

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/31/2023	
NAME OF PROVIDER OR SUPPLIER INDEPENDENCE VILLAGE OF ZIONSVILLE WEST		STREET ADDRESS, CITY, STATE, ZIP CODE 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 a Post Survey Revisit (PSR) to Investigation of Complaint IN00411530 completed on June 30, 2023. Complaint IN00411530-Corrected Survey dates: August 31, 2023 Facility number: 014059 Residential Census: 45 Independence Village Zionsville West was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to Investigation of Complaint IN00411530. Quality review completed on September 1, 2023. This visit was for a Post Survey Revisit (PSR) to Investigation of Complaint IN00411530 completed on June 30, 2023.	R 0000					

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

	Complaint IN00411530-Corrected Survey dates: August 31, 2023 Facility number: 014059 Residential Census: 45 Independence Village Zionsville West was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to Investigation of Complaint IN00411530. Quality review completed on September 1, 2023.			
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.	R 0052		
R 0090	Administration and Management - Deficiency 410 IAC 16.2-5-1.3(g)(1-6)	R 0090		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

(g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following:

(1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to:

(A) epidemic outbreaks;

(B) poisonings;

(C) fires; or

(D) major accidents.

If the division cannot be reached, a call shall be made to the emergency telephone number published by the division.

(2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative.

(3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility.

(4) Ensuring the facility maintains, on the premises, an accurate

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

record of actual time worked that indicates the:

(A) employee's full name; and

(B) dates and hours worked during the past twelve (12) months.

(5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability.

(6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request

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