STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDEPENDENCE VILLAGE OF CARMEL	13390 N ILLINOIS STREET, CARMEL, , 46032

(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. This visit included the Investigation of Complaint IN00453792. Complaint IN00453792-No deficiencies related to the allegations are cited. Survey dates: April 7 and 8, 2025 Facility Number: 013297 Residential Census: 65 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on April 11, 2025.	R 0000		
R 0092	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(i)(1-2) (i) The facility must maintain a	R 0092	R 092 Administration and Management Preparation and/or execution of	04/24/2025

	written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on interview and record review, the facility failed to ensure an attempt was made to hold the fire and disaster drills in conjunction with the local fire department at least every 6 months. This deficiency had the potential to affect 65 of 65 residents who resided in the facility. Findings include:		this plan of correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility. This plan of correction is submitted as the facility's credible allegation of compliance. Independence Village of Carmel ensures that the facility conducts fire and disaster drills at least every six months. The Corrective Actions which were accomplished for those residents were found to have been affected by the deficient practice. No residents were affected by the deficient practice. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:	

	On 4/7/25 at 10:50 a.m., documents of the facility held fire drills were reviewed from February 2024 to March 2025. The documents did not indicate the facility had invited the local fire department to any fire drills held between February 2024 to March 2025. During an interview, on 4/7/25 at 11:00 a.m., the Maintenance Director indicated the local fire department had not been invited to any fire drills in the past year. He was unaware the facility was supposed to be inviting them at least every 6 months. During an interview, on 4/8/25 at 8:30 a.m., the Executive Director indicated the facility followed all state regulations. During an interview, on 4/8/25 at 12:48 p.m., the Executive Director indicated the facility did not have a policy regarding fire department invites to fire drills held at the facility. Based on interview and record review, the facility failed to ensure an attempt was made to hold the fire and disaster drills in conjunction with the local fire department at least every 6 months. This deficiency had the potential to affect 65 of 65 residents who resided in the facility.		An ad hoc safety/quality meeting was held with all department leaders to discuss the deficient practice. All residents could be affected by the fire department not being invited to attend fire and disaster drills at least every six months. The Maintenance Director received in servicing from the Executive Director that an attempt must be made to hold the fire and disaster drills in conjunction with the local fire department at least every 6 months. Communication with the Fire Department on Monday April 14th verified that they received our invitation, and the community was informed that they will not be able to attend. The next invite has been scheduled on the	

	Findings include: On 4/7/25 at 10:50 a.m., documents of the facility held fire drills were reviewed from February 2024 to March 2025. The documents did not indicate the facility had invited the local fire department to any fire drills held between February 2024 to March 2025. During an interview, on 4/7/25 at 11:00 a.m., the Maintenance Director indicated the local fire department had not been invited to any fire drills in the past year. He was unaware the facility was supposed to be inviting them at least every 6 months. During an interview, on 4/8/25 at 8:30 a.m., the Executive Director indicated the facility followed all state regulations. During an interview, on 4/8/25 at 12:48 p.m., the Executive Director indicated the facility did not have a policy regarding fire department invites to fire drills held at the facility.		calendar to be sent in the month of October 2025. A reminder to send the invite has been added to the TELS technology-based system utilized by the building which is a platform for streamlining building management processes and ensuring life safety in senior living communities. The Corporate Office has now added a reminder to the Safety Calendar for the months of April and October to ensure that compliance continues. Compliance Date: 4/24/2025	
R 0117	Personnel - Deficiency 410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled	R 0117	R 117 Personnel - Deficiency Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider that a deficiency exists.	05/10/2025

	and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure staff on duty met the requirements of cardiopulmonary resuscitation (CPR) skills validation training in accordance with the applicable state laws and first aid training for 14 of the 14 (12-hour shifts) reviewed for CPR and first aid. (3/30/25 to 4/5/25) Findings include: On 4/8/25 at 12:45 p.m., the "as worked" facility schedule, from		This response is also not to be construed as an admission of fault by the facility. This plan of correction is submitted as the facility's credible allegation of compliance. Independence Village of Carmel ensures that the facility ensures staff on duty meet the required requirements. The Corrective Actions which were accomplished for those residents were found to have been affected by the deficient practice. No residents were affected by the deficient practice. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: An ad hoc safety/quality meeting was held with	

	3/30/25 to 4/5/25, was reviewed. The schedule did not indicate a staff member CPR certified worked in the facility on 4/2/25 during the 7:00 p.m. to 7:00 a.m. shift. The schedule did not indicate a staff member certified in first aid worked in the facility during any shift from 3/30/25 to 4/5/25. During an interview, on 4/8/25 at 1:03 p.m., the Executive Director indicated she was not aware the staff needed first aid certifications. During an interview, on 4/8/25 at 8:30 a.m., the Executive Director indicated the facility followed all state regulations. A current facility policy, titled "Staffing Requirements," dated as last reviewed 2/21/23 and received from the Executive Director on 4/8/25 at 1:08 p.m., indicated "...Staff shall be sufficient in number, qualifications, and training...to meet the twenty-four (24) hours scheduled and unscheduled needs of the residents and services provided...A minimum of one (1) awake staff person, with current CPR and first aid certificates, on site at all times...." Based on record review and interview, the facility failed to		all department leaders to discuss the deficient practice. All residents could be affected by not always having a staff member on duty that is up to date with CPR and First Aid Certification The Wellness Director or his/her designee is conducting audits of all schedules to ensure that it indicates that a CPR certified staff member is always on the schedule. A continuous auditing process has been created by the Executive Director to ensure compliance with ensuring that a staff member is on duty that is up to date with CPR and First Aid Certification Any deficiencies noted during internal audits will be addressed at the monthly safety/quality meeting. Mandatory CPR and First Aid	

	ensure staff on duty met the requirements of cardiopulmonary resuscitation (CPR) skills validation training in accordance with the applicable state laws and first aid training for 14 of the 14 (12-hour shifts) reviewed for CPR and first aid. (3/30/25 to 4/5/25) Findings include: On 4/8/25 at 12:45 p.m., the "as worked" facility schedule, from 3/30/25 to 4/5/25, was reviewed. The schedule did not indicate a staff member CPR certified worked in the facility on 4/2/25 during the 7:00 p.m. to 7:00 a.m. shift. The schedule did not indicate a staff member certified in first aid worked in the facility during any shift from 3/30/25 to 4/5/25. During an interview, on 4/8/25 at 1:03 p.m., the Executive Director indicated she was not aware the staff needed first aid certifications. During an interview, on 4/8/25 at 8:30 a.m., the Executive Director indicated the facility followed all state regulations. A current facility policy, titled "Staffing Requirements," dated as last reviewed 2/21/23 and received from the Executive Director on 4/8/25 at 1:08 p.m.,		Certification classes have been scheduled at the community for all Wellness staff on May 6, May 7th and May 9th. Compliance Date: 5/10/2025	

	indicated "...Staff shall be sufficient in number, qualifications, and training...to meet the twenty-four (24) hours scheduled and unscheduled needs of the residents and services provided...A minimum of one (1) awake staff person, with current CPR and first aid certificates, on site at all times...."			
R 0118	Personnel - Deficiency 410 IAC 16.2-5-1.4(c) (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. Existing facilities that are not licensed on the date of adoption of this rule and that seek licensure within one (1) year of adoption of this rule have two (2) months in which to ensure that all employees in this category are 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 a current state certification for 1 of 51 employees reviewed who required a license or certification. (QMA 6) Findings include: The employee records were	R 0118	R 118 Personnel - Deficiency Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility. This plan of correction is submitted as the facility's credible allegation of compliance. Independence Village of Carmel ensures that the facility ensures that all staff maintains a current state certification.	04/24/2025

	reviewed on 4/8/25. Qualified Medication Aide (QMA) 6's certification expired on 12/17/24. The facility schedule, dated 12/18/24 to 12/31/24, indicated QMA 6 worked and passed medications for 5 shifts on the Memory Care unit and 2 shifts on the Assisted Living unit. The facility schedule, dated 1/1/25 to 1/30/25, indicated QMA 6 worked and passed medications for 7 shifts on the Memory Care unit and 2 shifts on the Assisted Living unit. The facility schedule, dated 2/1/25 to 2/28/25, indicated QMA 6 worked and passed medications for 2 shifts on the Memory Care unit and 1 shift on the Assisted Living unit. During an interview, on 4/8/25 at 11:18 a.m., the Executive Director indicated QMA 6's certification did expire on 12/17/24. The Executive Director indicated QMA 6 had worked in the facility after the certification expired until she took leave at the end of February 2025.		The Corrective Actions which were accomplished for those residents were found to have been affected by the deficient practice. No residents were affected by the deficient practice. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: An ad hoc safety/quality meeting was held with all department leaders to discuss the deficient practice. All residents could be affected by a QMA on staff who do not have a current certification. The Executive Director has completed an audit of all licensed wellness staff	

	During an interview, on 4/8/25 at 11:56 a.m., the Assistant Director of Health indicated QMA 6 did work from 12/17/24 through February 2025 and did pass medications. During an interview, on 4/8/25 at 8:30 a.m., the Executive Director indicated the facility followed all state regulations. An untitled document, provided by the Executive Director on 4/8/25 at 1:15 p.m., indicated "...All certifications or license renewals must remain current and in good standing, at the expense of the employee...Failure to qualify or to maintain a certification or license may be sufficient cause for discharge..." A current facility policy, titled "Staffing Requirements," dated as last reviewed 2/21/23 and received from the Executive Director on 4/8/25 at 1:08 p.m., indicated "...Staff shall be sufficient in number, qualifications, and training...to meet the twenty-four (24) hours scheduled and unscheduled needs of the residents and services provided...Medications must be administered by a licensed nursing personnel or qualified medication aides...Qualified Medication Aide must have proof of the state certification...."		employee files to ensure that licensure and certifications are up to date. An ongoing spreadsheet has been created to ensure that the Wellness Director and Staff Scheduler have access to the spreadsheet and update as needed to ensure continued compliance. No other QMA's were found to be out of compliance. A continuous auditing process has been created to ensure compliance with ensuring staff are up to date with license and certification requirements. Any deficiencies noted during internal audits will be addressed at the monthly safety/quality meeting. Compliance Date: 4/24/2025	

	Based on interview and record review, the facility failed to ensure a staff member maintained a current state certification for 1 of 51 employees reviewed who required a license or certification. (QMA 6) Findings include: The employee records were reviewed on 4/8/25. Qualified Medication Aide (QMA) 6's certification expired on 12/17/24. The facility schedule, dated 12/18/24 to 12/31/24, indicated QMA 6 worked and passed medications for 5 shifts on the Memory Care unit and 2 shifts on the Assisted Living unit. The facility schedule, dated 1/1/25 to 1/30/25, indicated QMA 6 worked and passed medications for 7 shifts on the Memory Care unit and 2 shifts on the Assisted Living unit. The facility schedule, dated 2/1/25 to 2/28/25, indicated QMA 6 worked and passed medications for 2 shifts on the Memory Care unit and 1 shift on the Assisted Living unit. During an interview, on 4/8/25 at 11:18 a.m., the Executive Director indicated QMA 6's certification did expire on 12/17/24. The Executive			

	Director indicated QMA 6 had worked in the facility after the certification expired until she took leave at the end of February 2025. During an interview, on 4/8/25 at 11:56 a.m., the Assistant Director of Health indicated QMA 6 did work from 12/17/24 through February 2025 and did pass medications. During an interview, on 4/8/25 at 8:30 a.m., the Executive Director indicated the facility followed all state regulations. An untitled document, provided by the Executive Director on 4/8/25 at 1:15 p.m., indicated "...All certifications or license renewals must remain current and in good standing, at the expense of the employee...Failure to qualify or to maintain a certification or license may be sufficient cause for discharge..." A current facility policy, titled "Staffing Requirements," dated as last reviewed 2/21/23 and received from the Executive Director on 4/8/25 at 1:08 p.m., indicated "...Staff shall be sufficient in number, qualifications, and training...to meet the twenty-four (24) hours scheduled and unscheduled needs of the residents and services provided...Medications must be administered by a			

	licensed nursing personnel or qualified medication aides...Qualified Medication Aide must have proof of the state certification...."			
R 0119	Personnel - Noncompliance 410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3- (d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following: (1) Instructions on the needs of the specialized populations: (A) aged; (B) developmentally disabled; (C) mentally ill; (D) dementia; or (E) children; served in the facility. (2) A review of the facility's policy manual and applicable procedures, including: (A) organization chart; (B) personnel policies; (C) appearance and grooming policies for employees; and	R 0119	R 119 Personnel - Noncompliance Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility. This plan of correction is submitted as the facility's credible allegation of compliance. Independence Village of Carmel ensures that the facility provides all new employees with an orientation prior to working independently. The Corrective Actions which were accomplished for those residents were found to have been affected by the deficient practice.	04/24/2025

	(D) residents' rights. (3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures. (4) Review of ethical considerations and confidentiality in resident care and records. (5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care. (6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation. Based on interview and record review, the facility failed to ensure general, and job specific orientations were documented for 3 of 5 employees reviewed for orientation. (QMA 8, CNA 9, QMA 10) Findings include: The employee records were reviewed on 4/8/25. The facility was unable to provide documentation of the following: 1. QMA 8, with a start date of 10/14/24, did not have general orientation or job specific orientation on file. 2. CNA 9, with a start date of 11/12/24, did not have general orientation or job specific		No residents were affected by the deficient practice. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: An ad hoc safety/quality meeting was held with all department leaders to discuss the deficient practice. All residents could be affected by staff not receiving an orientation prior to working independently. The Executive Director or her designee is conducting audits of employee files to ensure that all staff have a completed orientation checklist to show completion of general and job specific orientation.	

	orientation on file. 3. QMA 10, with a start date of 11/12/24, did not have general orientation or job specific orientation on file. During an interview, on 4/8/25 at 11:58 a.m., the Property Administrator indicated the employees did not have a general orientation or job specific orientation in their files. During an interview, on 4/8/25 at 12:07 p.m., the Executive Director indicated all staff members should have had a general orientation and job specific orientation completed and in their employee files. During an interview, on 4/8/25 at 8:30 a.m., the Executive Director indicated the facility followed all state regulations. The facility did not provide a policy related to general orientation, job specific orientation prior to the survey exit date. Based on interview and record review, the facility failed to ensure general, and job specific orientations were documented for 3 of 5 employees reviewed for orientation. (QMA 8, CNA 9, QMA 10) Findings include: The employee records were		A continuous auditing process has been created to ensure compliance with ensuring staff complete an orientation check list. Any deficiencies noted during internal audits will be addressed at the monthly safety/quality meeting. Compliance Date: 4/24/2025	

	reviewed on 4/8/25. The facility was unable to provide documentation of the following: 1. QMA 8, with a start date of 10/14/24, did not have general orientation or job specific orientation on file. 2. CNA 9, with a start date of 11/12/24, did not have general orientation or job specific orientation on file. 3. QMA 10, with a start date of 11/12/24, did not have general orientation or job specific orientation on file. During an interview, on 4/8/25 at 11:58 a.m., the Property Administrator indicated the employees did not have a general orientation or job specific orientation in their files. During an interview, on 4/8/25 at 12:07 p.m., the Executive Director indicated all staff members should have had a general orientation and job specific orientation completed and in their employee files. During an interview, on 4/8/25 at 8:30 a.m., the Executive Director indicated the facility followed all state regulations.			

	The facility did not provide a policy related to general orientation, job specific orientation prior to the survey exit date.			
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 ensure opened items were dated and covered, gloves were changed between tasks, facial hair coverings were worn, and to ensure sanitizer solution was at the correct concentration levels in 1 of 1 kitchen reviewed. This deficient practice had the potential to affect 65 of 65 residents who received meals from the kitchen. Findings include: 1. During an observation of the facility kitchen, on 4/7/25 beginning at 9:06 a.m., five-gallon containers of sherbet, orange blossom, peach praline, vanilla and peanut butter pie ice cream were found to be stored in the Ice Cream freezer. The lids were not fully	R 0273	R 273 Food and Nutritional Services Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility. This plan of correction is submitted as the facility’s credible allegation of compliance. Independence Village of Carmel ensures that the facility does ensure that opened items in the kitchen are dated and covered, gloves are changed between tasks, facial hair coverings are worn and ensures that sanitizer solution is at the correct concentration levels. The Corrective Actions which were accomplished for those residents were found to have been affected by the	04/24/2025

	on the items, leaving them exposed to air. At that time, the Executive Chef indicated the lids should have been placed on the items correctly. 2. During an observation, on 4/7/25 at 9:08 a.m., Dishwasher 4 was observed to handle non-food items while wearing gloves and then place her gloved hand into a bag of bread to remove bread. She was not observed changing her gloves between tasks and proceeded to handle ready-to-eat food. At that time, the Executive Chef indicated that was not the correct procedure. 3. During the same observation of the kitchen, on 4/7/25, Kitchen Staff 4 and Kitchen Staff 5 were noted to have facial hair (mustaches and/or beards). Neither employee was using a facial hair cover. At that time, the Executive Chef indicated he thought if facial hair was 1/4 inch or less the hair covering was not required. He indicated both employees were noted to have facial hair greater than 1/4 inch. 4. During the kitchen observation, the pantry was found to have an eight ounce can of espresso. The can of espresso was close to empty and did not have a date it was opened on the container. A two-pound bag of pancake mix		deficient practice. No residents were affected by the deficient practice. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: An ad hoc safety/quality meeting was held with all department leaders to discuss the deficient practice. All residents could be affected by the food not being labeled and covered, gloves not being changed between tasks, facial hair not being covered and sanitizer solutions not being at the correct concentration. Executive Chef or his designee are conducting audits to ensure all food products are dated and	

	was found half full, wrapped in plastic and did not have an open date on the bag. Two one-pound bags of powdered sugar were found open, wrapped in plastic and did not have an open date on the bags. 5. The walk-in cooler had a half gallon container of butter milk without an open date, a 1/4 block (of a five-pound block) of white American cheese slices was found wrapped in plastic without an open date. During an interview, on 4/7/25 at 9:26 a.m., the Executive Chef indicated items should be labeled with an open date when they are opened. 6. During a subsequent visit to the kitchen, on 4/8/25 at 10:55 a.m., the sanitizer (used to clean the kitchen surfaces) was tested. The Executive Chef indicated the strip showed a concentration of about 150-200 parts per million and it was supposed to test between 200 and 400 parts per million. During the observation, the test strip did not register 200 parts per million. The Executive Chef tested the sanitizer a second time. The strip did not register, and it did not change color from the original light orange (per the directions, it should have changed to green). A third attempt was made. The strip lightened and indicated 0 parts		covered, staff covering facial hair, staff changing gloves between tasks and concentration of sanitizers twice weekly for 4 weeks, if no deficiencies are noted, will then audit monthly for 4 weeks. A continuous auditing process has been created to ensure compliance with proper food storage and culinary sanitation policies and procedures. Any deficiencies noted during internal audits will be addressed at the monthly safety/quality meeting. Compliance Date: 4/24/2025	

per million concentrations.

During an interview, on 4/8/25 at 11:13 a.m., the Executive Chef indicated he needed to check to see if the strips were the right test strips for the product he was using.

During an interview, on 4/8/25 at 11:48 a.m., the Executive Chef indicated he had ordered the incorrect test strips for checking the sanitizer solution.

7. During a subsequent visit to the kitchen, on 4/8/25 at 2:00 p.m., the salad preparation cooler was found to have hardboiled eggs, shredded cheese, lettuce, spinach and bacon pieces, all in separate containers and without lids. The dressing cooler was found to have a five-pound container of sour cream, half full, and without an open date.

During an interview, on 4/8/25 at 2:01 p.m., the Executive Chef indicated all the items had lids prior to the meal service and the staff should have placed the lids back on the items.

A current facility policy, titled "Proper Food Storage," dated as last revised on 6/6/22 and received from the Executive Director on 4/7/25 at 11:29 a.m., indicated "...Dry Stock...Label all open containers with an open date and expiration date...Cold Storage...Keep foods properly

wrapped or covered and dated with date opened and date expires...When to date mark foods...Anytime the original packaging is opened...."

A current facility policy, titled "Department Specific Procedures-Culinary Services," dated as implemented on 2/17/22 and received from the Executive Director on 4/7/25 at 11:29 a.m., indicated "...Sanitize environmental surfaces...."

A current facility policy, titled "Culinary Sanitation and Safety Manual," undated and received from the Executive Director on 4/7/25 at 1:10 p.m., indicated "...When used appropriately, single-use gloves can help reduce the spread of disease-causing organisms of ready to eat foods...single use gloves are for one specific purpose only...."

Based on observation, interview and record review, the facility failed to ensure opened items were dated and covered, gloves were changed between tasks, facial hair coverings were worn, and to ensure sanitizer solution was at the correct concentration levels in 1 of 1 kitchen reviewed. This deficient practice had the potential to affect 65 of 65 residents who received meals from the kitchen.

Findings include:

	1. During an observation of the facility kitchen, on 4/7/25 beginning at 9:06 a.m., five-gallon containers of sherbet, orange blossom, peach praline, vanilla and peanut butter pie ice cream were found to be stored in the Ice Cream freezer. The lids were not fully on the items, leaving them exposed to air. At that time, the Executive Chef indicated the lids should have been placed on the items correctly. 2. During an observation, on 4/7/25 at 9:08 a.m., Dishwasher 4 was observed to handle non-food items while wearing gloves and then place her gloved hand into a bag of bread to remove bread. She was not observed changing her gloves between tasks and proceeded to handle ready-to-eat food. At that time, the Executive Chef indicated that was not the correct procedure.			

	3. During the same observation of the kitchen, on 4/7/25, Kitchen Staff 4 and Kitchen Staff 5 were noted to have facial hair (mustaches and/or beards). Neither employee was using a facial hair cover. At that time, the Executive Chef indicated he thought if facial hair was 1/4 inch or less the hair covering was not required. He indicated both employees were noted to have facial hair greater than 1/4 inch. 4. During the kitchen observation, the pantry was found to have an eight ounce can of espresso. The can of espresso was close to empty and did not have a date it was opened on the container. A two-pound bag of pancake mix was found half full, wrapped in plastic and did not have an open date on the bag. Two one-pound bags of powdered sugar were found open, wrapped in plastic and did not have an open date on the bags. 5. The walk-in cooler had a half gallon container of butter milk without an open date, a 1/4 block (of a five-pound block) of white American cheese slices was found wrapped in plastic without an open date. During an interview, on 4/7/25 at 9:26 a.m., the Executive Chef indicated items should be labeled with an open date when			

	they are opened. 6. During a subsequent visit to the kitchen, on 4/8/25 at 10:55 a.m., the sanitizer (used to clean the kitchen surfaces) was tested. The Executive Chef indicated the strip showed a concentration of about 150-200 parts per million and it was supposed to test between 200 and 400 parts per million. During the observation, the test strip did not register 200 parts per million. The Executive Chef tested the sanitizer a second time. The strip did not register, and it did not change color from the original light orange (per the directions, it should have changed to green). A third attempt was made. The strip lightened and indicated 0 parts per million concentrations. During an interview, on 4/8/25 at 11:13 a.m., the Executive Chef indicated he needed to check to see if the strips were the right test strips for the product he was using. During an interview, on 4/8/25 at 11:48 a.m., the Executive Chef indicated he had ordered the incorrect test strips for checking the sanitizer solution. 7. During a subsequent visit to the kitchen, on 4/8/25 at 2:00 p.m., the salad preparation cooler was found to have hardboiled eggs, shredded			

	cheese, lettuce, spinach and bacon pieces, all in separate containers and without lids. The dressing cooler was found to have a five-pound container of sour cream, half full, and without an open date. During an interview, on 4/8/25 at 2:01 p.m., the Executive Chef indicated all the items had lids prior to the meal service and the staff should have placed the lids back on the items. A current facility policy, titled "Proper Food Storage," dated as last revised on 6/6/22 and received from the Executive Director on 4/7/25 at 11:29 a.m., indicated "...Dry Stock...Label all open containers with an open date and expiration date...Cold Storage...Keep foods properly wrapped or covered and dated with date opened and date expires...When to date mark foods...Anytime the original packaging is opened...." A current facility policy, titled "Department Specific Procedures-Culinary Services," dated as implemented on 2/17/22 and received from the Executive Director on 4/7/25 at 11:29 a.m., indicated "...Sanitize environmental surfaces...." A current facility policy, titled "Culinary Sanitation and Safety Manual," undated and received from the Executive Director on			

	4/7/25 at 1:10 p.m., indicated "...When used appropriately, single-use gloves can help reduce the spread of disease-causing organisms of ready to eat foods...single use gloves are for one specific purpose only...."			
R 0409	Infection Control - Noncompliance 410 IAC 16.2-5-12(d) (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on interview and record review, the facility failed to ensure an annual health statement was provided which showed the resident had no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter for 2 of 8 residents reviewed for annual heath statements. (Resident 1 and 7) Findings include: 1. The clinical record for Resident 1 was reviewed on 4/7/25 at 10:13 a.m. The diagnoses included, but were not limited to, major depressive disorder, fracture of the neck of	R 0409	R 409 Infection Control - Noncompliance Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility. This plan of correction is submitted as the facility's credible allegation of compliance. Independence Village of Carmel ensures that the Healthcare Provider Plan of Care provides a form and process for the resident's healthcare provider to provide a written record of a resident's health assessment. The Corrective Actions which were accomplished for those residents were found	04/24/2025

	the femur, and encounter for closed fracture. The resident was admitted to the facility on 1/22/21. The facility was unable to provide a current annual health statement. 2. The clinical record for Resident 7 was reviewed on 4/7/25. The diagnoses included, but were not limited to, hypertension, bradycardia (slow heartbeat), and glaucoma. The resident was admitted to the facility on 6/7/23. The facility was unable to provide a current annual health statement. During an interview, on 4/8/25 at 8:30 a.m., the Executive Director indicated the facility followed all state regulations. During an interview, on 4/8/25 at 8:54 a.m., the Assistant Director of Health indicated all resident information had been provided. The facility was not able to provide the annual health statements for Resident 1 and 7. A current facility policy, titled "Healthcare Provider Plan of Care-HCPPOC," dated as implemented on 6/25/24 and received from the Executive Director on 4/8/25 at 12:38 p.m.,		to have been affected by the deficient practice. R1 no longer resides in this community. R7 now has an Annual Health Statement in place. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: An ad hoc safety/quality meeting was held with all department leaders to discuss the deficient practice. All residents could be affected by the lack of an annual health statement. R1 and R7 now have an updated Health Statement.	

	indicated "...The Healthcare Provider Plan of Care provides a form and process for the resident's healthcare provider to provide a written record of a resident's health assessment...." Based on interview and record review, the facility failed to ensure an annual health statement was provided which showed the resident had no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter for 2 of 8 residents reviewed for annual heath statements. (Resident 1 and 7) Findings include: 1. The clinical record for Resident 1 was reviewed on 4/7/25 at 10:13 a.m. The diagnoses included, but were not limited to, major depressive disorder, fracture of the neck of the femur, and encounter for closed fracture. The resident was admitted to the facility on 1/22/21. The facility was unable to provide a current annual health statement. 2. The clinical record for Resident 7 was reviewed on 4/7/25. The diagnoses included, but were not limited to, hypertension, bradycardia (slow heartbeat), and glaucoma.		The Wellness Director or his/her designee is conducting audits of all charts to ensure all residents have a signed annual health statement by their Healthcare Provider. A continuous auditing process has been created to ensure all residents have a signed annual health statement. Any deficiencies noted during internal audits will be addressed at the monthly safety/quality meeting. Compliance Date: 4/24/2025	

	The resident was admitted to the facility on 6/7/23. The facility was unable to provide a current annual health statement. During an interview, on 4/8/25 at 8:30 a.m., the Executive Director indicated the facility followed all state regulations. During an interview, on 4/8/25 at 8:54 a.m., the Assistant Director of Health indicated all resident information had been provided. The facility was not able to provide the annual health statements for Resident 1 and 7. A current facility policy, titled "Healthcare Provider Plan of Care-HCPPOC," dated as implemented on 6/25/24 and received from the Executive Director on 4/8/25 at 12:38 p.m., indicated "...The Healthcare Provider Plan of Care provides a form and process for the resident's healthcare provider to provide a written record of a resident's health assessment...."			
R 0410	Infection Control - Noncompliance 410 IAC 16.2-5-12(e)(f)(g) (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72)	R 0410	R 410 Infection Control Noncompliance Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider that	04/24/2025

	hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents 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 within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on interview and record review, the facility failed to ensure a 2-step tuberculosis test was completed when a resident was admitted to the facility for 2 of 8 residents reviewed for tuberculosis. (Resident 4 and 8) Findings include: 1. The clinical record for Resident 4 was reviewed on 4/7/25. The diagnoses included, but were not limited to, chronic systolic heart failure, chronic kidney disease, and hypertension. The resident was admitted to		a deficiency exists. This response is also not to be construed as an admission of fault by the facility. This plan of correction is submitted as the facility's credible allegation of compliance. R TB and second step Independence Village of Carmel ensures that the facility performs TB testing via the 2-step method when required. The Corrective Actions which were accomplished for those residents were found to have been affected by the deficient practice. R4 TB skin test series has been restarted R8 TB skin test series has been restarted How the facility will identify other	

	the facility on 10/18/24. The first test of the 2-step tuberculosis test was completed on 10/23/24. The facility was not able to provide the second step testing information. 2. The clinical record for Resident 8 was reviewed on 4/7/25. The diagnoses included, but were not limited to, glaucoma, hypertension, and Parkinson's disease. The resident was admitted to the facility on 10/13/24. The first test of the 2-step tuberculosis test was completed on 10/22/24. The facility was not able to provide the second step testing information. During an interview, on 4/8/25 at 8:30 a.m., the Executive Director indicated the facility followed all state regulations. During an interview, on 4/8/25 at 8:54 a.m., the Assistant Director of Health indicated all resident information had been provided. The facility was unable to provide the second step test for tuberculosis for Resident 4 and 8. A current facility policy, titled "Tuberculosis Infection Control		residents having the potential to be affected by the same deficient practice and what corrective action will be taken: An ad hoc safety/quality meeting was held with all department leaders to discuss the deficient practice. All residents could be affected by a resident not receiving a 2nd TB skin test when indicated. The Wellness Director or his/her designee is conducting audits of all new admissions to ensure that a TB skin test as well as a 2nd step is performed when indicated. A continuous auditing process has been created to ensure continued compliance.	

	Plan-Indiana," dated as last reviewed on 8/23/24 and received from the Executive Director on 4/8/25 at 12:14 p.m., indicated "...New residents shall be screened within 3 months prior to move in or upon move-in as follows...Perform TB (tuberculosis) testing via 2-step...." A current facility agreement, titled "RESIDENCY AGREEMENT," dated 6/28/23 and received from the Executive Director on 4/8/25 at 12:14 p.m., indicated "...Residents will be screened for Tuberculosis (TB)...prior to admission...." Based on interview and record review, the facility failed to ensure a 2-step tuberculosis test was completed when a resident was admitted to the facility for 2 of 8 residents reviewed for tuberculosis. (Resident 4 and 8) Findings include: 1. The clinical record for Resident 4 was reviewed on 4/7/25. The diagnoses included, but were not limited to, chronic systolic heart failure, chronic kidney disease, and hypertension. The resident was admitted to the facility on 10/18/24. The first test of the 2-step tuberculosis test was completed		Any deficiencies noted during internal audits will be addressed at the monthly safety/quality meeting. Compliance Date: 4/24/2025	

on 10/23/24.

The facility was not able to provide the second step testing information.

2. The clinical record for Resident 8 was reviewed on 4/7/25. The diagnoses included, but were not limited to, glaucoma, hypertension, and Parkinson's disease.

The resident was admitted to the facility on 10/13/24.

The first test of the 2-step tuberculosis test was completed on 10/22/24.

The facility was not able to provide the second step testing information.

During an interview, on 4/8/25 at 8:30 a.m., the Executive Director indicated the facility followed all state regulations.

During an interview, on 4/8/25 at 8:54 a.m., the Assistant Director of Health indicated all resident information had been provided. The facility was unable to provide the second step test for tuberculosis for Resident 4 and 8.

A current facility policy, titled "Tuberculosis Infection Control Plan-Indiana," dated as last reviewed on 8/23/24 and received from the Executive Director on 4/8/25 at 12:14 p.m.,

	indicated "...New residents shall be screened within 3 months prior to move in or upon move-in as follows...Perform TB (tuberculosis) testing via 2-step...." A current facility agreement, titled "RESIDENCY AGREEMENT," dated 6/28/23 and received from the Executive Director on 4/8/25 at 12:14 p.m., indicated "...Residents will be screened for Tuberculosis (TB)...prior to admission...."			

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