

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>002999</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/13/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>INDEPENDENCE VILLAGE OF FISHERS SOUTH</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>9745 OLYMPIA DR</b> <b>FISHERS, IN 46038</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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) COMPLETE DATE
R 000	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for the Investigation of Complaint IN00429545.</p> <p>Complaint IN00429545 - No deficiencies related to the allegations are cited.</p> <p>Survey date: March 13, 2024</p> <p>Facility number: 002999</p> <p>Residential Census: 73</p> <p>Independence Village Of Fishers South was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00429545.</p> <p>Quality review completed on March 13, 2024</p>	R 000		

Indiana Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE