STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
INDEPENDENCE VILLAGE OF FISHERS EAST	12950 TALBLICK STREET FISHERS, IN 46037

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00447060 and IN00443453. Complaint IN00447060 - No deficiencies related to the allegations are cited. Complaint IN00443453 - State deficiencies related to the allegations are cited at R0091. Survey dates: November 21, 22, 25, and 26, 2024 Facility number: 013945 Residential Census: 58 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on December 5, 2024.	R 0000	Plan of Correction for Independence Village Fishers East. R000 Initial Comments. Preparation of execution of this plan of correction does not constitute admission or agreement of provider of the truth set forth on the statement of deficiencies. The plan of correction is prepared and execute solely because it is required by the position of Federal State Law. Please accept this plan of correction as the providers credible allegation of compliance.	
R 0034 Bldg. 00	410 IAC 16.2-5-1.2(i) Residents' Rights - Noncompliance Based on interview and record review, the facility failed to ensure advanced directives were developed upon admission to the facility for 1 of 5 residents reviewed for advanced directives.	R 0034	Resident B was affected by the alleged deficient practice. Resident B advance directives were completed by POA and signed by the	02/20/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mira Warner	Executive Director	12/23/2024

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	(Resident B) Findings include: The clinical record for Resident B was reviewed on 11/25/24 at 3:00 p.m. The diagnoses included, but were not limited to, anxiety disorder and hypertension. Resident B was admitted to the facility on 9/26/24. There was no code status form or indication of Resident B's code status in the clinical record. The service plan for Resident B, revised 11/15/24, did not indicate advanced directives or code status. The medication administration record (MAR), dated November of 2024, indicated the advanced directives for Resident B were blank. An interview conducted with the Wellness Director, on 11/25/24 at 11:09 a.m., indicated there was no paperwork to determine if Resident B was a full code or a do not resuscitate (DNR). The code status was unable to be located in Resident B's hard chart. A policy titled "Advance Directives", revised 10/18/22, was provided by the Wellness Director on 11/25/24 at 2:30 p.m. The policy indicated the following, "...Procedure...4. Resident preferences regarding treatment options shall be displayed prominently in the Resident's Medical Record... 5. Copies are maintained in the resident's chart and in the resident emergency information transfer binder...."		physician. A review of all records for advance directives will be complete by 2/20/2025. 7 charts per week will be audited to ensure no other residents are affected. Wellness Director/Designee will complete this review.	
R 0088	410 IAC 16.2-5-1.3(c)(1-2)(d)(1-2) Administration and Management -			

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Bldg. 00	Noncompliance Based on interview and record review, the facility failed to notify the Indiana Department of Health (IDOH) of a change in the Administrator and/or Executive Director within three days with the potential to affect 58 of 58 residents residing at the facility. Findings include: The consumer report for the facility, last revised 11/13/24, indicated the Executive Director (ED) of the facility was ED 3. An interview conducted with ED 2, on 11/25/24 at 11:38 a.m., indicated she started as the ED on 9/3/24. ED 3 was no longer employed at the facility and his last day was 7/24/24. There was an Interim for Corporate (Interim Corporate Staff 4), during that time from when ED 3 left to when ED 2 started.	R 0088	Regionals & Home Office will review license documentation to ensure license change is updated submitted in a timely manner within 3 working days of the departure of previous Administrator or Executive Director.	02/20/2025
R 0091 Bldg. 00	410 IAC 16.2-5-1.3(h)(1-4) Administration and Management - Noncompliance Based on interview and record review, the facility failed to ensure an incident report was completed and new intervention(s) were implemented after a resident had a fall for 1 of 3 residents reviewed for falls. (Resident B) Findings include: The clinical record for Resident B was reviewed on 11/25/24 at 3:00 p.m. The diagnoses included, but were not limited to, anxiety disorder and hypertension. Resident B was admitted to the facility on 9/26/24.	R 0091	Written policies will be implemented to ensure that 1-4 is completed. Policies will be made readily available upon request. Resident B as not affected by alleged allegation; the facility is aware of the importance of this documentation, the wellness nurse will check daily times 4 weeks, then weekly times monthly to ensure that incident reports are being created interventions are put	02/20/2025

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	A nursing progress note, dated 11/2/24, indicated "Resident had a fall in the 1st floor hallway this afternoon. Nurse was walking past as she fell and saw her go down. Resident did not hit her head or neck on the ground but she did hit the R [right] side of her forehead on her walker handle. Resident was right outside of room door and was walking back from the front. Resident denied dizziness, but stated her head was sore where she hit it at. Resident also had a gash in that place. no other injuries noted. resident assessed and vitals areas follows...Resident assisted off the floor x 2 [times two] staff members and placed in a wheel chair for safety. Resident assisted back into her room and onto her couch. Nurse offered to send resident out to be checked out and she declined. She stated she just wanted her family called. VM [voice mail] left for [Representative] called. Resident given prn [as needed] Tylenol for HA [headache] and a ice pack to put on area. WD [Wellness Director] and ED [Executive Director] notified via text. pcp [medical provider] notified...." The resident's clinical record nor the incident/accident log did not include a post fall assessment with new interventions put in place for Resident B's fall that occurred on 11/2/24. An interview was conducted with the Wellness Director on 11/26/24 at 10:36 a.m. She indicated an incident report should have been filled out after Resident B's fall. She was unable to locate one. A fall policy was provided by the Wellness Director on 11/22/24 at 9:48 a.m. It indicated, "...The purpose of the Resident's Falls policy is to provide guidelines for evaluating a resident after a fall and assist staff in identifying causes of		in place.	

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	falls...7. The healthcare provider is contacted for further instructions if the head was not involved in the fall and the resident is able to move all extremities...b. Staff complete the post falls documentation. c. The incident is recorded on the incident log with the post fall intervention..." This citation relates to IN00443453.			
R 0116 Bldg. 00	410 IAC 16.2-5-1.4(a) Personnel - Noncompliance Based on interview and record review, the facility failed to perform reference checks for 3 of 5 employee records reviewed. (Certified Nursing Assistant 10, Licensed Practical Nurse 11, and Qualified Medication Aide 12) Findings include: The employee files for Certified Nursing Assistant (CNA) 10, Licensed Practical Nurse (LPN) 11, and Qualified Medication Aide (QMA) 12 were provided by the Facility Administrator (FA) on 11/26/24 at 9:01 a.m. 1a. The employee file for CNA 10 was reviewed on 11/26/24 at 9:10 a.m. CNA 10 began employment on 8/6/24. The file did not contain information regarding reference checks being completed prior to employment. 1b. The employee file for LPN 11 was reviewed on 11/26/24 at 9:15 a.m. LPN 11 began employment on 10/22/24. The file did not contain information regarding reference checks being completed prior to employment. 1c. The employee file for QMA 12 was reviewed	R 0116	Reference checks are completed during onboarding through an off-site company, these reference checks are shared through an approved electronic file, prior to the hire date. Documentation will be made available upon review. Property Administrator will work with the Wellness Director/Designee to audit all current wellness employee files for reference checks and will print the reference checks from the electronic file and will house in the paper file. On a routine basis, 4 files per week will be audited by the property administrator/wellness designee.	02/20/2025

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	on 11/26/24 at 9:20 a.m. QMA 12 began employment on 10/22/24. The file did not contain information regarding reference checks being completed prior to employment. During an interview on 11/26/24 at 9:55 a.m., the Executive Director indicated reference checks should have been completed upon hire.			
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency Based on interview and record review, the facility failed to ensure one staff person was certified in Cardiopulmonary Resuscitation (CPR) and First Aid on each shift. This had a potential to affect 58 of 58 residents that resided in the facility. Findings include: The nursing schedule, as worked from November 11th through November 17, 2024, was provided by the Wellness Director (WD) on 11/25/24 at 11:30 a.m. The schedule indicated there was no employee certified in Cardiopulmonary Resuscitation (CPR) and First Aide on the evening and/or night shifts for the following date(s): - 11/11/24, - 11/12/24, - 11/13/24, - 11/14/24, - 11/15/24, - 11/16/24, and - 11/17/24. During an interview on 11/26/24 at 10:05 a.m., the WD indicated someone who was certified in CPR	R 0117	1. No residents were affected by the alleged deficient practice. 2. The community realizes that all residents have the potential to be affected by the alleged deficient practice. 3. All wellness personnel are required to have CPR & First Aid Training. A CPR and First Aid training class has been scheduled for 1/16/2025. All wellness staff must obtain these certifications by February 20th, 2024. 4. The wellness director/designee shall monitor that all Leads/QMA's complete in advance on a daily basis for the next six months to ensure at least one awake staff member is CPR & First Aid certified.	02/20/2025

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	and First Aid should work each shift. On 11/26/24 at 10:35 a.m., the WD provided the Staffing Requirements Policy, last reviewed 2/21/23, which read "...A minimum of one [1] awake staff person, with current CPR and First Aid certificates, on site at all times..."			
R 0123 Bldg. 00	410 IAC 16.2-5-1.4(h)(1-10) Personnel - Nonconformance Based on interview and record review, the facility failed to have job specific orientation and job descriptions for 3 of 5 employee records reviewed. (Certified Nursing Assistant 10, Licensed Practical Nurse 11, and Qualified Medication Aide 12) Findings include: The employee files for Certified Nursing Assistant (CNA) 10, Licensed Practical Nurse (LPN) 11, and Qualified Medication Aide (QMA) 12 were provided by the Facility Administrator (FA) on 11/26/24 at 9:01 a.m. 1a. The employee file for CNA 10 was reviewed on 11/26/24 at 9:10 a.m. CNA 10 began employment on 8/6/24. The file did not contain a job specific orientation or a job description. 1b. The employee file for LPN 11 was reviewed on 11/26/24 at 9:15 a.m. LPN 11 began employment on 10/22/24. The file did not contain a job specific orientation or a job description. 1c. The employee file for QMA 12 was reviewed on 11/26/24 at 9:20 a.m. QMA 12 began employment on 10/22/24. The file did not contain a job specific orientation or a job description.	R 0123	1-10 will be completed and housed in the individual employee files per regulations. Property Administrator/Wellness Designee will audit 4 files per week x 4 weeks, 3 files per week x 3 weeks, 2 files per week x 2 weeks and 1 file per week x 1 week.	02/20/2025

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R 0217 Bldg. 00	During an interview on 11/26/24 at 9:55 a.m., the Executive Director indicated a job specific orientation, and a job description should be present in the employee file. 410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency Based on interview and record review, the facility failed to ensure service plans were signed by the resident and/or resident representative for 5 of 5 residents reviewed for service plans. (Resident B, Resident 13, Resident C, Resident D, and Resident 60). Findings include: 1. The clinical record for Resident B was reviewed on 11/25/24 at 3:00 p.m. The diagnoses included, but were not limited to, anxiety disorder and hypertension. A service plan, initiated on 9/14/24 and revised on 11/15/24, did not have a resident and/or resident representative signature. 2. The clinical record for Resident 13 was reviewed on 11/25/24 at 2:00 p.m. The diagnoses included, but were not limited to, pain and stroke. Resident 13's clinical record did not include a signed service plan. 3. The clinical record for Resident C was reviewed on 11/21/24 at 2:48 p.m. The diagnoses included, but was not limited to, dementia with agitation. Resident C's clinical record did not include a signed service plan.	R 0217	1-5 will be completed, facility will audit all care plans and obtain all signatures and dates via resident or POA. All current service plans will be reviewed & signed within 4 weeks, service plans will be signed with a change in condition.	02/20/2025

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	4. The clinical record for Resident D was reviewed on 11/21/24 at 2:37 p.m. The diagnoses included, but was not limited to, anxiety disorder. Resident D's clinical record did not include a signed service plan. 5. The clinical record for Resident 60 was reviewed on 11/21/24 at 2:21 p.m. The diagnoses included, but was not limited to, Alzheimer's disease. Resident 60's clinical record did not include a signed service plan. An interview conducted with the Wellness Director, on 11/25/24 at 3:38 p.m., indicated the service plans for Residents B, 13, C, D, and 60 were not signed and should have been signed by the resident and/or resident representative.			
R 0240 Bldg. 00	410 IAC 16.2-5-4(d) Health Services - Deficiency Based on observation, interview, and record review, the facility failed to ensure priming of an insulin flex pen for 1 of 5 residents reviewed for medication administration. (Resident 13) Findings include: The clinical record for Resident 13 was reviewed on 11/25/24 at 2:00 p.m. The diagnoses included, but were not limited to, pain and stroke. A physician order, dated 11/20/24, indicated Resident 13 was to receive Novolog (fast acting insulin) utilizing a sliding scale. The sliding scale was the following:	R 0240	An In-service/Training was completed on 12/23/2024. Executive Director viewed the Wellness Director priming and administering Insulin.	02/20/2025

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	Blood sugar reading of 150 to 200 = 3 units of insulin, Blood sugar reading of 201 to 250 = 5 units of insulin, Blood sugar reading of 251 to 300 = 7 units of insulin, and Blood sugar reading of 301 to 350 = 9 units of insulin. An observation was made of insulin administration for Resident 13 with the Wellness Director Assistant (WDA) on 11/25/24 at 12:00 p.m. The WDA was observed pulling the Novolog flex pen, needle and alcohol swab from the medication cart. She then went to Resident 13. During that time, WDA had dialed up utilizing the Novolog flex pen and administered five units of Novolog in the resident's abdomen. There was no observation of WDA priming the insulin pen prior to administering the five units of Novolog. An interview was conducted with the WDA on 11/25/24 at 12:10 p.m. She indicated she primes the insulin flex pens when the pens are first opened and with the first usage. She did not continue to prime the insulin flex pens with each usage. "Novolog (insulin aspart injection) FlexTouch" manufacture instructions at website www.novologpro.com dated 2/2023, was retrieved on 11/27/24. It indicated "...Prescribing information...Giving the airshot before each injection...E. Turn the dose selector to select 2 units...F: Hold the Pen with the needle pointing up. Tap the top of the Pen gently a few times to let any air bubbles rise to the top...G: Hold the Pen with the needle pointing up. Press and hold in the dose button until the dose counter shows "0". The "0" must line up with the dose pointer. A			

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	drop of insulin should be seen at the needle tip... If you do not see a drop of insulin, repeat steps the procedure no more than 6 times...."			
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency Based on observation and interview, the facility failed to ensure that staff's personal items were not in the food preparation area with the potential to affect 25 of 25 residents residing on the dementia care unit. Findings include: On 11/22/24 at 11:35 a.m., dinning service was observed on the memory care unit. The dementia unit kitchen counter was observed to have a plastic cup that contained a pink liquid and had a domed lid with a straw and a clear plastic container of food with a spoon sticking out of the lid. In the corner of the dementia unit kitchen counter was another clear container with a lid. During an interview on 11/22/24 at 11:40 a.m., Certified Nursing Assistant (CNA) 8 indicated the plastic cup and the clear food containers belonged to the staff. During an interview on 11/26/24 at 10:13 a.m., the Executive Chef indicated staff food items should not be kept in the facility kitchens.	R 0273	Wellness/Designee, will provide an in-service with staff regarding personal items being in food prep areas. Staff will be instructed and educated on designated areas to store personal items. Signage will be posted prohibiting storage in personal food items in kitchenette area.	02/20/2025
R 0301 Bldg. 00	410 IAC 16.2-5-6(c)(5) Pharmaceutical Services - Deficiency Based on observation and interview, the facility failed to ensure employee food was not stored in a	R 0301	Wellness/Designee will have an in-service on proper storage of employee food	02/20/2025

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	medication refrigerator for 1 of 2 medication storage rooms observed. Findings include: An observation was made of the first-floor medication storage room with Qualified Medication Aide (QMA) 10 on 11/25/24 at 1:00 p.m. The medication supply refrigerator was observed with one cup of yogurt and one cup of applesauce. An interview was conducted with QMA 10 on 11/25/24 at 1:10 p.m. She indicated the yogurt and applesauce stored in the medication refrigerator belonged to an employee. The employee's food items should not be stored with medications.		Proper signage will placed on each medication refrigerator indicating medication only.	
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance Based on interview and record review, the facility failed to ensure medical records were complete and accurate for 1 of 7 resident records reviewed. (Resident 13) Findings include: The clinical record for Resident 13 was reviewed on 11/25/24 at 2:00 p.m. The diagnoses included, but were not limited to, pain and stroke. 1a. A physician order, dated 11/20/24, indicated Resident 13 was to receive Novolog (fast acting insulin) utilizing a sliding scale. The sliding scale was the following: Blood sugar reading of 150 to 200 = 3 units of insulin,	R 0349	Facility will update the system to provide a place to document insulin units administered for sliding scale orders. Facility will educate nursing on 1-4. Wellness/Designee will complete an In-service with staff on proper steps to complete documentation per physician's orders.	02/20/2025

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	Blood sugar reading of 201 to 250 = 5 units of insulin, Blood sugar reading of 251 to 300 = 7 units of insulin, and Blood sugar reading of 301 to 350 = 9 units of insulin. The November 2024 Medication Administration Record (MAR) indicated the following: The Novolog sliding scale was administered by nursing staff, but there was no insulin amount recorded on the following date(s) and time(s): 11/20/24 at 11:00 a.m., 11/21/24 at 11:00 a.m. and 4:00 p.m., 11/22/24 at 7:30 a.m. and 11:00 a.m., 11/23/24 at 7:30 a.m. and 11:00 a.m., 11/24/24 at 7:30 a.m., 11:00 a.m., and 4:00 p.m. 1b. A physician order, dated 7/17/24, indicated nursing staff was to notify the medical provider if Resident 13's morning blood sugar reading was less than 100 and/or greater than 150. The resident's blood sugar results were noted less than 100 and/or greater than 150, at 7:30 a.m., on the following date(s): 11/1/24, 11/7/24, 11/17/24, 11/19/24, 11/23/24, and 11/24/24. The resident's clinical record did not indicate the medical provider was notified as ordered. An interview was conducted with the Wellness			

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		A. BUILDING 00 B. WING	11/26/2024

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	Director on 11/26/24 at 10:36 a.m. She indicated after review of Resident 13's, November 2024, MAR, the insulin amounts for the Novolog sliding scale for some reason was not showing up on the MAR. The units were showing up on the MAR, but the actual unit amount administered was not showing up in error. She had notified the medical provider regarding clarification to the notification order for Resident 13's blood sugar readings. The order will be discontinued. It was unclear which medical provider put that order in. The order was unnecessary at that time. A medication administration policy was provided by the Wellness Director on 11/26/24 at 9:04 a.m. It indicated, "...Medications will be administered to residents as prescribed and by persons lawfully authorized to do so in a manner consistent with good infection control and standards of practice...Documentation: 1. The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented...."			
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance Based on observation and interview, the facility failed to ensure a resident was supervised while setting silverware on the tables in the dementia unit with the potential to affect 25 of 25 residents residing on the dementia unit. Findings include:	R 0407	1. Residents were affected by the alleged deficient practice. 2. The community realizes that all residents had the potential to be affected by this alleged deficient practice.	02/20/2025

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	On 11/25/24 at 10:55 a.m., a random observation of the dementia unit dining room was made with Maintenance Technician (MT) 9. A man was present in the dementia dining room and passing out silverware. The man was not wearing gloves and was touching the eating surface of the silverware as he removed them from the plastic containers. He then placed them at each place setting. He touched the dining chairs as he walked around the table and then picked up and placed more silverware at the next place setting. There were no staff members present in the dining room. During an interview on 11/25/24 at 10:55 a.m., MT 9 indicated the man was a resident of the dementia unit. The man must have been helping set the tables. During an interview on 11/26/24 at 9:55 a.m., the Executive Director indicated the resident should not have been setting the silverware on the tables without supervision. During an interview on 11/26/24 at 10:13 a.m., the Executive Chef indicated the silverware should not have been picked up and touched on the eating surface due to the chance of passing infection.		3. All staff performed hand hygiene competency validations with demonstrations. Dietary staff re-educated on proper serving procedures. All staff and residents educated on infection control policies and procedures, including but not limited to : *proper use of gloves *food and silverware handling p policies *when and how often to perform hand hygiene. All staff re-educated as above with regard to infection control policies, procedures and accordance with state and local guidelines. 4. The wellness director/designee will monitor all infection control policies and procedures by use of an audit tool weekly for the next six months. The wellness director/designee will ensure that staff are present to monitor and provide assistance. Meal service will be monitored by the Connection Points Director or the executive director/designee.	

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R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance Based on interview and record review, the facility failed to ensure a second step tuberculin skin test after admission to the facility for 1 of 5 residents reviewed for tuberculin skin testing (TST). (Resident B) Findings include: The clinical record for Resident B was reviewed on 11/25/24 at 3:00 p.m. The diagnoses included, but were not limited to, anxiety disorder and hypertension. Resident B was admitted to the facility on 9/26/24. A form titled "MANTOUX TESTING" indicated Resident B received a first step TST on 9/30/24. The second step TST part of the form was left blank. An interview conducted with the Wellness Director, on 11/25/24 at 11:09 a.m., indicated a second step TST was not found, as completed, for Resident B. A second step TST should have been conducted. A policy titled "Tuberculosis Infection Control Plan", reviewed 11/11/22, was provided by the Wellness Director on 11/26/24 at 9:04 a.m. The policy indicated residents were to receive a two-step TST unless one was documented in the previous 12 months.	R 0410	Wellness staff will ensure that each resident receives a two-step Mantoux skin test upon admission, resident charts will be audited weekly to ensure that resident remains in compliance.	02/20/2025
R 0414 Bldg. 00	410 IAC 16.2-5-12(k) Infection Control - Deficiency	R 0414	Wellness Director/Designee will	02/20/2025

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	Based on observation, interview, and record review, the facility failed to ensure hand hygiene was maintained during medication administration for 3 of 5 residents observed during medication administration. (Residents 18, 26, and 28) Findings include: An observation was made of medication administration with Qualified Medication Aide (QMA) 6 on 11/22/24 at 10:00 a.m. QMA 6 was observed preparing and administering medications to Resident 18. QMA 6 had utilized hand hygiene prior to preparing Resident 18's medications, but there was no observation of hand hygiene utilized after the administration. She then prepared Resident 26's medication at the medication cart. After, she went to the resident's room and administered the medication to the resident. There was no observation of hand hygiene prior to the medication administration. During medication administration, QMA 6 was observed utilizing hand hygiene prior to preparing Resident 28's medication but had dropped a pen on the floor. At that time, she had picked up the pen from the floor and grabbed an empty hand sanitizer bottle. She was unable to retrieve hand sanitizer from the bottle. She then looked outside the medication room and found a half full hand sanitizer bottle. She did not use the hand sanitizer at that time. She then picked up the pill medication cup for Resident 28 and administered the medications. An interview was conducted with the Wellness Director on 11/25/24 at 3:38 p.m. She indicated QMA 6 should have utilized hand sanitizer after each resident medication administration. A medication administration policy was provided		provide an In-service on proper hand hygiene prior to any resident care and or medication administration. This will be completed upon new hire and quarterly.	

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	by the Wellness Director on 11/26/24 at 9:04 a.m. It indicated, "...Medications will be administered to residents as prescribed and by persons lawfully authorized to do so in a manner consistent with good infection control and standards of practice...."			