STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDEPENDENCE VILLAGE OF FISHERS SOUTH	9745 OLYMPIA DR, FISHERS, , 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey dates: October 7, 8, and 9, 2025. Facility number: 002999 Residential Census: 93 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on October 14, 2025.	R 0000	The submission of the Plan of Correction does not indicate an admission by Independence Village of Fishers South that the findings and allegations contained herein are an accurate and true representation of the Quality of Care provided to the residents of Independence Village of Fishers South. The Community hereby maintains it is in substantial compliance with the requirements of participation for residential health care communities. To this end, the Plan of Correction shall serve as the Credible Allegation of Compliance with all State requirements governing the operations of this Community.	
R 0086	Administration and Management - Deficiency 410 IAC 16.2-5-1.3(a)(1-2)	R 0086	1 No residents were identified or affected by this deficient practice.	10/17/2025

	The licensee: (1) is responsible for compliance with all applicable laws; and (2) has full authority and responsibility for the: (A) organization; (B) management; (C) operation; and (D) control; of the licensed facility. The delegation of any authority by the licensee does not diminish the responsibilities of the licensee. Based on interview and record review, the facility failed to timely submit the application for certification for the Clinical Laboratory Improvement Amendments (CLIA) waiver. This had the potential to affect 8 of 8 residents who required blood glucose monitoring. Findings include: A document, entitled "CLIA Laboratory Details", was provided by the Executive Director on 10/7/2025 at 1:30 p.m. The document indicated the CLIA waiver certification was effective from 9/3/2023 to 9/4/2025. The CLIA waiver had expired. During an interview on		2The community realizes that all residents have the potential to be affected by the deficient practice. 3 The Executive Director did immediately complete the required paperwork to renew the CLIA license, and it was submitted with payment in full on October 17, 2025 4The Executive Director will monitor all building licenses monthly to ensure dates are compliant. This will include facility licenses, CLIA license and Residential Care Administrator License. This will be put into effect October 10,2025.	

	10/9/2025 at 12:10 p.m., the Executive Director indicated the waiver had lapsed because of oversight and she had reapplied for the waiver. Review of the facility provided list of residents with special care needs, on 10/7/2025 at 1:45 p.m., indicated eight residents required blood glucose testing. A Standard Operating Procedure entitled "CLIA Lab Waiver Application and Changes" was provided by the Executive Director on 10/8/2025 at 2:09 p.m. The document indicated "...You must have a CLIA Waiver even if you perform only one basic test..." Based on interview and record review, the facility failed to timely submit the application for certification for the Clinical Laboratory Improvement Amendments (CLIA) waiver. This had the potential to affect 8 of 8 residents who required blood glucose monitoring. Findings include: A document, entitled "CLIA Laboratory Details", was provided by the Executive Director on 10/7/2025 at 1:30 p.m. The document indicated the CLIA waiver certification was effective from 9/3/2023 to 9/4/2025. The CLIA waiver had expired.			

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R 0095	Administration and Management -Noncompliance 410 IAC 16.2-5-1.3(l)(1-2) (l) In facilities that are required under IC 12-10-5.5 to submit an Alzheimer's and dementia special care unit disclosure form, the facility must designate a director for the Alzheimer's and dementia special care unit. The director shall have an earned degree from an educational institution in a health care, mental health, or social service profession or be a licensed health facility administrator. The director shall have a minimum of one (1) year work experience with dementia or Alzheimer's residents, or both, within the past five (5)	R 0095	1 No residents were identified or affected by this deficient practice. 2 The community realizes that all residents have the potential to be affected by the deficient practice, and the community will develop action plans and implement them immediately to ensure no residents are affected in the future. 3 The executive director has completed the initial	11/15/2025

	years. Persons serving as a director for an existing Alzheimer's and dementia special care unit at the time of adoption of this rule are exempt from the degree and experience requirements. The director shall have a minimum of twelve (12) hours of dementia-specific training within three (3) months of initial employment as the director of the Alzheimer's and dementia special care unit and six (6) hours annually thereafter to: (1) meet the needs or preferences, or both, of cognitively impaired residents; and (2) gain understanding of the current standards of care for residents with dementia. Based on interview and record review, the facility failed to provide evidence of a timely submitted dementia special care unit disclosure form. This had the potential to affect 25 of 25 residents who resided on the dementia care unit. Findings include: A document entitled "Dementia Care Disclosure" was reviewed on 10/7/2025 at 1:30 p.m. The document indicated the disclosure was for calendar year 2024. During an interview on 10/9/2025 at 12:10 p.m., the Executive Director indicated she had filed a Dementia Care		application on the FSSA website and once approved we can move forward by completing the Alzheimer’s and dementia special care unit disclosure form. The Executive Director will also work with compliance to establish a process for all communities to follow moving forward. 4 The Executive Director will take responsibility for monitoring this application to ensure ongoing compliance. The Executive Director will establish reminders and regularly check on the progress of the application. This will ensure that all necessary steps are completed in advance and ahead of the deadline. This will ensure that the application is completed accurately and on time each year.	

	Disclosure for calendar year 2025, but she could not locate it. Review of the facility provided list of residents, on 10/7/2025 at 1:45 p.m., indicated 25 residents resided on the secured dementia care unit. During an interview on 10/9/2025 at 12:20 p.m., the Executive Director indicated she could not locate a Dementia Care Disclosure form at this time for calendar year 2025. It was the expectation of the facility to have an active Dementia Care Disclosure form, and it was her responsibility to complete this form every December for the upcoming year. Based on interview and record review, the facility failed to provide evidence of a timely submitted dementia special care unit disclosure form. This had the potential to affect 25 of 25 residents who resided on the dementia care unit. Findings include: A document entitled "Dementia Care Disclosure" was reviewed on 10/7/2025 at 1:30 p.m. The document indicated the disclosure was for calendar year 2024. During an interview on 10/9/2025 at 12:10 p.m., the			

	Executive Director indicated she had filed a Dementia Care Disclosure for calendar year 2025, but she could not locate it. Review of the facility provided list of residents, on 10/7/2025 at 1:45 p.m., indicated 25 residents resided on the secured dementia care unit. During an interview on 10/9/2025 at 12:20 p.m., the Executive Director indicated she could not locate a Dementia Care Disclosure form at this time for calendar year 2025. It was the expectation of the facility to have an active Dementia Care Disclosure form, and it was her responsibility to complete this form every December for the upcoming year.			
R 0153	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(j) (j) The facility shall observe safety precautions when oxygen is stored or administered in the facility. Residents on oxygen shall be instructed in safety measures concerning storage and administration of oxygen. Based on observation, interview, and record review, the facility failed to ensure proper storage of oxygen in a resident's	R 0153	1 The identified residents were affected by the deficient practice. 2 The community realizes that all residents have the potential to be affected by the deficient practice. Action plans will be developed and implemented immediately to ensure no additional residents are impacted by this deficiency.	11/07/2025

	room for 1 of 2 residents who used oxygen. (Resident 3) Findings include: The clinical record for Resident 3 was reviewed on 10/8/25 at 10:15 a.m. His diagnoses included, but were not limited to, chronic respiratory failure. He was admitted to the facility on 1/8/25. The 1/6/25 physician note, from prior to facility admission, indicated he continued to wear oxygen at 3 liters continuously per nasal cannula. The facility physician's orders did not include an order for oxygen use. The service plan, last reviewed 7/2/25, indicated there was a goal for his respiratory needs to be met with assistance. Interventions were that he required assistance with respiratory equipment supply order/maintenance and that care staff were to report any changes in ability with respiratory treatments. An observation and interview were conducted with Resident 3 in his room on 10/8/25 at 10:20 a.m. He was wearing oxygen per nasal cannula. He indicated he managed his own oxygen and wore it all day, and his oxygen tanks were filled every two weeks. There were eleven		3 The Wellness director will in-service with staff to ensure proper storage of oxygen per guidelines. In-service will be completed no later than November 7th, 2025. 4 This will be monitored monthly by the Wellness director and Executive director using the Oxygen therapy use and storage guide. Monitoring will begin immediately and will be ongoing.	

	cylinders of oxygen in the corner of his bedroom. Four of them were full with the tags still on them, located directly on the floor, not in a holder; one of the cylinders was empty; and six of them were full and contained in a rack on the floor. An interview was conducted with the DON (Director of Nursing) on 10/8/25 at 2:05 p.m. She indicated Resident 3 did not currently have an order for his oxygen use, but she placed a call for an actual order. A company came in and delivered the oxygen for Resident 3. She did not think there was another oxygen rack in his room to hold the four full cylinders that were on the floor. The Oxygen Therapy Use and Storage policy was provided by the Executive Director on 10/8/25 at 1:15 p.m. It indicated "Procedure 1. Oxygen therapy will be ordered by the Healthcare provider based on the Resident's medical condition. 2. The Resident's use of oxygen will be documented on the Service Plan and on the Medication Administration Record....Storage: Oxygen tanks will be stored according to fire safety regulations, in a secured, upright position....They may be stored in a resident's apartment or storage closet in an approved container or stand provided by the oxygen			

provider."

Based on observation, interview, and record review, the facility failed to ensure proper storage of oxygen in a resident's room for 1 of 2 residents who used oxygen. (Resident 3)

Findings include:

The clinical record for Resident 3 was reviewed on 10/8/25 at 10:15 a.m. His diagnoses included, but were not limited to, chronic respiratory failure. He was admitted to the facility on 1/8/25.

The 1/6/25 physician note, from prior to facility admission, indicated he continued to wear oxygen at 3 liters continuously per nasal cannula.

The facility physician's orders did not include an order for oxygen use.

The service plan, last reviewed 7/2/25, indicated there was a goal for his respiratory needs to be met with assistance. Interventions were that he required assistance with respiratory equipment supply order/maintenance and that care staff were to report any changes in ability with respiratory treatments.

An observation and interview were conducted with Resident 3 in his room on 10/8/25 at 10:20

	a.m. He was wearing oxygen per nasal cannula. He indicated he managed his own oxygen and wore it all day, and his oxygen tanks were filled every two weeks. There were eleven cylinders of oxygen in the corner of his bedroom. Four of them were full with the tags still on them, located directly on the floor, not in a holder; one of the cylinders was empty; and six of them were full and contained in a rack on the floor. An interview was conducted with the DON (Director of Nursing) on 10/8/25 at 2:05 p.m. She indicated Resident 3 did not currently have an order for his oxygen use, but she placed a call for an actual order. A company came in and delivered the oxygen for Resident 3. She did not think there was another oxygen rack in his room to hold the four full cylinders that were on the floor. The Oxygen Therapy Use and Storage policy was provided by the Executive Director on 10/8/25 at 1:15 p.m. It indicated "Procedure 1. Oxygen therapy will be ordered by the Healthcare provider based on the Resident's medical condition. 2. The Resident's use of oxygen will be documented on the Service Plan and on the Medication Administration Record....Storage: Oxygen tanks will be stored according to			

	fire safety regulations, in a secured, upright position....They may be stored in a resident's apartment or storage closet in an approved container or stand provided by the oxygen provider."			
R 0273	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(f) (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 properly store ice in the ice chest; ensure trash receptacles were covered when not in use; properly store food in the freezers and refrigerator; ensure cleanliness of the stove hood; and properly store clean dishes in the kitchen. This had the potential to affect 93 of 93 residents in the facility. Findings include: A tour of the kitchen was conducted with the SC (Sous Chef) on 10/8/25 at 11:25 a.m. An interview was conducted with the SC during the tour. During the tour, the ice chest was observed. There was a	R 0273	1 No residents were identified or affected by this deficient practice. 2 The community realizes that all residents have the potential to be affected by the deficient practice, and the community will develop action plans and implement them immediately to ensure no residents are affected in the future. 3 An immediate in-service with culinary staff regarding the process and procedures for storing food in the refrigerator and freezer, proper lid requirements, storing of dishes and overall cleanliness of the kitchen. This will be lead by the Executive Chef and the initial cleaning will be completed immediately.	11/15/2025

	gallon size plastic bag of ice resting on top of the rest of the ice inside of the ice chest. The Dining Room Manager removed the plastic bag of ice from the ice chest. The SC indicated the plastic bag of ice was not normally stored inside of the ice chest. Two of the trash receptacles located in the kitchen were uncovered and not currently in use. The walk-in freezer had three boxes of frozen food on the floor of the freezer. The SC indicated the boxes should have been stored on the shelves instead of the floor. The stove hood had a cobweb streaming across it on the right side above the ovens. The SC indicated a company came approximately every three weeks to clean the stove hood, but the kitchen staff could have wiped away the cobweb. The preparation freezer near the stove/oven area of the kitchen had a bag of chicken nuggets and a bag of onion rings that were opened and exposed to air. The SC indicated both of the foods were actively being used by staff for lunch. The clean dish racks near the dishwasher had two frying pans on the bottom shelf, not stored inverted. One of the pans had a		4 Ongoing monitoring of these deficiencies will be conducted by the Executive Chef and the Executive Director daily. The use of the cleaning checklist will be utilized and reviewed daily to ensure compliance in all areas.	

	fifty-cent sized piece of food debris resting on the bottom. The other pan had four water drops resting on the bottom. The SC removed the pan with food debris and indicated it was a piece of food on the bottom. The plates on the second from the top of another rack were all stored not inverted. The SC indicated the plates were always stored in that manner, as she placed her hand on top of two of the stacks of plates. There were several plastic carafes on a rack, a pitcher lid, and two cups that were whitish and cloudy in color. The SC indicated they needed to throw some of these items away, like the pitcher lid and one of the cups. The Activity Refrigerator on the Memory Care Unit of the facility had no thermometer in the refrigerator or freezer sections. There was wine spilled on the entire bottom of the refrigerator. There were crumbs along front of the freezer section. There were six open bottles of pop and juice and one open bottle of wine with no open dates in the refrigerator. The SC indicated they didn't do anything with the refrigerator as far as cleaning it or labeling open drinks, but if the refrigerator was in the main kitchen, there would have been open dates and thermometers. The LEL (Life Enrichment Lead) walked over to the refrigerator and indicated the activity			

	department did not clean the refrigerator. The Trash Removal policy was provided by the ED (Executive Director) on 10/8/25 at 1:40 p.m. It indicated, "Culinary 1. All trash cans for the kitchen will have a lid on at all times whether cans are used or unused. Culinary will have all used and unused trash cans with a lid on at all times. 2. Culinary staff will take out the Culinary garbage and make sure all garbage cans are covered at all times." The Culinary Ice Machine policy was provided by the ED on 10/8/25 at 1:15 p.m. It indicated, "Do not store anything but ice within the ice machine storage bin. This includes the scoop." The Proper Food Storage policy was provided by the ED on 10/8/25 at 1:15 p.m. It indicated, "Cold Storage...Keep foods properly wrapped or covered and dated with date opened and date expires." Based on observation, interview, and record review, the facility failed to properly store ice in the ice chest; ensure trash receptacles were covered when not in use; properly store food in the freezers and refrigerator; ensure cleanliness of the stove hood; and properly store clean dishes in the kitchen. This had			

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	and dated with date opened and date expires."			
R 9999	FINAL OBSERVATIONS 410 IAC 16.2-5-1.4 Personnel Authority: IC 16-28-1-7; IC 16-28-1-12 Affected: IC 16-28-5-1; IC 16-28-13-3 Sec. 1.4. ...(c) Any unlicensed employee providing more than limited assistance with the activities of daily living must be either a certified nurse aide or a home health aide. Based on interview and record review, the facility failed to ensure a staff member maintained an active CNA (Certified Nurse Aide) certification for 1 of 33 staff members whose licenses or certifications were reviewed. (CNA 7) Findings include: The Executive Director provided the completed Employee Records form on 10/7/2025 at 1:30 p.m. It indicated CNA 7's job title was a CNA and began working at the facility on 3/18/2025. The Executive Director provided the facility license binder on 10/8/2025 at 10:45 a.m. The	R 9999	1 No residents were identified or affected by this deficient practice. 2 The community realizes that all residents have the potential to be affected by the deficient practice, and the community will develop action plans and implement them immediately to ensure no residents are affected in the future. 3 An immediate audit of all staff licenses was conducted by the Wellness director. The employee who was found to have an expired license immediately renewed license per guidelines. 4 The implementation of a license tracking system will be utilized to effectively track all licenses for all applicable staff and will be monitored monthly to ensure that all licenses are current and valid. The Wellness Director will	11/15/2025

	certification for CNA 7 indicated an expiration date of 7/20/2025. According to https://mylicense.in.gov, CNA 7's certification was listed as "Expired" with an expiration date of 7/20/2025. An interview was conducted with the Executive Director on 10/9/2025 at 12:10 p.m. She indicated CNA 7 had renewed her certification on 10/8/2025. Between 7/20/2025 and 10/8/2025, CNA 7 had been working in the capacity of a CNA for the facility. It was the responsibility of the staff to make sure they keep their licenses/certifications valid and in good standing.		monitor this along with the Executive Director.	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATUREChristine N Bright	TITLEExecutive Director	(X6) DATE10/27/2025