STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDEPENDENCE VILLAGE OF AVON	182 S COUNTY ROAD 550 E, AVON, , 46123

(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: May 28 and 29, 2025 Facility number: 003902 Residential Census: 66 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on June 5, 2025.	R 0000	ATT: Suzanne Williams Director of Division Long Term Care 2 North Meridian Street Indianapolis, Indiana 46204 Re: State Residential Licensure Survey Independence Village of Avon 182 S County Road 550 E Avon, IN 46123 Dear Ms. Suzanne Williams, On May 29, 2025, a State Residential Licensure (ID 3Z6T11) Survey was conducted by the Indiana State Department of Health. Enclosed please find the Statement of Deficiencies with our facilities Plan of Correction for the alleged deficiency. Please consider this letter and Plan of Correction to be the	

			facility's credible allegation of compliance. We respectfully request a desk review to ensure that the facility has achieved substantial compliance with the applicable requirements as of the date set forth in the Plan of Correction of June 29th, 2025. Please feel free to call me with any further questions at 317-745-2766. Respectfully submitted, Romeo Behl Independence Village of Avon 182 S County Road 550 E Avon, IN 46123	
R 0121	Personnel - Noncompliance 410 IAC 16.2-5-1.4(f)(1-4) (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following:	R 0121	**R121 Personnel – noncompliance** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.***	06/29/2025

	(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on record review and interview, the facility failed to ensure new employees received		***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** **1) Immediate actions taken for those Employees identified:** Audit all associates for missing health screening separate from tuberculosis (TB). WD/AWD/ or Licensed nurse will complete all associates' health screening who are missing their health screening separate from TB. All health screenings are separate from TB completed by 6/29/25. ***2)How the facility identified other residents:*** Any resident residing in the facility had the potential to be affected. **3)Measures put into place/ System changes:**	

	a health screen, separate from a tuberculosis (TB) test for 3 of 5 newly hired employee record reviewed. Findings include: On 5/2925 at 9:30 a.m., five new employee records were reviewed. Certified Nursing Aide (CNA) 7 was hired on 2/10/25. Qualified Medication Assistant (QMA) was hired on 7/20/24. Life Enrichment Assistant 9 was hired on 2/6/25. The employee files lacked documentation of a health screen to rule out infectious disease (other than TB) and/or infectious skin lesions. During an interview on 5/25/25 at 11:59 a.m., the Executive Director (ED) indicated the facility did not conduct a separate health screen for new employees and the TB skin tests were considered sufficient for the health screen. The ED indicated there was not a specific policy for new hire procedures. The ED provided documentation, "Employee Foodborne Illness/Communicable Disease Reporting Agreement." Based on record review and interview, the facility failed to		WD/AWD or/ Licensed nurse will complete all associates' health screening who are missing their health screening separate from TB. All new hires' health screenings separate from TB test will be completed and reviewed by WD/ AWD/ or licensed nurses before their start date. WD/designee will review 3 employee files 1x weekly x 4 weeks, then 2 employee files 1 x weekly for 4 weeks and then I employee file 1x weekly 1 month to ensure all health screenings separate then TB test is conducted for compliance. **4)How the corrective actions will be monitored:** ED/Designee will be responsible for this plan of correction and Audit findings will be presented to the department heads' meeting once a month x 6 months. The results of these audits will be reviewed in the Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months.	

	ensure new employees received a health screen, separate from a tuberculosis (TB) test for 3 of 5 newly hired employee record reviewed. Findings include: On 5/2925 at 9:30 a.m., five new employee records were reviewed. Certified Nursing Aide (CNA) 7 was hired on 2/10/25. Qualified Medication Assistant (QMA) was hired on 7/20/24. Life Enrichment Assistant 9 was hired on 2/6/25. The employee files lacked documentation of a health screen to rule out infectious disease (other than TB) and/or infectious skin lesions. During an interview on 5/25/25 at 11:59 a.m., the Executive Director (ED) indicated the facility did not conduct a separate health screen for new employees and the TB skin tests were considered sufficient for the health screen. The ED indicated there was not a specific policy for new hire procedures. The ED provided documentation, "Employee Foodborne Illness/Communicable Disease Reporting Agreement."		**5)Date of compliance:6.29.25**	

R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.	R 0217	**R217 Evaluation-Deficiency** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.*** ***The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** ***1)Immediate actions taken for those residents identified:*** Residents 3 and 4 are no longer reside in the community. Resident 5's service plan has been signed by the resident and documented as per the company policy. ***2)How the facility identified***	06/29/2025

	(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on record review and interview, the facility failed to obtain signatures of the resident and/or family representative on their service plans for 4 of 7 residents reviewed (Resident 3, 4, 5, 8). Findings include: 1. On 5/28/25 at 1:30 p.m., a record review was completed for Resident 3. She had the following diagnoses which included but were not limited to Alzheimer's disease, major depression disorder, and hyperlipidemia (high cholesterol). Her last service plan was signed on 1/31/24. 2. On 5/28/25 at 1:45 p.m., a record review was completed for Resident 4. He had the following diagnoses which included but were not limited to mild cognitive impairment (memory loss) and dry eye syndrome. His last signed service plan was on 6/11/24. 3. On 5/28/25 at 2:00 p.m., a record review was completed for		***other residents:*** Any resident residing in the facility had the potential to be affected. WD re-educated all Resident evaluation and service plans must be signed by the resident and/or family representative. **3)Measures put into place/ System changes:** WD/Designee will Audit all service plans 3 times weekly x 4 weeks, then 2 x weekly for 4 weeks and then 1x weekly 1 month to ensure all resident evaluations and service plans are signed accurately and documented as per policy. **4)How the corrective actions will be monitored:** ED/Designee will be responsible for this plan of correction and Audit findings will be presented to the department heads' meeting once a month x 6 months. The results of these audits will be reviewed in the Meeting monthly for 6 months or until 100%	

	Resident 5. She had the following diagnoses which included but were not limited to insomnia, dysphagia (difficulty swallowing), and major depressive disorder. Her last service plan was signed on 619/24. On 5/29/25 at 11:59 p.m., the Wellness Director indicated the facility did not have every service plan signed when they were completed. The only service plans that got signed were for significant changes. A policy titled, "Resident Evaluation and Service Plan" was provided by the Wellness Director on 5/29/25 at 10:18 a.m. It indicated, " ...Service plans are to be maintained in the resident's electronic health record (eHR)-upload the signed copy in the eHR ....". Based on record review and interview, the facility failed to obtain signatures of the resident and/or family representative on their service plans for 4 of 7 residents reviewed (Resident 3, 4, 5, 8). Findings include: 1. On 5/28/25 at 1:30 p.m., a record review was completed for Resident 3. She had the following diagnoses which included but were not limited to Alzheimer's disease, major		compliance is achieved x3 consecutive months. **5)Date of compliance:6.29.25**	

depression disorder, and hyperlipidemia (high cholesterol).

Her last service plan was signed on 1/31/24.

2. On 5/28/25 at 1:45 p.m., a record review was completed for Resident 4. He had the following diagnoses which included but were not limited to mild cognitive impairment (memory loss) and dry eye syndrome.

His last signed service plan was on 6/11/24.

3. On 5/28/25 at 2:00 p.m., a record review was completed for Resident 5. She had the following diagnoses which included but were not limited to insomnia, dysphagia (difficulty swallowing), and major depressive disorder.

Her last service plan was signed on 619/24.

On 5/29/25 at 11:59 p.m., the Wellness Director indicated the facility did not have every service plan signed when they were completed. The only service plans that got signed were for significant changes.

A policy titled, "Resident Evaluation and Service Plan" was provided by the Wellness Director on 5/29/25 at 10:18 a.m. It indicated, " ...Service plans are to be maintained in

	the resident's electronic health record (eHR)-upload the signed copy in the eHR ....".			

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 SIGNATURE	TITLE	(X6) DATE