STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	02/25/2026

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 Intake 466366, 467746, and 468104. Intake 466366 - No deficiencies related to the allegations are cited. Intake 467746 - No deficiencies related to the allegations are cited. Intake 468104 - No deficiencies related to the allegations are cited. Survey dates: February 24 and 25, 2026 Facility number: 013297 Residential Census: 67 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed	R 0000		

	on February 27, 2026.			
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 (D) residents' rights. (3) Instruction in first aid, emergency procedures, and fire	R 0119	· What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? **No resident was 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? **No residents were affected by the deficient practice.** · What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? **All job descriptions will be added to new hire employee packets for new hire orientation.** How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? **We will follow the state**	03/05/2026

	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 documentation of job specific orientation was in the employee's personnel record for 2 of 10 employees reviewed for orientation. (QMA 2 and CNA 4) Findings include: The employee records were reviewed on 2/25/26. The facility was unable to provide documentation of job specific orientation for the following employees: 1. QMA (Qualified Medication Aide) 2, start date 6/19/25, no job specific orientation was on file. 2. CNA (Certified Nursing Assistant) 4, start date 6/12/25, no job specific orientation was		**guided check list for all employee files. Compliance will be monitored by property administrator.** By what date the systemic changes will be completed. **3/31/2026**	

	on file. During an interview, on 2/25/26 at 11:57 a.m., the Director of Nursing (DON) reviewed the orientation and competency checklist forms and indicated some of the employee forms did not include the job specific tasks. She was not sure why the checklist forms were titled the same and provided different checklist information. The facility did not provide a policy related to job specific orientation or records to be kept in employee files 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 hair nets were worn in food preparation areas, appropriate thinning agents were used when pureeing food, expired food products were discarded, chemicals were stored separate from food products, employee food was	R 0273	Hair Net Deficiency Statement On 2/24/26, a server was observed in the food prep area on 2 occasions without wearing a hair net or covering, despite the facility policy requiring hair constraints in food prep areas. Immediate Corrective Action Server was immediately instructed to obtain and wear a hair net prior to continuing work in the kitchen area. The server was re-educated on food safety requirements regarding hair restraints. How will the incident be	03/31/2026

	stored separate from resident food and food products were not stored on the floor for 1 of 1 kitchen reviewed. This deficient practice had the potential to affect 67 of 67 residents. Findings include: 1. During an observation, on 2/24/26 at 10:00 a.m., Server 6 was in a food preparation area and was not wearing a hair net. During an observation, on 2/24/26 at 11:35 a.m., Server 7 was in a food preparation area and was not wearing a hair net. During an observation, on 2/24/26 at 2:45 p.m., Server 7 was in a food preparation area and was not wearing a hair net. During an interview, on 2/24/26 at 11:50 a.m., the Executive Chef indicated employees needed to wear hair nets in the kitchen. 2. During a continuous observation and interview, on 2/24/26 at 11:35 a.m., Server 11 was completing food purees. She began to puree the fish by adding the cooked fish to the blender with hot water and thickening powder. After pureeing the fish, she pureed the cooked vegetables by adding the vegetables and hot water. After pureeing the cooked vegetables, she pureed		prevented? All culinary staff will be re-educated on the requirements of wearing a hair net or covering while in food prep areas. Hair nets wil be stocked and available at all times at all kitchen entry points. Expectations will be reinforced during daily shift meetings. Monitoring plan The executive chef or on duty will conduct daily kitchen observations to ensure staff are wearing hair restraints. Findings will be documented in kitchen logs. Puree Food Prep Deficiency Statement On 2/24/26, staff preparing pureed foods did not have standardized recipes or instructions regarding approved thinning agents or preparation procedures. Immediate Corrective Action The employee was immediately re-educated on proper pureed food prep procedures and instructed to stop preparing items without proper approved guidance. Systemic Changes	

	the French fried by adding the French fries and adding hot water. Server 11 indicated she had been working here for a few months and was trained to use either apple juice or water as a thinning agent. There was no recipe book to follow. There was no recipe for what thinning agents to use. During an interview, on 2/24/26 at 11:50 a.m., the Executive Chef indicated he was told they were to use either apple juice or water as thinning agents. He indicated he would use apple juice or water to thin the French fries and understood how it might taste bad. They did not have a recipe book or anything to tell them what thinning agents to use when pureeing food. Moving forward, they should consider using broths and other thinning agents to add flavor to the pureed foods. During an interview, on 2/25/26 at 10:45 a.m., the RD (Registered Dietician) indicated staff should not use water when pureeing foods. They should be using things like broths, milk, butter, or juices as thinning agents. 3. During a continuous kitchen observation and interview, on 2/24/26 at 10:00 a.m., there was an open bottle of Hot Ones Apollo hot sauce with an		A standardized puree recipe and prep guide will be placed in the kitchen. Training will be provided to all culinary staff on modified textured diets and proper preparation techniques. Only trained staff will prepare pureed foods. Monitoring Plan The Executive Chef will perform weekly audits for 3 months of puree prep to ensure recipes are followed and consistency is achieved. Responsible Party Executive Chef or designee • ¿Food Labeling Deficiency Statement On 2/24/26, several food safety concerns were observed, including expired product, items without receive or discard dates, and ice cream stored directly on the floor of the freezer. Immediate Corrective Action Expired products were immediately discarded. All open items were properly labeled, with receive and discard dates. Ice cream was moved to the appropriate shelving area in the freezer.	

	expiration date of 11/15/25 and no receive date or discard date. An open tub of cottage cheese with a best by date of 2/16/26 and no receive date or discard date. An open tub of French dressing with a date of "9/2" written on the top with no discard date. There were 2 bottles of sports drink "BodyArmour" and 2 bottled waters in the walk-in refrigerator. There were 10 large tubs of Hershey's and Blue Bunny ice cream stored on the floor in the walk-in freezer. The Executive Chef indicated the cottage cheese should have been discarded, and the French dressing should have been discarded. Staff should put labels on food products coming in with receive dates and open dates. Staff should not store ice cream or any food products on the floor, and it should be stored up on a rack in the freezer. 4. During an observation, on 2/24/26 at 11:40 a.m., there was a large bottle of citrus all-purpose cleaner degreaser sitting next to an opened box of bananas and cans of corned beef hash. During an interview, on 2/24/26 at 11:45 a.m., the Executive Chef indicated chemicals should not be stored next to food products.		Systemic Changes Staff will be re-educated on proper food labeling, date marking, and storage requirements. A standard labeling system will be implemented, requiring receive dates and discard dates on all opened food items. Monitoring Plan The executive chef or designee will perform daily walk-in cooler and freezer inspections to verify proper labeling, dating, and storage. Responsible Party Executive Chef or designee • ¿Chemical Storage Deficiency Statement On 2/24/26, a bottle of citrus all-purpose cleaner/degreaser was observed stored next to food products, including an open box of bananas and cans of corned beef hash. Immediate Corrective Action The chemical cleaner was immediately removed from the food storage area and relocated to the designated chemical storage location.	

	5. During an observation and interview, on 2/24/26 at 10:00 a.m., the high-temperature dishwasher wash and final rinse thermometer gauges were not working. The Executive Chef indicated the gauges were not working and he was unsure how staff ensured the dishwasher reached temperature this morning before they started washing the dishes. He could not find the dishwasher temp logs, and they were supposed to be keeping logs of the temperatures. During an interview, on 2/24/26 at 2:45 p.m., the service technician indicated the dishwasher final rinse was not getting up to the 180 degrees it should be. The booster was not working which gets it up to 180 degrees. During an interview, on 2/25/26 at 12:57 p.m., the Executive Director indicated they did not have a policy in regard to what liquids to use when pureeing food. A current facility policy, titled "Proper Food Storage Standard Operating Procedure", dated as last reviewed 6/6/22 and received from the DON on 2/25/26 at 11:25 a.m., indicated "...All food must be stored on shelves a minimum of 6 inches from the ground...Label all open		Systemic Changes All staff will be re-educated on proper chemical storage and the requirement that chemicals must never be stored next to or above food items or food contact surfaces. Monitoring Plan The executive chef or designee will conduct daily kitchen inspections to ensure chemicals are stored in designated areas. Responsible Party Executive chef or designee • ¿Dish machine Deficiency Statement On 2/24/26, during observation, the high-temp dishwasher wash and final rinse thermometer gauges were not functioning, and staff were unsure how proper sanitizing temperatures were being verified. Immediate Corrective Action The issue was immediately reported to maintenance, and service was requested to repair or replace the faulty thermometer gauges. Staff were instructed to manually verify sanitizing temperatures using a calibrated dishwasher	

	containers with open date and expiration date...Keep foods properly wrapped or covered and dated with date opened and date expires...." A current facility policy, titled "Culinary Uniform Standards Standard Operating Procedure", dated as last reviewed 4/8/25 and received from the DON on 2/25/26 at 11:25 a.m., indicated "...The purpose of the Culinary Uniform Standard Policy is to create and maintain a professional and safety based culinary appearance in all our communities...follow below...Chefs/Cooks/Dietary aides...Pillbox hat and/or hairnet...Service Staff...Hairnets in kitchen and dining areas...Dishwashers...Pillbox hat or hairnet...." A current facility policy, titled "Standard Operating Procedure (SOP): Chemical Storage in the Kitchen", undated and received from the DON on 2/25/26 at 11:25 a.m., indicated " ...All chemicals must be stored in a designated chemical storage area ...Never store chemicals on food shelves, above prep tables, food, or clean equipment, or inside walk-ins, or dry storage ...." A current facility policy, titled "Standard Operating Procedure (SOP) Expired Food Disposal -		thermometer or heat-sensitive test strips until repairs could be completed. Systemic Changes Staff will be re-educated on proper dish machine monitoring procedures including verifying wash and final rinse temperatures and documenting results on the temperature log. Preventative maintenance checks will be added to ensure gauges remain operational. Monitoring Plan The executive chef or designee will review the dish machine temperatures log daily to ensure sanitizing temperatures are being verified and documented. Responsible Party Executive chef or designee All deficiencies in this area will be within compliance by 3/31/26	

	Kitchen", undated and received from the DON on 2/25/26 at 11:25 a.m., indicated "...Expired Food: Any food item that has passed its manufacturer expiration date, use-by-date, or internal discard date, or shows signs of spoilage...Remove the item immediately from storage, prep, or service areas...Do not store expired food in active kitchen areas...."			
R 0298	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(2) (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days.	R 0298	R-0298 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were directly affected by this deficiency. 2. 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? Director of Nursing or Assistant Director of Nursing will keep a ,log of all pharmacy recommendations as they are completed. This log will be kept in a binder along with the recommendations and kept in the office of the DON. · What measures will be put into	03/31/2026

	Based on interview and record review, the facility failed to ensure pharmacy reviews were conducted every 2 months for 3 of 7 residents reviewed for pharmacy reviews. (Resident 4, 3, and 2) Findings include: 1. The clinical record for Resident 4 was reviewed on 2/24/26 at 1:45 p.m. The diagnoses included, but were not limited to, heart failure, hallucinations, and fall. Resident 4 was in the facility during January 2025 through February 2026. There was no documentation the pharmacy medication reviews were conducted for Resident 4 in January 2025, May 2025, or July 2025. 2. The clinical record for Resident 3 was reviewed on 2/24/26 at 11:35 a.m. The diagnoses included, but were not limited to, Parkinson's disease. Resident 3 was admitted to the facility on 5/14/25. There was no documentation the pharmacy medication reviews were conducted for Resident 3 in July 2025.		place or what systemic changes the facility will make to ensure that the deficient practice does not recur? Director of Nursing or Assistant Director of Nursing will keep a ,log of all pharmacy recommendations as they are completed. This log will be kept in a binder along with the recommendations and kept in the office of the DON. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? This corrective action will be an on going practice, to ensure that every 60 days Pharmacy Recommendations are completed. This will be a task to be completed by DON/ADON By what date the systemic changes will be completed? This deficiency will be corrected and implemented by 03/31/2026	

	3. The clinical record for Resident 2 was reviewed on 2/24/26 at 11:48 a.m. The diagnoses included, but were not limited to, congestive heart failure, pain, and chronic obstructive pulmonary disease. There was no documentation the pharmacy medication reviews were conducted for Resident 2 in January 2025, May 2025, and July 2025. During an interview, on 2/25/26 at 10:10 a.m., the Director of Nursing (DON) indicated pharmacy reviews were to be conducted every sixty (60) days, and she could not find documentation of pharmacy reviews for several months. She could only find reviews completed in March 2025, August 2025, October 2025, and December 2025. A current facility policy, titled "Pharmacy Services," dated 10/10/23 and provided by the DON on 2/25/26 at 12:08 p.m., indicated "...Medication Management Services include...Regularly scheduled reviews and medication monitoring...."			

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	TITLEHFA	(X6) DATE03/17/2026

SIGNATUREMarshall Bowman		