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	04/16/2025

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

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: April 15 and 16, 2025 Facility number: 014059 Residential Census: 57 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on April 29, 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 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency Based on interview and record review, the facility failed to ensure the minimum staffing requirements were met for first aide and cardiopulmonary resuscitation (CPR) coverage. This deficient practice had the potential to effect 57 of 57 residents who resided in the facility. Findings include: On 4/16/25 at 9:15 a.m., the Wellness Director (WD) provided the first aide and CPR binder for review. There were only two staff members with current CPR certifications. There were no staff members with current first aide certifications. The nursing schedule was reviewed for the	R 0117	What corrective action(s) will be accomplished for those resident(s) found to be affected by the deficient practice(s)? Training has been scheduled for CPR and First Aid for all QMA's, LPN's and Wellness Leader on May 21, 2025, May 30, 2025 and June 3, 2025 to ensure that at least one staff member is on site 24 hours a day, every day, who is certified in CPR and First Aid. 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? Training for CPR and First Aid will be scheduled quarterly for any new hire in the roles of QMA, LPN or Wellness	06/03/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jim	Gepp	05/19/2025

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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	previous week and there were not staff members for any shift with current first aide and CPR certification working. During an interview on 4/16/25 at 10:15 a.m., the WD indicated, when she started at the facility, she realized the first aide and CPR certifications were missing and/or out of date. She had scheduled a CPR class, and would be requiring her staff to take the class for dual certifications, but in the meantime, there was no first aide and CPR coverage as required by the Residential Rules.		Leadership without existing certification and for all team members with expiring certification. DON or designee will track all team member certification expiration dates. How will the corrective action(s) be monitored to ensure that the deficient practice(s) will not recur? The wellness schedule will be checked against the list of team members with current CPR and First Aid certifications at creation and at the time of any changes. DON or designee will monitor the as-worked schedule daily to ensure compliance.	
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 5 of 5 newly hired employee record reviewed. Findings include: On 4/15/25 at 1:00 p.m., five new employee records were reviewed. Certified Nursing Aide (CNA) 9 was hired on 2/17/25. Cook 10 was hired on 1/24/25. CNA 11 was hired on 9/5/24. CNA 12 was hired on 12/10/24.	R 0121	What corrective action(s) will be accomplished for those resident(s) found to be affected by the deficient practice(s)? All current team members will complete the health screening prior to 5/31/25. 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? A health screening tool has been created and effective immediately will be administered at the time of the first stage TB test prior to working independently. How will the corrective action(s) be monitored to ensure that the deficient practice(s) will not recur?	05/31/2025

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	Dietary Server was hired on 1/9/25. 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 4/16/25 at 12:00 p.m., the Executive Director (ED) indicated the facility did not conduct a separate health screen for new employees and the TB skin tests was considered sufficient for the health screen. The ED indicated there was no a specific policy for new hire procedures, but they followed the Residential Rules		DON or designee will retain and track health screen completion for all team members. A copy will be given to the Business Office Manager to be placed in the employee file.	
R 0123 Bldg. 00	410 IAC 16.2-5-1.4(h)(1-10) Personnel - Nonconformance Based on record review and interview, the facility failed to ensure new employees completed a general and job-specific orientation for 2 of 5 new hire records reviewed. Findings include: On 4/15/25 at 1:00 p.m., five new employee records were reviewed. Certified Nursing Aide (CNA) 9 was hired on 2/17/25. The general orientation and job specific orientation packets were included in her employee file, signed and dated 2/20/25, but nothing was checked off as completed. Cook 10 was hired on 1/24/25 and his employee record lacked documentation of general and job-specific orientation. During an interview on 4/16/25 at 12:00 p.m., the Executive Director (ED) indicated he could not	R 0123	What corrective action(s) will be accomplished for those resident(s) found to be affected by the deficient practice(s)? The Business Office Manager has completed a file audit and will collect general and specific orientation acknowledgments for all current team members by 05/31/25. All hiring leaders to be in-serviced on proper onboarding practices by 05/31/25. 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? How will the corrective action(s) be monitored to ensure that the deficient practice(s) will not recur? An automatic report of all new hires in a rolling prior 7 day period has been created to be	05/31/2025

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	find additional information for CNA 9 or Cook 10. The ED indicated there was no specific policy for new hire procedures, but the facility followed the Residential Rules.		received by the Business Office Manager and ED daily. The business office will track general and specific orientation acknowledgements to ensure that these have been completed for each team member prior to working independently.	
R 0156 Bldg. 00	410 IAC 16.2-5-1.5(m) Sanitation and Safety Standards - Deficiency Based on observation and interview, the facility failed to label and date foods as they were opened for 1 of 1 kitchen observation. Findings include: On 4/15/25 at 9:38 a.m., the kitchen was observed. Inside the walk-in fridge there was no label on the dessert. The croutons were not covered. The mayonnaise had no date on it. The italian dressing had no date on it. The milk was dated 4/14/25. The flank steak had no date on it when it was open. The cilantro had no date on it. The potato salad had no date on it. The celery and carrots mixture had no date on it. The shredded cheese had no date on it. During an interview with the Executive Chef on 4/15/25 at 10:00 a.m., he indicated he was new and would be correcting the lack of dates on items. A policy titled, "Proper Food Storage" was provided by the executive director on 4/16/25 at 11:58 a.m. It indicated, " ...When to date mark foods: Anytime the original packaging is opened ...."	R 0156	What corrective action(s) will be accomplished for those resident(s) found to be affected by the deficient practice(s)? An audit by the Sous Chef of all foods in cold or dry storage to be completed by 05/20/2025 to ensure proper labeling and dating and proper storage. 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 culinary staff to be inserviced on proper labeling and dating and proper storage of food by 05/31/2025. How will the corrective action(s) be monitored to ensure that the deficient practice(s) will not recur? Executive Chef or designee to audit cold and dry food storage areas weekly to ensure compliance.	05/31/2025

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R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance Based on interview and record review, the facility failed to ensure a resident had a current self-administration of medication assessment for 2 of 5 residents reviewed for self-administration of medication (Residents 4 and 50). Findings include: During an interview on 4/15/25 at 10:25 a.m., Resident 4 indicated he ordered, arranged and managed all of his own medications and helped his wife, Resident 50, with her medications. On 4/15/25 at 11:00 a.m., Resident 4's medical record was reviewed. He had a Medication Self-Administration Evaluation dated 6/20/24. The record lacked documentation of a current assessment which should have been completed no later than 12/20/24. The Evaluation also lacked documentation of Resident 4's ability and/or preference with and assessment of his ability to manage medications for his wife, Resident 50. Resident 4's service plan lacked revision to include an updated self-administration of medication and his ability or preference to assist his wife, Resident 50. During an interview on 4/16/25 at 12:07 p.m., the Wellness Director indicated, a new evaluation should have been completed in December of 2024. On 4/16/25 at 12:00 p.m., the Executive Director	R 0216	What corrective action(s) will be accomplished for those resident(s) found to be affected by the deficient practice(s)? Medication self-administration evaluations have been completed for affected residents which indicate the preference and ability of Resident 4 to assist his wife, Resident 50. How will the facility identify other residents having the potential to be affected by the deficient practice(s) and what corrective action(s) will be taken? DON or designee will audit by 05/31/2025 all residents who self-administer medications to ensure compliance. 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? System has been changed to trigger a self-administration assessment for all affected residents at the same time as the care plan reassessment every six months to ensure that completion is within the required timeframe. How will the corrective action(s) be monitored to ensure that the deficient practice(s) will not recur? DON or designee to review monthly to ensure that compliance.	05/31/2025

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	(ED) provided a copy of current facility policy titled, "Medication- Resident Self Administration," dated 6/1/22. The policy indicated, " ...the Wellness Leader or Designee will review the Self-Administration of Medication Evaluation with the resident to evaluate their ability to safely administer and store their own medication. Review shall be performed before the resident begins to self-administer medication, following a significant change in condition and with each evaluation ... responsibility for medication storage, administration, and refills shall be outlined on the resident's service plan ...."			
R 0242 Bldg. 00	410 IAC 16.2-5-4(e)(2) Health Services - Offense Based on record review and interview, the facility failed to obtain a blood pressure for a resident as ordered for 1 of 2 residents reviewed (Resident 2). Findings include: During a medication pass observation on 4/16/25 at 8:00 a.m., it was observed that Resident 2 was to have blood pressure taken daily. The blood pressure was not obtained. Resident 2's record was reviewed on 4/16/24 at 10:32 a.m. She had the following diagnoses which included but were not limited to major depression, anxiety, dementia, and essential hypertension. A review of her March and April medication administration records revealed that her blood pressure was not obtained daily as ordered for each day of the months. During an interview with Qualified Medication	R 0242	What corrective action(s) will be accomplished for those resident(s) found to be affected by the deficient practice(s)? Order for blood pressure monitoring had been discontinued by time of survey. How will the facility identify other residents having the potential to be affected by the deficient practice(s) and what corrective action(s) will be taken? DON or designee to review all current orders for current residents to look for similar issues by 05/31/25. 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? QMA's and LPN's to be inserviced by 05/31/25 on checking the indications for all orders for instructions on taking	05/31/2025

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	Assistant (QMA) 6 on 4/16/25 at 8:10 a.m. She indicated the computer screen did not alert her to obtain the blood pressure. A policy titled, "Medication Administration" was provided by the Executive Director (ED) on 4/16/25 at 12:00 p.m. It did not include any information regarding obtaining a blood pressure as ordered.		blood pressures or other monitoring of vital signs. Care staff to log blood pressures. How will the corrective action(s) be monitored to ensure that the deficient practice(s) will not recur? DON or designee to check BP log against orders weekly to ensure compliance.	
R 0302 Bldg. 00	410 IAC 16.2-5-6(c)(6) Pharmaceutical Services - Deficiency Based on observation, interview, and record review, the facility failed to label and date medications for 1 of 3 medication carts reviewed and 1 of 3 medication rooms observed. Findings include: On 4/15/25 at 11:36 a.m., the memory care medication room and medication cart were reviewed with Qualified Medication Assistant (QMA) 5. Resident 9 had a bottle of lorazepam in the refrigerator without a date to indicate when it was opened. Resident 2 had a bottle of lorazepam in the refrigerator without a date to indicate when it was opened. Resident 10 had two bottles of latanoprost eye drops in the medication cart. They lacked dates to indicate when they were open. She also had Systane eye drops with no date to indicate when it was opened. She had aspirin 81 mg and eye health tablets with no label on either one.	R 0302	What corrective action(s) will be accomplished for those resident(s) found to be affected by the deficient practice(s)? How will the facility identify other residents having the potential to be affected by the deficient practice(s) and what corrective action(s) will be taken? DON or designee to audit all medication carts by 05/23/25 to ensure proper labeling of all medications. 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 QMAs and LPNs to inserviced on proper labeling of medications by 05/31/25. How will the corrective action(s) be monitored to ensure that the deficient practice(s) will not recur? DON or designee to audit all medication carts every 2 weeks to ensure proper labeling of all medications.	05/31/2025

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	Resident 11 had an inhaler, albuterol, with no date to indicate when it was opened. Resident 12 had a bottle of latanoprost eye drops with no date to indicate when it was opened. She had a bottle of fluticasone in the cart with no date to indicate when it was opened. Resident 16 had a bottle of senoxon-S and melatonin with no label on the bottles. Resident 14 had a bottle of vitamin C, Macu Health, aspirin 81 mg, vitamin D3 2000 units, vitamin E 180 mg, melatonin 10 mg, pain relief liquid 500 mg/5 ml not labeled. He had an inhaler ipratropium bromide that lacked a date to indicate when it was opened. On 4/15/25 at 11:45 a.m., Qualified Medication Assistant (QMA) 5 took the undated items from the cart and indicated she would get labels for the rest of the medications. A policy titled, "Medication Destruction/Disposal," was provided by the Executive Director (ED) on 4/16/25 at 12:00 p.m. It indicated, " ...Expired medications are never administered. The designated staff person will inspect containers for expiration dates on a routine basis ...."			
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance Based on observation and interview, the facility failed to implement an infection control program that included tracking and surveillance of known infectious symptoms for 57 out of 57 residents. Findings include:	R 0407	What corrective action(s) will be accomplished for those resident(s) found to be affected by the deficient practice(s)? How will the facility identify other residents having the potential to be affected	05/19/2025

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	During a review of the infection control binder on 4/16/25 at 11:00 a.m., the binder lacked any documentation of any tracking or surveying of infections for January, February, March, and April. During an interview with the Wellness Director (WD), she indicated she was working on establishing a program. The Executive Director (ED) indicated they followed the state rules regarding infection control programming.		by the deficient practice(s) and what corrective action(s) will be taken? Infection control binder was updated for all affected residents as of the day of the survey. 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? DON or designee to update infection control binder with all new orders as appropriate and to document throughout the course of any relevant order. How will the corrective action(s) be monitored to ensure that the deficient practice(s) will not recur? DON or Assistant DON to check infection control binder weekly and sign off.	
R 0414 Bldg. 00	410 IAC 16.2-5-12(k) Infection Control - Deficiency Based on observation, interview, and record review, the facility failed to ensure appropriate hand hygiene was conducted during dining observations. This deficient practice had the potential to effect 20 of 20 residents observed eating in the main dining room. Findings include: On 4/15/25 at 12:00 p.m., 17 residents were observed gathered and dining in the main dining room. Dietary Aide (DA) 7 was observed. She wore a pair of black rubber gloves. She did not remove	R 0414	What corrective action(s) will be accomplished for those resident(s) found to be affected by the deficient practice(s)? How will the facility identify other residents having the potential to be affected by the deficient practice(s) and what corrective action(s) will be taken? Culinary leadership, which is present at all meal prep and service times, to immediately monitor for correct hand hygiene and correct any deficient practices. What measures will be put in	05/31/2025

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	her gloves and/or perform hand hygiene between her services. She was observed to gather dirty dishes, go in and out of the kitchen, take orders, adjust residents' chairs and place settings, and deliver lunch plates. She did not perform hand hygiene between clean and dirty tasks or in between her coming or going in and out of the kitchen. DA 8 was observed. She did not perform hand hygiene between her services. She was also observed to gather dirty dishes go in and out of the kitchen, take orders, adjust residents' chairs and place setting ,and deliver lunch plates. She did not perform hand hygiene between clean and dirty tasks or in between her coming or going in and out of the kitchen. DA 8 was observed serving beverages to several residents. She held the cup by the top rim of the glass with her fingertips and open palm over the unlidded cups. On 4/16/25 at 11:55 a.m., 20 residents were observed in the main dining room. Again, DA 7 and DA 8 were observed. Throughout the lunch service observation, they did not perform hand hygiene between clean and dirty tasks or in between their coming or going in and out of the kitchen. On 4/16/25 at 12:00 p.m., the Executive Director (ED) provided a copy of current facility policy titled, "Department Specific Procedures- Culinary Services," dated 2/17/22. The policy indicated, " ...Food handlers must wash their hands ...whenever reentering the kitchen, before handling any food surfaces, after handling soiled equipment or utensils, after engaging in other		place or what systemic changes will the facility make to ensure that the deficient practice(s) does not recur? All culinary staff to be inserviced on correct hand hygiene by 05/31/25. How will the corrective action(s) be monitored to ensure that the deficient practice(s) will not recur? Culinary leadership, which is present at all meal prep and service times, to immediately monitor for correct hand hygiene and correct any deficient practices.	

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	activities that contaminate the hands ...."			