STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	09/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDEPENDENCE VILLAGE OF ZIONSVILLE WEST	6800 CENTRAL BOULEVARD, ZIONSVILLE, , 46077

(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 IN00464355. Complaint IN00464355 - State deficiencies related to the allegations are cited at R0052. Survey date: September 16, 2025 Facility number: 014059 Residential Census: 61 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on September 25, 2025.	R 0000	Submission of this plan of correction shall not constitute or be construed as an admission by Independence Village of West Zionsville that the allegations contained in this survey report are accurate or reflect accurately the provision of services to residents of Independence Village of West Zionsville.	
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;	R 0052	What corrective action(s) will be accomplished for those resident(s) found to be affected by the deficient practice(s)? Staff member involved	10/17/2025

	(2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on observation, interview, and record review, the facility failed to prevent staff-to-resident physical abuse when a Certified Nursing Aide (CNA) pulled a resident by his legs and forcefully pushed the resident's legs down off the bed for 1 of 3 residents reviewed for abuse (Resident B). Findings include: A Facility Reported Incident (FRI), dated 8/23/25 at 11:55 a.m., indicated a resident representative reported seeing CNA 4 on an in-room camera grabbing, being physically aggressive, and using abusive language towards Resident B, who was refusing care. CNA 4 was suspended pending investigation and did not return. On 9/16/25 at 10:50 a.m., Resident B was observed lying on his bed sleeping while housekeeping staff cleaned his room. On 9/16/25 at 11:29 a.m., Resident B was observed lying		immediately removed from the community upon notification of the incident. Staff member has been terminated and has not returned. Resident examined for signs of injury and interviewed for signs of psychosocial impact. No signs of distress or injury noted in the initial or follow-up assessments. In subsequent investigation, no other resident showed signs of distress or injury. What measures will be put in place or what systemic changes will the facility make to ensure that the deficient practice(s) does not recur? All care staff are inserviced on resident’s rights and abuse detection and prevention prior to working with residents and annually therafter. All care staff will be inserviced in-person on resident’s rights, and abuse detection and prevention, with emphasis on appropriate approach when residents refuse or resist care and strategies for managing potential feelings of frustration.	

	on the bed sleeping, the door to his room closed. Resident B's clinical record was reviewed on 9/16/25 at 10:15 a.m. Diagnoses on Resident B's profile included Alzheimer's disease. A service plan report, admission date 6/9/25, indicated Resident B required assistance with redirection due to occasional confusion, deficits in judgement, and wandering. The resident was independent with tasks related to transfers, ambulation and toileting, and required reminders to get around the community. A late entry progress note created by the Wellness Director on 8/25/25 at 12:29 p.m., indicated on 8/23/25 at 11:56 a.m. a head-to-toe assessment was completed on Resident B. There were no bruises or injuries noted, and no psych-social distress. The resident was sitting in the dining room with family and eating his lunch. Resident B did not recall the incident, however the resident kept apologizing and stating he was sorry for anything that he had done wrong. A late entry progress note created by the Wellness Director on 8/28/25 at 7:24 p.m., indicated on 8/25/25 at 9:21 a.m., Resident B was sitting in		How will the corrective action(s) be monitored to ensure that the deficient practice(s) will not recur? Wellness Director or designee will ensure and document that all current and future care staff are inserviced on resident's rights and abuse detection and prevention prior to working with residents and annually thereafter; and that care staff is trained on appropriate approach when residents refuse or resist care and strategies for managing potential feelings of frustration.	

	the common area observing an activity with another male resident. The resident's vital signs were within normal limits, and he denied pain or discomfort. There were no signs or symptoms of psych social distress. A progress note, dated 8/28/25 at 8:30 a.m., indicated Resident B was assisted up for breakfast. He was alert to name, had no complaints of pain or discomfort, his vital signs were within normal limits, and he was ambulating independently. The resident tolerated care from staff for activities of daily living (ADLs), oral intake of food and medications, and was sitting at the table socializing with other residents. There were no signs or symptoms of psycho-social distress noted. On 3/24/25, CNA 4 signed and dated forms that included, an Understanding Abuse form, a Resident Rights Acknowledgment form, and an Employee Handbook training acknowledgement regarding Residents' Rights and Preventing, Recognizing, and Reporting Abuse.			

Nine (9) Certificates of Completion, dated 4/18/25 and 4/19/25, indicated CNA 4 had completed electronic education regarding abuse, dementia care, and resident rights.

A Corrective Action Form, dated 8/26/25, indicated CNA had been terminated due to refusal to follow instructions, breach of company rules, unsatisfactory performance, carelessness, and the employee physically abused a resident. The employee documented, "We had a meeting, and we disagree with what took place. I was not allowed to see the video. I had asked for help multiple times and no one did."

Witness statements, dated 8/29/25, from CNAs 7, 8, 9, 10, and 11, indicated they had not witnessed abuse in the memory care unit.

Review of video cam footage of interaction between Resident B and CNA 4, the ED indicated was dated 8/23/25, included,

a. CNA 4 was observed standing beside Resident B as he lay on the bed. There was no audio, but CNA 4 could be seen talking with the resident, shaking her head repeatedly. On 3 occasions CNA 4 was observed to take a hold of Resident B's ankles and pull them over the side of the bed

and push down.

b. CNA 4 was observed to exit and enter the room while the resident was lying on the bed. CNA 4 and Resident B could be seen having a conversation, with her shaking her head in the negative several times. CNA 4 was observed to take hold of the resident's wrists several times as the resident sat on the edge of the bed moving his hands in attempts to avoid her touch, and put her hand behind his shoulder as she pushed forward urging him to stand up, which he did not. While the resident was lying on the bed, CNA 4 was observed to pull the resident's legs off the bed and push them downward in attempts to get the resident to sit up, which he did twice, then he lay back down. Once after the resident was coaxed into a sitting position on the side of the bed, as CNA 4 attempted to put shoes on the resident, Resident B kicked out at her, then lay back down on the bed.

c. Resident B was observed walking towards the bathroom, then back towards his bed as CNA 4 re-entered the resident's room. CNA 4 took a hold of the resident's right hand, and he took a hold of her left wrist as she attempted to guide/push him back towards the door, and the resident was attempting to break her hold on him and walk

toward the bed. Frustration could be seen on CNA 4's face as she gestured towards the doorway and spoke with the resident for almost 2 minutes while the resident sat on the edge of the bed.

An attempt to contact CNA 4 for an interview during the survey process was unsuccessful.

During an interview on 9/16/25 at 10:52 a.m., the Life Enrichment Lead for the secured memory care unit, indicated to her knowledge Resident B did not have behaviors towards others, but it had been difficult to get him to come out of his room to attend any activity except those involving crafts and food.

During an interview on 9/16/25 at 11:01 a.m., QMA 13 indicated to her knowledge Resident B did not have behaviors, he was just slow to respond.

During an interview on 9/16/25 at 11:05 a.m., CNA 6 indicated Resident B did not have behaviors towards others. She had not been told about any abuse happening in the memory care unit, but if she did receive a report of abuse, she would immediately report that information to the management staff.

During an interview on 9/16/25 at 11:07 a.m., CNA 7 indicated

Resident B did not have behaviors. She had not received any reports of abuse from residents, family members, or other staff. If a report of abuse came to her, she would tell the Wellness Director.

During an interview on 9/16/25 at 12:23 p.m., a resident representative for Resident B indicated, on the morning of 8/23/25 she had received multiple alerts/phone notifications in a row, so she opened the video app on her cellphone, and she observed Resident B lying in bed and CNA 4 attempting to get the resident out of bed for about 40 minutes. There were at least 6 observations where CNA 4 "forced the resident's legs down to the side of the bed" in attempts to get him to sit up and he would lay back down. At one point, CNA 4 left the room and the resident got up and was seen going towards the bathroom. When Resident B was returning from the bathroom, CNA 4 re-entered the room, and as Resident B attempted to pass her to go back to bed, either she or he grabbed the other's arm, and they had a "little skirmish." There was no audio, but the resident could be seen getting upset and moving his head, he did not want to go to the dining room. The resident representative indicated that

she then went into the facility to check on the resident and make sure he was okay. Qualified Medication Aide (QMA) 12 was informed of what had been observed on the video cam, shown the video, and told that Resident B had always been a night owl and he did not have to get up in the morning for breakfast if he did not want to. QMA 12 called the Wellness Director to report the incident and the family member's concerns. The resident representative indicated, Resident B was normally a calm person, and she could not see him acting out with others unless provoked.

During an interview on 9/16/25 at 2:16 p.m., the Wellness Director indicated, on Saturday 8/23/25, she had received a call from QMA 12 to inform her a resident representative for Resident B had seen something on a video camera and came into the facility to report. The resident representative was upset and crying. QMA 12 indicated she had seen the recording and it was concerning as CNA 4 was seen "roughing up the resident." CNA 4 had been walked out of the facility by QMA 12 at the Wellness Director's request. CNA 4 had then texted the Wellness Director and indicated she did not know what had happened, she just got frustrated with

Resident B. The Wellness Director informed CNA 4 that she was suspended at that time, and the Executive Director (ED) was notified of the incident immediately. The Wellness Director indicated she had not seen the video, but CNA 4 had confirmed she had been attempting to pull Resident B by the legs/ankles out of the bed, was pushing him/trying to shove him out of the door, and when she was unsuccessful she got angry, hit him on the arm and walked out of the room. The Wellness Director indicated staff who worked in the memory care unit indicated Resident B had no behaviors, was sweet, and they were upset on his behalf regarding the situation.

During an interview on 9/16/25 at 2:16 p.m., the Wellness Director indicated, all staff who were hired to work in the memory care unit were educated regarding abuse live upon hire and bi-annually, and again quarterly using an electronic education program. On 9/1/25 an in-person abuse education/in-service was provided for all staff to discuss the incident with Resident B, get staff statements, and to assure all staff were informed regarding abuse.

During an interview on 9/16/25 at 2:41 p.m., the ED indicated, on 8/23/25 he was informed

Resident B's representative had seen a situation on a video cam application and reached out to the community. The resident representative had provided the video footage to the ED in 3 separate e-mails due to the size of the content. The ED indicated Resident B had not been hurt, but the situation was so straight forward CNA 4 had been immediately terminated for physical abuse. Employees were educated on abuse upon hire, and at lease annually.

On 9/16/25 at 5:25 p.m., the ED provided an Abuse, Neglect, or Exploitation policy, last updated 6/7/23, and indicated the policy was the one currently being used by the facility. The policy indicated, "Abuse, neglect, or exploitation of any resident will not be tolerated ...If a staff member is accused or suspected of abuse, neglect, or exploitation, the staff member will be immediately removed from the community and work schedule pending the outcome of the investigation ..."

This State citation relates to Intake IN00464355.

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resident's legs down off the bed for 1 of 3 residents reviewed for abuse (Resident B).

Findings include:

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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 SIGNATUREJim	TITLEGepp	(X6) DATE10/09/2025