STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/08/2025		
	NAME OF PROVIDER OR SUPPLIER INDEPENDENCE VILLAGE OF CARMEL			STREET ADDRESS, CITY, STATE, ZIP COD 13390 N ILLINOIS STREET CARMEL, IN 46032			
(X4) ID PREFIX TAG R 0000	(FACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTIO)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓΕ	(X5) COMPLETION DATE		
Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00453792. Complaint IN00453792-No deficiencies related to the allegations are cited. Survey dates: April 7 and 8, 2025 Facility Number: 013297 Residential Census: 65 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on April 11, 2025.		R 0	R 0000			
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance Based on interview and record review, the facility failed to ensure an attempt was made to hold the fire and disaster drills in conjunction with the local fire department at least every 6 months. This deficiency had the potential to affect 65 of 65 residents who resided in the facility. Findings include: On 4/7/25 at 10:50 a.m., documents of the facility held fire drills were reviewed from February 2024 to March 2025. The documents did not indicate the facility had invited the local fire department to any fire drills held between February 2024 to March 2025.		R 00	092	R 092 Administration and Management Preparation and/or execution of this plan of correction does no constitute admission or agreer by the provider that a deficience exists. This response is also not be construed as an admission of fault by the facility. This plan correction is submitted as the facility's credible allegation of compliance. Independence Village of Carmensures that the facility conductive and disaster drills at least every six months.	t ment cy oot oon n of	04/24/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Dana Larson Executive Director 04/24/2025

Any defiency statement 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.

State Form Event ID: NQ9811 Facility ID: 013297 If continuation sheet Page 1 of 14

PRINTED: 04/29/2025 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/08/2025			
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 13390 N ILLINOIS STREET CARMEL, IN 46032					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE			
TAG	During an interview Maintenance Direct department had not in the past year. He supposed to be invented to be invented and interview Executive Director all state regulations. During an interview Executive Director and interview Executive Director Executive Director Directo	w, on 4/7/25 at 11:00 a.m., the stor indicated the local fire to been invited to any fire drills was unaware the facility was iting them at least every 6 w, on 4/8/25 at 8:30 a.m., the indicated the facility followed s. w, on 4/8/25 at 12:48 p.m., the indicated the facility did not ding fire department invites to	TAG	The Corrective Actions which were accomplished for those residents were found to been affected by the deficien practice. No residents were affected the deficient practice. How the facility will ider other residents having the potential to be affected by the same deficient practice and vocrrective action will be taker. An ad hoc safety/quality meeting was held with all department leaders to discust deficient practice. All residents could be affected by the fire department not be invited to attend fire and disa drills at least every six month. The Maintenance Director received in servicing from the Executive Director that an att must be made to hold the fire disaster drills in conjunction with local fire department at leevery 6 months. Communication with the Fin Department on Monday April verified that they received ou invitation, and the community informed that they will not be to attend. The next invite has been	b have t by httify e what h: s the ted ing ster s. e empt e and with east re 14th r was			
				scheduled on the calendar to sent in the month of October 2025. A reminder to send the invi- has been added to the TELS				

State Form Event ID: NQ9811 Facility ID: 013297 If continuation sheet Page 2 of 14

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 04/08/2025		
		STREET ADDRESS, CITY, STATE, ZIP COD 13390 N ILLINOIS STREET CARMEL, IN 46032				
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE		
	• •		technology-based system utilize by the building which is a platfer for streamlining building management processes and ensuring life safety in senior live communities. The Corporate Office has not added a reminder to the Safety Calendar for the months of April and October to ensure that compliance continues. Compliance Date: 4/24/2025	ring w		
Based on record rev failed to ensure staf of cardiopulmonary validation training i applicable state law the 14 (12-hour shif aid. (3/30/25 to 4/5/Findings include: On 4/8/25 at 12:45 schedule, from 3/30 The schedule did not certified worked in 7:00 p.m. to 7:00 a.: The schedule did not certified in first aid any shift from 3/30/Puring an interview.	view and interview, the facility if on duty met the requirements resuscitation (CPR) skills in accordance with the s and first aid training for 14 of its) reviewed for CPR and first (25) p.m., the "as worked" facility (25 to 4/5/25, was reviewed. of indicate a staff member CPR the facility on 4/2/25 during the m. shift. of indicate a staff member worked in the facility during (25 to 4/5/25.	R 0117	R 117 Personnel - Deficiency Preparation and/or execution of this plan of correction does not constitute admission or agreen by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility. This plan correction is submitted as the facility's credible allegation of compliance. Independence Village of Carm ensures that the facility ensure staff on duty meet the required requirements. The Corrective Actions which were accomplished for those residents were found to been affected by the deficient practice. No residents were affected by the deficient practice.	t nent cy ot on of el es		
	PROVIDER OR SUPPLIER NDENCE VILLAGE SUMMARY: (EACH DEFICIEN REGULATORY OR 410 IAC 16.2-5-1. Personnel - Defici Based on record reversal failed to ensure staff of cardiopulmonary validation training is applicable state law the 14 (12-hour shift aid. (3/30/25 to 4/5/45). Findings include: On 4/8/25 at 12:45 schedule, from 3/30. The schedule did not certified worked in 7:00 p.m. to 7:00 a. The schedule did not certified in first aid any shift from 3/30/45.	PROVIDER OR SUPPLIER NDENCE VILLAGE OF CARMEL SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 410 IAC 16.2-5-1.4(b) Personnel - Deficiency Based on record review and interview, the facility failed to ensure staff on duty met the requirements of cardiopulmonary resuscitation (CPR) skills validation training in accordance with the applicable state laws and first aid training for 14 of the 14 (12-hour shifts) reviewed for CPR and first aid. (3/30/25 to 4/5/25)	PROVIDER OR SUPPLIER STREET 13390 CARM SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 410 IAC 16.2-5-1.4(b) Personnel - Deficiency Based on record review and interview, the facility failed to ensure staff on duty met the requirements of cardiopulmonary resuscitation (CPR) skills validation training in accordance with the applicable state laws and first aid training for 14 of the 14 (12-hour shifts) reviewed for CPR and first aid. (3/30/25 to 4/5/25) Findings include: On 4/8/25 at 12:45 p.m., the "as worked" facility schedule, from 3/30/25 to 4/5/25, was reviewed. The schedule did not indicate a staff member CPR certified worked in the facility on 4/2/25 during the 7:00 p.m. to 7:00 a.m. shift. The schedule did not indicate a staff member certified in first aid worked in the facility during any shift from 3/30/25 to 4/5/25. During an interview, on 4/8/25 at 1:03 p.m., the	PROVIDER OR SUPPLIER NDENCE VILLAGE OF CARMEL SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY PLLL REGULATORY OR LSC IDENTIFYING INFORMATION TAG TO STREET ADDRESS, CITY, STATE, ZIP COD 13390 N ILLINOIS STREET CARMEL, IN 46032 TECHNOLOGY DESCRIPTION OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY PLLL REGULATORY OR LSC IDENTIFYING INFORMATION TAG TO STREET CORMEL, IN 46032 TECHNOLOGY-based system utiliz by the building which is a plate for streamlining building management processes and ensuring life safety in senior lik communities. The Corporate Office has no added a reminder to the Safety Calendar for the months of Ap and October to ensure that compliance continues. Compliance Date: 4/24/2025 410 IAC 16.2-5-1.4(b) Personnel - Deficiency Based on record review and interview, the facility failed to ensure staff on duty met the requirements of cardiopulmonary resuscitation (CPR) skills validation training in accordance with the applicable state laws and first aid training for 14 of the 14 (12-hour shifts) reviewed for CPR and first aid. (3/30/25 to 4/5/25) Findings include: On 4/8/25 at 12-45 p.m., the "as worked" facility schedule, from 3/30/25 to 4/5/25, was reviewed. The schedule did not indicate a staff member certified in first aid worked in the facility on the facility during any shift from 3/30/25 to 4/5/25. During an interview, on 4/8/25 at 1:03 p.m., the		

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PRINTED: 04/29/2025 FORM APPROVED OMB NO. 0938-039

	IENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTR. A. BUILDING OC B. WING		onstruction 00	(X3) DATE SURVEY COMPLETED 04/08/2025			
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 13390 N ILLINOIS STREET CARMEL, IN 46032				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
	Executive Director all state regulations A current facility por Requirements," data received from the Editor 1:08 p.m., indicated number, qualification twenty-four (24) hours cheduled needs provided A minim	or, on 4/8/25 at 8:30 a.m., the indicated the facility followed blicy, titled "Staffing ed as last reviewed 2/21/23 and executive Director on 4/8/25 at 1"Staff shall be sufficient in lons, and trainingto meet the lours scheduled and of the residents and services for a sum of one (1) awake staff t CPR and first aid certificates,			How the facility will ident other residents having the potential to be affected by the same deficient practice and w corrective action will be taken: An ad hoc safety/quality meeting was held with all department leaders to discuss deficient practice. All residents could be affected by not always having a staff member on duty that is up to dwith CPR and First Aid Certification The Wellness Director or his designee is conducting audits all schedules to ensure that it indicates that a CPR certified member is always on the schedule. A continuous auditing proceinas been created by the Exect Director to ensure compliance ensuring that a staff member iduty that is up to date with CP and First Aid Certification Any deficiencies noted during internal audits will be addresse the monthly safety/quality meeting. Mandatory CPR and First Aid Certification classes have been scheduled at the community for Wellness staff on May 6, May and May 9th. Compliance Date: 5/10/2025	the ed date /her of staff ss utive with s on R g ed at d n or all	

State Form Event ID: NQ9811 Facility ID: 013297 If continuation sheet Page 4 of 14

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING B. WING	onstruction (00	X3) DATE SURVEY COMPLETED 04/08/2025	
		STREET ADDRESS, CITY, STATE, ZIP COD 13390 N ILLINOIS STREET CARMEL, IN 46032			
(EACH DEFICIEN REGULATORY OF	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	(X5) COMPLETION DATE	
	• •				
failed to ensure a st current state certific reviewed who required (QMA 6) Findings include: The employee reconstruction of the employee reconstruction of 12/17/24 The facility schedulindicated QMA 6 where the facility schedulindicated Q	aff member maintained a cation for 1 of 51 employees ired a license or certification. and the description of the description o	R 0118	R 118 Personnel - Deficiency Preparation and/or execution of this plan of correction does not constitute admission or agreemely the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility. This plant correction is submitted as the facility's credible allegation of compliance. Independence Village of Carme ensures that the facility ensures that all staff maintains a current state certification. The Corrective Actions which were accomplished for those residents were found to been affected by the deficient practice. No residents were affected by the deficient practice. How the facility will identife other residents having the potential to be affected by the same deficient practice and wh corrective action will be taken: An ad hoc safety/quality meeting was held with all department leaders to discuss deficient practice. All residents could be affected by a QMA on staff who do not have a current certification. The Executive Director has	nent y out on of el s t t nave y fy at the d	
_			The Executive Director has completed an audit of all licens	ed	
	PROVIDER OR SUPPLIEF NDENCE VILLAGE SUMMARY (EACH DEFICIEN REGULATORY OF 410 IAC 16.2-5-1. Personnel - Defici Based on interview failed to ensure a st current state certific reviewed who requi (QMA 6) Findings include: The employee recon Qualified Medication expired on 12/17/24 The facility schedul indicated QMA 6 w for 5 shifts on the N on the Assisted Liv The facility schedul indicated QMA 6 w for 7 shifts on the N on the Assisted Liv The facility schedul indicated QMA 6 w for 2 shifts on the N on the Assisted Liv During an interview Executive Director did expire on 12/17 indicated QMA 6 h the certification exp end of February 200 During an interview end of February 200 During an interview end of February 200	OF CORRECTION IDENTIFICATION NUMBER PROVIDER OR SUPPLIER NDENCE VILLAGE OF CARMEL SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 410 IAC 16.2-5-1.4(c) Personnel - Deficiency Based on interview and record review, the facility failed to ensure a staff member maintained a current state certification for 1 of 51 employees reviewed who required a license or certification. (QMA 6)	DENTIFICATION NUMBER A BUILDING B. WING PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 410 IAC 16.2-5-1.4(c) Personnel - Deficiency Based on interview and record review, the facility failed to ensure a staff member maintained a current state certification for 1 of 51 employees reviewed who required a license or certification. (QMA 6) Findings include: The employee records were reviewed on 4/8/25. Qualified Medication Aide (QMA) 6's certification expired on 12/17/24. The facility schedule, dated 12/18/24 to 12/31/24, indicated QMA 6 worked and passed medications for 5 shifts on the Memory Care unit and 2 shifts on the Assisted Living unit. The facility schedule, dated 1/1/25 to 1/30/25, indicated QMA 6 worked and passed medications for 7 shifts on the Memory Care unit and 2 shifts on the Assisted Living unit. The facility schedule, dated 2/1/25 to 2/28/25, indicated QMA 6 worked and passed medications for 2 shifts on the Memory Care unit and 1 shift on the Assisted Living unit. During an interview, on 4/8/25 at 11:18 a.m., the Executive Director indicated QMA 6 had worked in the facility after the certification expired until she took leave at the end of February 2025. During an interview, on 4/8/25 at 11:56 a.m., the	PROVIDER OR SUPPLIER NDENCE VILLAGE OF CARMEL SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTITYING INFORMATION 410 IAC 16.2-5-1.4(c) Personnel - Deficiency Based on interview and record review, the facility failed to ensure a staff member maintained a current state certification for 1 of 51 employees reviewed who required a license or certification. (QMA 6) Findings include: The employee records were reviewed on 4/8/25. Qualified Medication Aide (QMA) 6's certification expired on 12/17/24. The facility schedule, dated 12/18/24 to 12/31/24, indicated QMA 6 worked and passed medications for 5 shifts on the Memory Care unit and 2 shifts on the Assisted Living unit. The facility schedule, dated 2/1/25 to 2/28/25, indicated QMA 6 worked and passed medications for 7 shifts on the Memory Care unit and 2 shifts on the Assisted Living unit. The facility schedule, dated 2/1/25 to 2/28/25, indicated QMA 6 worked and passed medications for 7 shifts on the Memory Care unit and 2 shifts on the Assisted Living unit. The facility schedule, dated 2/1/25 to 2/28/25, indicated QMA 6 worked and passed medications for 2 shifts on the Memory Care unit and 2 shifts on the Assisted Living unit. The facility schedule, dated 2/1/25 to 2/28/25, indicated QMA 6 worked and passed medications for 2 shifts on the Memory Care unit and 1 shift on the Assisted Living unit. The facility schedule, dated 2/1/25 to 2/28/25, indicated QMA 6 worked and passed medications for 2 shifts on the Memory Care unit and 1 shift on the Assisted Living unit. The facility schedule, dated 2/1/25 to 2/28/25, indicated QMA 6 worked and passed medications for 2 shifts on the Memory Care unit and 2 shifts on the Assisted Living unit. The facility is schedule, dated 2/1/25 to 2/28/25, indicated QMA 6 worked and passed medications for 2 shifts on the Memory Care unit and 2 shifts on the Assisted Living unit. The facility is schedule, dated 2/1/25 to 1/30/25, indicated QMA 6 worked and passed medicat	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/08/2025			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 13390 N ILLINOIS STREET CARMEL, IN 46032				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
R 0119	work from 12/17/24 pass medications. During an interview Executive Director all state regulations. An untitled docume Director on 4/8/25 a certifications or lice current and in good the employeeFailucertification or licer discharge" A current facility por Requirements," date received from the E 1:08 p.m., indicated number, qualification twenty-four (24) ho unscheduled needs of providedMedicatilicensed nursing per aidesQualified Medicatilicensed from the state certification of the state certification of the state certification.	through February 2025 and did a, on 4/8/25 at 8:30 a.m., the indicated the facility followed ant, provided by the Executive at 1:15 p.m., indicated "All mase renewals must remain standing, at the expense of are to qualify or to maintain a asse may be sufficient cause for a seemal be sufficient cause for the company of the residents and services and trainingto meet the company of the residents and services ons must be administered by a resonnel or qualified medication edication Aide must have proof		wellness staff employee files to ensure that licensure and certifications are up to date. A ongoing spreadsheet has been created to ensure that the Wellness Director and Staff Scheduler have access to the spreadsheet and update as needed to ensure continued compliance. No other QMA's of found to be out of compliance. A continuous auditing proce has been created to ensure compliance with ensuring staff up to date with license and certification requirements. Any deficiencies noted during internal audits will be address the monthly safety/quality meeting. Compliance Date: 4/24/2025	were . ss f are		
Bldg. 00	Personnel - Nonco	ompliance	D 0110	D 440 D Nov	04/04/0005		
	failed to ensure gen- orientations were do employees reviewed CNA 9, QMA 10) Findings include:	and record review, the facility eral, and job specific becumented for 3 of 5 d for orientation. (QMA 8,	R 0119	R 119 Personnel - Noncompli- Preparation and/or execution this plan of correction does no constitute admission or agree by the provider that a deficien exists. This response is also r to be construed as an admiss of fault by the facility. This pla correction is submitted as the facility's credible allegation of	of ot ment cy not ion		

State Form Event ID: NQ9811 Facility ID: 013297 If continuation sheet Page 6 of 14

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X			X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u> COMPL			ETED
			B. W	B. WING			2025
				CTREET	ADDRESS SITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIEF	R			ADDRESS, CITY, STATE, ZIP COD		
INIDEDEN	IDENOE VII I AOE	OF CARME!			N ILLINOIS STREET		
INDEPER	NDENCE VILLAGE	OF CARMEL		CARME	EL, IN 46032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
	of the following:				compliance.		
					Independence Village of Carm	nel	
	1. QMA 8, with a s	tart date of 10/14/24, did not			ensures that the facility provid		
		ation or job specific orientation			all new employees with an		
	on file.				orientation prior to working		
	2. CNA 9, with a st	tart date of 11/12/24, did not			independently.		
		ation or job specific orientation			The Corrective Actions		
	on file.				which were accomplished for		
		start date of 11/12/24, did not			those residents were found to	have	
		ation or job specific orientation			been affected by the deficient		
	on file.	J 1			practice.		
					No residents were affected by)V	
	During an interview, on 4/8/25 at 11:58 a.m., the				the deficient practice.	-,	
	~	rator indicated the employees			The delicion produce.		
		eral orientation or job specific			How the facility will ident	ifv	
	orientation in their				other residents having the	iii y	
		11105.			potential to be affected by the		
	During an interviev	v, on 4/8/25 at 12:07 p.m., the			same deficient practice and w		
	_	indicated all staff members			corrective action will be taken:		
		general orientation and job			An ad hoc safety/quality	•	
	_	completed and in their			meeting was held with all		
	employee files.	t compresse and in their			department leaders to discuss	the	
	omprojee mes.				deficient practice.	, 110	
	During an interview	v, on 4/8/25 at 8:30 a.m., the			All residents could be affecte	ed	
	_	indicated the facility followed			by staff not receiving an orient		
	all state regulations	-			prior to working independently		
					The Executive Director or he		
	The facility did not	provide a policy related to			designee is conducting audits		
	-	, job specific orientation prior			employee files to ensure that		
	to the survey exit d				staff have a completed orienta		
					checklist to show completion of		
					general and job specific		
					orientation.		
					A continuous auditing proce	ss	
					has been created to ensure		
					compliance with ensuring staf	f	
					complete an orientation check		
					Any deficiencies noted durin		
					internal audits will be address	-	
						c u at	
					the monthly safety/quality		

State Form Event ID: NQ9811 Facility ID: 013297 If continuation sheet Page 7 of 14

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u> COMPLE			LETED	
			B. W.	B. WING 04/08/2025				
NAME OF I	ADOLUDED OD GUDDU IER			STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIEF			13390	N ILLINOIS STREET			
INDEPE	NDENCE VILLAGE	OF CARMEL		CARME	EL, IN 46032			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE	
					meeting.			
					Compliance Date: 4/24/2025			
R 0273	410 IAC 16.2-5-5.	1(f)						
	Food and Nutrition	nal Services - Deficiency						
Bldg. 00								
		on, interview and record	R 0	273	R 273 Food and Nutritional		04/24/2025	
	_	failed to ensure opened items			Services	- f		
		ered, gloves were changed			Preparation and/or execution			
		al hair coverings were worn, zer solution was at the correct			this plan of correction does no			
		s in 1 of 1 kitchen reviewed.			constitute admission or agree			
		ice had the potential to affect			by the provider that a deficient exists. This response is also n	-		
	_	who received meals from the			to be construed as an admissi			
	kitchen.	viio received means from the			of fault by the facility. This pla			
	Kitchen.				correction is submitted as the	11 01		
	Findings include:				facility's credible allegation of			
	S				compliance.			
	1. During an observ	ration of the facility kitchen, on			Independence Village of Carm	nel		
	4/7/25 beginning at	9:06 a.m., five-gallon			ensures that the facility does			
	containers of sherbe	et, orange blossom, peach			ensure that opened items in the	ne		
	praline, vanilla and	peanut butter pie ice cream			kitchen are dated and covered	1 ,		
		ored in the Ice Cream freezer.			gloves are changed between			
		illy on the items, leaving them			tasks, facial hair coverings are			
		hat time, the Executive Chef			worn and ensures that sanitize	er		
		ould have been placed on the			solution is at the correct			
	items correctly.				concentration levels.			
	0 D : 1	A/7/05 + 0.00			The Corrective Actions			
	_	ration, on 4/7/25 at 9:08 a.m.,			which were accomplished for	l		
		observed to handle non-food g gloves and then place her			those residents were found to			
		bag of bread to remove bread.			been affected by the deficient practice.			
		ed changing her gloves			No residents were affected by	3 V		
	between tasks and p				the deficient practice.	у		
		At that time, the Executive Chef			and denoterit practice.			
		not the correct procedure.			How the facility will ident	tifv		
		1			other residents having the	<i>j</i>		
	3. During the same	observation of the kitchen, on			potential to be affected by the			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED		
			B. WING			04/08/	04/08/2025	
			<u> </u>	CTREET (ADDRESS CITY STATE ZIR COR			
NAME OF I	PROVIDER OR SUPPLIEF	R			ADDRESS, CITY, STATE, ZIP COD			
	NDENCE VIII ACE	OF CARME!			N ILLINOIS STREET			
	NDENCE VILLAGE	OF CARIVIEL		CARIME	EL, IN 46032			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	4/7/25, Kitchen Sta	off 4 and Kitchen Staff 5 were			same deficient practice and w	hat		
	noted to have facial	l hair (mustaches and/or			corrective action will be taken:			
	beards). Neither employee was using a facial hair				An ad hoc safety/quality			
	cover. At that time,	the Executive Chef indicated			meeting was held with all			
	he thought if facial hair was 1/4 inch or less the				department leaders to discuss	the		
	hair covering was n	not required. He indicated both			deficient practice.			
	employees were noted to have facial hair greater				All residents could be affect	ed		
	than 1/4 inch.				by the food not being labeled	and		
					covered, gloves not being cha	nged		
	4. During the kitch	en observation, the pantry was			between tasks, facial hair not			
	found to have an ei	ght ounce can of espresso.			being covered and sanitizer			
	The can of espresso was close to empty and did				solutions not being at the corre	ect		
	not have a date it was opened on the container. A				concentration.			
	two-pound bag of pancake mix was found half full,				Executive Chef or his design	nee		
	wrapped in plastic a	and did not have an open date			are conducting audits to ensu	re all		
	on the bag. Two on	e-pound bags of powdered			food products are dated and			
	sugar were found o	pen, wrapped in plastic and			covered, staff covering facial h	nair,		
	did not have an ope	en date on the bags.			staff changing gloves betweer	1		
					tasks and concentration of			
		ler had a half gallon container of			sanitizers twice weekly for 4			
		an open date, a 1/4 block (of a			weeks, if no deficiencies are			
		of white American cheese slices			noted, will then audit monthly	for 4		
	was found wrapped	l in plastic without an open			weeks.			
	date.				A continuous auditing proce	SS		
					has been created to ensure			
	_	v, on 4/7/25 at 9:26 a.m., the			compliance with proper food			
		licated items should be labeled			storage and culinary sanitation	า		
	with an open date v	when they are opened.			policies and procedures.			
					Any deficiencies noted durin	•		
		uent visit to the kitchen, on			internal audits will be address	ed at		
		a., the sanitizer (used to clean the			the monthly safety/quality			
	· · · · · · · · · · · · · · · · · · ·	ras tested. The Executive Chef			meeting.			
	_	showed a concentration of			Compliance Date: 4/24/2025			
	about 150-200 parts per million and it was							
	supposed to test between 200 and 400 parts per							
	million. During the observation, the test strip did							
		rts per million. The Executive						
		itizer a second time. The strip						
	_	d it did not change color from						
	the original light orange (per the directions, it							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/08/2025				
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 13390 N ILLINOIS STREET CARMEL, IN 46032				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	_	d to green). A third attempt be lightened and indicated 0 neentrations.					
	Executive Chef indi	y, on 4/8/25 at 11:13 a.m., the icated he needed to check to e the right test strips for the ag.					
	Executive Chef indi	y, on 4/8/25 at 11:48 a.m., the icated he had ordered the for checking the sanitizer					
	4/8/25 at 2:00 p.m., was found to have I cheese, lettuce, spin separate containers dressing cooler was	tent visit to the kitchen, on the salad preparation cooler hardboiled eggs, shredded hach and bacon pieces, all in and without lids. The found to have a five-pound eam, half full, and without an					
	Executive Chef indi	y, on 4/8/25 at 2:01 p.m., the icated all the items had lids rvice and the staff should have on the items.					
	Storage," dated as la received from the E 11:29 a.m., indicate containers with an odateCold Storage. wrapped or covered and date expiresW	olicy, titled "Proper Food ast revised on 6/6/22 and executive Director on 4/7/25 at d "Dry StockLabel all open open date and expiration Keep foods properly and dated with date opened When to date mark e original packaging is					
	A current facility po	olicy, titled "Department					

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AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 04/08/2025	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 13390 N ILLINOIS STREET CARMEL, IN 46032				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL 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 0409 Bldg. 00	implemented on 2/1 Executive Director indicated "Sanitiz A current facility po Sanitation and Safet received from the E 1:10 p.m., indicated single-use gloves ca disease-causing org foodssingle use gl purpose only" 410 IAC 16.2-5-12 Infection Control -	• •	R 04	100	R 409 Infection Control -		04/24/2025
	failed to ensure an a provided which sho evidence of tubercu verified upon admis of 8 residents review statements. (Residents include: 1. The clinical record on 4/7/25 at 10:13 a but were not limited fracture of the neck for closed fracture. The resident was ad 1/22/21. The facility was una annual health staten	annual health statement was wed the resident had no losis in an infectious stage as assion and yearly thereafter for 2 wed for annual heath and 1 and 7) and for Resident 1 was reviewed a.m. The diagnoses included, at to, major depressive disorder, of the femur, and encounter amitted to the facility on able to provide a current	K 0-	1 09	Noncompliance Preparation and/or execution of this plan of correction does no constitute admission or agreer by the provider that a deficience exists. This response is also not be construed as an admission of fault by the facility. This plan correction is submitted as the facility's credible allegation of compliance. Independence Village of Carmensures that the Healthcare Provider Plan of Care provides form and process for the residental healthcare provider to provide written record of a resident's health assessment. The Corrective Actions which were accomplished for those residents were found to been affected by the deficient	t ment Cy ot on n of eel s a ent's a	04/24/2023

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/08/2025		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 13390 N ILLINOIS STREET CARMEL, IN 46032				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PRI	D EFIX 'AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	limited to, hypertenheartbeat), and glau The resident was ac	Imitted to the facility on 6/7/23.			practice. R1 no longer resides in this community. R7 now has an Annual Healt Statement in place. How the facility will ident		
	Executive Director all state regulations	v, on 4/8/25 at 8:30 a.m., the indicated the facility followed.			other residents having the potential to be affected by the same deficient practice and wl corrective action will be taken: An ad hoc safety/quality meeting was held with all		
	Assistant Director of information had be	or, on 4/8/25 at 8:54 a.m., the of Health indicated all resident en provided. The facility was the annual health statements 7.			department leaders to discuss deficient practice. All residents could be affected by the lack of an annual health statement. R1 and R7 now have an upon	ed 1	
	Provider Plan of Ca implemented on 6/2 Executive Director indicated "The Ho provides a form and	policy, titled "Healthcare are-HCPPOC," dated as 25/24 and received from the on 4/8/25 at 12:38 p.m., ealthcare Provider Plan of Care disprocess for the resident's to provide a written record of sssessment"			Health Statement. The Wellness Director or his designee is conducting audits all charts to ensure all resident have a signed annual health statement by their Healthcare Provider. A continuous auditing procest has been created to ensure all residents have a signed annual health statement. Any deficiencies noted during internal audits will be addressed the monthly safety/quality meeting. Compliance Date: 4/24/2025	/her of ts ss l	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING O D NUMBER O O O O O O O O O O O O O			(X3) DATE SURVEY COMPLETED 04/08/2025			
			B. Wl	ING		04/08/	/2025		
NAME OF PROVIDER OR SUPPLIER INDEPENDENCE VILLAGE OF CARMEL				STREET ADDRESS, CITY, STATE, ZIP COD 13390 N ILLINOIS STREET CARMEL, IN 46032					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION		
TAG				TAG			DATE		
R 0410 Bldg. 00	410 IAC 16.2-5-12 Infection Control - Based on interview failed to ensure a 2 completed when a refacility for 2 of 8 results tuberculosis. (Residual Findings include: 1. The clinical record on 4/7/25. The diagonal limited to, chronic kidney disease, and the resident was at 10/18/24. The first test of the completed on 10/22. The clinical record on 4/7/25. The diagonal limited to, glaucom 2. The clinical record on 4/7/25. The diagonal limited to, glaucom Parkinson's disease. The resident was at 10/13/24. The first test of the completed on 10/22.	2(e)(f)(g) Noncompliance and record review, the facility step tuberculosis test was resident was admitted to the esidents reviewed for dent 4 and 8) and for Resident 4 was reviewed gnoses included, but were not systolic heart failure, chronic I hypertension. I hypertension. I hypertension test was 3/24. It able to provide the second ation. I and for Resident 8 was reviewed gnoses included, but were not has, hypertension, and I dmitted to the facility on 2-step tuberculosis test was All dmitted to the facility on 2-step tuberculosis test was All dmitted to the facility on	R 04		R 410 Infection Control Noncompliance Preparation and/or execution this plan of correction does no constitute admission or agree by the provider that a deficient exists. This response is also no to be construed as an admission of fault by the facility. This plat correction is submitted as the facility's credible allegation of compliance. R TB and second step Independence Village of Carrensures that the facility perfor TB testing via the 2-step meth when required. The Corrective Actions which were accomplished for those residents were found to been affected by the deficient practice. R4 TB skin test series has be restarted How the facility will iden other residents having the potential to be affected by the same deficient practice and we corrective action will be taken An ad hoc safety/quality meeting was held with all	ot ment acy not ion an of mel ms nod been been tify	04/24/2025		
	step testing informa	ation.			department leaders to discuss	s the			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/08/2025				
NAME OF PROVIDER OR SUPPLIER INDEPENDENCE VILLAGE OF CARMEL				STREET ADDRESS, CITY, STATE, ZIP COD 13390 N ILLINOIS STREET CARMEL, IN 46032					
(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		
	(EACH DEFICIENCY MUST BE PRECEDED BY FULL				deficient practice. All residents could be affected by a resident not receiving a 2nd TB skin test when indicated. The Wellness Director or his/her designee is conducting audits of all new admissions to ensure that a TB skin test as well as a 2nd step is performed when indicated. A continuous auditing process has been created to ensure continued compliance. Any deficiencies noted during internal audits will be addressed at the monthly safety/quality meeting. Compliance Date: 4/24/2025				

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