STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
INDEPENDENCE VILLAGE OF AVON	182 S COUNTY ROAD 550 E AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: May 28 and 29, 2025 Facility number: 003902 Residential Census: 66 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on June 5, 2025.	R 0000	ATT: Suzanne Williams Director of Division Long Term Care 2 North Meridian Street Indianapolis, Indiana 46204 Re: State Residential Licensure Survey Independence Village of Avon 182 S County Road 550 E Avon, IN 46123 Dear Ms. Suzanne Williams, On May 29, 2025, a State Residential Licensure (ID 3Z6T11) Survey was conducted by the Indiana State Department of Health. Enclosed please find the Statement of Deficiencies with our facilities Plan of Correction for the alleged deficiency.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Romeo Behl	Executive Director	06/12/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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			Please consider this letter and Plan of Correction to be the facility's credible allegation of compliance. We respectfully request a desk review to ensure that the facility has achieved substantial compliance with the applicable requirements as of the date set forth in the Plan of Correction of June 29th, 2025. Please feel free to call me with any further questions at 317-745-2766. Respectfully submitted, Romeo Behl Independence Village of Avon 182 S County Road 550 E Avon, IN 46123	
R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance Based on record review and interview, the facility failed to ensure new employees received a health screen, separate from a tuberculosis (TB) test for 3 of 5 newly hired employee record reviewed.	R 0121	**R121 Personnel – noncompliance** **The facility requests paper compliance for this citation.**	06/29/2025

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	Findings include: On 5/2925 at 9:30 a.m., five new employee records were reviewed. Certified Nursing Aide (CNA) 7 was hired on 2/10/25. Qualified Medication Assistant (QMA) was hired on 7/20/24. Life Enrichment Assistant 9 was hired on 2/6/25. The employee files lacked documentation of a health screen to rule out infectious disease (other than TB) and/or infectious skin lesions. During an interview on 5/25/25 at 11:59 a.m., the Executive Director (ED) indicated the facility did not conduct a separate health screen for new employees and the TB skin tests were considered sufficient for the health screen. The ED indicated there was not a specific policy for new hire procedures. The ED provided documentation, "Employee Foodborne Illness/Communicable Disease Reporting Agreement."		***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** **1) Immediate actions taken for those Employees identified:** Audit all associates for missing health screening separate from tuberculosis (TB). WD/AWD/ or Licensed nurse will complete all associates' health screening who are missing their health screening separate from TB. All health screenings are separate from TB completed by 6/29/25. ***2)How the facility identified other residents:*** Any resident residing in the facility had the potential to be affected. **3)Measures put into place/ System changes:** WD/AWD or/ Licensed nurse will complete all associates' health screening who are missing their health screening separate from TB. All new hires' health screenings separate from TB test	

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			will be completed and reviewed by WD/ AWD/ or licensed nurses before their start date. WD/designee will review 3 employee files 1x weekly x 4 weeks, then 2 employee files 1 x weekly for 4 weeks and then I employee file 1x weekly 1 month to ensure all health screenings separate then TB test is conducted for compliance. **4)How the corrective actions will be monitored:** ED/Designee will be responsible for this plan of correction and Audit findings will be presented to the department heads' meeting once a month x 6 months. The results of these audits will be reviewed in the Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. **5) Date of compliance: 6.29.25**	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency Based on record review and interview, the facility failed to obtain signatures of the resident and/or family representative on their service plans for 4 of 7 residents reviewed (Resident 3, 4, 5, 8). Findings include:	R 0217	**R217 Evaluation-Deficiency** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of***	06/29/2025

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	1. On 5/28/25 at 1:30 p.m., a record review was completed for Resident 3. She had the following diagnoses which included but were not limited to Alzheimer's disease, major depression disorder, and hyperlipidemia (high cholesterol). Her last service plan was signed on 1/31/24. 2. On 5/28/25 at 1:45 p.m., a record review was completed for Resident 4. He had the following diagnoses which included but were not limited to mild cognitive impairment (memory loss) and dry eye syndrome. His last signed service plan was on 6/11/24. 3. On 5/28/25 at 2:00 p.m., a record review was completed for Resident 5. She had the following diagnoses which included but were not limited to insomnia, dysphagia (difficulty swallowing), and major depressive disorder. Her last service plan was signed on 619/24. On 5/29/25 at 11:59 p.m., the Wellness Director indicated the facility did not have every service plan signed when they were completed. The only service plans that got signed were for significant changes. A policy titled, "Resident Evaluation and Service Plan" was provided by the Wellness Director on 5/29/25 at 10:18 a.m. It indicated, " ...Service plans are to be maintained in the resident's electronic health record (eHR)-upload the signed copy in the eHR ....".		***this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** ***1)Immediate actions taken for those residents identified:*** Residents 3 and 4 are no longer reside in the community. Resident 5's service plan has been signed by the resident and documented as per the company policy. ***2)How the facility identified other residents:*** Any resident residing in the facility had the potential to be affected. WD re-educated all Resident evaluation and service plans must be signed by the resident and/or family representative. **3)Measures put into place/ System changes:** WD/Designee will Audit all service plans 3 times weekly x 4 weeks, then 2 x weekly for 4 weeks and then 1x weekly 1 month to ensure all resident evaluations and service plans are signed accurately and documented as per policy. **4)How the corrective actions will be monitored:** ED/Designee will be responsible for this plan of correction and Audit findings will be presented to the department heads' meeting	

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			once a month x 6 months. The results of these audits will be reviewed in the Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. **5) Date of compliance: 6.29.25**	