STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	02/05/2026

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 the Investigation of Intake 467258. Intake 466258- State deficiency related to the allegations are cited at R0052. Survey date: February 5, 2026 Facility number: 002999 Residential Census: 91 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on February 9, 2026.	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 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from: (1) sexual abuse;	R 0052	1. The identified resident was affected by the deficient practice. The resident did not show any signs of distress or discomfort and was monitored by staff for 24 hours after the incident.	02/11/2026

	(2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on interview, observation, and record review, the facility failed to ensure a resident was free from physical abuse from a staff member resulting in a CNA physically striking a resident with her hand for 1 of 3 residents review for abuse. (Resident B) Findings include: The clinical record for Resident B was reviewed on 2/5/2026 at 12:00 PM. The resident's diagnoses included, but were not limited to, dementia (mental decline), anxiety, and vertigo (dizziness). An Individualized Service Plan, revised on 1/12/2026, indicated Resident B was hit by a staff member when being redirected. The interventions included, but were not limited to, monitor for changes in mood, behaviors, and physical status. An Incident Note, dated 1/11/2026, indicated " ...Writer received a call from QMA [qualified medication aide] at		2. The community realizes that all residents have the potential to be affected by the deficient practice. 3. All staff have were educated on 1-12-2026 regarding behavior monitoring and abuse and anger and aggression. Staff also attended an Inservice on 2-17-2026 to educate on how to de-escalate a staff member and how to escort them out of the community. Staff will also be required to call the Wellness director and Executive Director immediately to provide report and get additional directions if needed. 4. Effective 1-12-2026 the Wellness Director and Executive Director will be notified immediately of any allegations of staff-to-resident abuse. The Wellness Director/Executive Director will review the 24-hour report for any reported allegations. This will be monitored daily and tracked with the use of the sign off sheet.	

community. QMA reported that this resident was hit by a staff member. QMA stated that she knew that the staff member hit resident but did not know exactly where but heard the sound. QMA went on to say that afterward the Staff member left the memory care neighborhood with all of her belongings. QMA stated that she has checked on resident and found no visible discoloration or injury to resident and that resident was as per her usual baseline of walking around neighborhood ..."

A written statement, dated 1/11/2026, was completed by QMA 3. The statement indicated, "During breakfast I was giving [Resident] his medication ... I heard a thud, I turned around [Resident B] was clutching her chest, I asked [CNA 2] if she hit [Resident B] and she said yes it was a reflex. I told her that wasn't okay, she then walked off, I went to go look for her in the office and noticed her things were gone. Then I called [Director of Wellness] and [QMA 7]."

A progress note, dated 1/12/2026, indicated no changes in Resident B's behaviors or physical status.

Review of security footage was completed on 2/5/2026 at 12:50 P.M. The Administrator indicated the footage was of the

dementia unit's dining room, dated 1/11/2026 at 9:00:00 A.M. The footage review showed Resident B sitting at a table in the dining room with a meal in front of her and her back to the camera. CNA 2 was in the dining room, cleaning up dishes from residents that had already left. QMA 3 was at the far edge of the dining room assisting another resident with oral intake. At 9:01 A.M., Resident B stood up at the table with her back to the camera. Resident B appears to be moving something in front of her and had been observed to have a napkin in her hand prior to this. At 9:03 A.M., Resident B was observed to have the napkin in her hand and began to walk around the table then towards CNA 2. CNA 2's back was facing the camera and was between the center of the dining area and the serving counter. When Resident B came near CNA 2, CNA 2 used both hands to forcibly attempt to remove the object from Resident B's hands. When CNA 2 removed the object from Resident B's hand, Resident B slapped CNA 2 on the back of the right shoulder. CNA 2 reached back with her hand and contacted what appears to be the upper portion of Resident B's left upper extremity. QMA 3 was still assisting another resident at the back right hand edge of the

dining room. After the contact, QMA 3 appeared to lift her head and was focused on CNA 2. No audio was provided via the security footage. At this time, Resident B left the dining area. CNA 2 continued to clean up the tables with QMA 3 continued to assist the other resident. CNA 4 came into the dining area for a brief amount of time. QMA 3 left the viewpoint of the camera at 9:05 A.M. with CNA 2 and CNA 4 still in the dining area. QMA 3 returns to the dining area at 9:07 A.M. At 9:09 A.M., CNA 2 was then witnessed to leave the vantage point of the camera for 22 seconds before returning. CNA 2 then went to Resident G's room with the doorway visible on from the camera. Resident G was last known to be in the dining room. CNA 2 promptly returned to the hallway with her own belongings before leaving the premises.

During an interview, on 2/5/2026 at 12:51 PM, the Administrator indicated she was made aware of the incident after QMA 3 had alerted the Director of Wellness. CNA 2 left the facility and was informed she may not return to work until further notice. The next day, the Administrator reviewed the cameras as they cannot be reviewed remotely. Based upon review of the footage and statement from the staff, CNA 2 was terminated.

Staff in-services were completed for all staff members.

A policy entitled, "RESIDENTS' RIGHTS", was provided by the Administrator on 2/5/2026 at 2:20 PM. The policy indicated, " ...Residents have the rights to be free from: ...physical abuse ..."

This deficiency relates to Intake 467258.

Based on interview, observation, and record review, the facility failed to ensure a resident was free from physical abuse from a staff member resulting in a CNA physically striking a resident with her hand for 1 of 3 residents review for abuse. (Resident B)

Findings include:

The clinical record for Resident B was reviewed on 2/5/2026 at 12:00 PM. The resident's diagnoses included, but were not limited to, dementia (mental decline), anxiety, and vertigo (dizziness).

An Individualized Service Plan, revised on 1/12/2026, indicated Resident B was hit by a staff member when being redirected. The interventions included, but were not limited to, monitor for changes in mood, behaviors, and physical status.

An Incident Note, dated 1/11/2026, indicated " ...Writer received a call from QMA [qualified medication aide] at community. QMA reported that this resident was hit by a staff member. QMA stated that she knew that the staff member hit resident but did not know exactly where but heard the sound. QMA went on to say that afterward the Staff member left the memory care neighborhood with all of her belongings. QMA stated that she has checked on resident and found no visible discoloration or injury to resident and that resident was as per her usual baseline of walking around neighborhood ..."

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	cannot be reviewed remotely. Based upon review of the footage and statement from the staff, CNA 2 was terminated. Staff in-services were completed for all staff members. A policy entitled, "RESIDENTS' RIGHTS", was provided by the Administrator on 2/5/2026 at 2:20 PM. The policy indicated, " ...Residents have the rights to be free from: ...physical abuse ..." This deficiency relates to Intake 467258.			

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) DATE02/19/2026