/1",
e. An opened jar of beef base, in the refrigerator, was dated "3/14-3/19",
f. In the refrigerator, an opened container of thickened water did not have an open date.

An interview with DM at the same time as above observations indicated open food or drink items should be labeled, have open dates, be sealed from environment to prevent contamination, and
Consumed or discarded by use by dates.

3. In the 700 unit dining room on 5/8/19 at 12:53 p.m., were 10 glasses of pre-poured orange drink without lids on the counter near sink.

An interview with Resident Care Coordinator at 1:06 p.m. that same day, indicated that the glasses of orange drink should have been covered prior to service.

A Food Storage policy received on 5/14/19 at 3:35 p.m. from DON states, "....4...All containers must be accurately labeled and dated....12. Leftover prepared foods...food must be labeled with the name of the product, the date it was prepared and marked to indicate the date by which the food shall be consumed or discarded. Leftover food can be held...for no more than 3 days....13. Refrigerated, ready to eat, potentially hazardous food... shall be clearly marked with the date the original container is opened and the date by which the food shall be consumed or discarded. This opened food can be held...for no more than 7 days and the date marked may not exceed the manufacturer's use by date....14. Thickened liquids must be dated with the date opened and consumed or discarded...15...f. All foods should be covered or wrapped tightly, labeled and dated."

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<td>F 0880 SS=E Bldg. 00</td>
<td>483.80(a)(1)(2)(4)(e)(f)</td>
<td>Infection Prevention &amp; Control</td>
<td>The facility must establish and maintain an infection prevention and control program</td>
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§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv) When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
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<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
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<tr>
<td>F 0880</td>
<td>1. LPNs 11 and 12 were immediately educated on infection control practices in regards to medication pass upon notification on concern. Residents 16, 21, and 48 showed no adverse complications from breach in infection control practices. CNA 17 was immediately educated on infection control practices in regards to meal pass upon notification of concern. Resident 90 showed no adverse...</td>
<td>06/10/2019</td>
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Based on observation, interview, and record review, the facility failed to maintain infection control with hand hygiene during medication administrations, maintain proper infection control related to not ensuring handles of tongs used for plating tomatoes and lettuce did not come in contact with food in the main kitchen, touching the tops of fruit bowls and lunch plates with bare thumbs and not using hand hygiene between residents when serving food for 2 of 7 residents in 700 dining room and for 3 of 9 residents observed during medications pass. (Resident 16, 21, 48, 72, 90, and F 0880).
Findings include:

1. The clinical record for Resident 16 was reviewed on 5/13/19 at 3:00 p.m. The diagnosis for Resident 16 included, but was not limited to, edema.

The clinical record for Resident 48 was reviewed on 5/13/19 at 2:00 p.m. The diagnosis for Resident 48 included, but was not limited to, hypertension.

A medication administration with License Practical Nurse (LPN) 12 was made on 5/13/19 on 9:18 a.m. LPN 12 was observed after a resident's administration using hand hygiene. Then she returned to her cart and started prepping for Resident 16's medication administration. During that time LPN 12 had dropped a pill on the floor. LPN 12 then picked up the dropped pill and discarded. There was no hand hygiene observed at that time. She then continued with popping medication from the med cards into a cup. As LPN 12 was preparing to crush the medication she had dropped a pill on the medication cart. LPN 12 picked up the medication and placed in the sleeve to crush. After, she went to Resident 16's room and administered the medications to Resident 16. There was no hand hygiene observed prior to administration to Resident 16. LPN 12 left Resident 16's room and was observed using hand hygiene. LPN 12 returned to her cart and started prepping Resident 48's medication. She then entered Resident 48's room to administer the medication. There was no hand hygiene observed prior to entering Resident 48's room. LPN 12 was observed going into Resident 48's bathroom and had retrieved some toilet paper for her eye drop complications from breach in infection control practices.

2. All residents have the potential to be affected by this deficiency. Upon notification, facility CEC began immediate in-service for licensed nurses and certified nursing assistants on infection control practices specific to hand hygiene, medication pass, and meal pass.

3. CEC/designee will complete in-service and medication pass skill validations for licensed nurses and qualified medication aides. CEC/designee will complete in-service for nursing staff specific to hand hygiene and meal pass procedures to be completed by 6/10/2019.

4. Unit managers/designee will complete real time medication pass infection control observations utilizing the Medication Pass Validation tool, Assigned dining room manager/designee will complete meal observations using the Dining Room Manager Checklist. 4. Unit managers/designee will complete real time medication pass infection control observations utilizing the Medication Pass Validation tool, totaling 3 observations per manager per week for 13 weeks with goal/threshold of 95% compliance rate. Assigned dining room manager/designee will complete meal observations using the...
administration. LPN 12 donned on gloves and moved Resident 48's bed and administered eye drops to Resident 48. She then administered the pills to Resident 48. After administration, LPN 12 was observed using hand hygiene.

2. The clinical record for Resident 21 was reviewed on 5/13/19 at 2:10 p.m. The diagnosis for Resident 21 included, but was not limited to, vascular dementia with behavioral disturbance.

An observation of medication administration was made with LPN 11 on 5/13/19 at 11:32 a.m. During the prepping of a blood sugar LPN 11 had dropped her pen on the floor. LPN 11 picked up the pen off the floor and continued gathering her supplies to obtain a blood sugar. There was no hand hygiene at that time. She then went to the resident's room but she was not available to obtain the blood sugar at that time. LPN 11 returned to her cart. She placed all the supplies for the blood sugar back into her cart, and then prepped for Resident 21's medication administration. LPN 11 was observed pulling medication card from her cart and popping the pill in a medication cup. She then went to Resident 21's room and assisted Resident 21 to a sitting position. After, LPN 11 administered the medication to Resident 21. She then left the room and used hand hygiene.

An interview was conducted with Assisted Director of Nursing Services (ADNS) on 5/13/19 at 3:53 p.m. She indicated LPN 12 should have not administered the medication that was dropped on the medication cart to the resident and hand hygiene should be used if nursing staff pick items off the floor. LPN 12 should have used hand hygiene prior to administration of eye drops.

3. On 5/8/19 at 12:53 p.m., an observation was Dining Room Manager Checklist in alternating dining rooms 5 times a week for 4 weeks, then weekly for 4 weeks, and monthly for 3 months and document on Dining Room Manager Checklist with a goal/threshold of 95% compliance rate. All observations will be given to Assistant Director of Nursing/designee for review. Assistant Director of Nursing will present results during monthly QAPI meeting, overseen by Executive Director, to determine further actions, educational needs, and frequency of ongoing monitoring.
made of CNA 17 touching the top of the plate with her bare thumb when taking the plate off the tray. CNA 17 then went back to lunch tray cart and pulled out another lunch tray. No hand hygiene was performed after touching the top of resident 72's plate or before she pulled out resident 90's lunch tray.

4. On 5/8/19 at 12:55 p.m., an observation was made of CNA 17 touching the top of resident 90's plate with her bare thumb when taking the plate off the tray. CNA 17 then went back to lunch tray cart. No hand hygiene was performed prior to touching the top of resident 90's plate.

An interview with Resident Care Coordinator, on the same day, at 1:06 p.m. indicated, that CNA 17 should not be touching the tops of the lunch plates and should be performing hand hygiene after serving each resident.

On 5/14/19 at 12:11 p.m., an observation was made of the Assistant Dietary Manager (ADM) plating lettuce using a pair of tongs. She grabbed a pair of tongs, with her bare hands, by the ends then placed a leaf of lettuce on the plate and when she placed the tongs back into the bowl of lettuce, the handles (end of tongs) touched the remaining lettuce in the bowl.

On 5/14/19 at 12:12 p.m., an observation was made of the ADM plating tomatoes using a pair of tongs. She grabbed a pair of tongs, with bare hands, by the ends then placed tomatoes on a plate and when she placed the tongs back into the bowl of tomatoes, the handles (end of tongs) touched the remaining tomatoes in the bowl.

An interview on the same day at 12:13 p.m. with DM indicated that the handles of the tongs...
On 5/14/19 at 12:09 p.m. an observation was made of a kitchen staff member placing fruit bowls on trays for lunch service using bare hands and touching the top rims of the bowls with her bare thumb.

An interview on the same day at 12:10 p.m. with DM indicated that the kitchen staff member should not touch the tops of the bowls with her bare thumb and was immediately educated on the correct way to handle the bowls of fruit.

A General Food Preparation and Handling policy received from DON, on 5/14/15, states, "...4. Bare hands should never touch raw or ready to eat food directly. Food will be prepared and served with clean tongs, scoops, and forks...to avoid bare hand contact of prepared foods...14. Handle utensils, cups...in such a way as to avoid touching surfaces which food or drink will come into contact..."

3.1-18
3.1-20
3.1-21

3.1-14 Personnel

(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.

1. The facility scheduled LPN9 and CNA10 for the required dementia training for 6/12/19.

2. The facility conducts a 6 hour dementia training course for new hires weekly. LPN9 and CNA10 will attend this 6 hour training course. Non-compliance will result in corrective action.

F 9999

Bldg. 00
(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 personal 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 annual dementia training was completed for 2 of 13 staff members personnel files reviewed. (License Practical Nurse (LPN) 9, and Certified Nursing Assistant (CNA) 10)

Findings include:

A personnel file for LPN 9 was reviewed on 5/15/19 at 2:00 p.m. It indicated LPN 9 had a start date 7/4/17. It did not include annual dementia training for LPN 9.

A personnel file for CNA 10 was reviewed on 5/15/19 at 2:15 p.m. It indicated CNA 10 had a start date 2/6/18. It did not include annual dementia training for CNA 10.

An interview was conducted with the Staff Development Coordinator on 5/15/19 at 3:59 p.m. He indicated LPN 9 and CNA 10's working status were part time, and he could not locate annual dementia training for LPN 9 or CNA 10.
This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey with the Investigation of Complaint IN00294091- Substantiated. No deficiencies related to the allegations are cited.

Survey dates: May 8, 9, 10, 13, 14, and 15, 2019.

Facility number: 00189

Residential Census: 58

These State Residential Findings are cited in accordance with 410 IAC 16.2-5.

Quality review completed on May 24, 2019

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 May 15, 2019. 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.

410 IAC 16.2-5-1.4(b)

Personnel - Deficiency

(b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility

R 0000
regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review the facility failed to ensure a staff member, certified in first aide, was scheduled on each shift. This had a potential to affect 58 of 58 residents that reside in residential.

Findings include:

A worked schedule dated, 5/8/2019 through 5/14/2019, was provided by the Administrator on 5/14/2019 at 11:00 a.m. It indicated the following days and shifts there were no staff members scheduled that were first aide certified:

- 5/8/2019 - 1st shift, 2nd shift and 3rd shift,
- 5/9/2019 - 1st shift, 2nd shift and 3rd shift,
- 5/10/2019 - 1st shift, 2nd shift and 3rd shift,
- 5/11/2019 - 1st shift, 2nd shift and 3rd shift,
- 5/12/2019 - 1st shift, 2nd shift and 3rd shift,
- 5/13/2019 - 1st shift, 2nd shift, and 3rd shift, and

An interview was conducted with the SDC (Staff Development Coordinator) on 5/15/2019 at 2:30 p.m. He indicated there was not a staff member in the building that was first aide certified working regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review the facility failed to ensure a staff member, certified in first aide, was scheduled on each shift. This had a potential to affect 58 of 58 residents that reside in residential.

Findings include:

A worked schedule dated, 5/8/2019 through 5/14/2019, was provided by the Administrator on 5/14/2019 at 11:00 a.m. It indicated the following days and shifts there were no staff members scheduled that were first aide certified:

- 5/8/2019 - 1st shift, 2nd shift and 3rd shift,
- 5/9/2019 - 1st shift, 2nd shift and 3rd shift,
- 5/10/2019 - 1st shift, 2nd shift and 3rd shift,
- 5/11/2019 - 1st shift, 2nd shift and 3rd shift,
- 5/12/2019 - 1st shift, 2nd shift and 3rd shift,
- 5/13/2019 - 1st shift, 2nd shift, and 3rd shift, and

An interview was conducted with the SDC (Staff Development Coordinator) on 5/15/2019 at 2:30 p.m. He indicated there was not a staff member in the building that was first aide certified working
on those days and shifts.

410 IAC 16.2-5-1.5(e)(1-4)
Sanitation and Safety Standards - Deficiency
(e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows:

(1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility.
(2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes.
(3) All plumbing shall function properly and comply with state plumbing codes.
(4) At least yearly, heating and ventilating systems shall be inspected.

Based on observation, interview, and record review, the facility failed to ensure chemicals were kept secured on the Memory Care Unit for 1 cognitively impaired, independently ambulatory resident of 2 residents whose rooms were observed on the unit. (Resident 56)

Findings include:

The clinical record for Resident 56 was reviewed on 5/15/19 at 11:00 a.m. The diagnoses for Resident 56 included, but were not limited to, dementia.

Resident 56's 10/26/18 service plan indicated she was aggressive and wandered.

An environmental tour of the facility was

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<tr>
<td>R 0148</td>
<td>Bldg. 00</td>
<td>00</td>
<td>-</td>
<td>1. Chemicals were immediately removed from the room of the one client cited. Resident's family was notified and informed not to bring chemicals into the resident's room.</td>
<td>06/10/2019</td>
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conducted with the Maintenance Supervisor on 5/15/19 at 11:30 a.m. During the tour, Resident 56’s kitchen area was observed with a can of Lysol and a bottle of neutral disinfectant spray, unsecured in a cabinet underneath the sink. A container of Comet with bleach was unsecured in a cabinet above the sink.

An interview was conducted with CNA (Certified Nursing Assistant) 8 on 5/15/19 during the environmental tour, while on the Memory Care Unit. She indicated chemicals were kept in residents' cabinets on the Memory Care Unit.

An interview was conducted with QMA (Qualified Medication Aide) 15 on 5/15/19 at 1:55 p.m. She indicated Resident 56 propelled herself in her wheelchair everywhere on the unit, as she did not require assistance for ambulating about the unit.

The MSDS (material safety data sheet) for the Comet with bleach was provided by the Administrator on 5/15/19 at 3:58 p.m. The toxicological information section indicated the product was irritating to skin. Contact may irritate or burn eyes. Chronic effects were hazardous by OSHA (Occupational Safety and Health Administration) criteria.

The MSDS for the Lysol was provided by the Administrator on 5/15/19 at 3:58 p.m. It read, "Routes of exposure Eye, Skin, Inhalation, Ingestion. Eyes: Moderately irritating to the eyes. Skin: Slightly irritating to the skin. Inhalation: None expected during normal conditions of use. However intentional misuse by deliberately concentrating and inhaling the contents may be harmful or fatal. Ingestion: May be harmful if swallowed."

3. Staff have begun checking resident's apartments at least twice per week on scheduled shower days to ensure no chemical hazards are present in the resident's apartments.

4. Staff will be responsible for reporting any chemical hazards to the Clinical Director or Assistant Clinical Director. CD and ACD will monitor weekly by random apartment checks to include at least 10 rooms per week. Random apartment checks will be ongoing.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**IDENTIFICATION NUMBER**
155292

**MULTIPLE CONSTRUCTION**
A. BUILDING 00
B. WING

**DATE SURVEY COMPLETED**
05/15/2019

**NAME OF PROVIDER OR SUPPLIER**
AMERICAN VILLAGE

**STREET ADDRESS, CITY, STATE, ZIP CODE**
2026 E 54TH ST, INDIANAPOLIS, IN 46220

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<tr>
<td>R 0155</td>
<td>Bldg. 00</td>
<td>An interview was conducted with the Administrator on 5/15/19 at 12:25 p.m. He indicated the facility had no policy regarding the keeping chemicals secured.</td>
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**Regulatory or LSC Identifying Information**

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<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>R 0155</td>
<td>0155</td>
<td>1. Deficiency did not name any specific residents.</td>
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<td></td>
<td></td>
<td>2. All residents have the potential to be affected by this deficiency. The facility immediately cleaned the dumpster area, closed dumpster lids, cleaned portable trash carts, and placed lids on trash.</td>
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<td>3. The facility in-serviced maintenance, floor care, and dietary staff regarding the following:</td>
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<td></td>
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<td>- Gray rolling trash receptacles will remain covered when not in use</td>
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<tr>
<td></td>
<td></td>
<td>- Cleaning schedule for gray rolling trash receptacles will be shared between dietary and floor care. Cleaning schedule will be posted.</td>
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<td></td>
<td></td>
<td>- Dumpster area will be monitored daily by maintenance, dietary, and floor care.</td>
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<td>- Dumpster lids and gate to</td>
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</tbody>
</table>
noun, a plastic spoon, an aluminum can, styrofoam bowls, and other trash were on the ground within the dumpster area.

An interview was conducted with the Maintenance Supervisor during the observation of the dumpster area. He indicated the last time he recalled the dumpster area being cleaned up was in February, 2019.

An interview was conducted with the Administrator on 5/15/19 at 12:25 p.m. He indicated the facility had no policy regarding the dumpster.

4. Dietary Supervisor and Housekeeping Supervisor to monitor weekly on a rotating schedule. Each have been provided a calendar for the next year for their monitoring.

   410 IAC 16.2-5-1.6(k)
   Physical Plant Standards - Deficiency
   (k) Hot water temperature for all bathing and hand washing facilities shall be controlled by an automatic control valve. Water temperature at point of use must be maintained between one hundred (100) degrees Fahrenheit and one hundred twenty (120) degrees Fahrenheit.

   Based on observation and interview, the facility failed to maintain water temperatures at point of use between 100 degrees Fahrenheit and 120 degrees Fahrenheit for 4 of 5 residents whose room water temperatures were retrieved. (Residents 2, 31, 40, and 56)

   Findings include:

   An environmental tour of the facility was conducted with the Maintenance Supervisor and the Administrator on 5/15/19 at 11:30 a.m.

   The following temperatures were retrieved by the Maintenance Supervisor during the tour:

<table>
<thead>
<tr>
<th>Deficiency</th>
<th>Completion Date</th>
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<tbody>
<tr>
<td>R 0187</td>
<td>06/10/2019</td>
</tr>
</tbody>
</table>

1. After receiving 2567 on 5/31/19, Maintenance Supervisor went to the five deficient rooms and all rooms registered between 100 and 120 degrees.

2. All residents have the potential to be affected by this deficiency. The facility will complete water temperature checks on all AL and Memory Care apartments by 6/10/19.

3. Maintenance staff currently completes routine, weekly water temperature checks M-F and
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCY</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>RESIDENT 2'S BATHROOM SINK - 125.2 DEGREES FAHRENHEIT</td>
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<td></td>
<td>records temperatures in the Preventative Maintenance Binder. Adjustments are made to the water heating units when temperatures are found to be out of range. The routine, weekly water temperature checks will be expanded to include all apartments for one week, followed by even numbered apartments for 2 weeks, then odd numbered apartments for 2 weeks, and monthly checks ongoing. All water temperatures for AL and memory care will be monitored in the Preventative Maintenance Manual.</td>
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<td></td>
<td>RESIDENT 56'S KITCHENETTE SINK - 77.7 DEGREES FAHRENHEIT</td>
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<td>4. The Maintenance Supervisor will monitor all water temperature logs on an ongoing basis. Should any apartment water temperature fall outside of 100-120 degrees adjustments will be made immediately.</td>
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<tr>
<td></td>
<td>RESIDENT 40'S KITCHENETTE SINK- 122.1 DEGREES FAHRENHEIT</td>
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<tr>
<td></td>
<td>RESIDENT 40'S BATHROOM SINK - 124.7 DEGREES FAHRENHEIT</td>
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<tr>
<td></td>
<td>RESIDENT 31'S BATHROOM SINK - 126.3 DEGREES FAHRENHEIT</td>
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<tr>
<td></td>
<td>RESIDENT 31'S KITCHENETTE SINK - 129.2 DEGREES FAHRENHEIT</td>
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</table>

An interview was conducted with the Maintenance Supervisor during the above water temperature retrievals. He indicated he took water temperatures daily at the hot water heaters, but he did not retrieve residents' room water temperatures regularly.

An interview was conducted with the Administrator on 5/15/19 at 12:25 p.m. He indicated the facility had no policy, regarding the residents' room water temperatures.