STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155472	A. BUILDING 00 B. WING	03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HOOSIER VILLAGE	9875 CHERRYLEAF DR INDIANAPOLIS, IN 46268

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a Non-Certified Comprehensive (NCC) Licensure Survey. This visit included a State Residential Licensure. This visit included the Investigation of Complaint IN00419238. Complaint IN00419238 - No deficiencies related to the allegations are cited. Survey dates: March 18, 19, 20, 21 and 22, 2024. Facility number: 000548 Provider number: 155472 Census Bed Type: SNF: 8 Residential: 246 NCC: 52 Total: 306 Census Payor Type: Medicare: 8 Total: 8 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 4, 2024.	F 0000	Submission of this plan of correction shall not constitute or be construed as an admission that Hoosier Village provides anything other than a high quality of care to its residents. Hoosier Village considers itself to be a partner with the Indiana State Department of Health and other entities in an ongoing effort to continually improve the services provided in long term care facilities. We believe that any feedback provided to us should be taken very seriously, and we are committed to using our resources to make any adjustments necessary to achieve better outcomes for residents. As required, the facility submits the following plan of correction: Hoosier Village is requesting a desk review of the plans of corrections submitted.	
F 0655 SS=D Bldg. 00	483.21(a)(1)-(3) Baseline Care Plan §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mindy Kantz	RN, Executive Director	04/18/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary.			

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	Based on interview and record review, the facility failed to ensure a baseline care plan was developed within 48-hours of admission for 1 of 4 residents reviewed for new admission. (Resident 216) Findings include: On 3/19/24 at 12:31 p.m., a comprehensive record review was completed for Resident 216. Resident 216 was a long-term care resident who had diagnoses which included, but were not limited to, displaced fracture of left femur, displaced fracture of left humerus and Alzheimer's disease. Resident 216 was admitted to the facility on 3/12/24. Resident 216's baseline care plan was reviewed and had not been initiated until 3/16/24. During an interview on 3/20/24 at 9:33 a.m., the Director of Nursing (DON) and Executive Director (ED) indicated the admitting nurse was responsible for initiation of a resident's baseline care plan within 48-hours of admission. The DON and ED indicated the baseline care plan should include information pertinent for the resident's immediate health needs. On 3/20/24 at 11:09 a.m., the DON provided the current policy titled, "Care Plans - Baseline," revised 3/2022. The policy indicated, "A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission..."	F 0655	Resident #216 did have a baseline care plan; however, it was completed on day 4, and therefore outside of the 48 hour timeline. A copy of the baseline care plan was provided to Resident #216 and/or their responsible party. No adverse effects for this resident. An admission audit has been completed on current residents to validate baseline care plans have been completed and presented to each resident and/or responsible party within 48 hours. No other residents were affected. The IDT and nursing staff have been provided with the baseline care plan policy and re-educated on initiating baseline care plans at time of admission, completing and signing within 48 hours, and providing a copy of the care plan to the resident and/or responsible party. Administrator will be responsible to conduct auditing of new admissions to validate that the baseline care plans have been completed and presented within the 48 hours. Any issues identified will be immediately addressed with 1:1 re-education. Audits will be completed weekly for 4 weeks, and then monthly for 3 months. The reviews of the base line care plan audits will be forwarded to the Executive Director for review by the Quality Assurance Performance Improvement Committee monthly for 3 months,	04/30/2024

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			or until the QAPI Committee determines substantial compliance has been achieved.	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on interview and record review, the facility failed to ensure a resident's comprehensive care plan was revised to meet their wishes for advance directive planning for 1 of 2 residents reviewed for advance directives. (Resident 8)	F 0657	Residents # 8's comprehensive care plan was revised to meet their wishes for advanced directive planning immediately. The resident did have a physician's	04/30/2024

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	Findings include: On 3/18/24 at 2:07 p.m., a record review was completed for Resident 8. She had diagnoses which included, but were not limited to, type 2 diabetes mellitus (a blood sugar disorder), essential hypertension (high blood pressure), and congestive heart failure. Resident 8 had a care plan, dated 12/20/23, which indicated her code status was "full code." An "Out of Hospital" form, dated 2/8/24, and indicated Resident 8 elected to have an order for do not resuscitate (DNR). The record lacked documentation that her care plan was revised to match her updated wishes to change her code status from a full code to a DNR. During an interview on 3/19/24 at 11:00 a.m., the Director of Nursing (DON) indicated she confirmed with Resident 8 that she no longer wished to be a full code. The DON changed Resident 8's care plan and provided a copy of the revision. On 3/20/24 at 11:00 a.m., the DON provided a copy of the current, but undated facility policy titled, "Care Plans, Comprehensive Person-Centered." The policy indicated, "...The care plan process will: Incorporate the resident's personal and cultural preferences in developing the goals of care ...." 3.1-35(c) 3.1-35(l)		order with the updated code status, and her care profile had already been updated to reflect the physicians order. No adverse effects for this resident. An audit of all current residents' Advanced Directives has been completed to ensure each resident's Advanced Directive wishes are reflected on their care plan. Social Services, MDS Coordinator, and IDT have been educated on care plan timing and revisions specifically as related to Advanced Directives. New orders for Advanced Directives will be reviewed in the daily morning meeting and the weekly QAPI sub-committee meeting to validate that each new order is present in the resident's plan of care. MDS/Designee will audit new admission, quarterly, annual, and significant change assessment care plans weekly for 4 weeks, then monthly for 3 months to ensure care plan accurately reflects the most current advanced directive. Any issues identified will be immediately addressed. Audit results will be submitted to the Executive Director for review by the Quality Assurance Performance Improvement Committee monthly for 3 months, or until the QAPI Committee determines substantial compliance has been achieved. The QAPI committee reserves the	

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			right to modify or extend monitoring times according to outcomes.	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to prevent the potential for accidents by ensuring medications were not left at resident's bedsides for 2 of 4 residents reviewed for self-administration of medications (Residents 168 and 169). Findings include: 1. During an observation on 3/18/24 at 11:19 a.m., Resident 168 was lying in bed. She had nystop powder (used to treat yeast infections) and fluticasone (used to treat allergies) at her bedside. On 3/20/24 at 12:21 p.m., a record review was completed for Resident 163. She had diagnoses which included, but were not limited to, anxiety, hypotension (low blood pressure), chronic pain, mood disorder, and chronic obstructive pulmonary disease (COPD). The record lacked documentation of a physician's order, or assessment of the resident's ability to	F 0689	Resident #168 and #169 over-the-counter medications were immediately removed from the bedside, and self-administration assessments were completed. Resident/ responsible parties were educated regarding medication storage in the healthcare center. Resident #168 has been discharged to home. Neither resident experienced adverse effects. All residents room were checked to determine if other residents had medications at bedside, no other residents were affected. All nursing staff have been educated on conducting self-administration assessments for all residents wanting to keep any medications at their bedside or in their room. Education	04/30/2024

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	store and/or administer her own medications at bedside. 2. During an observation on 3/18/24 at 11:25 a.m., Resident 169 was sitting in her recliner. She had salonpas (used to treat pain), biofreeze (used to treat pain), and ketoconazole shampoo at her bedside. On 3/20/24 at 1:51 p.m. a record review was completed. She had diagnoses which included, but were not limited to, hypertension, overactive bladder, gastro-esophageal reflux disease (GERD), osteoporosis (OP), and unspecified protein-calorie malnutrition. The record lacked documentation of physician's orders for the observed medications at her bedside. The record lacked documentation of an assessment or physician order to store and/or administer her medications at bedside. During an interview with the Director of Nursing (DON) on 3/20/24, she indicated the medications should not be at bedside. She indicated there was no policy for medications at bedside and provided a medication self-administration assessment for Resident 169. 3.1-45(a)		included conducting a self-administration assessment, and receiving a physician's order. Newly admitted residents will be educated on the process required to self-administer their own medications by the Admissions Coordinator during their initial admission meeting. DON or the Administrator will conduct weekly rounds to ensure medications are not in residents' rooms without residents going through a self-administration assessment. The DON/Administrator will conduct weekly rounds for 3 weeks, and then monthly rounds for 3 months, to audit for any medications at bedside and if so, the resident has been assessed to have them at bedside. Any issues identified will be immediately addressed with 1:1 education provided to all nursing staff on the unit. The audits will be forwarded to the Executive Director and will be under review by the QAPI Committee for the next 2 quarterly QAPI meetings or until the Committee deems substantial compliance has been achieved.	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who			

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	needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation and interview, the facility failed to date and bag respiratory equipment to protect residents from potential infections for 2 of 3 residents observed (Resident 3 and 168). Findings include: 1. During an observation on 3/18/24 at 11:03 a.m., Resident 3 was observed sitting up in his recliner. He had a nebulizer machine with a mask and oxygen per nasal cannula at 2 liters per minute. The respiratory equipment was not dated or bagged. During an observation on 3/19/24 at 9:50 a.m., Resident 3 was observed sitting up in his recliner. He was observed to have an oxygen tank with oxygen tubing and a nebulizer machine with tubing and a mask attached. He had oxygen at 2 liters per minute. The respiratory equipment was not dated or bagged. On 3/20/24 at 12:29 p.m. a record review was completed. Resident 3 had the following diagnoses which included, but were not limited to, presence of a cardiac pacemaker, gastro-esophageal reflux disease (GERD), hyperlipidemia, hypertension, hallucinations, glaucoma, vascular dementia, type 2 diabetes mellitus, congestive heart failure, and anxiety. Resident had an order, dated 3/20/24, for oxygen at 2 liters per minute.	F 0695	Oxygen and Nebulizer tubing were changed and dated for the 2 affected residents. Orders were placed in the residents Medication administration Resident #3 remains in facility, resident #168 has since been discharged. No adverse effects. Any residents receiving oxygen/nebulizer treatments have been identified to ensure they each have proper tubing changing and cleaning orders as well as dating tubing. An audit has been performed to ensure all residents with respiratory treatments have appropriate orders in place and equipment is bagged and dated. Nursing staff are being re-educated regarding care of respiratory equipment with mandatory in-services and signature required the week of April 22nd. DON/designee will monitor residents with respiratory equipment to ensure it is bagged, dated, and changed weekly x4 weeks, then monthly for 3 months.	04/30/2024

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	He had an order to change oxygen tubing weekly dated 2/22/24. 2. During an observation on 3/18/24 at 11:19 a.m., Resident 168 was lying in bed. She had a nebulizer machine with a mask and tubing that were not bagged or dated. During an observation on 3/19/24 at 10:02 a.m., Resident 168 was observed lying in bed. Her nebulizer mask was attached with tubing to the machine. It was not bagged and was not dated. On 3/20/24 at 12:21 p.m., a record review was completed for Resident 163. She had the following diagnoses which included but were not limited to anxiety, hypotension, hyperlipidemia, chronic pain, mood disorder, chronic obstructive pulmonary disease (COPD), hypertension, and sleep apnea. Resident 168 had an order for budesonide 0.5 mg/2 ml suspension (a medication inhaled for COPD), inhale 1 vial per nebulizer twice daily for COPD. Her record lacked a care plan for COPD. During an interview with RN 46, she indicated there was missing documentation for Resident 168's nebulizer equipment should be changed one time weekly on Wednesday. RN 46 indicated if it was not charted in the electronic medical record (eMAR) then it was not completed. RN 46 indicated she planned to change the equipment today. She indicated she already updated orders for resident's with respiratory equipment because there were some missing orders in the resident's records.		Results will be submitted to Associate Executive Director for review to ensure compliance goals. QAPI committee reserves the right to modify or extend monitoring times according to outcomes.	

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	A policy titled, "Departmental (Respiratory Therapy)-Prevention of Infection," dated November 2011, was provided by the Director of Nursing (DON) on 3/20/24 at 2:37 p.m. It indicated, "...Store the circuit in plastic bag, marked with date and resident's name, between uses and discard the administration 'set up' every 7 days ...." 3.1-47(a)(6)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing			

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	dose can be readily detected. Based on observations and interview, the facility failed to store medications appropriately for 2 of 8 residents reviewed for medication storage (Residents 3 and 217) and 1 of 1 medication storage room observed and 1 of 1 medication cart observed. Findings include: 1. Resident 3 had a bottle of Centrum (a vitamin) on the medication cart. It lacked a label indicating instructions for use. He had a bottle of Travoprost 0.004% (used to treat glaucoma) with no date to indicate when it was opened. He had a bottle of saline nasal spray 0.65% (used to treat stuffy nose) with no date to indicate when it was opened. 2. The skilled medication room had a vial of tuberculin (used to test for tuberculosis (TB) with no date to indicate when it was opened. 3. Resident 217 had a bottle of gugilipid (used as a supplement) with no label on the bottle. On 3/22/24 at 12:24 p.m., a policy titled, "Medication Labeling and Storage" dated February 2011, was provided by the Director of Nursing (DON). It indicated, " ...multi-dose vials that have been opened or accessed are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer dated for the open vial...." and " ...Medication labeling, the medication label includes at a minimum, a.) medication name (generic and/or brand), b.) prescribed dose, c.) strength, d.) expiration date,	F 0761	Resident #3 and #217 medications that were not properly labeled were removed from the carts and replaced with proper labeling. Resident #217 has since been discharged home, resident #3 remains in the facility. No adverse effects. Medication cart audits were completed to ensure medications were labeled appropriately, and expired medications were properly destroyed and replaced. Re-education done for nursing staff regarding Medication Storage policy to appropriate storage and labeling of opened medications and destruction/replacement of expired medications. In addition, the DON has also scheduled quarterly unannounced visits to have medication storage audited by pharmacy consultant and pharmacy nursing consultant. Re-education will be conducted during mandatory nurses meeting with signatures required the week of April 22nd. The DON/designee will perform Medication cart storage audits weekly x 4 weeks; then monthly for 3 months; then ongoing. Audit results will be shared weekly during the QAPI sub-committee meetings for 4 weeks, monthly for 3 months, and then quarterly for 2 quarters, or until the QAPI Committee determines substantial compliance has been achieved.	04/30/2024

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	e.) resident's name, f.) route of administration; and g.) appropriate instructions and precautions ...." 3.1-25(j) 3.1-25(m) 3.1-25(n)		The QAPI committee reserves the right to modify or extend monitoring times according to outcomes.	
F 9999 Bldg. 00	3.1-11 SELF-ADMINISTRATOIN OF DRUGS (a) An individual resident may self-administer drugs if the interdisciplinary team has determined that the practice is safe. This state rule was not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that unsecured medications were not in resident's room for 2 of 3 residents reviewed for unsecured medications (Resident 45 and 28). Findings include: 1 On 3/19/24 at 9:52 a.m., two over the counter (OTC) medications were observed in Resident 45's room. A canister of Icy Hot spray (pain relief) was observed on her bedside table and Vicks Vapo-Rub (nasal decongestant) was observed with her in her bed. She indicated she used the Icy Hot for aches in her left knee. On 3/20/24 at 12:01 p.m., Nizoral anti-dandruff shampoo was observed from Resident 45's doorway. It did not have a visible prescription label. On 3/19/24 at 9:52 a.m. Resident 45's record was	F 9999	1. Resident #45 and #28 over-the-counter medications were immediately removed from the bedside and secured. All residents room were checked to determine if other residents had medications at bedside, no other residents were affected. All nursing staff have been educated on conducting self-administration assessments for all residents wanting to keep any medications at their bedside or in their room. Education included conducting a self-administration assessment, and receiving a physician's order. Newly admitted residents will be educated on the process required to self-administer their own medications by the Admissions Coordinator during their initial admission meeting. DON or the Administrator will conduct weekly rounds to ensure medications are not in residents' rooms without residents going through a self-administration assessment.	04/30/2024

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	reviewed. She was admitted on 8/15/22. She did not have a medication self-administration assessment for any medication. Her diagnoses included, but were not limited to, non-rheumatic aortic valve stenosis (thickening and narrowing of the aortic valve), osteoarthritis (degenerative joint disease), and dyspnea (difficulty breathing). Her Service Plan included, but was not limited to, the potential for altered respiratory status related to abnormalities of breathing with a goal of no complications related to shortness of breath. Her physician pharmacy and OTC medication orders did not include Icy Hot spray or Vicks Vapo-Rub. 2. On 3/19/24 at 9:58 a.m., zinc oxide skin protectant paste was found in Resident 28's room on his bedside table. An unidentified Licensed Practical Nurse (LPN) working the 300 Hall medication cart indicated residents were allowed to keep over-the -counter (OTC) medications in their rooms. On 3/19/24 at 2:24 p.m., Resident 28's record was reviewed. He was admitted on 2/4/21. He did not have a medication self-administration assessment for any medication. His diagnoses, included, but were not limited to, Parkinson's disease (a brain condition that causes problems with movement and mental health), aphonia (loss of voice) and vascular dementia (impaired blood supply causing impairment of memory, thinking and personality change).		The DON/Administrator will conduct weekly rounds for 3 weeks, and then monthly rounds for 3 months, to audit for any medications at bedside and if so, the resident has been assessed to have them at bedside. Any issues identified will be immediately addressed with 1:1 education provided to all nursing staff on the unit. The audits will be forwarded to the Executive Director and will be under review by the QAPI Committee for the next 2 quarterly QAPI meetings or until the Committee deems substantial compliance has been achieved. 2. Hoosier Village is committed to thoroughly investigating all allegations. The Director of Nursing promptly initiated investigations into the incidents mentioned, resulting in the termination of involved employees. LPN #2 and #3 have been dismissed and reported to the authorities. Regrettably, Resident #54 has passed away. Resident #145, who currently resides in our facility, has had their narcotic discontinued as it was not in use, with no adverse effects observed. The Director of Nursing has collaborated with our facility pharmacy consultant to review records for any inconsistencies, and no further concerns have been identified. As of now, there have been no new allegations of misappropriation.	

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	His Service Plan included, but was not limited to, he was at risk for skin breakdown related to incontinence and limited mobility. His physician pharmacy and OTC medication orders did not include zinc oxide skin protectant paste. On 3/20/24 at 9:40 a.m., Director of Nursing (DON) indicated the facility did not have resident self-administration assessments for Resident 45 or 28 and they should not have had any medications in their rooms. On 3/21/24 at 10:16 a.m., the DON provided the names of resident who had, "Roam Alerts," as of 3/18/24. The list included: a. Resident 35. His Service Plan, dated 1/2/24, indicated he had cognitive deficits related to dementia and was at risk for elopement. b. Resident 16. Her Service Plan, dated 2/29/24, indicated she had cognitive deficits related to dementia and was at risk for elopement. c. Resident 37. Her Service Plan, dated 1/2/24, indicated she was an elopement risk/wanderer related to Alzheimer's disease. d. Resident 36. Her Service Plan, dated 12/26/23, indicated Elopement: She was at Risk for Wandering, e. Resident 25. His Service Plan, dated 3/11/24, indicated he was an elopement risk/wanderer related to impaired safety awareness and dementia. f. Resident 17. Her Service Plan, dated 2/27/24, indicated she was an elopement risk/wanderer related to impaired safety awareness and dementia. A current policy, titled, "Medication Labeling and		All licensed Nursing staff re-educated on the following: misappropriation of a resident's controlled narcotic medication; drug diversion policy and procedures; procedure for administering and disposition of medications; drug destruction policy and procedure, including all narcotics must be destroyed with the Director of Nursing or her designee; pertinent procedures to prevent recurrence and the investigative process. Facility will ensure 100% compliance with staff education, or they will be removed from the schedule until education has been completed. An investigative checklist has been implemented to ensure a thorough investigation is completed and the findings given a final review by the Executive Director and reported to the local, state, and federal authorities as required. 3. Fall interventions were put in place immediately for resident #25 and added to the care plan. Day time caregiver was already in place. No adverse effects. Hoosier Village IDT conducts weekly risk/fall meetings and at that time will add interventions to residents careplans. Residents with falls for the last 30 days have been audited to ensure thorough assessments of residents were completed, care plans were updated or revised to	

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	Storage," dated February 2023, was provided by the DON, on 3/22/24 at 12:24 p.m. A review of the policy indicated, " ...This facility stores all medications and biologicals in locked compartments under proper temperature, humidity, and light controls. Only authorized personnel have keys. 3.1-28 STAFF TREATMENT OF RESIDENTS (d) The facility must have evidence that all alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in progress. This state rule was not met as evidenced by: Based on observation, interviews and record review, the facility failed to thoroughly investigate a misappropriation of a resident's controlled narcotic medication or put effective interventions in place to prevent a second resident from the misappropriation of her controlled narcotic medication for 2 of 3 residents reviewed for abuse. Findings include: 1. On 3/19/24 at 11:55 a.m., an Indiana Department of Health Facility Incident Report's investigation was reviewed. On 2/28/24 the Director of Nursing (DON) received a call from a local law enforcement officer and was notified that Licensed Practical Nurse (LPN) 2 had been arrested after he was involved in a car accident, found to be obviously impaired and was in possession of a bottle of liquid morphine and a needle. The facility immediately began an investigation		prevent the potential for future falls and CNA care guides updated. DON/Designee have reviewed Fall policy and procedure with nursing staff to ensure thorough assessments are completed after falls; and ensuring that interventions are updated or revised in the care plan to prevent the potential for future falls. Fall reviews are a standing agenda item for the weekly QAPI sub-committee meeting. Fall audit tool will be reviewed weekly for 4 weeks, and then monthly for 2 quarters, and reviewed with the QAPI team quarterly for 2 quarters, or until such time as QAPI committee determines substantial compliance has been achieved. 4. Resident's #6, #10, #3, #8, #17 medications were removed from the carts, and replaced. Tubersol vials were removed and replaced from medication room refrigerator. No adverse effects. Medication carts/ medication rooms were audited to ensure medications were dated and labeled appropriately, and expired medications destroyed and replaced. Re-education provided to nursing staff on the Medication Storage policy regarding the appropriate storage, dating, and labeling of opened medications, and destruction/replacement of expired medications. DON has also	

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	and discovered the following: LPN 2 had worked the night shift on 2/28/24 and the facility had a resident (Resident 54) who passed away the previous day who had been on hospice services and received liquid morphine. Her name was on the bottled found with LPN 2. When camera footage was reviewed, LPN 2 approached the nurse's station with a piece of paper which Registered Nurse (RN) 4 signed. RN 4 continued to work on the computer and LPN 2 walked away. RN 4 provided a written statement which indicated, "[LPN 4] asked me to sign off on him destroying medications ... I was busy on the computer there working on an admission ... unfortunately, I never saw these medications being destroyed ...." The DON reconciled in-house narcotics as well as reviewed all liquid morphine and found no further evidence of tampering or misappropriation. The DON reviewed Resident 54's medications and administration records. LPN 2 was immediately terminated, and RN 4 was "counseled." A Verbal Warning was provided to RN 4 on 2/28/24 which indicated, "Signed for as witness to MS04 [an abbreviation for 'morphine sulfate' which is no longer recognized and was added to a 'Do-Not-Use' list to avoid medication errors] destruction but did not visually witness the destruction. Reviewed policy for narcotic count-destruction." RN 4 did not sign for employee acknowledgement. On 3/18/24 at 2:30 p.m., Resident 54's record was reviewed. She had been a long-term care resident		scheduled quarterly unannounced visits to have medication storage audited by pharmacy consultant and pharmacy nursing consultant. The DON/designee will perform Medication cart storage audits weekly x 4 weeks; then monthly for 3 months; then ongoing. Audit results will be shared weekly during the QAPI sub-committee meetings for 4 weeks, monthly for 3 months, and then quarterly for 3 quarters, or until the QAPI Committee determines substantial compliance has been achieved. The QAPI committee reserves the right to modify or extend monitoring times according to outcomes.	

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	with diagnoses which included, but were not limited to, a cerebral infarction (stroke). She received palliative care and a nursing progress note dated 9/26/24 at 7:50 p.m., indicated her respirations had ceased and she passed away. Her medication administration record was reviewed and revealed the following: On 2/26/24 at 11:34 p.m., (4 hours after Resident 54 passed away) a dose of her morphine was "administered" for shortness of breath and at that same time, a dose of her Lorazepam (an antianxiety medication) was "administered" for anxiety. On 2/27/24 at 5:13 a.m., (more than 10 hours after Resident 54 passed away), a dose of her morphine was "administered" for shortness of breath and a dose of her Lorazepam was "administered" for anxiety. During an interview on 3/19/24 at 2:20 p.m., the DON indicated she had not noticed the above errors that Resident 54's medications were documented as having been administered after her death, but she assumed it had to be a documentation error. The DON indicated since she had not identified the error, there had been no re-education or further audits of additional Medication Administrations of controlled substances for review of accuracy. Resident 54's controlled drug use record for her liquid morphine was used by LPN 2 for the medication disposition record and was not transcribed to a Medication Disposition form. The record lacked documentation of what form of destruction was used.			

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	A Drug Diversion Policy and Procedure in-service was provided on 2/29/24 but only 12 of the 20 nursing staff who could administer medications had signed as having received the education. A second in-service was provided on 3/6/24 where only 3 additional nursing staff signed as having received the education. On that same day, 3/6/24 Indiana Department of Health Facility Reported Incident #145 was reported which indicated LPN 3 had stolen a 7.5/325 milligram (mg) Norco (a narcotic pain medication combined with Tylenol) from Resident 29. A conclusion of the facilities investigation indicated, " ...after reviewing the footage from the cameras and considering the timeline, it was confirmed that the Norco pill was not administered to the resident for whom it was prescribed. As a result, LPN 3 has been terminated ...." On 3/19/24 at 9:58 a.m., Resident 29 was observed. She was seated in a broad wheelchair in her room and looked out the window. Although she was alert to verbal stimuli, she was unable to engage in meaningful conversation and unable to answer simple questions. On 3/19/24 at 10:00 a.m., Resident 29's medical record was reviewed. She was a long-term care resident with diagnoses which included, but not limited to, Alzheimer's disease and Parkinson's disease. She had a physician's order for scheduled and as needed Norco 7.5/325 mg.			

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	On 3/19/24 at 11:34 a.m., Resident 29's controlled substance record was reviewed at the nurse's medication cart. Although there did not appear to be any discrepancies at that time, the 12-hour controlled drug-count record was reviewed and revealed several holes which lacked documentation. On 3/19/24 at 11:40 a.m., the 12-hour controlled drug-count records were pulled from each medication cart and nurses' station from February-March 2024. Two variations of the form were in use, and one master count sheet was in use, however the majority of the forms lacked complete and thorough documentation. The "Narcotic Master Count Sheet" for January, February and March, were observed to be over-copied and difficult to read. The forms gave no instructions and were not labeled with medication cart or medication storage room names. Version 1: "12-Hour Controlled Drug-Count Record," gave no instructions, and on 3/6/24, LPN 3 did not sign that she received count/reconciliation with the outgoing nurse. Version 2: "12-Hour Controlled Drug-Count Record," gave instructions which indicated, "signing below acknowledges that you have counted the controlled drugs on hand and have found that the quantity of each medication counted is in agreement with the quantity stated on the Controlled Drug Administration Record." The records for February and March lacked complete and thorough documentation of shift-to-shift nurse signs offs. During an interview on 3/19/24 at 2:20 p.m., the			

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	DON indicated, during her investigation, it was noted there were several documentation errors on the controlled substance shift-to-shift reconciliations. On 3/20/24 at 11:00 a.m., the DON provided a copy of current facility policy titled, "Discarding and Destroying Medications," revised 4/2019. The policy indicated, "Medications will be disposed of in accordance with federal, state and local regulations governing management of non-hazardous pharmaceuticals, hazardous waste and controlled substances ... schedule II, III and IV (non-hazardous) controlled substances will be disposed of in accordance with state regulations and federal guidelines regarding disposition of non-hazardous controlled medications ... include the signatures of at least two witnesses ... the medication disposition record will contain the following information: the residents name, date medication disposed, the name and strength of the medication, the name of the dispensing pharmacy, the quantity disposed, method of disposition and signature of witnesses ...." On 3/20/24 at 11:00 a.m., the DON provided a copy of current facility policy titled, "Abuse Investigating and Reporting," revised 7/2017. The Policy indicated, "All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source, shall be promptly reported to local, state and federal agencies and thoroughly investigated by facility management. Findings of abuse investigations will also be reported ... the Administrator will ensure that any further potential abuse, neglect exploitation or mistreatment is prevented ... the individual conducting the investigation will, as a minimum: review and complete documentation forms, review			

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	the resident's medical record to determine events leading up to the incident ...." 3.1-45 ACCIDENTS (a) The facility must ensure the following: (2) Each resident receives adequate supervision and assistive devices to prevent accidents. This state rule was not met as evidenced by: Based on observations, interview and record review, the facility failed to ensure a resident, (Resident 25) who had a history of falls with fracture, had adequate supervision and/or interventions to prevent falls for 1 of 3 residents reviewed for falls. Findings include: On 3/18/24 at 2:18 p.m., Resident 25 was observed. He was seated in a chair in his room and watched T.V. He was alert and oriented, and answered simple yes/no questions, but did not engage in conversation. He had a private sitter who indicated she had worked with Resident 25 for a long time. She indicated Resident 25 had fallen when he lived in the Assisted Living facility and sustained a fracture, so he went to the skilled unit for rehab and had recently transferred to the long-term care hall. She sat with him Monday-Fridays from 8:00 a.m., until 5:00-6:00 p.m., and came some weekends. The only concern she indicated was her opinion that there were not enough facility staff to watch him closely after she left. He would often have sundowning symptoms and would wander or try to do things he didn't remember he couldn't and had resulted in two falls thus far.			

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	On 3/20/24 at 9:50 a.m., Resident 25's medical record was reviewed. He was a long-term care resident with diagnoses which included, but were not limited to, fractures of one rib, unspecified fall, dementia, behavioral disturbance and anxiety. He admitted to the skilled Medicare hall on 2/19/24 after a hospitalization where had been treated for a rib fracture after a fall. On 3/5/24 he was transferred to a new room in the Non-Certified Comprehensive (NCC) Hall. A nursing progress note dated 3/5/24 at 3:16 p.m., indicated Resident 25 moved from room on Medicare unit to room on B-Wing (NCC). The record lacked an admission assessment of Resident 25's fall risk. Resident 25's care plans were reviewed and lacked baseline and comprehensive revision to identify his risk for falls and implement interventions to prevent falls. A nursing progress note, dated 3/15/24 at 12:46 a.m., indicated Resident 25 was found on the floor next to his bed. He sustained a small laceration on the back of his head. The record lacked documentation of neurological checks. A nursing progress note dated 3/16/24 at 6:02 a.m., indicated, Resident 25 had been sitting on the edge of his bed while the aide helped him get dressed. He began to lean forward, and the aide was afraid he would fall, so she lowered the bed and slid Resident 25 off the lowered end of the			

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	bed onto the floor in an upright position. He was assisted by three staff off the floor and put back into bed without injury. The record lacked post-fall follow up, Interdisciplinary Team (IDT) review, and/or care plans and interventions to prevent future falls. During an interview on 3/18/24 at 2:30 p.m., Certified Nursing Aide (CNA) 25 and CNA in training (T-CNA) 66 indicated, there were usually only two aides on the long-term care halls, one on each end. Because there were a lot of residents who required attention and incontinent care, it was very difficult to supervise all the residents all the time. CNA 25 indicated, Resident 25 did often wander up and down the halls and would forget to call for help or use his walker, but she could not always watch him because she would be in other resident's rooms with the door closed for privacy. During an interview on 3/21/24 at 10:16 a.m., The Director of Nursing (DON) indicated, fall assessments and follow up should be conducted the same on NCC as in the Medicare Hall, and residents at risk should be assessed and interventions put in place. On 3/21/24 at 10:16 At that time the DON provided a copy of current facility policy titled, "Risk Management Program," dated 3/5/24. The policy indicated, "It is the policy of our community to promote a culture of safety for residents and to prevent negative outcomes, to the extent practicable, through the development of an interdisciplinary team dedicated to addressing areas of risk as identified through resident assessments and observations ...." On 3/21/24 at 10:16 At that time the DON provided			

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	a copy of current facility policy titled, "Falls and Fall Risk- Managing," revised 3/2018. The policy indicated, "Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling ... the staff with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factors of falls for each resident at risk or with a history of falls ...."3.1-25 PHARMACY SERVICES (j) Over-the-counter medications, prescription drugs, and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (k) Labeling of prescription drugs shall include the following: (1) Resident's full name. (2) Physician's name. (3) Prescription number. (4) Name and strength of drug. (5) Directions for use. (6) Date of issue and expiration date (when applicable). (7) Name and address of the pharmacy that filled the prescription. If a facility is supplied medication in a unit dose packaging, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted. (o) Discontinued, outdated, or deteriorated medication shall not be maintained or used in the facility. Medications shall be disposed of in compliance with federal, state, and local laws.			

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	155472	A. BUILDING 00 B. WING	03/22/2024

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	This state rule was not met as evidenced by: Based on observation and interview, the facility failed to store medications appropriately for 1 of 2 medication storage rooms observed and 1 of 3 medication carts observed (Residents 6, 10, 3, 8 and 17). Findings include: 1. Resident 6 had a bottle of combigan 0.2-0.5% (used to treat glaucoma) in the medication cart with no date to indicate when it was opened. The manufacturer recommends discarding after opening in 90 days. She had a bottle of lorazepam (used to treat anxiety) in the medication room refrigerator that lacked a date to indicate when it was opened. 2. Resident 10 had a bottle of refresh tears 0.5% (used to treat dry eyes) in the medication cart with no date to indicate when it was opened. 3. Resident 3 had a disc of Advair (used to treat respiratory diseases) in the cart with no date to indicate when it was opened. 4. Resident 8 had 6 medications on the medication cart without labels to indicate directions for use. a.) fleet suppositories (for constipation), b.) acetaminophen 500mg (used to treat pain and temperature), c.) super B complex (a supplement) 2 bottles, d.) allergy relief 10mg, 24 hours and e.) smooth lax stool softener 100mg (used to treat constipation). 5. Resident 17 had a bottle of lorazepam (used to treat anxiety) in the medication refrigerator. The bottle was not dated when opened. The			

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	manufacturer recommends discarding after opening in 90 days. 6. Inside the refrigerator was 2 vials of tuberculin serum (used to test for tuberculosis (TB) with no date to indicate when they were opened. On 3/22/24 at 12:24 p.m., a policy titled, "Medication Labeling and Storage" dated February 2011, was provided by the Director of Nursing (DON). It indicated, " ...multi-dose vials that have been opened or accessed are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer dated for the open vial...." and " ...Medication labeling, the medication label includes at a minimum, a.) medication name (generic and/or brand), b.) prescribed dose, c.) strength, d.) expiration date, e.) resident's name, f.) route of administration; and g.) appropriate instructions and precautions ...."			
R 0000 Bldg. 00	This visit was for a State Residential Licensure. This visit included a Recertification and State Licensure Survey. This visit included a Non-Certified Comprehensive (NCC) Licensure Survey. This visit included the Investigation of Complaint IN00419238. Complaint IN00419238 - No deficiencies related to the allegations are cited. Survey dates: March 18, 19, 20, 21 and 22, 2024. Facility number: 000548 Residential Census: 246	R 0000	Submission of this plan of correction shall not constitute or be construed as an admission that Hoosier Village provides anything other than a high quality of care to its residents. Hoosier Village considers itself to be a partner with the Indiana State Department of Health and other entities in an ongoing effort to continually improve the services provided in long term care facilities. We believe that any feedback provided to us should be taken very seriously, and we are committed to using our resources to make	

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	These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on April 4, 2024.		any adjustments necessary to achieve better outcomes for residents. As required, the facility submits the following plan of correction: Hoosier Village is requesting a desk review of the plans of corrections submitted.	
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 record review and interview, the facility failed to ensure thorough assessments were completed for a resident after falls with injury to monitor for latent adverse injuries, and the facility failed to ensure interventions were updated or revised to prevent the potential to future falls for 1 of 3 residents reviewed for falls (Resident 8). Findings include: On 3/21/24 at 11:37 a.m., Resident 8's medical record was reviewed. She was an Assisted Living resident who resided in the secured memory care facility. She had diagnoses which included, but were not limited to, Alzheimer's disease and unspecified dementia with agitation and psychotic disturbances.	R 0214	This tag was cited due to lack of follow up assessments after a fall not being completed for resident #8. This was noted in a discharge chart for a resident that has since passed away. In order to identify other residents who may need post-fall follow up, an audit of residents with falls in the last 30 days has been performed to ensure thorough assessments of residents were completed, care plans were updated or revised, interventions put into place to prevent the potential for future falls and CNA assignment sheets are updated. The Director of Memory Care Services has reviewed fall policy and procedure with nursing	04/30/2024

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	A nursing progress note, dated 7/8/23 at 2:55 p.m., indicated Resident 8 wandered into another resident's room without her walker and fell through the doorway. She hit her face on a dresser and "busted her nose." Her nose was noted to be swollen and crooked, and there was also an abrasion to her left eyebrow. The family was notified and requested she not be sent to the hospital. The record lacked documentation the physician was notified. A nursing progress note, dated 7/8/23 at 11:21 p.m., indicated a Hospice nurse came to visit and assessed Resident 8. He agreed that her nose appeared to be broken. Bruising appeared to pool alongside the nose and under the left eye. A nursing progress note, dated 7/10/23 at 6:36 a.m., indicated Resident 8 had been given Tylenol for facial pain. The record lacked documentation of an Interdisciplinary team (IDT) review of the fall. The record lacked documentation of revision to her interventions to prevent future falls. The record lacked documentation of follow-up neurological checks. A nursing progress note, dated 10/7/23 at 4:45 p.m., indicated Resident 8 was found in a sitting position on the dining room. An Aide indicated she found Resident 8 sitting on the floor. Resident 8's vital signs were within normal limits at that time, and she did not complain of any pain.		staff to ensure thorough assessments are completed after falls, and ensuring that interventions are updated/revised as appropriate in order to prevent the potential for future falls. Falls are reviewed weekly during the IDT (interdisciplinary team) RISK meetings. Further, in order to monitor and prevent future occurrences the DMCS will audit all falls (Attachment 10) weekly x3, monthly x2 and then, quarterly, or until such time as QAPI committee deems substantial compliance has been achieved. Any issues identified will be immediately addressed, with 1:1 re-education provided.	

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	The record lacked documentation of an Interdisciplinary team (IDT) review of the fall. The record lacked documentation of revision to her interventions to prevent future falls. The record lacked documentation of follow-up neurological checks. A nursing progress note, dated 11/27/23 at 7:28 a.m., indicated Staff heard a "thud" and found Resident 8 on the floor. It appeared she had attempted to stand and fell. No injuries were noted at that time, and she did not complain of pain. The record lacked documentation of an Interdisciplinary team (IDT) review of the fall. The record lacked documentation of revision to her interventions to prevent future falls. The record lacked documentation of follow-up neurological checks. A nursing progress note, dated 12/4/23 at 3:59 p.m., indicated Resident 8 was at a musical activity when she stood up, lost her balance and fell to the ground. She hit her head on the wheelchair. Her vital signs and neuro check were within normal limits at that time. The record lacked documentation of an Interdisciplinary team (IDT) review of the fall. The record lacked documentation of revision to her interventions to prevent future falls. The record lacked documentation of follow-up neurological checks.			

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	During an interview on 3/22/24 at 12:05 p.m., the Memory Care Director (MCD) indicated she could not find documentation of follow-up neuro checks for Resident 8. Interventions for falls were reviewed in weekly meetings and added or changed on the CNAs assignment sheets, but she was unable to locate Resident 8's previous assignment sheets as she was no longer a resident at the facility. On 3/21/24 at 10:16 a.m., the DON provided a copy of current facility policy titled, "Risk Management Program," dated 3/5/24. The policy indicated, "It is the policy of our community to promote a culture of safety for residents and to prevent negative outcomes, to the extent practicable, through the development of an interdisciplinary team dedicated to addressing areas of risk as identified through resident assessments and observations ...." On 3/21/24 at 10:16 a.m., the DON provided a copy of current facility policy titled, "Falls and Fall Risk- Managing," revised 3/2018. The policy indicated, "Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling ... the staff with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factors of falls for each resident at risk or with a history of falls...."			