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	06/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
INDEPENDENCE VILLAGE OF WEST ZIONSVILLE	6800 CENTRAL BOULEVARD ZIONSVILLE, IN 46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00356118. Complaint IN00356118 - Unsubstantiated due to lack of evidence. Survey dates: June 24 and 25, 2021. Facility number: 014059 Residential Census: 40 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on July 2, 2021.	R 0000	The creation and submission of this plan of correction does not constitute an admission by this provider or any conclusion set forth in the statement of deficiencies, or any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and requests desk review in lieu of post survey review	
R 0214 Bldg. 00	410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on observation, interview and record review, the facility failed to ensure a re-admission, change of condition nursing assessment for a resident was completed upon a resident's return from the hospital for 1 of 8 residents reviewed (Resident 19). Findings include:	R 0214	With regards to finding R-0214, This facility will: **What corrective actions will be accomplished for those residents found to have been affected by the finding:** Resident 19 had an assessment completed on 6/3/2021 to ensure continued stay upon return. On	07/05/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	06/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
INDEPENDENCE VILLAGE OF WEST ZIONSVILLE	6800 CENTRAL BOULEVARD ZIONSVILLE, IN 46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 6/24/21 at 10:35 a.m., Resident 19 was observed in her room. She sat in a recliner chair, she wore lace-up shoes, and a call pendant was observed around her neck. Resident 19 indicated she wore a call pendant because she fell and that was how she would get assistance if needed. She did not use to need a lot of help, but she needed more help since she had been to the hospital a couple times. On 6/24/21 at 11:00 a.m. a comprehensive record review was completed for Resident 19. Resident 19 was most recently re-admitted on 6/12/21 and had diagnoses which included but were not limited to, anxiety and chronic pain. A nursing progress note, dated 6/6/21 at 9:15 a.m. indicated, Resident 19 experienced an ample amount rectum bleeding which saturated a pad and the toilet. She was sent to the Emergency Department for evaluation and treatment. A nursing progress note, dated 6/12/21 at 7:00 p.m. indicated, Resident 19 returned from the hospital with a new order for an iron supplement. The record lacked documentation of a nursing re-admission evaluation and/or a change of condition evaluation. During an interview on 6/26/21 at 10:40 a.m., the Wellness Director indicated, Resident 19 had been sent to the hospital for rectum bleeding, and it turned out she had a GI bleed (Gastrointestinal (GI) bleeding). The Wellness Director indicated, Resident 19 had been admitted to the hospital for several days and a Change of Condition and Re-Admission evaluation should have been completed upon her return. Those documents		6/5 nursing notes were completed upon return but an updated care plan post pre-admission care plan was not completed. A plan of care was updated post exit on June 25th. **How will you identify other residents having the potential to be affected by the same finding and what corrective action will be taken:** An audit of all resident care plans was conducted on 6/25/21 for 40 of 40 residents and all were completed every 6 months for assisted living residents and 3 months for memory care residents. All care plans were reviewed and signed by the resident or responsible party, executive director, and director of nursing. 1 of 40 residents did not have care plan completed upon return from a higher level of care. The policy also states that residents will have care plans complete upon significant change which includes returning from a higher level of care. **What measures will be put in place or what systemic changes the facility will make to ensure the deficient practice does not recur?** The Executive director implements a new standard operation procedure on July 5th where all LOA residents will be reviewed every morning with anticipated discharge date and location.	

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	06/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
INDEPENDENCE VILLAGE OF WEST ZIONSVILLE	6800 CENTRAL BOULEVARD ZIONSVILLE, IN 46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	would have summarized the need for her hospital stay, the treatment she received, and the required plan of care for the resident upon her return. On 6/26/21 at 12:15 p.m., the Executive Director provided a copy of current facility policy. The Policy was titled, "Admission- Assisted Living and Memory Care," dated 8/2012, and revised 1/2015. The policy indicated, "...The appropriateness of each resident's continued residency at the community will be reassessed periodically as well as upon any re-admission from a higher level of care setting or after a significant change of condition..."		When resident is returned, ED will review with HSD that all proper assessments were completed and signed within 24 hours of admission. How the corrective action(s) will be monitored to ensure the finding will not recur: Documents will be electronically logged and tracked to ensure continued compliance. When the resident whom is LOA or subject to significant change will be added to the tracking device that triggers an assessment is needed. The individual will remain on the tracker until the ED signs the new care plan as well as with all responsible parties. This is to be done within 24 hours of return or observation. The tracker is kept electronically for 7 days allowing for the ED or designee to perform a weekly audit ensuring compliance is completed and signature obtained. **By what date the systemic changes will be completed:** July 5th, 2021	
R 0240 Bldg. 00	410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on observation, interview, and record review, the facility failed to ensure physician's	R 0240	**This facility requests a desk (paper) review for the Informal Dispute Resolution Process.**	06/25/2021

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	06/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
INDEPENDENCE VILLAGE OF WEST ZIONSVILLE	6800 CENTRAL BOULEVARD ZIONSVILLE, IN 46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	orders were in place for all medications and treatments for a resident receiving an antibiotic eye medication and treatment for 1 of 8 residents reviewed for medication administration (Resident 11), and the facility failed to ensure a resident's nebulizer machine was maintained in a sanitary condition for 1 of 8 residents reviewed for medication administration (Resident 6). Findings included: 1. On 6/25/21 at 8:10 a.m. during a medication pass observation on the second floor of the Assisted Living (AL), the Memory Care Charge Nurse (MCCN) was observed as she prepared a medication pass for Resident 11. The orders on the Medication Administration Record (MAR) indicated Resident 11 received glipizide (diabetic medication) 1/2 of a 5 mg (milligram) tablet QOD (every other day) and losartan, (a blood pressure medication) 50 mg BID (twice a day). MCCN indicated Resident 11 had some moisture eye drops in her room that she administered herself. She had a self-administration order for her eye drops. On 6/25/21 at 8:15 a.m., MCCN entered Resident 11's apartment. Resident 11 came into the kitchen area and sat down at the table with MCCN's direction. The nurse informed her it was time for her morning medications. She proceeded to check Resident 11's blood pressure and blood sugar. The nurse removed a small cardboard box from the top of the refrigerator which contained the resident's glucose meter (blood sugar monitoring equipment) with supplies, and a large bottle of "Sterilid Antimicrobial eyelid cleanser." The resident talked about her macular degeneration (a condition causing worsening sight loss). Resident 11 asked the nurse if the other nurses had told her		**With regards to finding R-0240, this community will:** **What corrective actions will be accomplished for those residents found to have been affected by the finding:** The PRN nebulizer treatment for resident 6 was last received on March 11, 2021 and cleaned and stored to manufacturers recommendations. Since the last treatment, the responsible party or resident had relocated the machine for pick up. A request for the order to be cancelled was faxed on 6/25/21. Order was dropped off to resident 11 by caregiver on 5/24 at 5:10pm. 5/25 HSD obtained eye ointment from resident and called prescribing physician to receive an order for administration which was received on 6/25/21. Treatment began. Documentation of two prior treatments as noted in the survey for resident 11 was performed by power of attorney, not the facility as facility was not aware of medication at this time. **How will you identify other residents having the potential to be affected by the same finding and what corrective action will be taken:** 1 of 40 residents has a PRN nebulizer treatment and medication administration is completed for 38 of 40 residents. No resident was found to be adversely affected. Resident 6 did	

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	06/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
INDEPENDENCE VILLAGE OF WEST ZIONSVILLE	6800 CENTRAL BOULEVARD ZIONSVILLE, IN 46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	about the new orders from the eye doctor. MCCN indicated she didn't usually pass medications in the AL and was unfamiliar with any new orders. Resident 11 asked MCCN if she remembered that big stye she had on her eye. MCCN leaned forward and looked at the resident's right eye. She indicated she had recalled seeing it and it looked much better. Resident 11 informed the nurse she had gone to the doctor two days ago. He had numbed it and used two sticks to pop it open. It had drained and felt much better now. She had the new orders there (pointing on the table) for the treatments. She told the nurse "You might want to come back later, after you finish with the others' medications to do the treatment, because it does take a while to do it all." On the table was a white sheet of plain paper with 6/24/21 largely handwritten at the top. Three times were listed on the paper, morning 10 AM, afternoon 1 PM, and night 9 PM. A prescription box was next to the paper. The box read erythromycin (antibiotic) ointment, apply to right eye three times a day, for 10 days. A (Name of Pharmacy) pharmacy bag with instructions stapled to the bag was also on the table, above the medication and hand printed paper. The resident described the treatment in great detail, which she indicated had been done by the other nurses the day before. "The eye had to be soaked with a warm compress for 15 minutes, with the steroid in the bottle." MCCN indicated "the Sterilid?" Resident 11 agreed. After the soak a small amount of antibiotic eye ointment needed to be applied to the eye. MCCN told Resident 11 she would come back to do the treatment in about an hour, after she had completed the medication pass. On 6/25/21 at 8:45 a.m., during an interview, MCCN indicated she had been unaware of any new orders for Resident 11. She didn't usually do		not receive a PRN nebulizer treatment and the medication for resident 11 was submitted was stored and order from the doctor received within 24 hours. An audit was completed to determine if all other residents doctors orders matched the medication administration record and all were within compliance. **What measures will be put in place or what systemic changes the facility will make to ensure the deficient practice does not recur?** Nebulizer storage will follow policy and manufacturers recommendation as previously completed. Education will be performed for resident and responsible party of the importance of keeping nebulizer safely clean and stored. All residents were issued the signed agreement included in the residential agreement that states: “Resident or legal responsible party shall provide Community with original prescription copies when returning from healthcare appointments. These are to be given to the nurse/clinical leader on duty. Prescriptions will then be processed through resident pharmacy choice”. **How the corrective action(s) will be monitored to ensure the finding will not recur:** There currently is not a resident on nebulizer treatment, but for	

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	06/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
INDEPENDENCE VILLAGE OF WEST ZIONSVILLE	6800 CENTRAL BOULEVARD ZIONSVILLE, IN 46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the medication pass on AL. The night nurse had not reported any medication changes or new orders for Resident 11. She was observed as she reviewed the orders on the electronic record and the MAR. She indicated there were no new orders, and it should have been entered as a new order when it was initiated. On 6/25/21 at 10:35 a.m., during an interview, the Wellness Director (WD) indicated Resident 11 went to the doctor and took her prescription to the (Name of Pharmacy) herself, and had it filled. The staff was not aware she had a new medication and treatment order. If the medication was done yesterday, she (the resident) must have done it herself. The WD had called the AL Manager (who had worked evening shift the day before) on the phone. The AL Manager was aware the resident had direction from the doctor to do the warm compresses, but she had not entered the order and not put any ointment in the resident's eye. She had an order to self-administer her own eye drops, from before. The antibiotic order and treatment should have been entered into the orders, but the resident did not inform them she had seen the doctor or had new orders. The only thing she gave the AL Manager was the paper from the doctor on how to do the soaks (warm compresses). On 6/25/21 at 11:00 a.m., Resident 11's medical record was reviewed. The diagnoses included, but was not limited to, macular degeneration, glaucoma (a progressive eye disease) and legal blindness. She had a handwritten prescription in the paper record, dated 9/10/19. It indicated "Resident can administer her own eye medications." There was no order for erythromycin eye ointment or warm compresses to the right eye three times a day.		100% of residents and responsible party whom have an order for treatment will be instructed on the importance of leaving the cleaned machine properly stored. This conversation will be noted in chart. Reference to the resident orders will be reviewed for the next 6 months at all resident council meetings. **By what date the systemic changes will be completed:** 6/26/21	

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	06/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
INDEPENDENCE VILLAGE OF WEST ZIONSVILLE	6800 CENTRAL BOULEVARD ZIONSVILLE, IN 46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 6/25/21 at 10:47 a.m., the WD provided a current policy, dated 5/17, titled "Medication and Treatment Management." This policy indicated "All medications or treatments require a medication or treatment order...verify the resident has one of the following: a written order from the prescriber, a fax of the order from the prescriber, written documentation by a Licensed Nurse or a phone order from the prescriber...Compare the Electronic Medication Administration Record [eMar] to the medication label and verify...sign the eMAR to correspond with medication given...." 2. On 6/25/21 at 8:55 a.m., MCCN was observed as she administered morning medications to Resident 6 in her apartment. Resident 6 sat in a large recliner with a small side table on her left. The table was piled with papers and various items. A nebulizer machine (used for therapeutic breathing treatments) was on the table. The tubing flowed off the table onto the floor. The mouthpiece laid on the floor, uncovered, beside a wastebasket, which was full and had overflowed onto the floor, under the table. There was no label on the tubing to indicate when it was changed last. The carpet had several stains around the resident's feet. There was a soft ball sized spill that was brown and crusty next to the resident's foot. On 6/25/21 at 9:15 a.m., during an interview, MCCN indicated Resident 11 received PRN (as needed) nebulizer treatments. They were ordered when she had some respiratory symptoms, earlier in the year, maybe February. She had never given her a treatment because she usually worked MC. She had never changed the tubing (same reason) and did not know the procedure, or if there was an order for routine tubing changes or machine care.			

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	06/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
INDEPENDENCE VILLAGE OF WEST ZIONSVILLE	6800 CENTRAL BOULEVARD ZIONSVILLE, IN 46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 6/25/21 at 10:30 a.m., Resident 6's medical record was reviewed. The diagnoses included, but were not limited to heart disease, kidney failure, and glaucoma. The MAR and physician's orders, dated 4/8/20, indicated, "Iprat-Albut 0.5-3(2.5) mg/ 3 ml [medication name and dose] inhale 3 ml via nebulizer every 4 hours as needed for wheezing/dyspnea [shortness of breath with audible whistling or rattling sound in chest]. " The orders or MAR did not contain any direction/documentation of care for the nebulizer machine. The last documented treatment, on the MAR was 3/11/21. On 6/25/21 at 10:35 a.m., during an interview, the Wellness Director (WD) indicated Resident 6 had not received any nebulizer treatments for a while, she thought February. The order probably should have been discontinued. The care of the machine would be to change the tubing, at least once a month, if it was being used, and bag the mouthpiece in a ziploc bag. The mouthpiece should have been clipped on the side of the machine and never on the floor. There were no physician's orders to provide care of the machine, but the machine belonged to the resident. The resident was responsible to buy her own tubing. On 6/25/21 at 10:57 a.m., the WD provided a current policy, dated 4/2/21, titled "Nebulizer Use." This policy indicated...Daily: Disassemble parts. Do not wash tubing. Wash neb cup in hot soapy water, rinse neb cup with hot water, air dry on clean paper towel. Weekly: Disassemble parts. Do not wash tubing. Wash neb cup in hot soapy water. Soak in 1part white vinegar to 3 parts water for 30 minutes. Rinse well with hot water. Air dry on clean paper towel. Unplug the compressor. Wipe with clean damp cloth. Dry with a paper towel before use...."			

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	06/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
INDEPENDENCE VILLAGE OF WEST ZIONSVILLE	6800 CENTRAL BOULEVARD ZIONSVILLE, IN 46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0274 Bldg. 00	410 IAC 16.2-5-5.1(g)(1-3) Food and Nutritional Services - Noncompliance (g) There shall be an organized food service department directed by a supervisor competent in food service management and knowledgeable in sanitation standards, food handling, food preparation, and meal service. (1) The supervisor must be one (1) of the following: (A) A dietitian. (B) A graduate or student enrolled in and within one (1) year from completing a division approved, minimum ninety (90) hour classroom instruction course that provides classroom instruction in food service supervision who has a minimum of one (1) year of experience in some aspect of institutional food service management. (C) A graduate of a dietetic technician program approved by the American Dietetic Association. (D) A graduate of an accredited college or university or within one (1) year of graduating from an accredited college or university with a degree in foods and nutrition or food administration with a minimum of one (1) year of experience in some aspect of food service management. (E) An individual with training and experience in food service supervision and management. (2) If the supervisor is not a dietitian, a dietitian shall provide consultant services on the premises at peak periods of operation on a regularly scheduled basis. (3) Food service staff shall be on duty to ensure proper food preparation, serving, and sanitation. Based on observation, interview, and record review, the facility failed to ensure the memory	R 0274	With regards to finding R-0274, The facility will:	06/29/2021

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	06/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
INDEPENDENCE VILLAGE OF WEST ZIONSVILLE	6800 CENTRAL BOULEVARD ZIONSVILLE, IN 46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	care staff were knowledgeable regarding the memory care dishwasher's required temperatures according to manufacturer requirements for 1 of 1 month reviewed. This deficient practice in memory care had the potential to effect 16 of 16 memory care residents who were served food in the memory care area. The facility failed to ensure the main kitchen staff maintained the main kitchen dishwasher temperature log for 1 of 1 month reviewed. This deficient practice had the potential to effect 40 of 40 assisted living residents who were served food from the main kitchen. Findings include: 1. On 6/24 21 at 9:35 a.m., Cook 11 indicated the Dietary Manager (DM) was off on medical leave and he was in-charge on the day shift until the DM returned. He provided the kitchen tour. On 6/24/21 at 12:26 p.m., Cook 11 indicated the memory care dishwasher temperatures for wash and rinse should have been 160 degrees Fahrenheit (F) and 150 degrees F, respectively. On 6/24/21 at 12:30 p.m., the memory care dishwasher was observed while running with dishes in it. The wash temperature achieved 111 degrees F and the rinse temperature achieved 190 degrees F. During an interview, on 6/24/21 at 12:34 p.m., the Memory Care Charge Nurse (MCCN) indicated she did not know what the memory care dishwasher temperatures should have been for wash or rinse cycle and, "kind of," watched the temperature levels. The memory care dishes stayed in the memory care area for re-use after every meal.		**What corrective actions will be accomplished for those residents found to have been affected by the finding:** No negative outcomes identified for residents affected. **How will you identify other residents having the potential to be affected by the same finding and what corrective action will be taken:** All residents had the potential to be affected. No resident was adversely affected. An audit was completed to further identify any dishwasher temperature logs for the prior 12 months and all months were completed and stored electronically. The manufacturer was called to review working condition of the dishwasher on 6/25. It was determined the dishwasher was functioning to manufacturers recommendations and the alarm for low temperature warnings was functioning. **What measures will be put in place or what systemic changes the facility will make to ensure the deficient practice does not recur?** An In-service was conducted to the Memory Care Manager, Assisted Living Manager, Director of Nursing, and Executive Director and related CNA, LPN, QMA, HHA whom may use the dish machine in memory care. This in-service trained personnel on	

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	06/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
INDEPENDENCE VILLAGE OF WEST ZIONSVILLE	6800 CENTRAL BOULEVARD ZIONSVILLE, IN 46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A memory care kitchen document, titled, "Dishmachine Temperature Log June 2021 MC," was provided by the MCCN, on 6/24/21 at 12:40 p.m. A review of the document indicated the dishwasher temperature should have been logged daily for breakfast, lunch and dinner. The document had 15 entries where the temperature was logged below the minimum stated temperature at the bottom of the document. It indicated, " ...Low temperature machines = 120 degrees F - 150 degrees F wash/rinse (or per manufacturer's guidelines)." The temperatures outside the guidelines were as follows: a. The temperature logged for Breakfast, on 6/3/21, was 114 degrees F for washing. b. The temperature logged for Lunch, on 6/3/21, was 119 degrees F for washing. c. The temperature logged for Breakfast, on 6/5/21, was 115 degrees F for washing. d. The temperature logged for Breakfast, on 6/12/21, was 117 degrees F for washing. e. The temperature logged for Breakfast, on 6/17/21, was 115 degrees F for washing. f. The temperature logged for Breakfast, on 6/18/21, was 116 degrees F for washing. g. The temperature logged for Lunch, on 6/18/21, was 113 degrees F for washing. h. The temperature logged for Breakfast, on 6/19/21, was 112 degrees F for washing. i. The temperature logged for Lunch, on 6/19/21, was 112 degrees F for washing. j. The temperature logged for Breakfast, on 6/20/21, was 118 degrees F for washing. k. The temperature logged for Lunch, on 6/20/21, was 118 degrees F for washing. l. The temperature logged for Breakfast, on 6/22/21, was 113 degrees F for washing. m. The temperature logged for Breakfast, on 6/24/21, was 115 degrees F for washing. n. The temperature logged for Lunch, on 6/24/21,		when to measure the temperature during a cycle, the functionality of the temperature alarm, and who to do in the even a temperature was below threshold. In addition, the temperature log for the main kitchen was added to the job description of the dishwasher and in service provided that the cook on duty is to ensure all logs are completed. **How the corrective action(s) will be monitored to ensure the finding will not recur:** Previous monitoring include all temperature logs being submitted to the ED monthly for review and stored electronically for the prior 12 months. This will continue. To further monitor, a daily task in the maintenance system has been triggered for the Director of Maintenance to review the temperature logs daily for 3 months. If compliance is achieved, the frequency will be weekly for 3 months. If after 6 months compliance is achieved, frequency will revert back to monthly. **By what date the systemic changes will be completed:** 06/29/2021	

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	06/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
INDEPENDENCE VILLAGE OF WEST ZIONSVILLE	6800 CENTRAL BOULEVARD ZIONSVILLE, IN 46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was 111 degrees F for washing. During an interview, on 6/24/21 at 2:26 p.m., the Executive Director (ED) indicated he thought the staff in the memory care area were logging initial wash and rinse temperatures instead of running wash and rinse temperatures. During an interview, on 6/24/21 at 2:41 p.m., the MCCN indicated she ran 3 loads of lunch dishes in the memory care dishwasher and the dishwasher temperature did not get to up 123 degrees F until the third load. On 6/24/21 at 2:43 p.m., for demonstration purposes, the Maintenance Director (MM) emptied the water from the memory care dishwasher, put in it start up mode, and the starting temperature was 153 degrees F. Then, he ran the wash/rinse cycle of the dishwasher. The temperatures were 146 and 188 degrees F. During an interview, on 6/24/21 at 2:54 p.m., the MCCN indicated she wrote down the running temperatures of the dishwasher while dishes were in it or right after they came out. On 6/24/21 at 2:00 p.m., the ED provided the manufacturer's manual for the dishwasher in the memory care area. The manual indicated it was a, "U-LT Low Temperature Undercounter Dishmachine." After review of the manual, it indicated, " ...Operating Temperatures ...Wash (minimum 120 degrees F ...Sanitizing Rinse (minimum) 120 degrees F...." 2. On 6/24/21 at 10:03 a.m., the main kitchen dishwasher was observed running. The temperatures were 159 degrees F for the wash cycle and 189 degrees F for the rinse cycle.			

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	06/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
INDEPENDENCE VILLAGE OF WEST ZIONSVILLE	6800 CENTRAL BOULEVARD ZIONSVILLE, IN 46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview, on 6/25/21 at 2:00 p.m., Cook 11 indicated he did not know if the main dishwasher was a high or low temperature dishwasher. He believed the standard temperature for dishwashers was 185 degrees F. The staff had not been filling out the main kitchen dishwasher log sheet because no one specifically had the job of dishwasher. Staff filled in the position of dishwasher as needed. For demonstration purposes, without dishes, 2 dishwasher cycles were run. The first wash/rinse cycle was 164 degrees F and 198 degrees F. The second cycle was 160 degrees F and 194 degrees F. A main kitchen document titled, "Dishmachine Temperature Log June 2021," was provided by the Regional Administrator, on 6/24/21 at 2:12 p.m. A review of the document indicated the dishwasher temperatures should have been logged daily for breakfast, lunch and dinner. The document had nothing logged after 6/7/21. No dishwasher temperatures were logged for the dishwasher after any resident meals from 6/8/21 to 6/24/21. During an interview, on 6/24/21 at 2:23 p.m., the ED indicated the Dietary Manager (DM) had been gone since 6/7/21, but the main kitchen dishwasher logs should have been logged daily with every meal. On 6/24/21 at 2:26 p.m., the ED provided the manufacturer's manual for the dishwasher in the main kitchen. The manual indicated it was a, "EHT Dishmachine." After review of the manual, it indicated, " ...Operating Temperatures ...Wash (minimum 155 (degrees) F...Sanitizing Rinse (minimum) 180 (degrees) F...."			