STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDEPENDENCE VILLAGE OF FISHERS EAST	12950 TALBLICK STREET, FISHERS, , 46037

(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 Intakes 469355 and 469360. This visit was in conjunction with a Post Survey Revisit (PSR) for the Investigation of Intake 467853 completed on February 17, 2026. Intake 469355 - State Residential Findings related to the allegations are cited at R0297 and R0300. Intake 469360 - State Residential Findings related to the allegations are cited at R0297 and R0300. Intake 467853 - Corrected Survey dates: May 6, 11 and 12, 2026 Facility number: 013945 Residential Census: 73 These State Residential	R 0000		

	Findings are cited in accordance with 410 IAC (Indiana Administrative Code) 16.2-5. Quality review completed on May 21, 2026.			
R 0297	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(c)(1) (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana.	R 0297	• Monthly inservice on QMA scope of practice and upon new hire • Monthly inservice on medication administration and upon new hire to include 5 rights; right resident, right med, right dose, right time, right route and check against MAR 3 times- and proper labeling of OTC medications • Monthly inservice on controlled substance policy and upon new hire • Monthly inservice on med errors and upon new hire • Weekly med cart audits x 4 weeks and then monthly • Weekly med pass observations x 4 weeks and then monthly • WD or designee will pull missed med report and med pass status report daily for review and follow up • Resident responsible party and attending physician will be notified of any med errors and all will be documented in the	06/03/2026

	Based on interview and record review, the facility failed to ensure residents received the correct medication and dosage with each medication administration, followed the facility's policies and procedures related to medication administration, notified the resident's responsible party and attending practitioner of any errors with medication receipt and documented all medication errors in the resident's clinical record for 3 of 4 resident reviewed for Pharmacy Services. (Residents K, P and Q) Findings include: 1. In an interview with a family member of Resident Q on 5-12-26 at 1:40 p.m., the family member indicated they questioned Resident Q had received her thyroid medication as prescribe while at the facility. The faciliy staff indicated the resident's thyroid medication had been stopped on 2-6-26. On 5-8-26, the family member received a call from the resident's Nurse Practitioner who informed him "she had been taken off the thyroid medicine again, about 3 weeks prior. The resident's records looked like the thyroid medications had been stopped as of 4-22-26.		resident clinical record by licensed nurse • Weekly narcotic and narcotic log book audits 2 x weekly for 4 weeks, then 2 x weekly for 3 weeks, then 2 x weekly for 2 weeks, then weekly • Weekly wellness leadership meeting x 4 weeks and then monthly to review trending med incidents and provide follow up to reduce risk of recurrence • All new hires will be oriented to med cart/checked off for competency by a licensed nurse before they may work independently • Licensed nurse will put away all med deliveries and will not approve/confirm any new orders in PCC until the med have arrived to the community to check instructions on package against what the pharmacy has entered in PCC and the written order. Nurse will notify resident responsible party of all new orders/discontinued orders in the resident clinical chart, initial/date written copy, and place in resident hard chart • Any unavailable	

	The resident's medication administration record (MAR) for February 2026, indicated the resident was prescribed levothyroxine 100 micrograms (mcg) daily. The levothyroxine was administered from 2-1-26 through 2-6-26, when it was discontinued. There were no specific attending practitioner orders located to reflect who had discontinued this medication. A review of the MAR for February 2026, indicated the original order date as 1-26-26 and discontinued on 2-5-24, and she received this from 2-1-26 through 2-5-26. A second order of the same dose and frequency was initiated on 2-5-26 and discontinued on 2-6-26, with one dose administered on 2-6-26. The resident's MAR for March 2026, indicated the resident was prescribed levothyroxine 50 mcg daily as beginning on 3-1-26 and ending on 3-13-26. The levothyroxine was administered on 3-2-26 and 3-4-26 through 3-13-26, with no administration documented as administered on 3-3-26 as evidenced by the administration block on the MAR being blank. The corresponding progress notes for 3-2-26 documented Resident Q returned to the facility on 3-1-26, from a hospitalization with updated orders for "Synthroid [thyroid medication] 50 mcg due		medications will be investigated and corrected by licensed nurse • WD will review all completed narcotic proof of use sheets for potential trends and accuracy and will initial/date before placing in resident clinical record • Community will not accept medications from family without copy of the written order. Family will provide copy or community will call responsible pharmacy to have copy sent • All narcotics pill, tablet, caplet form will be in bubble packs per community policy • "Directions changed refer to MAR" stickers will be placed over any med order changes on the package instructions by licensed nurse * WD/designee responsible for all the above*	

	to thyroid levels." On 3-13-26, an order for levothyroxine 50 mcg daily was entered onto the MAR, without an end or discontinuation date. The administration blocks for 3-13-26 through 3-15-26 were blank, but the medication was documented as administered from 3-15-26 through 3-31-26. The resident's MAR for April 2026, indicated on 3-13-26, the resident had an order for levothyroxine 50 mcg daily entered onto the MAR, without an end or discontinuation date. The MAR reflected the resident received the medication from 4-1-26 through 4-9-26. On 4-8-26, the resident had an order for levothyroxine 75 mg daily entered onto the MAR with a discontinuation date of 4-21-26. The MAR reflected the resident's medication was received 4-9-26 through 4-21-26. On 4-9-26, the resident had an order for levothyroxine 112 mg daily was entered onto the MAR with directions to hold [not administer] on 4-13-26 and 4-14-26. A discontinuation date of 4-14-26 was present. The MAR reflected the medication was received 4-12-26 and 4-13-26. The MAR reflected Resident Q did not have any active orders to receive thyroid medication for			

	4-22-26 through 4-30-26, nor were any doses acknowledged as administered. A review of the progress notes for April, 2026 lacked any notations related to Resident Q's thyroid medications, including any notations related to receiving doses of 75 mcg and 112 mcg on 4-12-26 and 4-13-26, as evidenced by the administration blocks on those dates for both dates being filled in to document administration. The clinical record failed to identify if the attending provider had been notified or if a medication error was identified. The clinical record failed to identify any notations related to Resident Q failing to have active orders for administration for 4-22-26 through 4-30-26 or to identify if the attending provider notificaton. The MAR reflected Resident Q did not have any active orders to receive thyroid medication for 5-1-26 through 5-8-26, nor were any doses acknowledged as administered. The clinical record failed to identify if the attending provider had been notified or if a medication error was identified. On 5-8-26, the resident had an order for levothyroxine 75 mg daily entered onto the MAR with a discontinuation date of 5-11-26. The MAR reflected the resident received the medication			

	on 5-10-26 and 5-11-26. On 5-9-26, an order for levothyroxine 75 mg daily was entered onto the MAR with a discontinuation date of 5-9-26. The MAR reflected the resident received the medication on 5-9-26. In an interview with the Executive Director (ED) on 5-12-26 at 5:00 p.m., the Ed indicated she had been unaware of any issues with Resident Q's receipt of her thyroid medications. The Nurse Practitioner addressed her concerns on 5-8-26 related to Resident Q not receiving multiple doses of her thyroid medication, as well as the resident's family member's concerns related to the resident's lack of medication. The ED indicated she was unaware of LPN 3 filing any medication error reports. The Licensed Practical Nures (LPN) had discharged the resident's thyroid order and did not share that information with anyone. 2. During a medication pass observation on 5-11-26 at 12:45 p.m., with QMA 3 spoke with Resident P who indicated she was having significant pain in her right shoulder. The QMA contacted LPN 4 to seek approval to provide the resident's prn (as needed)			

	medication. The resident's medication administration record (MAR) indicated the resident was to receive oxycodone 5 milligrams (mg) every 4 hours as needed for pain. Upon obtaining the oxycodone from the locked area of the medication section of the medication cart, the QMA identified a discrepancy between the medication order and the label of the bottle as oxycodone 10 mg three times daily as needed for pain. The associated "Controlled Substance Proof-Of-Use Count Sheet (also known as a narcotic log or narcotic count sheet)," specified this medication's strength as 5 mg for prescription with 85 tabs received on 5-4-26. In an interview with QMA 3 on 5-11-26 at 2:46 p.m., the QMA indicated the family had brought the prescription pain medication into facility for Resident P and apparently a transcription error had occurred, related to the current order of 5 mg and bottle label indicating a strength of 10 mg. In an interview with LPN 4 on 5-11-26 at 3:15 p.m., the LPN indicated Resident P was a fairly new admission. She recalled QMA 3, had contacted her earlier that afternoon about			

	Resident P's orders for her oxycodone and the bottle label not being right. She shared she had reached out to the resident's medical provider and received updated orders and updated the paperwork by writing over the 5 mg to make it 10 mg. A review of Resident P's MAR for May 2026, indicated an order was received on 5-4-26, and discontinued on 5-11-26, for oxycodone 5 mg every 4 hours as needed for pain. A second order was received on 5-11-26, for oxycodone 10 mg every 4 hours as needed for pain. The administration blocks for both of these orders were empty, signifying these medications were not administered. The associated "Controlled Substance Proof-Of-Use Count Sheet (also known as a narcotic log or narcotic count sheet)," indicated doses of the oxycodone were administered on 5-5-26 at 7:00 p.m., on 5-6-26 at 8:00 p.m., 5-7-26 at 8:00 p.m., 5-8-26 at 8:00 p.m., 5-9-26 at 8:00 p.m., 5-10-26 at 8:00 p.m., 5-11-26 at 2:43 p.m. and at 8:00 p.m.			

	In an interview with the Executive Director on 5-12-26 at 5:00 p.m., the ED indicated the medication error reports have not been done like they should have. 3. The clinical record of Resident K was reviewed on 5-11-26 at 1:10 p.m. The resident's diagnoses included, but were not limited to, unspecified osteoarthritis, vertebral disc degeneration of the thoracic spine and vascular dementia. A review of Resident K's current physician order, dated 2-4-26, indicated the resident was prescribed hydrocodone/acetaminophen (pain medication) 10-300 mg (milligrams), 1.5 tablets, three times daily for pain. The resident's MAR for May 2026, indicated the resident's Hydrocodone/acetaminophen was to be administered every 8 hours, at 6:00 a.m., 2:00 p.m., and 10:00 p.m. The resident's MAR lacked administration of the residents hydrocodone/acetaminophen on 5/3/26 at 10:00 p.m. The resident's "Controlled Substance Proof-Of-Use Count Sheet," indicated the resident's hydrocodone/acetaminophen doses for 5-7-26 at 10:00 p.m.,			

	and 5-10-26 at 2:00 p.m., were not documented as signed for administration. On 5-12-26 at 12:45 p.m., the Executive Director provided a copy of a policy entitled, "General Medication Preparation, Assistance, Administration, and Observation," with a revision date of 5-4-22. This policy indicated its purpose as, "to prepare and administer medications in accordance with infection control principles and the give [sic] medication rights...Medication label is checked against the Medication Administration Record three times...to verify: Right Resident; Right Medication; Right Dose/Dosage Form; Right Route; Right Time....Meds administered shall be to [sic] the following: Right Resident; Right Medication; Right Dose/Dosage Form; Right Route; Right Time. On 5-12-26 at 12:45, the Executive Director provided a copy of a policy entitled, "Medication Administration," with a last review date of 4-11-22. This policy indicated, "Medication label is checked against the Medication Administration Record three times...to verify: Right Resident, Right Medication, Right Dose/Dosage Form, Right Route, Right Time...Medications			

	are administered in accordance with written orders of the attending healthcare provider." On 5-12-26 at 12:45, the Executive Director provided a copy of a policy entitled, "Controlled Substance," with a last review date of 7-30-25. This policy indicated its purpose as, "to outline expectations for controlled substances per regulatory standards regarding storage, administration, documentation, and destruction as well as minimize risk for drug diversion....State specific licensing regulations regarding controlled substances are to be followed...Immediately upon receipt of controlled substances from either pharmacy or other provider (family, hospice, etc.), the staff member receiving the medication shall count and verify the contents with the incoming provider. If unable to count with the incoming provider, contents shall be counted with another authorized staff member...Each controlled substance package shall have an individual corresponding Proof-Of-Use Count (POU) sheet. If more than one blister pack is received for the same medication, each blister pack shall be labeled with the package number. (Example: 1 of 3, 2 of 3, 3 of 3) and the Proof of Use Count sheets shall show the total count of			

	medication received. (Example: 90 tablets/3 blister packs.) When available, utilize the contracted pharmacy proof-of-use count sheet. If a pharmacy proof-of-use count sheet isn't available, initiate a numbered internal Proof of Use Count sheet. Place the Proof-of-Use Count Sheet in the Controlled Substance Binder/Log. Enter each controlled substance Inventory Log. Communities may not hold controlled substances in "overflow" storage...Only those permitted under Licensing rules and regulations and scope of practice may administer controlled substances...Controlled substance administration are documented on both the POU sheet and on the MAR for: Controlled substances administered by Community Staff; Controlled substances consumed via supervision with self-administration...As needed (PRN) controlled substance medication usage and medication effectiveness shall also be documented on the resident's chart. Completed Proof of Use Count Sheets are then kept in the resident chart...Any controlled substance that has been destroyed or sent home with the resident at time of discharge shall be documented on the Proof-of-Use Count sheet and			

	the Controlled Substance Transfer and Destruction Record. Each controlled substance shall have its own Proof-of-Use (POU) sheet and an inventory log shall be maintained...Any discrepancies that occur shall be immediately reported to the Wellness Director or Designee...For suspected drug diversion, an investigation shall be completed to determine the exact amount of medication missing and any other information to assess concerns of discrepancy...Authorized management and front-line staff members receive training regarding responsibilities for controlled substances during orientation or assumption of duties with controlled substance." On 5-12-26 at 12:45, the Executive Director provided a copy of a policy entitled, "Medication Error," with a last review date of 9-23-23. This policy indicated its purpose as, "to document, review, and report all identified medication errors to assure the most compliant environment and provide appropriate follow-up for the resident according to the type and severity of the medication incident...A medication error is defined as a failure to follow the healthcare prescriber's instructions when			

	administering a prescription medication, including;...Administration of the wrong dose of medication...Failure to prepare, store, or administer a medication with instructions of the manufacturer or the pharmacist; Failure to administer the medication as ordered; A variation from the healthcare provider orders...Medication incident/error is defined as any medication given or not given according to physician orders in regard to right resident, right medication, right dosage, right time, and right route. This also includes medications administered that are not in accordance with the manufacturer's directions in regard to preparation and administration or any prescribing or dispensing error...also identified if medication given was listed as a direct allergy, expired medication, or without a physician order. The resident's right to refuse will not be considered a medication incident. When a medication incident/error occurs, immediate action shall be taken as necessary to protect the resident's well-being...The resident's physician shall be notified of the medication incident promptly and staff shall implement instructions given by			

	the physician...The Wellness Leader or Designee shall be notified promptly...The resident or resident's designated representative shall be notified of the medication incident...The Administrator/Designee shall notify the Licensing Division according to licensing rules if the medication incident warrants. A medication error report form shall be completed. Document the medication incident in the resident's chart note section. Complete incident report when warranted. The Wellness Leader or Designee along with the safety committee shall be responsible for tracking/trending medication incidents and provide follow-up to reduce the risk of recurrence." This citation relates to Intakes 469355 and 469360.			
R 0300	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(4) (4) Over-the-counter medications, prescription drugs, and biologicals used in the facility must be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date.	R 0300	• Weekly med cart audits to include verification of properly labeled OTC medications to include the appropriate accessory and cautionary instructions and the expiration date per state regulation • Monthly inservice(s) to include proper labeling of OTC medications	06/03/2026

Based on observation, interview and record review, the facility failed to ensure proper labeling of an over-the-counter (OTC) medication was present for 1 of 5 residents observed for pharmacy services (Resident R)

Findings include:

During a medication pass observation with Qualified Medication Assistant (QMA) 3, on 5-11-26 at 1:55 p.m., the QMA prepared Resident R's medication administration. The QMA obtained a bottle of over the counter Tylenol gelcaps (pain medication) 500 milligrams (mg). The bottle lacked a resident's name or the ordering practitioner's name present on the bottle.

The Tylenol gelcaps manufacturer's instructions for use label indicated to take two (2) gelcaps every six (6) hours while symptoms last and do not take more than 6 capsules in a 24 hour timeline.

The attending practitioner's orders indicated the staff were to administer the resident 1000 mg (or two tablets) three times daily.

During an interview on 5-11-26 at 1:57 p.m., QMA 3 indicated the family had brought the medication into facility for Resident R's use and she was

	not aware of labeling requirements for OTC medications. On 5-12-26 at 12:45, the Executive Director provided a copy of a policy entitled, "Medication Administration," with a last review date of 4-11-22. This policy indicated, "Medication label is checked against the Medication Administration Record three times...to verify: Right Resident, Right Medication, Right Dose/Dosage Form, Right Route, Right Time...Medications are administered in accordance with written orders of the attending healthcare provider. This citation relates to Intakes 469355 and 469360. 2.5-6(c)(1) 2.5-6(c)(4) 2.5-6(c)(6)(A) 2.5-6(c)(6)(B)			

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 SIGNATUREAimee Baker	TITLERegional Wellness Director	(X6) DATE06/03/2026