STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE PARK RESIDENTIAL CARE	2075 RIPLEY ST, LAKE STATION, , 46405

(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 State Residential Licensure Survey. This visit included the Investigation of Complaints IN00454508 and IN00458671. Complaint IN00454508 - No deficiencies related to the allegations are cited. Complaint IN00458671 - State deficiency related to the allegations is cited at R0241. Survey dates: 5/1/25 and 5/2/25 Facility number: 001136 Residential Census: 94 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 5/6/25.	R 0000		
R 0036	Residents' Rights- Deficiency 410 IAC 16.2-5-1.2(k)(1-2)	R 0036		06/03/2025

	(k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on record review and interview, the facility failed to ensure the resident's physician was notified of blood sugar results outside parameters and of insulin being held for 2 of 7 resident records reviewed. (Residents B and 2) Findings include: 1. The record for Resident B was reviewed on 5/1/25 at 1:15 p.m. Diagnoses included, but were not limited to, diabetes and hypertension. A current Physician's Order indicated the resident was to receive sliding scale Humalog insulin at 6:00 a.m. and 8:00 p.m. based on the following blood sugar results: 151-200=4 units		1. What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice. Resident B's physician was notified that resident's, Lantus insulin on 02/08/2025 at 6:00AM with a blood sugar of 77 and at 8:00PM due to a blood sugar of 96 was held. Resident B's physician was notified that resident's insulin was held on 03/05/2025 at 8:00PM due to a blood sugar of 102. Late entry documentation of notification to physician has been done. Resident 2's physician was notified that Lantus insulin, 50 units was held on 02/05/25 and 03/18/2025 at 6:00AM both dates due to blood sugar being below 60 for both dates. Resident 2's physician was notified that insulin was being held on 03/26/2025 at 8:00PM due to resident's refusal. QMA that attempted to administer insulin to resident states he refused insulin as ordered.	

	201-250=8 units 251-300=12 units 301-350=16 units 351-400=20 units The Physician was to be notified if the resident's blood sugar was less than 60 or greater than 400. The February 2025 Diabetic Flow sheet indicated the physician was not notified of blood sugar results less than 60 on 2/6/25 at 8:00 p.m., 2/11/25 at 8:00 p.m., and 2/17/25 at 6:00 a.m. The February 2025 Physician's Order Summary (POS) indicated the resident was to receive Lantus insulin 30 units twice a day. The February 2025 Medication Administration Record (MAR) indicated QMA 1 held the resident's insulin on 2/8/25 at 6:00 a.m. due to a blood sugar of 77 and at 8:00 p.m. due to a blood sugar of 96. There was no documentation indicating the physician was notified of the resident's insulin being held.		QMA documented insulin was held instead of documenting that insulin was refused on 2/5/2025 and 3/5/2025. 2. How the facility will identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken. All residents receiving insulin have the potential to be affected by the alleged deficient practice. 3. What measures will be put into place or what systemic changes the facility will make to ensure that the alleged deficient practice does not recur. Director of Nursing and Nursing Consultant will re- Inservice Nursing staff on contacting the residents primary physician when blood sugar results are outside parameters and insulin needs to be held. Nursing staff will also be in serviced n the importance of notifying physician if insulin is to be held and also if a resident refuses insulin to be given. 4. How will the corrective actions	

	The March 2025 MAR indicated the resident's Lantus insulin was held on 3/5/25 at 8:00 p.m. due to a blood sugar of 102. There was no documentation indicating the physician was notified of the resident's insulin being held. During an interview on 5/2/25 at 2:30 p.m., the Director of Nursing indicated there was no documentation indicating the resident's physician had been notified of the blood sugars less than 60 and the insulin being held. 2. The record for Resident 2 was reviewed on 5/1/25 at 3:00 p.m. Diagnoses included, but were not limited to, type 2 diabetes and hypertension. The February and March 2025 Diabetic Flow Sheets indicated the resident was to receive sliding scale insulin coverage three times a day at 6:00 a.m., 11:00 a.m., and 4:00 p.m. The resident's physician was to be notified if the blood sugar was less than 60 or greater than 400. The February Diabetic Flow Sheet indicated the resident's blood sugar was 57 at 6:00 a.m. on 2/5/25. The March Diabetic Flow Sheet indicated the resident's blood sugar was 53 at 6:00 a.m. on		be monitored to ensure the alleged deficient practice will not recur. i.e. what quality assurance program will be put into place. Director of Nursing and/or designee will check blood sugar documentation weekly on Mondays for 30 days, and thereafter blood sugar documentation will be checked monthly and thereafter at random quarterly. 5. By what date the systemic changes will be changed. June 3, 2025	

	3/18/25. There was no documentation indicating the physician had been notified of the blood sugars below 60 for both dates. A current Physician's Order indicated the resident was to receive Lantus insulin 50 units in the morning and 15 units at bedtime. The March 2025 Medication Administration Record (MAR) indicated QMA 1 held the resident's insulin due to a blood sugar of 92 on 3/26/25 at 8:00 p.m. There was no documentation indicating the physician was notified of the insulin being held. During an interview on 5/2/25 at 2:30 p.m., the Director of Nursing indicated there was no documentation indicating the resident's physician had been notified of the blood sugars less than 60 and the insulin being held. Based on record review and interview, the facility failed to ensure the resident's physician was notified of blood sugar results outside parameters and of insulin being held for 2 of 7 resident records reviewed. (Residents B and 2) Findings include:			

	1. The record for Resident B was reviewed on 5/1/25 at 1:15 p.m. Diagnoses included, but were not limited to, diabetes and hypertension. A current Physician's Order indicated the resident was to receive sliding scale Humalog insulin at 6:00 a.m. and 8:00 p.m. based on the following blood sugar results: 151-200=4 units 201-250=8 units 251-300=12 units 301-350=16 units 351-400=20 units The Physician was to be notified if the resident's blood sugar was less than 60 or greater than 400. The February 2025 Diabetic Flow sheet indicated the physician was not notified of blood sugar results less than 60 on 2/6/25 at 8:00 p.m., 2/11/25 at 8:00 p.m., and 2/17/25 at 6:00 a.m. The February 2025 Physician's Order Summary (POS) indicated the resident was to receive Lantus insulin 30 units twice a day. The February 2025 Medication Administration Record (MAR)			

indicated QMA 1 held the resident's insulin on 2/8/25 at 6:00 a.m. due to a blood sugar of 77 and at 8:00 p.m. due to a blood sugar of 96.

There was no documentation indicating the physician was notified of the resident's insulin being held.

The March 2025 MAR indicated the resident's Lantus insulin was held on 3/5/25 at 8:00 p.m. due to a blood sugar of 102.

There was no documentation indicating the physician was notified of the resident's insulin being held.

During an interview on 5/2/25 at 2:30 p.m., the Director of Nursing indicated there was no documentation indicating the resident's physician had been notified of the blood sugars less than 60 and the insulin being held.

2. The record for Resident 2 was reviewed on 5/1/25 at 3:00 p.m. Diagnoses included, but were not limited to, type 2 diabetes and hypertension.

The February and March 2025 Diabetic Flow Sheets indicated the resident was to receive sliding scale insulin coverage three times a day at 6:00 a.m., 11:00 a.m., and 4:00 p.m. The resident's physician was to be notified if the blood sugar was

less than 60 or greater than 400.

The February Diabetic Flow Sheet indicated the resident's blood sugar was 57 at 6:00 a.m. on 2/5/25.

The March Diabetic Flow Sheet indicated the resident's blood sugar was 53 at 6:00 a.m. on 3/18/25.

There was no documentation indicating the physician had been notified of the blood sugars below 60 for both dates.

A current Physician's Order indicated the resident was to receive Lantus insulin 50 units in the morning and 15 units at bedtime.

The March 2025 Medication Administration Record (MAR) indicated QMA 1 held the resident's insulin due to a blood sugar of 92 on 3/26/25 at 8:00 p.m.

There was no documentation indicating the physician was notified of the insulin being held.

During an interview on 5/2/25 at 2:30 p.m., the Director of Nursing indicated there was no documentation indicating the resident's physician had been notified of the blood sugars less than 60 and the insulin being held.

R 0241	Health Services - Offense 410 IAC 16.2-5-4(e)(1) (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on record review and interview, the facility failed to ensure medications were administered as ordered to the correct resident. This deficient practice resulted in Resident B receiving the wrong medications which resulted in the resident being hospitalized. The facility also failed to ensure sliding scale insulin was administered as ordered for 1 of 7 records reviewed. (Resident B) Finding includes: The record for Resident B was reviewed on 5/1/25 at 1:15 p.m. Diagnoses included, but were not limited to, diabetes and hypertension. A Service Plan, dated 2/20/25, indicated the resident needed assist with decisions as needed for new situations/tasks and	R 0241	1. What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice. Resident B's physician, was notified immediately within minutes of the incorrect medication being administered, was in route to facility upon notification and planned to evaluate resident B upon arrival. Nursing staff called 9ll when resident B had difficulty ambulating down hall and then was transported to Powers Health Hospital for evaluation. Resident B was admitted for observation and returned back to facility two days later without any adverse affects and no new orders. Resident B has not received the incorrect medication since return and no other medication errors have occurred. QMA2 was in serviced immediately after resident was administered incorrect medication by the Director of Nursing and was also given a formal warning. Inservice included ways to identify residents through pictures, asking resident their first and last name, room number and staff assistance if needed, QMA2 will be re-in serviced and will also be shadowed by licensed and registered nurses for completion of orientation time	05/30/2025

	assist to enhance resident self-performance patterns, and verbal prompting. A facility Unusual Event Report, dated 4/30/25, indicated Resident B received Resident C's morning medications which consisted of Amlodipine (a medication used to treat chest pain and high blood pressure) 5 milligrams (mg), Austedo (a medication to treat involuntary movements) 9 mg, Entresto (a medication used to treat heart failure) 24-26 mg, Metoprolol (a cardiac medication) 100 mg, Pantoprazole (a heartburn medication) 40 mg, KCl Micro (a potassium supplement) 20 milliequivalents (meq) ER (extended release) tablet, Ziprasidone (an antipsychotic medication) 60 mg, and Clozapine (an antipsychotic medication) 200 mg. The resident was supposed to receive Amlodipine 10 mg, Lipitor (a cholesterol medication) 80 mg, Zyrtec (an allergy medication) 10 mg, Plavix (an antiplatelet) 75 mg, Colace (a stool softener) 100 mg, Duloxetine (an antidepressant) 30 mg, Farxiga (a diabetes medication) 5 mg, Lasix (a diuretic) 40 mg, Gabapentin (a medication for nerve pain) 300 mg, Oxybutynin (a medication for an overactive bladder) 5 mg, Prednisone (a steroid) 10 mg, Spironolactone		focusing on medication administration. 2. How the facility will identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken. All residents have the potential to be affected by the alleged deficient practice. 3. What measures will be put into place or what systemic changes the facility will make to ensure that the alleged deficient practice does not recur. The Nursing staff will be re-in serviced by the Director of Nursing and Nursing Consultant to ensure that medications are administered as ordered to the correct resident.	

	(a diuretic) 50 mg and Vitamin C 500 mg. After receiving the medications, the resident ambulated down to dietary. After eating breakfast, the staff was made aware by housekeeping that Resident B was down the hall and leaning on the wall. He was being held up by Case Management staff. The staff immediately went to assess the resident and 911 was called. The resident was assisted into a wheelchair and brought to the physician's office for evaluation. The resident appeared lethargic, gray in the face, and short of breath. The resident's vital signs were taken by staff. His blood pressure was 72/53 and his heart rate was 89. Emergency Medical Services (EMS) arrived and transported the resident to the hospital where he was admitted for observation. An IDOH reported incident, dated 5/1/25, indicated on 4/30/25 at 7:40 a.m., Resident B received the wrong medications from QMA 2. QMA 2 indicated the resident came to the nurse's station for his medication. She asked the resident his name three times and stated his voice was jumbled but she thought he said his name was Resident C's name. She administered Resident C's medications to		Nursing staff have been in serviced and will be re-in serviced to ask every resident prior to administering their medications, their first and last names room number that they reside in and also check the MAR along with information given and look at the residents picture that is available to ensure that mediation is given to the correct person. Especially if resident has similar names or initials. The Director of Nursing and the Nursing Consutant will in-service all nursing staff about the administration of sliding scale insulin. 4. How will the corrective actions be monitored to ensure the alleged deficient practice will not recur. i.e. what quality assurance program will be put into place. The Director of Nursing and/or designee will randomly monitor a medication pass weekly for a month, and then will randomly check a medication pass one a month, and then thereafter quarterly to ensure medications are administered correctly. The Director of Nursing and/or	

	Resident B and realized immediately after it was not his medications. She immediately informed the nurse on duty, RN 1, and then both informed the Director of Nursing, who immediately informed the Primary Care Physician. The physician was on her way to the facility when the incident occurred. The resident was sent to the emergency room for evaluation and he was admitted to the hospital for low blood pressure and low heart rate. On 5/1/25, the QMA was immediately inserviced about medication administration. Nursing staff was also informed about medication administration procedures. The Director of Nursing (DON) and Nursing Consultant would also give continuing education to the QMA and the entire nursing staff on medication administration. During an interview on 5/1/25 at 2:50 p.m., the Administrator and the DON indicated QMA 2 had only been employed by the facility for 5-6 days. The DON indicated she was a newer QMA as well but she had already been on the medication cart since she started working. The QMA told them she asked the resident several times for his name and she couldn't understand, she thought he was saying Resident C's name. She		designee will monitor a sliding scale insulin administration at random weekly for a month and there after will monitor at random monthly, and after 60 days will monitor quarterly. In addition Director of Nursing will audit sliding scale insulin documentation monthly for 30 days and there after quarterly. 5. By what date the systemic changes will be changed. May 30, 2025	

	then administered the resident his medication. The DON indicated that if the QMA couldn't understand what the resident was saying, she should have asked him for his room number as they are provided with a sheet of resident's names and room numbers for their carts. There were also pictures of the residents and the QMA should have asked the nurse who the resident was if she couldn't understand him. A current Physician's Order indicated the resident was to receive sliding scale Humalog insulin at 6:00 a.m. and 8:00 p.m. based on the following blood sugar results: 151-200=4 units 201-250=8 units 251-300=12 units 301-350=16 units 351-400=20 units The Physician was to be notified if the resident's blood sugar was less than 60 or greater than 400. The February 2025 Diabetic Flow Sheet indicated the resident's blood sugar on 2/7/25 at 8:00 p.m. was 147. He received 4 units of insulin. On 2/12/25 at 8:00 p.m., the			

	resident's blood sugar was 173 and there was no insulin administration documentation. The April 2025 Diabetic Flow Sheet indicated the resident's blood sugar on 4/8/25 at 6:00 a.m. was 153. There was no documentation of insulin administration. During an interview on 5/2/25 at 2:30 p.m., the DON indicated the resident did not receive his sliding scale insulin as ordered. This citation relates to Complaint IN00458671. Based on record review and interview, the facility failed to ensure medications were administered as ordered to the correct resident. This deficient practice resulted in Resident B receiving the wrong medications which resulted in the resident being hospitalized. The facility also failed to ensure sliding scale insulin was administered as ordered for 1 of 7 records reviewed. (Resident B) Finding includes: The record for Resident B was reviewed on 5/1/25 at 1:15 p.m. Diagnoses included, but were not limited to, diabetes and hypertension. A Service Plan, dated 2/20/25, indicated the resident needed assist with decisions as needed			

	for new situations/tasks and assist to enhance resident self-performance patterns, and verbal prompting. A facility Unusual Event Report, dated 4/30/25, indicated Resident B received Resident C's morning medications which consisted of Amlodipine (a medication used to treat chest pain and high blood pressure) 5 milligrams (mg), Austedo (a medication to treat involuntary movements) 9 mg, Entresto (a medication used to treat heart failure) 24-26 mg, Metoprolol (a cardiac medication) 100 mg, Pantoprazole (a heartburn medication) 40 mg, KCl Micro (a potassium supplement) 20 milliequivalents (meq) ER (extended release) tablet, Ziprasidone (an antipsychotic medication) 60 mg, and Clozapine (an antipsychotic medication) 200 mg. The resident was supposed to receive Amlodipine 10 mg, Lipitor (a cholesterol medication) 80 mg, Zyrtec (an allergy medication) 10 mg, Plavix (an antiplatelet) 75 mg, Colace (a stool softener) 100 mg, Duloxetine (an antidepressant) 30 mg, Farxiga (a diabetes medication) 5 mg, Lasix (a diuretic) 40 mg, Gabapentin (a medication for nerve pain) 300 mg, Oxybutynin (a medication for an overactive bladder) 5 mg, Prednisone (a			

	steroid) 10 mg, Spironolactone (a diuretic) 50 mg and Vitamin C 500 mg. After receiving the medications, the resident ambulated down to dietary. After eating breakfast, the staff was made aware by housekeeping that Resident B was down the hall and leaning on the wall. He was being held up by Case Management staff. The staff immediately went to assess the resident and 911 was called. The resident was assisted into a wheelchair and brought to the physician's office for evaluation. The resident appeared lethargic, gray in the face, and short of breath. The resident's vital signs were taken by staff. His blood pressure was 72/53 and his heart rate was 89. Emergency Medical Services (EMS) arrived and transported the resident to the hospital where he was admitted for observation. An IDOH reported incident, dated 5/1/25, indicated on 4/30/25 at 7:40 a.m., Resident B received the wrong medications from QMA 2. QMA 2 indicated the resident came to the nurse's station for his medication. She asked the resident his name three times and stated his voice was jumbled but she thought he said his name was Resident C's name. She administered			

	Resident C's medications to Resident B and realized immediately after it was not his medications. She immediately informed the nurse on duty, RN 1, and then both informed the Director of Nursing, who immediately informed the Primary Care Physician. The physician was on her way to the facility when the incident occurred. The resident was sent to the emergency room for evaluation and he was admitted to the hospital for low blood pressure and low heart rate. On 5/1/25, the QMA was immediately inserviced about medication administration. Nursing staff was also informed about medication administration procedures. The Director of Nursing (DON) and Nursing Consultant would also give continuing education to the QMA and the entire nursing staff on medication administration. During an interview on 5/1/25 at 2:50 p.m., the Administrator and the DON indicated QMA 2 had only been employed by the facility for 5-6 days. The DON indicated she was a newer QMA as well but she had already been on the medication cart since she started working. The QMA told them she asked the resident several times for his name and she couldn't understand, she thought he was			

	saying Resident C's name. She then administered the resident his medication. The DON indicated that if the QMA couldn't understand what the resident was saying, she should have asked him for his room number as they are provided with a sheet of resident's names and room numbers for their carts. There were also pictures of the residents and the QMA should have asked the nurse who the resident was if she couldn't understand him. A current Physician's Order indicated the resident was to receive sliding scale Humalog insulin at 6:00 a.m. and 8:00 p.m. based on the following blood sugar results: 151-200=4 units 201-250=8 units 251-300=12 units 301-350=16 units 351-400=20 units The Physician was to be notified if the resident's blood sugar was less than 60 or greater than 400. The February 2025 Diabetic Flow Sheet indicated the resident's blood sugar on 2/7/25 at 8:00 p.m. was 147. He received 4 units of insulin.			

	On 2/12/25 at 8:00 p.m., the resident's blood sugar was 173 and there was no insulin administration documentation. The April 2025 Diabetic Flow Sheet indicated the resident's blood sugar on 4/8/25 at 6:00 a.m. was 153. There was no documentation of insulin administration. During an interview on 5/2/25 at 2:30 p.m., the DON indicated the resident did not receive his sliding scale insulin as ordered. This citation relates to Complaint IN00458671.			
R 0301	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(5) (5) Labeling of prescription drugs shall include the following: (A) Resident ' s full name. (B) Physician ' s name. (C) Prescription number. (D) Name and strength of the drug. (E) Directions for use. (F) Date of issue and expiration date (when applicable). (G) Name and address of the pharmacy that filled the prescription.	R 0301	1. What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice. The fifteen (15) insulin pens in Medication Cart 1 and nine (9) insulin pens in Medication Cart 3 were labelled with the residents full name, dosage and date insulin pen opened. Insulin pens are labelled upon the receipt in the box and were labelled with the residents last name. Director of Nursing and Administrator contacted Genoa Pharmacy and requested that two sets of labels be sent with the insulin pens when they are delivered.	06/03/2025

	If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted. Based on observation, record review and interview, the facility failed to ensure insulin pens were labeled and dated in 2 of 3 medication carts observed. (Medication Carts 1 and 3) Finding includes: On 5/2/25 at 8:16 a.m., 15 insulin pens were observed in Medication Cart 1. The resident's last name was handwritten on the pen. There was no physician's name, what dose the resident was to receive, and no date of when the insulin pen was opened. At 8:18 a.m., 9 insulin pens were observed in Medication Cart 3. The resident's last name was handwritten on the pen. There was no physician's name, what dose the resident was to receive, and no date of when the insulin pen was opened. During an interview on 5/2/25 at 10:00 a.m., the Director of Nursing indicated the insulin pens should have been labeled appropriately and dated when opened. The current facility policy titled, "Insulin Pen Storage and Use" provided by the Administrator on		2. How the facility will identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken. All residents needing insulin pens have the potential to be affected by the alleged deficient practice. Labels will be sent by Genoa Pharmacy to ensure all information needed is on each individual insulin pen. 3. What measures will be put into place or what systemic changes the facility will make to ensure that the alleged deficient practice does not recur. Genoa pharmacy will supply two sets of labels for all insulin pens. One label will be on the box when the pens are delivered to the facility. The second set of labels will be used when the box is opened and it will contain the residents name, dosage, the physicians name and the date	

	5/2/25 at 10:11 a.m., indicated once an insulin pen was in use, it could be kept at room temperature up to 28 days. Based on observation, record review and interview, the facility failed to ensure insulin pens were labeled and dated in 2 of 3 medication carts observed. (Medication Carts 1 and 3) Finding includes: On 5/2/25 at 8:16 a.m., 15 insulin pens were observed in Medication Cart 1. The resident's last name was handwritten on the pen. There was no physician's name, what dose the resident was to receive, and no date of when the insulin pen was opened. At 8:18 a.m., 9 insulin pens were observed in Medication Cart 3. The resident's last name was handwritten on the pen. There was no physician's name, what dose the resident was to receive, and no date of when the insulin pen was opened. During an interview on 5/2/25 at 10:00 a.m., the Director of Nursing indicated the insulin pens should have been labeled appropriately and dated when opened. The current facility policy titled, "Insulin Pen Storage and Use" provided by the Administrator on 5/2/25 at 10:11 a.m., indicated		when the insulin pen was opened. 4. How will the corrective actions be monitored to ensure the alleged deficient practice will not recur. i.e. what quality assurance program will be put into place. The Director of Nursing and/or designee will monitor the insulin pens at random weekly for a monthly to ensure they are labelled , and thereafter monthly for 60 days and thereafter quarterly. 5. By what date the systemic changes will be changed. June 3, 2025	

	once an insulin pen was in use, it could be kept at room temperature up to 28 days.			
R 0349	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(a)(1-4) (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to ensure clinical records were complete and accurately documented related to oxygen use for 1 of 1 residents reviewed for oxygen. (Resident 4) Finding includes: During an interview on 5/1/25 at 11:24 a.m., the Director of Nursing (DON) indicated Resident 4 used supplemental oxygen. The record for Resident 4 was reviewed on 5/2/25 at 10:45 a.m. Diagnoses included but	R 0349	1. What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice. Resident 4's physician was contacted during survey process, and a new order was noted on resident's Medication Administration Record. Director of Nursing ensured staff was aware of the new order for oxygen. Resident was given an order to discontinue continuous oxygen 1 liter per nasal cannula. Oxygen is PRN if pulse oximetry is below 90. Check pulse oximetry BID. 2. How the facility will identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken. Any resident on oxygen have the potential to be affected by the alleged deficient practice. At present Resident 4 is the only resident with oxygen orders.	06/03/2025

	were not limited to, depression and paranoid schizophrenia. In a note, dated 4/22/25, the nurse indicated she spoke to the resident about when to use her "room oxygen" and when to use the portable oxygen. The record lacked a physician's order for the oxygen. The Medication Administration Record (MAR) did not include oxygen. During an interview on 5/2/25 at 1:15 p.m., the DON indicated the resident had the oxygen when she came back from the hospital, but they did not write an order for it. The administration of oxygen used to be on the MAR when staff documented on paper, but it must have dropped off when they switched to electronic charting. Based on record review and interview, the facility failed to ensure clinical records were complete and accurately documented related to oxygen use for 1 of 1 residents reviewed for oxygen. (Resident 4) Finding includes:		3. What measures will be put into place or what systemic changes the facility will make to ensure that the alleged deficient practice does not recur. Any resident who returns to facility on oxygen from the hospital will have orders reviewed with primary physician upon readmission and oxygen orders will be documented in the MAR. The Director of Nursing and/or designee will in-service staff on oxygen orders on residents when readmitted from hospital and to document such orders in the MAR, to ensure that resident has accurate orders complete, documented, readily accessible and systematically organized. 4. How will the corrective actions be monitored to ensure the alleged deficient practice will not recur. i.e. what quality assurance program will be put into place. Director of Nursing and/or designee will monitor all admission and readmissions to ensure if resident has oxygen orders that are received are carried out properly and documented	

	During an interview on 5/1/25 at 11:24 a.m., the Director of Nursing (DON) indicated Resident 4 used supplemental oxygen. The record for Resident 4 was reviewed on 5/2/25 at 10:45 a.m. Diagnoses included but were not limited to, depression and paranoid schizophrenia. In a note, dated 4/22/25, the nurse indicated she spoke to the resident about when to use her "room oxygen" and when to use the portable oxygen. The record lacked a physician's order for the oxygen. The Medication Administration Record (MAR) did not include oxygen. During an interview on 5/2/25 at 1:15 p.m., the DON indicated the resident had the oxygen when she came back from the hospital, but they did not write an order for it. The administration of oxygen used to be on the MAR when staff documented on paper, but it must have dropped off when they switched to electronic charting.		accurately. Thereafter Director of Nursing and/or designee will randomly audit oxygen orders monthly for 30 days, and quarterly every 90 days. . By what date the systemic changes will be changed. June 3, 2025	
R 0354	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(g)(1-7) (g) A transfer form shall include the following:	R 0354	1. What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice.	06/03/2025

(1) Identification data.

(2) Name of the transferring institution.

(3) Name of the receiving institution and date of transfer.

(4) Resident ' s personal property when transferred to an acute care facility.

(5) Nurses ' notes relating to the resident ' s:

(A) functional abilities and physical limitations;

(B) nursing care;

(C) medications;

(D) treatment; and

(E) current diet and condition on transfer.

(6) Diagnosis.

(7) Date of chest x-ray and skin test for tuberculosis.

Based on record review and interview, the facility failed to ensure a transfer/discharge form was completed for 2 of 7 residents reviewed. (Residents 5 and 4)

Findings include:

1. Record review for Resident 5 was completed on 5/1/25 at 1:16 p.m. Diagnoses included, but were not limited to,

A discharge form was competed for residents 4 and 5 after survey process indicating name of hospital, date of transfer, nursing information related to resident, functional abilities, physical limitations, nursing care, medications, treatment, current diet and resident condition upon transfer.

When residents 4 and 5 were transferred to receiving hospital-medications, diagnosis, identification data were given to EMT's transferring resident as well as a verbal report about functional abilities, physical limitations and reason for transfer. Contact notes were done for both resident 4 and 5 upon transfer.

2. How the facility will identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken.

All residents have the potential to be affected by the alleged deficient practice.

3. What measures will be put into place or what systemic changes the facility will make to ensure that the alleged deficient practice does not recur.

schizophrenia, hypertension, and Graves' disease.

A Contact Note, dated 4/28/25, indicated the resident had been sent out to the hospital due to chest pain.

There was a lack of documentation to indicate a transfer form was completed and sent to the hospital on 4/28/25 that included the name of the receiving institution and date of transfer, nursing notes related to the resident, functional abilities and physical limitations, nursing care, medications, treatments, current diet, or resident condition upon transfer.

During an interview on 5/2/25 at 2:55 p.m., the Director of Nursing indicated no transfer form had been completed.

2. Record review for Resident 4 was completed on 5/2/25 at 10:45 a.m. Diagnoses included, but were not limited to, depression and paranoid schizophrenia.

A Nurse's Note from 4/3/25 at 10:15 p.m. indicated the resident was transferring to the hospital due to trouble breathing.

There was no documentation of a transfer form completed for the resident.

Director of Nursing will Inservice Nursing staff on accurately completing a Transfer form when a resident is being transferred by the Nursing Department to the hospital or receiving institution.

4. How will the corrective actions be monitored to ensure the alleged deficient practice will not recur. i.e. what quality assurance program will be put into place.

Director of Nursing will in-service staff on completing a discharge form with every discharge made by nursing staff to another institution. The discharge form will have identification data, name of receiving institution , name of transferring institution, residents physical property when transferred to an acute care facility. Nursing notes relating to the residents functional abilities and physical limitations, nursing care, medications, treatment, current diet, diagnosis, and date of chest x-ray and skin test for tuberculosis.

Director of Nursing and/or designee will audit discharge forms after each discharge, for thirty days and then weekly thereafter.

	During an interview on 5/2/25 at 2:50 p.m., the DON indicated a transfer form was not completed for the resident going to the hospital. Based on record review and interview, the facility failed to ensure a transfer/discharge form was completed for 2 of 7 residents reviewed. (Residents 5 and 4) Findings include: 1. Record review for Resident 5 was completed on 5/1/25 at 1:16 p.m. Diagnoses included, but were not limited to, schizophrenia, hypertension, and Graves' disease. A Contact Note, dated 4/28/25, indicated the resident had been sent out to the hospital due to chest pain. There was a lack of documentation to indicate a transfer form was completed and sent to the hospital on 4/28/25 that included the name of the receiving institution and date of transfer, nursing notes related to the resident, functional abilities and physical limitations, nursing care, medications, treatments, current diet, or resident condition upon transfer. During an interview on 5/2/25 at 2:55 p.m., the Director of Nursing indicated no transfer		5. By what date the systemic changes will be changed. June 3, 2025	

form had been completed.

2. Record review for Resident 4 was completed on 5/2/25 at 10:45 a.m. Diagnoses included, but were not limited to, depression and paranoid schizophrenia.

A Nurse's Note from 4/3/25 at 10:15 p.m. indicated the resident was transferring to the hospital due to trouble breathing.

There was no documentation of a transfer form completed for the resident.

During an interview on 5/2/25 at 2:50 p.m., the DON indicated a transfer form was not completed for the resident going to the hospital.

Based on record review and interview, the facility failed to ensure a transfer/discharge form was completed for 2 of 7 residents reviewed. (Residents 5 and 4)

Findings include:

1. Record review for Resident 5 was completed on 5/1/25 at 1:16 p.m. Diagnoses included, but were not limited to, schizophrenia, hypertension, and Graves' disease.

A Contact Note, dated 4/28/25, indicated the resident had been sent out to the hospital due to

chest pain.

There was a lack of documentation to indicate a transfer form was completed and sent to the hospital on 4/28/25 that included the name of the receiving institution and date of transfer, nursing notes related to the resident, functional abilities and physical limitations, nursing care, medications, treatments, current diet, or resident condition upon transfer.

During an interview on 5/2/25 at 2:55 p.m., the Director of Nursing indicated no transfer form had been completed.

2. Record review for Resident 4 was completed on 5/2/25 at 10:45 a.m. Diagnoses included, but were not limited to, depression and paranoid schizophrenia.

A Nurse's Note from 4/3/25 at 10:15 p.m. indicated the resident was transferring to the hospital due to trouble breathing.

There was no documentation of a transfer form completed for the resident.

During an interview on 5/2/25 at 2:50 p.m., the DON indicated a transfer form was not completed for the resident going to the hospital.

Based on record review and interview, the facility failed to ensure a transfer/discharge form was completed for 2 of 7 residents reviewed. (Residents 5 and 4)

Findings include:

1. Record review for Resident 5 was completed on 5/1/25 at 1:16 p.m. Diagnoses included, but were not limited to, schizophrenia, hypertension, and Graves' disease.

A Contact Note, dated 4/28/25, indicated the resident had been sent out to the hospital due to chest pain.

There was a lack of documentation to indicate a transfer form was completed and sent to the hospital on 4/28/25 that included the name of the receiving institution and date of transfer, nursing notes related to the resident, functional abilities and physical limitations, nursing care, medications, treatments, current diet, or resident condition upon transfer.

During an interview on 5/2/25 at 2:55 p.m., the Director of Nursing indicated no transfer form had been completed.

2. Record review for Resident 4 was completed on 5/2/25 at 10:45 a.m. Diagnoses included, but were not limited to,

	depression and paranoid schizophrenia. A Nurse's Note from 4/3/25 at 10:15 p.m. indicated the resident was transferring to the hospital due to trouble breathing. There was no documentation of a transfer form completed for the resident. During an interview on 5/2/25 at 2:50 p.m., the DON indicated a transfer form was not completed for the resident going to the hospital.			

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