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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155472 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/22/2024 |
| NAME OF PROVIDER OR SUPPLIER Hoosier Village | | STREET ADDRESS, CITY, STATE, ZIP CODE 9875 Cherryleaf Dr Indianapolis, IN 46268 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| <p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49890</p> <p>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)</p> <p>Findings include:</p> <p>On 3/19/24 at 12:31 p.m., a comprehensive record review was completed for Resident 216.</p> <p>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.</p> <p>Resident 216 was admitted to the facility on [DATE].</p> <p>Resident 216's baseline care plan was reviewed and had not been initiated until 3/16/24.</p> <p>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.</p> <p>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 .</p> |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>46414</p> <p>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)</p> <p>Findings include:</p> <p>On 3/18/24 at 2:07 p.m., a record review was completed for Resident 8.</p> <p>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.</p> <p>Resident 8 had a care plan, dated 12/20/23, which indicated her code status was full code.</p> <p>An Out of Hospital form, dated 2/8/24, and indicated Resident 8 elected to have an order for do not resuscitate (DNR).</p> <p>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.</p> <p>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.</p> <p>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</p> <p>3.1-35(c)</p> <p>3.1-35(l)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>46414</p> <p>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).</p> <p>Findings include:</p> <p>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.</p> <p>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).</p> <p>The record lacked documentation of a physician's order, or assessment of the resident's ability to store and/or administer her own medications at bedside.</p> <p>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.</p> <p>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.</p> <p>The record lacked documentation of physician's orders for the observed medications at her bedside.</p> <p>The record lacked documentation of an assessment or physician order to store and/or administer her medications at bedside.</p> <p>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.</p> <p>3.1-45(a)</p> | | |

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| <p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>46414</p> <p>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).</p> <p>Findings include:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Resident had an order, dated 3/20/24, for oxygen at 2 liters per minute.</p> <p>He had an order to change oxygen tubing weekly dated 2/22/24.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Her record lacked a care plan for COPD.</p> <p>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.</p> <p>(continued on next page)</p> | | |

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| <p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>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</p> <p>3.1-47(a)(6)</p> | | |

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| <p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>46414</p> <p>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.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Resident 3 had a bottle of Centrum (a vitamin) on the medication cart. It lacked a label indicating instructions for use. <p>He had a bottle of Travoprost 0.004% (used to treat glaucoma) with no date to indicate when it was opened.</p> <p>He had a bottle of saline nasal spray 0.65% (used to treat stuffy nose) with no date to indicate when it was opened.</p> <ol style="list-style-type: none"> The skilled medication room had a vial of tuberculin (used to test for tuberculosis (TB) with no date to indicate when it was opened. Resident 217 had a bottle of gugalipid (used as a supplement) with no label on the bottle. <p>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</p> <p>3.1-25(j)</p> <p>3.1-25(m)</p> <p>3.1-25(n)</p> | | |