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	08/02/2023

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

(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 IN00410420. Complaint IN00410420 - State deficiencies related to the allegations are cited at R117, R217, R240, R407 and R414. Survey dates: July 31, August 1, and 2, 2023 Facility number: 013945 Residential Census: 87 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on August 8, 2023	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 and State Law. The plan of Correction is submitted to respond to the allegation of non-compliance cited during the Annual Survey which included Complaint Survey IN00410420, completed August 2, 2023. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
R 0036 Bldg. 00	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s			

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	08/02/2023

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

(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
	physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on interview and record review, the facility failed to timely address a change in a resident's condition resulting in the resident being admitted to an acute care hospital with sepsis (widespread infection) secondary to pneumonia for 1 of 2 closed records reviewed, (Resident E) Findings include: The clinical record for Resident E was reviewed on 7/31/23 at 1:47 p.m. The Resident's diagnosis included, but were not limited to, diabetes and falls. He was discharged from the facility to an acute care hospital on 6/29/23. A service plan, dated 3/22/23, indicated Resident E was alert, but forgetful, and needed assist with his gait due to balance issues. He required the use of a cane, walker, or assistance. A Nursing Note, dated 6/24/23 at 11:28 p.m., indicated Resident E had an unwitnessed fall. He was found sitting in the doorway of his restroom. He had been returning to his bed after using the restroom and had lost his balance and fallen. He complained of pain in his buttocks and his left elbow. A bruise was noted on his left elbow. His blood pressure was 160/63, respirations were 18, pulse was 67. Post fall assessment. Assisted up by staff. Post fall monitoring for safety and changes. His family and the Wellness Director were notified. A Nursing Note, dated 6/26/23 at 5:49 p.m.,	R 0036	1. Resident "E" was affected by the alleged deficient practice. The Service Plan has been updated. 2. The community realizes that all residents have the potential to be affected by the alleged deficient practice. 3. The Wellness staff will be re-educated by October 1, 2023 regarding the Community's Change of Condition Standard Operating Procedure, which includes but is not limited to the following: *All Qualified Medication Aides must immediately notify the nurse on duty, nurse on call or triage nurse with any changes in condition. *The Qualified Medication Aide will document exactly what was reported to the licensed nurse and when and what actions were taken. *The licensed nurse will notify the Provider of any change of condition and follow any new orders given. 4. The Wellness Director/designee shall review the 24 hour report daily by use of an auditing tool and take action as necessary for the next six months. All findings will be	10/01/2023

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	08/02/2023

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

(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
	indicated Resident E had complained of pain and requested a Tylenol. The medication was administered with positive results. A Medication Administration Note, dated 6/27/23 at 4:25 p.m., indicated he had received two acetaminophen tables for pain or fever, which were effective. A Nursing Note, entered by QMA (Qualified Medication Aide)13 on 6/27/23 at 6:07 p.m., indicated Resident E's wife had indicated he was complaining of back and side pain. An as needed Tylenol was administered per direction of the triage nurse. Resident E had not been himself all day. He had needed assistance getting dressed and to stand. He had not gone to the dining room for dinner and had not eaten the meal his wife had brought to his room for him. He had slept a lot that day. A General Note from the electronic record, dated 6/28/23 at 10:09 p.m., indicated Resident E had been unable to walk with his walker and had to use a wheelchair. It had taken 2 staff members to assist him to bed. A Nursing Note, dated 6/29/23 at 7:26 p.m., indicated Resident E's wife was taking him to an acute care hospital due to shortness of breath, vomiting, and fever. His temperature was 100.5 degrees Fahrenheit, pulse was 105, blood pressure was 178/91, and oxygen saturations were 82%. The clinical record did not contain information that a licensed nurse or physician had been informed of the changes in Resident E's condition. An acute care hospital Admitting Providers Note, dated 6/29/23 at 11:40 p.m., read "...History of		reported to the Wellness Committee (QAPI) for review and further recommendations as needed.	

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	08/02/2023

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

(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
	Present Illness/ Subjective...was brought to the ER [Emergency Room] with worsening AMS [Altered Mental Status] ...Pt [Patient] is poor historian so most information obtained from wife at bedside states that since Monday [6/26/23] pt[sic] was having fever and global weakness with recent worsening confusion and more recent low reading on pulse Ox [sic]. Work up in the ER showing patient to be septic likely source being PNA [Pneumonia]. During an interview on 8/2/23 at 12:08 p.m., the WD (Wellness Director) indicated the QMA's should have informed the nurse and the physician of the changes in condition. The Wellness Director or the Nurse on duty should follow up and assess. As of last weekend, there is a nurse in the building each day, including the weekends.			
R 0117 Bldg. 00	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 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			

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	08/02/2023

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

(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
	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 one awake staff person with first aid certification was on site at all times for 87 of 87 residents in the facility. Findings include: On 8/2/23 at 8:30 a.m., the ED (Executive Director) provided the completed Residential Care Employee Records form. It indicated QMA (Qualified Medication Aid) 10 was the staff member with First Aid certification on the following dates and 12 hour shifts: 2nd shift on 7/23/23, 2nd shift on 7/25/23, 2nd shift on 7/27/23, 2nd shift on 7/28/23, and 1st and 2nd shifts on 7/29/23. No staff member was indicated as having First Aid Certification 1st shift on 7/23/23. An interview was conducted with the ED on 8/2/23 at 11:05 a.m. He indicated they did not have CPR and First Aid Certification coverage on all shifts. QMA 10 was CPR certified only, so there was no First Aid certification coverage second shift on 7/25/23, 7/27/23, or 7/28/23 and no First Aid certification coverage for either first or second shifts on 7/23/23 and 7/29/23. The ED provided the Basic Life Support certification verification for QMA 10 on 8/2/23 at 11:05 a.m. It did not include First Aid certification. This Residential Tag relates to Complaint IN00410420.	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 and First Aid Training. A CPR and first aid training class has been scheduled. All wellness staff must obtained these certifications by October 1, 2023. In addition, all new hires will be required to provide these certifications upon hire. 4. The Wellness Director/designee shall monitor scheduled staff in advance on a daily basis for the next six months to ensure at least one awake staff member is CPR and First Aid certified. Any negative findings will be immediately corrected and forwarded to the Wellness Committee (QAPI) monthly for further review and recommendations as necessary.	10/01/2023

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	08/02/2023

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

(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 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature.	R 0120	1. No residents were affected by	10/01/2023

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	08/02/2023

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

(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
	Based on interview and record review, the facility failed to ensure a staff member who had contact with residents had 6 hours of dementia-specific training within 6 months of employment for 1 of 5 staff members reviewed for dementia training. (CNA-Certified Nursing Assistant 9) Findings include: On 8/2/23 at 8:30 a.m., the ED (Executive Director) provided the completed Residential Care Employee Records form. The form indicated CNA 9 began working at the facility on 11/18/22. On 8/2/23 at 10:30 a.m., the ED provided the employee file for CNA 9. It did not include verification of any dementia training. An interview was conducted with the ED on 8/2/23 at 12:28 p.m. He indicated he was unable to provide verification of dementia training for CNA 9. The staffing schedules were provided by the ED on 8/1/23 at 10:00 a.m. They indicated CNA 9 worked as a CNA for the following number of hours on the following dates: 12 hours on 6/3/23, 12 hours on 6/4/23, 12 hours on 7/23/23, 12 hours on 7/24/23, 12 hours on 7/26/23, and 12 hours on 7/31/23. As of 8/2/23 at 1:50 p.m., the ED was unable to provide a policy on staff dementia training.		the alleged deficient practice. 2. The community realizes that all residents have the potential to be affected by the alleged deficient practice. 3. Initial and Annual training shall include Resident's Rights, Infection Control, Fire Prevention, Safety and Accident Prevention, the needs of specialized populations served, i.e. Initial Dementia training, 30-day dementia training, Medication Administration, Nursing car, 8 hours of Inservice for nursing personnel, 6 hours of dementia specific training for nursing personnel within six months and 3 hours annually thereafter to meet the needs and preferences, or both of cognitively impaired residents, effectively, and to gain an understanding of the current standards of care for residents with Dementia .Community wide on-boarding process changed to include weekly training in classroom for all new staff. All staff to receive Dementia specific training by October 1, 2023. 4. Inservice records shall be maintained by the Wellness Director. The Wellness Director, Executive Director or designee shall monitor employee training weekly x 4 weeks, then monthly x 6 months, then bi-annually thereafter. All findings will be forwarded to the Wellness Committee (QAPI) for further	

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	08/02/2023

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

(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
			review and recommendations as needed.	
R 0187 Bldg. 00	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 ensure water temperatures did not exceed 120 degrees Fahrenheit, at point of use, for 2 of 3 residents whose water temperatures were observed (Residents S and Resident T), with the potential to effect 18 of 21 Residents residing on the Memory Care unit. Findings include: On 8/1/23 at 11:10 a.m., the bathroom for Resident S, who resided on the Memory Care Unit, was observed with the DM (Director of Maintenance) and HD (Director of Housekeeping). The hot water coming from the sink faucet was 120.7 degrees Fahrenheit. The bathroom for Resident T, who resides on the Memory Care Unit, was observed with the DM and HD. The hot water temperature coming out of the sink was 121.8 degrees Fahrenheit with steam noted to be rising from the sink. During an interview on 8/1/23 at 11:10 a.m., the HD indicated the water at point of use should be below 120 degrees Fahrenheit. Resident S and	R 0187	1. No residents were affected by the alleged deficient practice. 2. The Community realizes that residents have the potential to be affected by the alleged deficient practice. 3. Immediate repair/correction of water temperature completed by Maintenance Director on 8/1/23 Mixing valves were checked that morning and were below 120 degrees. Mixing valve was adjusted and tested. Measures/systemic changes put into place to prevent recurrence of deficiency. 4. Monitoring is as follows below: * Water temperatures are routinely checked weekly. *Water temperatures to be checked daily x 4 weeks then weekly thereafter indefinitely. * Random temperatures taken on water in resident's rooms daily x 4	08/28/2023

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	08/02/2023

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

(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
	Resident T were both ambulatory. On 8/1/23 at 11:15 a.m., the mixing valve was observed with the DM and HD. The temperature at the mixing valve was 123.2 degrees Fahrenheit. During an interview on 8/1/23 at 11:15 a.m., the DM indicated he would adjust the mixing valve temperature down to decrease the temperature of the water at point of use. During an interview on 8/1/23 at 11:45 a.m., the DM indicated he did not normally test water temperatures in resident's rooms. He normally tested the water temperatures in the common areas of the building. On 8/1/23 at 11:56 a.m., the DM provided the Water Temperature Log for the mixing valve temperatures, which indicated water temperatures at the mixing valve were 120 degrees Fahrenheit or above on the following days: 7/18/23- 120, 7/19/23- 121, 7/20/23- 120, 7/21/23- 120, and 7/25/23- 121. During an interview on 8/1/23 at 2:15 p.m., the Memory Care Director indicated that there were 18 residents residing on the memory care unit who were ambulatory and non-interviewable due to decreased cognition. On 8/1/23 at 11:56 a.m., the DM provided the Weekly Water Temperature Log Policy, last revised 2/12/21, which read "...Test water temperature at the point of use in the Licensed area, Assisted Living and Memory Care Sections of the building to ensure that hot water at faucets		weeks, then weekly thereafter, per current water temperature policy which consists of a) Test water temperature at the point of use in licensed area, Assisted living and Memory care sections of the Community to ensure that hot water at faucets falls between 105-120*F. b) Hot water at the point of use in the resident's units will be tested for temperature and logged in the log sheet weekly. c) 5-7 apartments will be checked weekly and logged. Room checks will be rotated. This practice will be on-going and documented for review by the Executive Director monthly for the next six months. Any findings will be forwarded to the Wellness Committee (QAPI) for further review and recommendations as necessary.	

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	08/02/2023

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

(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
	falls between 105-120 F[sic]. Hot water at the point of use in the residents' units will be tested for temperature and logged into the log sheet weekly...Test between 5-7 rooms weekly and use log sheet...rotate rooms every week..."			
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on interview and record review, the facility failed to ensure service plans were revised to	R 0217	1. Residents were affected by the deficient practice. All service plans	11/01/2023

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	08/02/2023

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

(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
	reflect their current services for 2 of 3 residents reviewed for bathing and toileting. (Residents F and G) Findings include: 1. The clinical record for Resident F on 7/31/23 at 2:00 p.m. Her diagnoses included, but were not limited to, anxiety, hypertension, and diabetes. She was admitted to the facility on 8/11/20. The service plan initiated 2/26/23, indicated Resident F was independent with bathing and bathed herself without assistance. It indicated she was independent with toileting and was able to get to and from the toilet. A tour of the facility was conducted with LPN (Licensed Practical Nurse) 5 and HHA (Home Health Aide) 7 on 7/31/23 at 11:00 a.m. During the tour, HHA 7 indicated Resident F required extensive assistance with her activities of daily living, including bathing and toileting. An interview was conducted with the WD (Wellness Director) on 8/1/23 at 10:25 a.m. She indicated service plans were not current, and she'd been working on updating them. 2. The clinical record for Resident G on 7/31/23 at 2:30 p.m. Her diagnoses included, but were not limited to, dementia, Parkinson's disease, and hypertension . She was admitted to the facility on 5/24/22. The service plan initiated 8/4/22, indicated Resident G was independent with toileting activities. A tour of the facility was conducted with LPN		of the identified residents have been updated to reflect any changes. 2. The Community realizes that residents have the potential to be affected by the alleged deficient practice. Full audit of all charts to completed by October 1, 2023, then as indicated per "Resident Evaluation and Service plan policy" Any charts found to be out of compliance during audit will be updated and discussed with family. Completion of updates and family discussions to be completed by November 1, 2023 3. Inservice for all nursing staff to include notification to nursing specifically Wellness Director or charge nurse, of any changes in resident's ADL status so service plan can be updated in a timely manner. Measures/systemic changes put into place to prevent recurrence of cited deficiency) Current EHR system can trigger/notify Wellness Director or designee about upcoming service plan due dates. 4. With regard to the monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and or/in compliance with the regulatory requirements, after initial measures completed, random audits will be conducted x 4	

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	08/02/2023

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

(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
	(Licensed Practical Nurse) 5 and HHA (Home Health Aide) 7 on 7/31/23 at 11:00 a.m. During the tour, HHA 7 indicated Resident G required extensive assistance with her activities of daily living, including toileting. An interview was conducted with the WD (Wellness Director) on 8/1/23 at 10:25 a.m. She indicated service plans were not current, and she'd been working on updating them. The Resident Evaluation and Service Plan policy was provided by the WD on 8/1/23 at 11:04 a.m. It read, "The Service Plan will be reviewed and updated at least annually and when resident's needs or preferences change." This Residential Tag relates to Complaint IN00410420.		weeks, then weekly thereafter by WD or designee for the next s months. All findings will be forwarded to the Wellness Committee (QAPI) for further review and recommendations as needed.	
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 interview and record review, the facility failed to ensure staff assistance with showers, the coordination of ordering medications from the correct pharmacy and ensuring residents ingested medications for 4 of 6 residents records reviewed and 1 of 1 random observations. (Resident B, F, G, K and L) Findings include: 1. The clinical record for Resident F on 7/31/23 at 2:00 p.m. Her diagnoses included, but were not limited to, anxiety, hypertension, and diabetes. She was admitted to the facility on 8/11/20.	R 0240	1. Residents F, B, G, L and K were affected by the alleged deficient practices. Shower schedules have been updated on the Services Plans of those residents affected F, G, and B. Resident K has been issued a credit to their account to offset the cost difference by ordering from the wrong pharmacy. Resident K's service plan updated to reflect that family will manage insulin refills, medication is not to be order through facility pharmacy. Resident L has moved into the	10/01/2023

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	08/02/2023

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

(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 service plan initiated 2/26/23, indicated Resident F was independent with bathing and bathed herself without assistance. A tour of the facility was conducted with LPN (Licensed Practical Nurse) 5 and HHA (Home Health Aide) 7 on 7/31/23 at 11:00 a.m. During the tour, HHA 7 indicated Resident F required extensive assistance with her activities of daily living, including bathing. An interview was conducted with the WD (Wellness Director) on 8/1/23 at 10:25 a.m. She indicated service plans were not current, and she'd been working on updating them. The residents' bathing schedule for the facility was provided by the WD on 8/1/23 at 11:06 a.m. It indicated Resident F's bathing days were Monday and Thursday. On 8/1/23 at 11:05 a.m., and interview was conducted with the WD, who provided the July, 2023 shower sheets for Resident F at this time. They included only one shower sheet dated 7/31/23. The WD indicated the 7/31/23 shower sheet was all there was to verify bathing for Resident F in the month of July, 2023. 2. The clinical record for Resident G on 7/31/23 at 2:30 p.m. Her diagnoses included, but were not limited to, dementia, Parkinson's disease, and hypertension . She was admitted to the facility on 5/24/22. The service plan initiated 8/4/22, indicated Resident G required staff assistance with bathing. A tour of the facility was conducted with LPN		Memory Care neighborhood. 2. The community realizes that all residents have the potential to be affected by the alleged deficient practice. 3. Wellness staff will be educated regarding resident showers, medication administration and ordering from the correct pharmacy. Staff to continue to use shower sheets and turn them in to the Wellness Director/ designee daily for review. Staff to complete a shower sheet for refusals and 2nd attempts and turn those into WD or designee. Showers will be audited. Scheduled nursing in-service to include shower duties, responsibilities and processes In the event that something unexpected occurs and shower is not given at scheduled time, the next shift will offer a shower or the next day, whichever is in line with resident's wishes. In addition to above interventions. Medication administration will be monitored by the Wellness Director/designee by random medication pass observations. The Wellness Director/designee will conduct random audits on both the Showers and the Medication pass. Both audits will be conducted daily x 4 weeks, then monthly for the next 6 months. All findings will be	

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	08/02/2023

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

(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
	(Licensed Practical Nurse) 5 and HHA (Home Health Aide) 7 on 7/31/23 at 11:00 a.m. During the tour, HHA 7 indicated Resident G required extensive assistance with her activities of daily living, including bathing, and that all residents on Resident G's unit required assistance with bathing. The residents' bathing schedule for the facility was provided by the WD (Wellness Director) on 8/1/23 at 11:06 a.m. It indicated Resident G's bathing days were Monday and Thursday nights. An interview was conducted with the Memory Care Director on 8/1/23 at 9:48 a.m. She indicated the staff filled out shower sheets every time they assisted a resident with bathing, so there should be one for each shower/bath provided. On 8/1/23 at 11:05 a.m., an interview was conducted with the WD, who provided the July, 2023 shower sheets for Resident G at this time. They included 2 shower sheets dated 7/17/23 and 7/27/23. She indicated the 7/17/23 and 7/27/23 shower sheets were all there was to verify bathing for Resident G in the month of July, 2023. The 7/7/23 progress note, written by QMA (Qualified Medication Aide) 10, read, "CNA [name of CNA-Certified Nursing Assistant] refuse [sic] to give res [resident] shower even after reminding CNA several times." 3. The clinical record for Resident B was reviewed on 7/31/23 at 12:00 p.m. The diagnosis for Resident B included, but was not limited to, dementia. A service plan dated 2/26/23 indicated staff was to provide showers on Mondays, Wednesdays, and		forwarded monthly to the Wellness Committee (QAPI) for further review and recommendation as needed.	

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	08/02/2023

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

(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
	Fridays. The June 2023 and July 2023 shower sheets were provided by the Wellness Director (WD) on 8/1/23 at 1:44 p.m. The following days Resident B had not received showers as scheduled: 6/2/23 - Friday, 6/5/23 - Monday, 6/7/23 - Wednesday, 6/12/23 - Monday, 6/14/23 - Wednesday, 6/16/23 - Friday, 6/21/23 - Wednesday, 6/23/23 - Friday, 6/30/23 - Friday, 7/3/23 - Monday, 7/14/23 - Friday, 7/17/23 - Monday, 7/19/23 - Wednesday, and 7/24/23 - Monday, During a confidential interview 22, Resident B had not received all his scheduled showers. An interview was conducted with WD on 8/1/23 at 3:00 p.m. She was unable to provide any additional shower sheets that indicated showers were completed for Resident B. The Resident Evaluation and Service Plan policy was provided by the WD on 8/1/23 at 11:04 a.m. It read, "The purpose of the Service Plan is to provide a description of the services that will be provided to the resident based on his or her individual needs and preferences." 4. The clinical record for Resident L was reviewed			

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	08/02/2023

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

(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 8/2/23 at 11:00 a.m. The diagnosis for Resident L included, but was not limited to, hypertension. A service plans dated 8/4/22 indicated Resident L's medications were managed by staff. The goal indicated the resident "Will be supported to take all medications safely and as ordered." An observation was made of Resident L in her room with Qualified Medication Aide (QMA) 13 on 8/1/23 at 9:28 a.m. QMA 13 was administrating morning medications to Resident L at the bedside. During that time, a white pill that was wet and dissolving was observed in the resident's kitchen sink. An interview was conducted with QMA 13 at 8/1/23 at 9:30 a.m. She indicated Resident L had become more confused lately, and the facility was in the process of transferring the resident to the Memory Care Unit. She was unsure why the pill medication was in the sink. The staff either did not stay in the room while she was taking her medications or the resident during the administration had not swallow the pill and spit it out after staff had left. 5. The clinical record for Resident K was reviewed on 8/2/23 at 9:00 a.m. The diagnosis for Resident K included, but was not limited to, type 2 diabetes mellitus. A service plan revision date 2/26/23 indicated "Administer diabetic medications as ordered by physician..." An evaluation dated 2/11/23 indicated "Medication Administration...2. Assistance with ordering & coordinating medication between family and/or health care providers..."			

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	08/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A physician order dated 5/18/23 indicated Resident K was to receive a sliding scale of novolog insulin twice a day. The following was the sliding scale: blood sugar reading of 150-200 = 4 units, blood sugar reading of 201-250 = 6 units, blood sugar reading of 251-300 = 8 units, blood sugar reading of 301 - 350 = 10 units, blood sugar reading greater than 350 = call medical provider During a confidential interview 23, they indicated they had concerns with Resident K's medications. Resident K's insulin supply was to be ordered by the family utilizing their pharmacy. In error, the facility pharmacy had filled and delivered the resident's novolog insulin pens. The former WD was to send the box of the insulin pens back to the facility pharmacy, but it did not happened. The resident was running out of her insulin, so the resident's family had attempted to order the novolog insulin pens through their pharmacy and was told it was too early to fill. The resident's representative had to allow the facility to go ahead and use the novolog insulin pens that was suppose to be sent back due to her running out. The medication error has not been addressed. A conversation between Resident K's Representative and facility staff via email was provided by the WD on 8/2/23 at 11:58 a.m. An email dated 6/1/23 indicated "[Former WD], Can you check your office to see if you have a box of insulin pens with Novolog. [Resident K] is down to her last pen with # 15 units. When I tried to get the refill from [family pharmacy] they said it was to soon since it was delivered to the facility on May 19th. I have told everyone there do not order insulin from [facility pharmacy]. How did it get			

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	08/02/2023

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

(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
	ordered?...They over charge me..." An email response dated 6/2/23 at 9:16 a.m. by the Executive Director indicated "[Resident K's Representative], I have given your pens to the nurse. We will use the ones from [Facility pharmacy]. I do not know how they got ordered. [Former WD] is off until Monday, and she will investigate how this happened. Please let me know how the extra cost is for this order and we will credit it back to [Resident K]. So sorry for this issue..." An email response from Resident K's Representative dated 6/2/23 at 1:11 p.m. It indicated "[Executive Director], Thanks for the follow and reply. I talked to [Former WD] early this morning. The reason I could not get the insulin from [family pharmacy] is [Former WD] had the box of pens from [facility pharmacy] in her office since May 20th that was suppose to be returned. Medicare would not cover the cost because it was too early to reorder. We have to pay more for insulin coming from [facility pharmacy] compared to [family pharmacy]..." An interview was conducted with WD on 8/2/23 at 12:09 p.m. She indicated she was unaware of the concerns with Resident K's novolog insulin medication. The former WD had not addressed the medications supply error. She has called the pharmacy that day and was addressing. This State Tag relates to complaint IN00410420.			
R 0272 Bldg. 00	410 IAC 16.2-5-5.1(e) Food and Nutritional Services - Deficiency (e) All food shall be served at a safe and appropriate temperature. Based on observation, interview, and record review, the facility failed to serve food at appropriate temperatures on the Memory Care	R 0272	1. No residents were affected by the alleged deficient practice. 2 The Community realizes that residents have the potential to be	10/01/2023

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	08/02/2023

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

(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
	Unit, with the potential to affect 21 of 21 residents residing on the unit. Findings include: On 7/31/23 at 11:50 a.m., lunch service in the memory care dining room was observed with DS (Dietary Staff) 15. DS 15 indicated that the memory care unit was served "family style". A large bowl of corn wrapped in clear plastic wrap, was observed on the counter of the kitchen. The temperature of the corn was 107 degrees Fahrenheit. The bowl of corn was then taken by a staff member to the table and served to 2 residents. There were 2 covered plates on the kitchen counter. DS 15 indicated they were mechanical soft plates of chicken salad and cottage cheese that were for specific residents who needed mechanically altered diets. They had been sent from the kitchen on the cart at the same time. A staff member requested DS 15 hand one of the bowls to him so that he could assist the resident in eating. Prior to the plate being served the temperatures of the items on the plate were observed. DS 15 indicated the mechanically altered chicken salad was 89 degrees Fahrenheit and the cottage cheese on the plate was 86 degrees Fahrenheit. DS 15 indicated the temperatures of the chicken salad and cottage cheese should be cooler when served and that new plates would be brought to the unit for the 2 residents who required mechanically altered diets. On 7/31/23 at 1:45 p.m., the Executive Director provided the Food Temperature Recording policy, last reviewed on 6/8/22, which read "...Hot Foods in the steam table are maintained at 185 degrees F [sic] so that items arrive at approximately > [sic] 150 degrees F[sic] when the resident is served...Cold foods are maintained and served at		affected by the alleged deficient practice. 3. All dietary staff were re-trained on food temperature regulations Training included, but was not limited to: * Hot/cold food temperatures * Hot/cold food transport * Safe food storage * Steam table temperatures * Food temperature recording policy * Food temperature logs * Reporting temperature variances and follow up procedures .All new staff will receive training on policy and procedure, temperature and food delivery, storage and serving regulations. As a systemic change, additional bi-annual in-services for all dietary staff. 4. Dietary Manager or designee will monitor/audit temperature logs for each meal daily x 4 weeks, then daily indefinitely for the next six months. All findings will be forwarded monthly to the Wellness Committee (QAPI) for further review and recommendations as necessary.	

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	08/02/2023

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

(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
	41 degrees F[sic] or less..."			
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to store refrigerated items in closed containers, label and date items stored in the refrigerator, properly thaw salmon filets, and to ensure that dietary staff's personal items were not in the food preparation area with the potential to affect 85 of 85 Residents who receive meals from the facility kitchen. Findings include: On 7/31/23 at 10:58 a.m., the facility kitchen was observed with DS (Dietary Staff) 15. A large silver pan filled with water and multiple individually vacuum-packed salmon filets. DS 15 indicated the salmon was for the evening meal. The salmon fillets were covered with water and were going to be put into the refrigerator to thaw. The salad bar cooler was observed to have a raw hamburger patty in an open vacuum sealed container. The hamburger patty was open to air. There were 2 open to air cartons of egg substitute. DS 15 indicated the open hamburger patty should have been inside of the silver container with a lid, and the open cartons of egg substitute were left over from the morning meal and should have been thrown away. The serving line shelf was observed to have a	R 0273	1. No residents were affected by the alleged deficient practice. 2. The Community realizes that residents have the potential to be affected by the alleged deficient practices 3. Employees have been educated. The education included but was not limited to: a) Thawing of food b) Cold food storage c) Labeling, dating and storing opened containers. d) Salad bar temperature control values and separation e) Raw food storage f) Personal property/items storage 4. Dietary Manager or designee will monitor/audit food storage, labeling and observe for any personal items stored in kitchen area weekly X 4 weeks and monthly thereafter for the next 6 months. All findings will be forwarded to the Wellness Committee (QAPI) for further review and recommendations as	10/01/2023

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	08/02/2023

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

(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
	container of "Collagen Burn" and a pink cup with a lid and straw. DS 15 indicated the items belonged to the cook. The reach in refrigerator had 2 covered pitchers with red liquid in them on the floor of the refrigerator, neither pitcher had a label or date present. DS 15 indicated the pitcher contained juice and that they should have been labeled and dated. During an interview on 7/31/23 at 1:45 p.m., the Executive Director indicated that the staffs' personal items should not be stored in the kitchen. On 7//31/23 at 1:45 p.m., the Executive Director provided the Proper Food Storage policy, last reviewed 6/6/22, which read "...keep foods properly wrapped or covered and dated with date opened and date expired... All cooked or prepped foods need to be in containers that are covered, labeled, and dated with date made and date expired..." 410 IAC 7-24-199 Thawing of food Sec. 199. (a) Except as specified in subdivision (4), potentially hazardous food shall be thawed: (1) under refrigeration that maintains the food temperature at forty-one (41) degrees Fahrenheit or less or at forty-five (45) degrees Fahrenheit or less as specified under section 187(a)(2)(B) of this rule. (2) completely submerged under running water: (A) at a water temperature of seventy (70) degrees Fahrenheit or below; (B) with sufficient water velocity to agitate and float off loose particles in an overflow; (C) for a period of time that does not allow thawed		needed.	

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	08/02/2023

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

(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
	portions of ready-to-eat food to rise above forty-one			
R 0298 Bldg. 00	410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. Based on interview and record review, the facility failed to ensure pharmacy reviewed residents' drug regimens at least once every 60 days and pharmacy recommendations were addressed timely for 3 of 6 resident records reviewed. (Residents B, F and G) Findings include: 1. The clinical record for Resident F on 7/31/23 at 2:00 p.m. Her diagnoses included, but were not limited to, anxiety, hypertension, and diabetes. She was admitted to the facility on 8/11/20. The service plan initiated 2/26/23, indicated Resident F would be supported to take all medications safely and as ordered. She required daily supervision of medication.	R 0298	1. Residents B, F and G were affected by the alleged deficient practice deficient practice. Their respective pharmacy recommendations have been reviewed and updated as needed. 2. The community realizes that all residents have the potential to be affected by the deficient practice. 3. Systemic changes/measures implemented to prevent recurrence of cited deficiency: Contracted Pharmacy has implemented a policy regarding pharmacy reviews every 60 days Calendar reminders set for wellness Director or designee for	10/01/2023

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	08/02/2023

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

(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 July, 2023 MAR (medication administration record) indicated staff administered her medications. On 8/1/23 at 9:33 a.m., the WD (Wellness Director) provided the 7/23/23 Consultant Pharmacist's Medication Regimen Review: Listing of Residents Reviewed with No Recommendations. Resident F was on the list as having her medications reviewed, but not requiring any recommendations. An interview was conducted with the WD on 8/1/23 at 9:33 a.m. She indicated she was unable to locate verification of any pharmacy medication reviews prior to July, 2023. 2. The clinical record for Resident G on 7/31/23 at 2:30 p.m. Her diagnoses included, but were not limited to, dementia, Parkinson's disease, and hypertension . She was admitted to the facility on 5/24/22. The service plan initiated 8/4/22, indicated Resident G would be supported to take all medications safely and as ordered. She required assistance with ordering medications and daily supervision of medication. The July, 2023 MAR (medication administration record) indicated staff administered her medications. On 8/1/23 at 9:33 a.m., the WD (Wellness Director) provided the 7/23/23 Consultant Pharmacist's Medication Regimen Review: Listing of Residents Reviewed with No Recommendations. Resident G was on the list as having her medications reviewed, but not requiring any recommendations. An interview was conducted with the WD on		follow-up. Wellness Director or designee will track pharmacy reviews every 60 days indefinitely. 4, The Wellness Director/designee will monitor weekly for provider response to pharmacy recommendations and implement as necessary. Pharmacy Recommendations will be completed by the Wellness Director or designee and submitted to providers as appropriate. The Wellness Director or designee will complete the nursing recommendations within 7 days of receipt of pharmacy recommendations weekly X 4 weeks and monthly thereafter for the next 6 months. All findings will be forwarded to the Wellness Committee (QAPI) for further review and recommendations as necessary.	

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	08/02/2023

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

(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
	8/1/23 at 9:33 a.m. She indicated she was unable to locate verification of any pharmacy medication reviews prior to July, 2023.3. The clinical record for Resident B was reviewed on 7/31/23 at 12:00 p.m. The diagnosis for Resident B included, but was not limited to, dementia. A physician order dated 5/19/23 indicated Resident B was to receive 10 milligrams of donepezil nightly. A physician order dated 5/19/23 indicated Resident B was to receive 50 milligrams of myrbetriq daily. A pharmacy recommendation for Resident B dated 7/23/23 indicated "This resident has dementia and is receiving a medication to aid this condition (donepezil), and one that interfere with the aforementioned medication action (Myrbetriq) by decreasing acetylcholine. Please consider d/cing [discontinuing] the offending medication..." A physician communication note dated 8/1/23 at 7:41 a.m., indicated "Sent Pharm [pharmacy] Rec [recommendation] to provider, explained pharm recs received late..." An interview was conducted with the WD on 8/1/23 at 11:32 a.m. She indicated she had requested the pharmacy recommendation to be resent for Resident B, because she had not received. She indicated it was possible the pharmacy had sent to the Former WD in error. The pharmacy resent the recommendation to her on 7/31/23. She has forwarded it to the physician to address on 8/1/23.			
R 0301	410 IAC 16.2-5-6(c)(5) Pharmaceutical Services - Deficiency			

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	08/02/2023

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

(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
Bldg. 00	(5) Labeling of prescription drugs shall include the following: (A) Resident ' s full name. (B) Physician ' s name. (C) Prescription number. (D) Name and strength of the drug. (E) Directions for use. (F) Date of issue and expiration date (when applicable). (G) Name and address of the pharmacy that filled the prescription. If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted. Based on observation, interview and record review, the facility failed to ensure medications and food items that were stored in medication storage rooms and medication carts were labeled and dated for 2 of 2 med rooms observed and 1 of 2 medication carts observed. (Resident's K and M) Findings include: An observation was made of the medication storage room in the Memory Care Unit with Qualified Medication Aide (QMA) 2 on 8/1/23 at 8:20 a.m. The refrigerator was observed with 1 opened bottle of chocolate syrup and 1 unopened bottle of chocolate syrup. There was no open date or expiration date on the syrup bottles. QMA 2 indicated at that time she used the chocolate syrup at times for a resident that liked the syrup instead of apple sauce to take her medications. The chocolate syrup comes from the kitchen which should have dates on them. The last time she had used the chocolate syrup was approximately 2 weeks ago.	R 0301	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 deficient practice. 3, All clinical staff educated on proper procedures, including but not limited to: a. Medication storage labeling and dating b. Specimen storage c. Safe food storage and dating and use of opened products d. Insulin dating and storage and all other procedures for the safe storage of medication per the medication storage policy. 4. Cart audits shall be done by Wellness Director/designee for compliance daily x 4 weeks then monthly for the next 6 months. All findings will be forwarded monthly	10/01/2023

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	08/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	An observation was made of the 2nd floor medication cart QMA 13 on 8/1/23 at 9:40 a.m. The medication was observed with 1 lispro insulin flex pen with no open date, 1 novolog insulin flex pen with no name or open date, 1 tresiba insulin pen with no open date. QMA 13 at that time indicated the novolog and tresiba insulin belonged to Resident K, and the lispro insulin belonged to Resident M. An interview was conducted with QMA 13 on 8/1/23 at 9:42 a.m. She indicated the insulin pens should be labeled and dated with open and/or expiration date. The medication storage policy was provided by the Wellness Director on 8/2/23 at 9:50 a.m. It indicated "...The purpose of the Medication Storage Policy is to establish a procedure to be followed for safe, consistent storage of medications...2. Medication labels must include: resident name, medication name, medication strength/dose, frequency, route, and the expiration date..."		to the Wellness Committee (QAPI) for further review and recommendations as needed. Medication rooms shell be inspected for cleanliness and compliance daily x 4 weeks, then monthly for the next 6 months. All findings will be forwarded to the Wellness Committee (QAPI) for further review and recommendations as needed.	
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the			

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	08/02/2023

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

(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
	family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on interview and record review, the facility failed to ensure the phone number of the primary care physician was present on the face Sheet for 1 of 2 residents reviewed for closed records (Resident E). Findings include: The clinical record for Resident E was reviewed on 7/31/23 at 1:47 p.m. The Resident's diagnosis included, but were not limited to, diabetes and falls. A Nursing Note, entered by Triage LPN (Licensed Practical Nurse) 12 on 6/24/23 at 11:28 p.m., indicated Resident E had an unwitnessed fall. He was found sitting in the doorway of his restroom. He had been returning to his bed after using the restroom and had lost his balance and fallen. He complained of pain in his buttocks and his left elbow. A bruise was noted on his left elbow. His blood pressure was 160/63, respirations were 18, pulse was 67. Post fall assessment. Assisted up by staff. Post fall monitoring for safety and changes. His family and the Wellness Director were notified. On 8/1/23 at 9:45 a.m., the WD (Wellness Director) provided the Nurse Triage Phone Call Template, completed on dated 6/24/23 at 8:12 p.m. by Triage LPN 12, which indicated the Triage LPN had	R 0356	1. Residents "E" was affected by the deficient practice. The resident's face sheet has been update to include the telephone number of the Primary Care Provider. 2. The Community realizes that residents have the potential to be affected by the deficient practice. 3. All resident face sheets have been audited to ensure that all contact telephone numbers were present and correct. 4. The Wellness Director/designee will complete an admission audit within 24 hours of admission to ensure that all pertinent information is in the chart and accessible. This practice will be on-going.	10/01/2023

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	08/02/2023

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

(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
	received a call from QMA (Qualified Medication Aide) 10 due to Resident E having an unwitnessed fall. He was found sitting in the doorway of his restroom. He had been returning to his bed after using the restroom and had lost his balance and fallen. He complained of pain in his buttocks and his left elbow. A bruise was noted on his left elbow. His blood pressure was 160/63, respirations were 18, pulse was 67. The Members/ Case Managers Notified via: Incident report, nursing note, family, the PCP (Primary Care Provider) had no contact number listed only name, Oncoming day shift nurse, and Wellness Director. During an interview on 8/1/23 at 10:38 a.m., the WD (Wellness Director) indicated the primary care providers phone number should have been on the face sheet so that the provider could have been contacted in case of an emergency.			
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on observation and interview, the facility failed to ensure staff used serving utensils when serving ready to eat foods from the kitchen with the potential to affect 85 of 85 residents residing at the facility, and to ensure infection control was	R 0407	1. Residents were affected by the alleged deficient practice. 2. The Community realizes that all residents had the potential to	10/01/2023

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	08/02/2023

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

(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
	maintained by not placing residents' insulin medications on tables in other residents' rooms and ensuring cleaning and/or disinfecting of insulin flex pen hubs prior to needle placement for 2 of 2 residents observed during medication administration. (Resident F and Resident N) Findings include: 1. On 7/31/23 at 11:23 a.m., the lunch meal services was observed with DS (Dietary Staff) 15. FC (Facility Cook) 16 was observed picking up a bag of dinner rolls and removing a dinner roll with her gloved hand, then tying the dinner roll bag and putting it back on the shelf. FC 16 then went to the serving line and picked up a sandwich with her gloved hand and took it to the cutting board and cut the sandwich, placing it on a plate. FC 16 then used her gloved hand to pick up french fries from the serving pan and placed them on the plate, handing the plate to the server to be served in the dining room. FC 16 removed tickets from the ticket printer and hung them on the line. She did not perform hand hygiene or change her gloves. She then picked up another sandwich with her gloved hands and cut it with a knife, placed it on the plate and picked up more french fries with her gloved hands, placing them on the plate to be served. Tongs were available on the serving line to use for the french fries and the sandwiches. During an interview on 7/31/23 at 11:30 a.m., DS 15 indicated the tongs should have been utilized to serve the food from the serving line and not hands. 2. The clinical record for Resident F was reviewed on 8/1/23 at 12:00 p.m. The diagnosis for Resident F included, but was not limited to, type 2 diabetes mellitus. A physician order dated 5/13/23 indicated		be affected by this alleged deficient practice 3. All staff performed hand hygiene competency validations with demonstrations. Dietary staff re-educated on proper serving procedures. All staff educated on infection control policies and procedures, including but not limited to: * proper use of gloves * food handling standards and policies * when and how often to perform hand hygiene. All staff re-educated as above with regard to infection control policies, procedures and in 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. Findings will be forwarded monthly to the Wellness Committee (QAPI) for further review and recommendations as necessary.	

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	08/02/2023

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

(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
	Resident F was to receive 22 units of levemir insulin at 8:00 a.m. A physician order dated 7/19/23 indicated Resident F was to receive 0.5 milligrams of ozempic insulin once a week. 3. The clinical record for Resident N was reviewed on 8/1/23 at 12:15 p.m. The diagnosis for Resident N included, but was not limited to, type 2 diabetes mellitus. A physician order dated 12/19/23 indicated Resident N was to receive 17 units of lantus insulin daily. An observation was made of Qualified Medication Aide (QMA) 13 administering medications on 8/1/23 at 9:12 a.m. At 9:13 a.m., QMA 13 was observed gathering supplies and 3 insulin flex pens for Resident F and Resident N. She then left the medication room with both residents insulin pens and entered Resident N's room. QMA 13 was observed placing Resident F's 2 insulin flex pens on Resident N's night table. After, she placed the needle on the hub of the Resident N's lantus. She then wiped the resident's abdomen with an alcohol wipe and administered the insulin to the resident. There was no observation of disinfecting the hub of the flex pen prior to needle placement. An observation was made of QMA 13 administering insulin medications on 8/1/23 at 9:23 a.m. QMA 13 was observed entering Resident F's room with Resident F and Resident N's insulin flex pens. QMA 13 placed Resident N's lantus flex pen that was not capped with the used needle still attached on Resident F's table. She then placed the needles on Resident F's levemir insulin and ozempic insulin. There was no observation of			

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	08/02/2023

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

(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
	disinfecting the hub of the flex pen prior to placement of the needle. She then using an alcohol wipe disinfected Resident F's abdomen and administered the insulins. An interview was conducted with Wellness Director on 8/1/23 at 3:03 p.m. She indicated QMA 13 should be using better infection control practices. This State Tag relates to complaint IN00410420.			
R 0414 Bldg. 00	410 IAC 16.2-5-12(k) Infection Control - Deficiency (k) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Based on observation, interview and record review, the facility failed to ensure infection control was maintained by utilizing hand hygiene when coming in contact with residents and their environment for 10 of 11 residents observed during medication administrations. (Resident's L, F, N, TT, PP, QQ, RR, SS, VV, and WW) Findings include: An observation was made of Qualified Medication Aide (QMA) 13 on 8/1/23 at 8:47 a.m. QMA 13 was observed with a tray of medications cups administering medications at the door of Resident TT. She handed the resident her medication cup and water cup in the doorway of the resident's room. After, she went directly to Resident PP's door, entered the room and administered the medication and water cups to the resident. She then left the resident's room and went into Resident QQ and Resident RR's room. QMA 13 was observed administering medications to both	R 0414	1. No residents were affected by the alleged deficient practice. 2. The Community realizes that residents could have been affected by the alleged deficient practice. 3. Facility wide hand hygiene/hand washing competency validations performed with return demonstrations All staff re-trained on infection control policies and procedures in accordance with state and local guidelines All new staff shall be required to perform a hand hygiene demonstration in the new hire orientation. As a systemic change, the Wellness Director/designee will conduct Bi-Annual competency evaluations to be performed and documented	10/01/2023

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	08/02/2023

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

(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
	residents. There was no observation of hand hygiene utilized before or after the medication administrations to Resident's TT, PP, QQ and RR. An observation was made of QMA 13 during the medication administration on 8/1/23 at 9:00 a.m. QMA 13 was observed obtaining blood pressure readings for Resident SS. She picked up the blood pressure cuff and placed it on the resident's arm. During that time, QMA 13 had wiped her nose with her hand, touched resident's arm, table, paper, pen, keys and blood pressure cuff. There was no hand hygiene observed before or after coming in contact with her face, of Resident SS's arm, blood pressure equipment or the resident's personal items in her apartment. At 9:07 a.m., QMA 13 returned to her medication cart and was observed pulling Resident VV's medications. During that time, QMA 13 was observed taking a medication bottle and pouring 1 pill out of the bottle into her bare hand then placing it in a medication cup. After preparing the medications, she went into Resident VV's room and administered the medication to the resident. Upon leaving the resident's room she had dropped an empty medication cup on the floor, picked it up and exited the room. There was no hand hygiene observed prior to preparing the medications, before or after medication administration nor after coming in contact with the floor of the resident's room. During the medication administration with QMA 13 at 9:12 a.m., QMA 13 was observed entering Resident WW's room. She donned on gloves and assisted the resident placing ted hose on the resident's legs. After, she left the resident's room and went to the medication cart. There was no observation of hand hygiene prior to donning on her gloves nor did she doff her gloves after		on all staff. 4. Random hand washing validations to be performed weekly for the next six months. All findings will be forwarded monthly to the Wellness Committee (QAPI) for further review and recommendations as needed. The Wellness Director/designee will conduct Bi-Annual competency evaluations to be performed and documented on all staff.	

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	08/02/2023

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

(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
	assistance. At 9:14 a.m., QMA 13 was observed at the medication cart pulling insulin pens out for Resident N and Resident F with her gloved hands. At 9:16 a.m., QMA 13 was in Resident F's room administering the resident's insulin with the gloved hands. She then left the resident's room and entered Resident N's room. During that time, she doffed her gloves after she placed the needle on the hub of the flex pen. QMA 13 then administered the insulin medication in Resident N's abdomen with her bare hands. There was no observation of QMA 13 utilizing hand hygiene before or after doffing gloves, or before or after insulin medication administrations. An observation was made of QMA 13 during a medication administration on 8/1/23 at 9:28 a.m. QMA 13 was observed preparing medications for Resident L. After, she entered the resident's room and administered the medications. During that time, QMA 13 was observed assisting with the resident's shoes. She then exited the room. There was no hand hygiene before or after the medication administration or coming in contact with the floor, and the resident's shoes. An interview was conducted with the Wellness Director (WD) on 8/1/23 at 3:03 p.m. She indicated QMA 13 should have utilized hand hygiene. She had already educated QMA 13 regarding walking in the hallways with gloves on her hands. She will reeducate QMA 13. A "Use of Gloves" policy was provided by the WD on 8/2/23 at 9:50 a.m. It indicated "...The use of gloves is to protect residents/clients, family members and friends and staff from the spread of infection. Procedure: Wear gloves whenever there is a reasonable expectation of contact with blood or body fluids...To apply gloves:..2. Wash hands			

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	08/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and dry thoroughly 3. Put on gloves...To remove gloves:..6. Discard both gloves in a plastic trash bag...7. Wash hands..." A hand hygiene policy was provided by the WD on 8/2/23 at 9:50 a.m. It indicated "...Hand hygiene will be done by all employees, volunteers and contract staff to reduce the transfer of microbes to patients and to prevent the growth of microorganisms on the nails, hands and forearms...1. Indications for hand hygiene are: Before and after direct patient care,...2. All employees, volunteers and contract staff are responsible for implementing hand hygiene procedures in an ongoing attempt to prevent and/or contain infectious processes and communicable diseases..." This State Tag relates to complaint IN00410420.			