STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	02/17/2026

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 Intake 467853. Intake 467853 - State Residential Findings related to the allegations are cited at R0036 and R0052. Survey dates: February 16 and 17, 2026 Facility number: 013945 Residential Census: 76 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on February 23, 2026.	R 0000		
R 0036	Residents' Rights- Deficiency 410 IAC 16.2-5-1.2(k)(1-2) (k) The facility must immediately consult the resident ' s physician and the resident ' s legal	R 0036	• . The community realizes that all residents have the potential to be affected by the alleged deficient practice.	03/31/2026

	representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on interview and record review, the facility failed to immediatly consult with the resident's responsible party when a cognitive impaired resident was taken out of the facility by a facility staff member, transported in a personal vehicle, and left unattended with the resident's cognitively impaired family member at a local hospital for 1 of 3 residents reviewed for resident rights. (Resident B) Findings include: On 2-1-26, the facility filed a reportable occurrence with the Indiana Department of Health's Long Term Care Division. This document indicated on 1-31-26 at approximately 10:30 p.m., CNA 3 "without authorization from management or family, transferred this resident [Resident B] from this community [sic] secured neighborhood [secured		• . Inservice for all staff on community's SOP for Resident Rights and Abuse & Neglect completed by the Wellness Team by 3/31/26 which includes but is not limited to the following: *Wellness Director/Designee immediately regarding Resident Rights or Abuse & Neglect violations. *Wellness Director/Designee to notify resident physician & legal representative of any Resident Rights or Abuse violations. • . Memory Care Neighborhood employees will not take any residents out of the locked unit and off community property without permission of legal representative.	

	dementia unit]. CNA [3] responded he was going to take resident to the hospital and leave him with his [family member] in the ER, resident's [family member] who also resides in community secured neighborhood was transported via ambulance d/t [due to] fall incident. CNA [3] also responded tha he did not care about rules and would take the hit for it. CNA [3] then left community grounds with resident in CNA [3]'s personal vehicle...Resident and spouse both reside in community secured neighborhood due to DX [diagnosis of] dementia." In an interview on 2-16-26 at 12:45 p.m., with the Executive Director [ED], she indicated CNA 3, on duty on the evening of 1-31-26, transported the resident to the hospital ER with his own vehicle without receiving permission from the facility management or with the family's approval. The CNA ended up leaving Resident B at the hospital without facility staff supervision. He then returned to work, where he was then sent home. In an interview with the ED and Wellness Director (WD) on 2-17-26 at 9:20 a.m., the ED indicated QMA 4 had notified the Responsible Party/Power of Attorney (POA) of Resident C,			

	Resident B's family member, regarding the fall incident and of plans to transport her to the local ER for further evaluation and treatment. However, the same Responsible Party/POA had not been notified of Resident B being taken out of the facility's secured dementia unit and facility, and then transported to the local ER. LPN 5 did document in Resident B's clinical record Resident B he had left the building with a CNA. However, there was a lack of documentation regarding when he returned or if there were any issues with his status post return. In an interview with Resident B's Responsible Party/POA on 2-17-26 at 10:22 a.m., he indicated he had not been notified on evening of 1-31-26, regarding Resident B having been transported to the same place to be with Resident C. He was very surprised and upset when he arrived around midnight at the ER and found Residents B there with no supervision from the facility's staff. "It was very cold outside. If he [Resident B] had attempted to go outside, he could have very easily gotten lost..." The clinical record for Resident B was reviewed on 2-16-26 at 12:07 p.m. His diagnoses included, but were not limited to			

	unspecified dementia and anxiety disorder. Resident B's admission wellness evaluation, dated 10-9-25, indicated he had limited safety awareness, required supervision when outside on campus grounds and may experience occasional confusion, forgetfulness or memory loss. A cognitive screening test, the Global Deterioration Scale, conducted on 10-10-25, indicated he had major memory deficits, disorientation to time and place, experienced difficulty with concentration, had diminished knowledge and memory related to current or recent events, had difficulty managing finances, had difficulty completing tasks and displayed denial about these symptoms, experienced difficulty finding the correct words, may get lost when in unfamilar locations, difficulty with retaining information. On 2-16-26 at 1:40 p.m., the ED provided an undated copy of a document entitled, "Resident Bill of Rights." This document indicated, "Residents have the right to have their rights recognized by the licensee [facility]...The facility must immediately consult the resident's...the resident's legal representative when the facility has noticed...a need to alter			

	treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment...Residents have the right to be free from...neglect." This citation relates to Intake 467853. 2.5-1.2(k)(2)			
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on interview and record review, the facility failed to ensure a resident was free from neglect when a staff member removed a cognitively impaired resident from a secured facility, transported the resident in the staff members personal vehicle, and left the resident unattended with another cognitively impaired resident at a local	R 0052	• . The community realizes that all residents have the potential to be affected by the alleged deficient practice. • . Inservice for all staff on community's SOP for Resident Rights and Abuse & Neglect completed by the Wellness Team by 3/31/26 which includes but is not limited to the following: *Wellness Director/Designee immediately regarding Resident Rights or Abuse & Neglect violations. *Wellness Director/Designee to notify resident physician & legal representative of any Resident Rights or Abuse violations. * Change of	02/26/2026

	hospital without the responsible part notification and/or timely notification of facility management for 1 of 3 residents reviewed for neglect. (Resident B) Findings include: On 2-1-26, the facility filed a reportable occurrence with the Indiana Department of Health's Long Term Care Division. This document indicated on 1-31-26 at approximately 10:30 p.m., CNA 3 "without authorization from management or family, transferred this resident [Resident B] from this community [sic] secured neighborhood [secured dementia unit]. CNA [3] responded he was going to take resident to the hospital and leave him with his spouse in the ER, resident's spouse who also resides in community secured neighborhood was transported via ambulance d/t [due to] fall incident. CNA [3] also responded that he did not care about rules and would take the hit for it. CNA [3] then left community grounds with resident in CNA [3]'s personal vehicle...Resident and spouse both reside in community secured neighborhood due to DX [diagnosis of] dementia." In an interview on 2-16-26 at 12:45 p.m., with the Executive Director (ED), she indicated a		Condition, Wandering or Exit Seeking.	

	CNA on duty on the evening of 1-31-26, informed the QMA on duty that he was taking Resident B to the hospital to be with his family member and he made it clear that he didn't care what the rules were about that happening. Apparently Resident B was saying he wanted to go to the hospital with his family member and the ambulance service could not take him to be with her. She indicated CNA 3 transported the resident to the hospital ER with his own vehicle without receiving permission from the facility management or with the family's approval. CNA 3 ended up leaving Resident B at the hospital without facility staff supervision. He then returned to work, where he was then sent home. The facility communicated with CNA 3 on 2-1-26, to explain to him that he was suspended, pending the results of our investigation. "We ended up terminating him for not following policies. He apparently did not understand that we have rules and regulations for a reason. Nor did he seem to acknowledge the resident was on a secured dementia unit for a reason. The CNA even said to the QMA that he did not care about rules and would take the hit for it." She added CNA 3 then returned to work and was sent home. The ED had not learned about any of this until the next day, on 2-1-26. "I			

understand he may have been compassionate about what the resident was saying [regarding wanting to be with his family member], but we do have rules for a reason. He told the QMA that he was taking the resident to the ER to be with his [family member], who also resided on the secured memory care unit and was going to leave [name of Resident B with his family member] there. [Name of Resident B] ended up being brought back to the facility by a family member."

In an interview with the ED and Wellness Director (WD) on 2-17-26 at 9:20 a.m., the ED indicated QMA 4 had notified the Responsible Party/Power of Attorney (POA) of Resident C on 1-31-26, Resident B's family member, regarding the fall incident and of plans to transport her to the local ER for further evaluation and treatment. However, the same Responsible Party/POA had not been notified of Resident B being taken out of the facility's secured dementia unit and facility and then transported to the local ER. LPN 5 did document in Resident B's clinical record Resident B had left the building with a CNA. However, there was a lack of documentation regarding when Resident B returned to the facility or if there were any

issues with his status post return.

The WD indicated there was some confusion and question regarding the accuracy of LPN 5's documentation, dated 1-31-26 at 10:45 p.m. The ED interjected, "As I said, [the WD] and myself were not made aware of any issues going on with [name of Resident B] until the next day, even though the [nursing progress] note says that we were notified the evening before [1-31-26]. The author of the note was [name of] LPN 5." The ED indicated she was not sure if the facility had a specific policy regarding notification of change or for unusual occurences, "my expectation is the employee would call me, not text me, of any change in condition or unusual occurrence." The ED added she was notified of the events of 1-31-26 at 8:47 a.m., with Resident B, by the Regional Wellness Director.

In an interview with Resident B's Responsible Party/POA (power of attorney) on 2-17-26 at 10:22 a.m., he indicated he had been notified on evening of 1-31-26, regarding Resident C having a fall and was going to be sent out to the local ER for further assessment and evaluation. He added he was not informed of Resident B going to be

transported to the same place to be with Resident C. He was very surprised and upset when he arrived around midnight at the ER and found Residents B and C there with no supervision from the facility's staff. "It was very cold outside. If he [Resident B] had attempted to go outside, he could have very easily gotten lost and froze to death." The hospital staff asked him when he arrived if he was a family member and if he could return Resident B to the facility. He was unable to find out how long Resident B had been at the hospital ER from hospital staff.

In an interview with the facility secured memory care director on 2-16-26 at 2:32 p.m., she indicated she had found a text message on her phone from CNA 3 on 2-1-26 between 11:00 a.m. and noon. Her cell phone indicated the text message had been sent on 1-31-26 at 10:54 p.m. The text message had a photograph attached of Resident B sitting in an empty waiting area that she presumed was the local ER. The message indicated Resident C had a fall at the facility and "she's being brought to [name of local hospital]. I'm staying with [name of Resident B] until [name of Resident C] gets here." When she found the text message, she immediately notified the Regional Wellness Director of

the situation by phone.

The clinical record for Resident B was reviewed on 2-16-26 at 12:07 p.m. His diagnoses included, but were not limited to unspecified dementia (mental decline) and anxiety disorder. Resident B's admission wellness evaluation, dated 10-9-25, indicated he had limited safety awareness, required supervision when outside on campus grounds and may experience occasional confusion, forgetfulness, or memory loss.

A cognitive screening test, the Global Deterioration Scale, conducted on 10-10-25, indicated Resident B had major memory deficits, disorientation to time and place, experienced difficulty with concentration, had diminished knowledge and memory related to current or recent events, had difficulty managing finances, had difficulty completing tasks and displayed denial about these symptoms, experienced difficulty finding the correct words, may get lost when in unfamiliar locations, difficulty with retaining information.

In an interview with Residents B and C on 2-16-26 at 2:05 p.m., neither resident was able to recall being at the local ER in the last month.

A review of CNA 3's employee record was conducted on 2-16-26, indicated he had been employed by the facility for over one year. His most recent training on abuse prohibition was on 1-9-26 and his most recent training on resident rights, including neglect, was on 12-29-25.

A review of QMA 4's employee record was conducted on 2-16-26, indicated she had been employed by the facility for over one year. Her most recent training on abuse prohibition was on 1-9-26 and her most recent training on resident rights, including neglect, was on 8-6-25.

A review of LPN 5's employee record on 2-16-26, indicated she had been employed by the facility for over nine months. Her most recent training on abuse prohibition and on resident rights, including neglect, was on 5-14-25.

On 2-16-26 at 1:40 p.m., the ED provided an undated copy of a document entitled, "Resident Bill of Rights." This document indicated, "Residents have the right to have their rights recognized by the licensee [facility]...The facility must immediately consult the resident's physician and the resident's legal representative when the facility has noticed...a

	need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment...Residents have the right to be free from...neglect." On 2-17-26 at 9:20 a.m., the ED indicated she was not sure if the facility had a specific policy regarding notification of change or for unusual occurrences, "my expectation is the employee would call me, not text me, of any change in condition or unusual occurrence." This citation relates to Intake 467853. 2.5-1.2(v)(5)			

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 SIGNATUREAndrea Lake	TITLEExecutive Director	(X6) DATE03/09/2026