STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWNE CENTRE ASSISTED LIVING LLC	7252 ARTHUR BLVD, MERRILLVILLE, , 46410

(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 the Investigation of Intakes IN00465317, IN00465354, IN00465443, and IN00465664. Intake IN00465317 - State deficiencies related to the allegations are cited at R0240, R0243, and R0349. Intake IN00465354 - No deficiencies related to the allegations are cited. Intake IN00465443 - No deficiencies related to the allegations are cited. Intake IN00465664 - State deficiencies related to the allegations are cited at R0052. Unrelated deficiencies are cited. Survey dates: October 22 and 23, 2025 Facility number: 002392 Residential Census: 218	R 0000	This plan of correction is submitted as required under State and Federal Law. The submission of the Plan of Correction does not constitute an admission on conclusions drawn therefrom- Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as the concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies."	

	These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 10/29/25.			
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on record review and interview, the facility failed to protect a resident's right to be free from abuse related to a resident with dementia being physically abused by a dietary employee who willingly admitted he had pushed the resident to the ground. This resulted in the resident being sent out to the hospital for an evaluation and observation. (Resident J) Finding includes: The record for Resident J was reviewed on 10/23/25 at 2:00 p.m. Diagnoses included, but	R 0052	R052 • The employee involved was immediately terminated and escorted from the premises by the Merrillville Police Department. • The resident was promptly sent to the hospital for evaluation to ensure their safety and well-being. • The facility conducted interviews with all other residents in the Memory Care unit to determine if any additional incidents of abuse had occurred. No other residents were found to be affected. Measures to Prevent Recurrence of the Deficient Practice • The employee was	11/25/2025

	were not limited to dementia. The resident as admitted to the facility on 9/4/25. A Service Plan, dated 10/23/25, indicated the resident had intermittent aggression, was occasionally disruptive, and staff were to redirect the resident to activities. The resident was oriented to person with mild impairment and disorientation. The resident was independent with transfers and ambulation and was considered to be at risk for falls. A Nurse's Note, dated 10/12/25 at 10:00 a.m., indicated staff had reported the resident walked by a CNA and hit her on the shoulder. Another CNA reported the resident shoved her and tried to take another resident's walker. A dietary aide indicated the resident tried to involve herself with the clean up process and had to be escorted out of the dining room. An activity aide assisted with redirecting the resident. A Nurse's Notes, dated 10/16/25 at 7:15 p.m., indicated the resident was at the nurses' station and was talking negatively to some staff and residents. She was redirected and the conversation was changed. On 10/23/25 at 1:00 p.m., the Administrator indicated she had		permanently terminated. • All staff received mandatory training on abuse and neglect prevention, with ongoing monthly education sessions scheduled for the next six months. • A monitoring tool has been implemented to track compliance and effectiveness of corrective actions and abuse prevention. This tool will be reviewed weekly by both the Human Resources Director and the Executive Director. Systemic Completion Date November 25, 2025	

	just been informed a dietary employee had pushed the resident to the ground and was in route to the unit to find out what happened. A Incident Report, dated 10/23/25 at 1:01 p.m., indicated "staff reported resident was in dining room removing cups from table. Employee stated that resident [name] proceeded to push the employee and the dietary employee shoved resident back. Resident fell down, it is believed she bumped her head however resident stood up and began walking. Neuro checks, assessment initiated, no apparent injuries. 911 called for support and transport." The employee was immediately removed from the unit. A head to toe assessment was performed on the resident with no apparent injuries. 911 was called to request ambulance transport and police assistance. The physician, family and Nurse Practitioner (NP) were notified. The resident agreed to be transported to the hospital for an evaluation. During an interview on 10/23/25 at 1:35 p.m. the Administrator indicated Dietary Employee 1 admitted to pushing down a resident on the Assisted Living Unit after she was observed moving cups around. The			

	Dietary Employee indicated she had pushed him first so he pushed her back and she fell to the floor. Nursing staff called 911 and police responded as well. She immediately started the investigation and reported the incident to the State Agency as well as notified the resident's son. The resident was sent out to the hospital for an evaluation. During an interview on 10/23/25 at 1:41 p.m., CNA 1 indicated she was walking by the dining room and the small door was open. At that time, she heard commotion and witnessed the resident falling to the ground. She did not witness Dietary Employee 1 pushing the resident down. She immediately went over to help the resident and other staff got the nurse. She indicated the resident was not responding after the fall. During an interview on 10/23/25 at 1:45 p.m., Dietary Employee 2 indicated she was passing room trays and was not in the dining room at the time of the incident. Dietary Employee 1 came and got her and told her what had happened. During an interview on 10/23/25 at 1:50 p.m., Resident K indicated she was seated at a table in the dining room eating her lunch. Resident J was walking around the tables and she heard Dietary Employee 1			

say to Resident J "move away from the cart, move away from the cart." Resident K indicated she was not looking up at Resident J because she was eating and when she looked up, Resident J was on the ground.

During an interview on 10/23/25 at 2:10 p.m., the Administrator indicated Dietary Employee 1 was arrested and taken to jail. He admitted what he had done to the police and his actions were captured on the camera that was located in the dining room.

This citation relates to Intake IN00465664.

Based on record review and interview, the facility failed to protect a resident's right to be free from abuse related to a resident with dementia being physically abused by a dietary employee who willingly admitted he had pushed the resident to the ground. This resulted in the resident being sent out to the hospital for an evaluation and observation. (Resident J)

Finding includes:

The record for Resident J was reviewed on 10/23/25 at 2:00 p.m. Diagnoses included, but were not limited to dementia. The resident as admitted to the facility on 9/4/25.

A Service Plan, dated 10/23/25,

	indicated the resident had intermittent aggression, was occasionally disruptive, and staff were to redirect the resident to activities. The resident was oriented to person with mild impairment and disorientation. The resident was independent with transfers and ambulation and was considered to be at risk for falls. A Nurse's Note, dated 10/12/25 at 10:00 a.m., indicated staff had reported the resident walked by a CNA and hit her on the shoulder. Another CNA reported the resident shoved her and tried to take another resident's walker. A dietary aide indicated the resident tried to involve herself with the clean up process and had to be escorted out of the dining room. An activity aide assisted with redirecting the resident. A Nurse's Notes, dated 10/16/25 at 7:15 p.m., indicated the resident was at the nurses' station and was talking negatively to some staff and residents. She was redirected and the conversation was changed.			

	On 10/23/25 at 1:00 p.m., the Administrator indicated she had just been informed a dietary employee had pushed the resident to the ground and was in route to the unit to find out what happened. A Incident Report, dated 10/23/25 at 1:01 p.m., indicated "staff reported resident was in dining room removing cups from table. Employee stated that resident [name] proceeded to push the employee and the dietary employee shoved resident back. Resident fell down, it is believed she bumped her head however resident stood up and began walking. Neuro checks, assessment initiated, no apparent injuries. 911 called for support and transport." The employee was immediately removed from the unit. A head to toe assessment was performed on the resident with no apparent injuries. 911 was called to request ambulance transport and police assistance. The physician, family and Nurse Practitioner (NP) were notified. The resident agreed to be transported to the hospital for an evaluation. During an interview on 10/23/25 at 1:35 p.m. the Administrator indicated Dietary Employee 1 admitted to pushing down a resident on the Assisted Living			

	Unit after she was observed moving cups around. The Dietary Employee indicated she had pushed him first so he pushed her back and she fell to the floor. Nursing staff called 911 and police responded as well. She immediately started the investigation and reported the incident to the State Agency as well as notified the resident's son. The resident was sent out to the hospital for an evaluation. During an interview on 10/23/25 at 1:41 p.m., CNA 1 indicated she was walking by the dining room and the small door was open. At that time, she heard commotion and witnessed the resident falling to the ground. She did not witness Dietary Employee 1 pushing the resident down. She immediately went over to help the resident and other staff got the nurse. She indicated the resident was not responding after the fall. During an interview on 10/23/25 at 1:45 p.m., Dietary Employee 2 indicated she was passing room trays and was not in the dining room at the time of the incident. Dietary Employee 1 came and got her and told her what had happened. During an interview on 10/23/25 at 1:50 p.m., Resident K indicated she was seated at a table in the dining room eating her lunch. Resident J was			

	walking around the tables and she heard Dietary Employee 1 say to Resident J "move away from the cart, move away from the cart." Resident K indicated she was not looking up at Resident J because she was eating and when she looked up, Resident J was on the ground. During an interview on 10/23/25 at 2:10 p.m., the Administrator indicated Dietary Employee 1 was arrested and taken to jail. He admitted what he had done to the police and his actions were captured on the camera that was located in the dining room. This citation relates to Intake IN00465664.			
R 0240	Health Services - Deficiency 410 IAC 16.2-5-4(d) (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on record review and interview, the facility failed to provide personal care and assistance with activities of daily living (ADLs) related to showers for 3 of 8 sampled residents. (Residents C, G, and H) Findings include: 1. The record for Resident C	R 0240	R240 1. Corrective actions for residents found to have been affected: Resident C, G, and H each received showers upon identification of the missed care opportunities. Their Service Plans were reviewed and updated to ensure shower preferences, refusals, and any modifications are	11/17/2025

	was reviewed on 10/22/25 at 11:25 a.m. Diagnoses included, but were not limited to, dementia, anxiety, adult failure to thrive and high blood pressure. The Service Plan, dated 5/29/25, indicated the resident refused showers and the family was aware. The resident was to receive a shower on Monday and Thursday during the day. The hand written shower records indicated the resident did not receive a shower on 8/2, 8/19, 8/30, 9/2, 9/9, 9/16, 9/20, 9/23, 9/27, 10/2, and 10/7/25. There was no documentation in the nursing progress notes the resident refused to take shower on the above mentioned dates. During an interview on 10/23/25 at 3:30 p.m., the Assistant Director of Nursing indicated the resident should have received at least two showers a week. 2. The record for Resident G was reviewed on 10/23/25 at 8:40 a.m. Diagnoses included, but were not limited to, altered mental status and hallucinations. A Service Plan, dated 6/2024, indicated the resident needed full assistance with bathing. The resident was to receive a		clearly documented. On 11/7-11/13 Nursing and direct care staff will be re-educated on the importance of documenting shower refusals and notifying the nurse or supervisor of any refusals or missed ADL care. Families of the affected residents were notified of corrective actions taken. 2. Identification of other residents with potential to be affected and corrective actions: A facility-wide audit of all residents' shower schedules and ADL documentation were completed on 11/6/2025 by the Director of Nursing for the past 30 days was completed to identify any missed or undocumented showers. Any missed care was immediately provided, and documentation was updated. Any patterns of refusals or	

	shower on Sunday and Wednesday during the day. The hand written shower record for 9/2025 indicated the resident did not receive a shower on 9/7/25. During an interview on 10/23/25 at 3:30 p.m., the Assistant Director of Nursing indicated the resident should have received at least two showers a week. 3. The record for Resident H was reviewed on 10/23/25 at 7:25 a.m. Diagnoses included, but were not limited to, dementia, chronic kidney disease, high blood pressure, and hypothyroidism. A Service Plan dated 6/1/25, indicated the resident needed full assistance with bathing. The resident was to receive a shower on Tuesday and Saturday during the day. The hand written shower records for 9/2025 and 10/20/25 indicated the resident did not receive a shower on 9/6, 9/13, and 10/11/25. During an interview on 10/23/25 at 3:30 p.m., the Assistant Director of Nursing indicated the resident should have received at least two showers a week. This citation relates to Intake IN00465317. Based on record review and		missed ADLs were reviewed by the Director of Nursing and care plans were revised accordingly. 3. Measures or systemic changes to ensure the deficient practice does not recur: A Shower and ADL Documentation Policy have been created and reviewed by the facility's care managers to ensure that: All shower refusals are documented at the time of occurrence, with the reason noted. The nurse on duty reviews daily shower logs for completeness and follows up on any missed showers. All direct care staff received re-education on ADL care expectations, shower scheduling, and documentation requirements on November 5th-November 13 regarding shower procedures. The DON or designee will review shower schedules three	

	interview, the facility failed to provide personal care and assistance with activities of daily living (ADLs) related to showers for 3 of 8 sampled residents. (Residents C, G, and H) Findings include: 1. The record for Resident C was reviewed on 10/22/25 at 11:25 a.m. Diagnoses included, but were not limited to, dementia, anxiety, adult failure to thrive and high blood pressure. The Service Plan, dated 5/29/25, indicated the resident refused showers and the family was aware. The resident was to receive a shower on Monday and Thursday during the day. The hand written shower records indicated the resident did not receive a shower on 8/2, 8/19, 8/30, 9/2, 9/9, 9/16, 9/20, 9/23, 9/27, 10/2, and 10/7/25. There was no documentation in the nursing progress notes the resident refused to take shower on the above mentioned dates. During an interview on 10/23/25 at 3:30 p.m., the Assistant Director of Nursing indicated the resident should have received at least two showers a week. 2. The record for Resident G was reviewed on 10/23/25 at		times per week to verify compliance and address barriers to care (e.g., resident refusals, scheduling conflicts). 4. Monitoring to ensure the deficient practice will not recur (Quality Assurance): The DON or designee will conduct weekly audits of shower records three times per week for 6 months then weekly for 6 months toverify that all residents receive showers per their Service Plans or have documented refusals. Results of audits will be reviewed in the Quality Assurance and Performance Improvement Committee meetings monthly for ongoing monitoring and corrective follow-up. Any identified trends or noncompliance will result in immediate re-education and corrective action. 5. Completion date for systemic changes:	

	8:40 a.m. Diagnoses included, but were not limited to, altered mental status and hallucinations. A Service Plan, dated 6/2024, indicated the resident needed full assistance with bathing. The resident was to receive a shower on Sunday and Wednesday during the day. The hand written shower record for 9/2025 indicated the resident did not receive a shower on 9/7/25. During an interview on 10/23/25 at 3:30 p.m., the Assistant Director of Nursing indicated the resident should have received at least two showers a week. 3. The record for Resident H was reviewed on 10/23/25 at 7:25 a.m. Diagnoses included, but were not limited to, dementia, chronic kidney disease, high blood pressure, and hypothyroidism. A Service Plan dated 6/1/25, indicated the resident needed full assistance with bathing. The resident was to receive a shower on Tuesday and Saturday during the day. The hand written shower records for 9/2025 and 10/20/25 indicated the resident did not receive a shower on 9/6, 9/13, and 10/11/25.		All corrective actions and systemic changes will be completed by 11/17/25	

	During an interview on 10/23/25 at 3:30 p.m., the Assistant Director of Nursing indicated the resident should have received at least two showers a week. This citation relates to Intake IN00465317.			
R 0243	Health Services - Deficiency 410 IAC 16.2-5-4(e)(3) (3) The individual administering the medication shall document the administration in the individual ' s medication and treatment records that indicate the: (A) time; (B) name of medication or treatment; (C) dosage (if applicable); and (D) name or initials of the person administering the drug or treatment. Based on record review and interview, the facility failed to ensure medications were signed out as being administered for 3 of 9 records reviewed. (Residents D, G, and H) Findings include: 1. The record for Resident D was reviewed on 10/22/25 at 11:20 a.m. Diagnoses included, but were not limited to, congestive heart failure (CHF),	R 0243	R 243 Resident D: Corrective actions were not applicable, as the resident has passed away. Residents H and G: The family and attending physician were notified of the identified deficiency. Two health assessments were completed to evaluate any potential health factors related to the deficiency; no concerns were noted at that time. Facility-Wide Actions: To identify other residents potentially affected by the deficient practice, the facility	11/21/2025

	chronic obstructive pulmonary disease (COPD), and diabetes. Physician's Orders, dated 9/12/25, indicated the resident was to receive Morphine (a pain medication) 100 milligrams (mg) per 5 milliliters (ml) give 0.25 ml's every 4 hours as needed (PRN) for shortness of breath or agitation and Lorazepam (an antianxiety medication) 0.5 mg every 4 hours PRN. The Individual Resident Controlled Substance Count Sheet indicated the resident received the Morphine on 9/9/25 at 4:25 a.m., and on 9/30/25 at 8:30 p.m. and 10:30 p.m. The Lorazepam was administered on 9/30/25 at 10:22 a.m. and 6:30 p.m. The September 2025 Medication Administration Record (MAR), indicated the Morphine and Lorazepam for the above dates were signed out on the Controlled Substance Count Sheet but not on the MAR. Physician's Orders, dated 10/1/25, indicated the PRN Morphine and Lorazepam were to be given every two hours. The Individual Resident Controlled Substance Count Sheet indicated the resident received the Morphine on 10/1/25 at 7:45 p.m., 9:45 p.m., and 11:45 p.m. as well as on		conducted a comprehensive audit of all medication records from October 1 through October 31, were reviewed by facility care management team. Meetings are scheduled with all facility nurses and Qualified Medication Aides (QMAs) on November 7 through November 11 to confirm that all medications were administered in accordance with physicians' orders. An in-service training for all nursing and QMA staff is scheduled from November 10 through November 15, focusing on proper medication administration and documentation procedures. Preventive Measures: To prevent recurrence of the deficient practice, the Director of Nursing will conduct monthly in-service trainings on medication administration and documentation for all nurses and QMAs over the next six months.	

	10/2/25 at 1:45 a.m. The Lorazepam was given on 10/1/25 at 7:45 p.m., 9:45 p.m., and 11:45 p.m. as well as on 10/2/25 at 1:40 a.m. and 3:40 a.m. The October 2025 Medication Administration Record (MAR), indicated the Morphine and Lorazepam for the above dates were signed out on the Controlled Substance Count Sheet but not on the MAR. During an interview on 10/23/25 at 3:41 p.m., the Director of Nursing indicated the medications should have been signed out on the Controlled Substance Count Sheet and the MAR. 2. The record for Resident G was reviewed on 10/23/25 at 8:40 a.m. Diagnoses included, but were not limited to, altered mental status and hallucinations. A Nurse's Note, dated 8/8/25 (no time), indicated the resident fell out of bed and an ambulance was called. The resident was admitted to the hospital. A Nurse's Note, dated 8/11/25 at 3:15 p.m., indicated the resident returned from hospital with new orders for an antibiotic for an urinary tract infection (UTI).		Additionally, the Director of Nursing or a designated staff member will review medication administration records three times per week for six months, followed by monthly reviews for an additional six months to ensure compliance. Monitoring: Corrective actions will be tracked using a quality assurance tool to ensure ongoing compliance and effectiveness. Completion Date for Systemic Changes: All systemic changes will be fully implemented by November 21, 2025.	

	A Physician's Order, dated 8/11/25, indicated Cefdinir (an antibiotic) 300 milligrams (mg) twice a day for five days. The Medication Administration Record for 8/2025, indicated the antibiotic was not available on 8/12/25 and a handwritten note on the backside of MAR indicated "the a.m. and p.m. doses were not available med not passed." The antibiotic was signed out as being administrated on 8/13, 8/14, 8/15, and 8/16 twice a day, however, it was stopped after 8/16/25 and not administered for the full five days. During an interview on 10/23/25 at 11:00 a.m., the Assistant Director of Nursing indicated the antibiotic should have administered as ordered by the Physician. 3. The record for Resident H was reviewed on 10/23/25 at 7:25 a.m. Diagnoses included, but were not limited to, dementia, chronic kidney disease, high blood pressure, and hypothyroidism.			

Physician Orders, dated 6/2/25, indicated Levothyroxine (a medication used for the thyroid) 88 micrograms (mcg) upon rising. Aspirin 81 milligrams (mg) and Omeprazole 40 mg daily in the morning.

A Physician's Order, dated 6/4/25, indicated Trelegy 1 puff daily in the morning.

A Physician's Order, dated 8/1/25, indicated Amlodipine (a medication used to lower the blood pressure) 5 mg daily in the morning.

A Physician's Order, dated 8/25/25, indicated Vitamin D 2 1.25 mg/50,000 units take 1 capsule every Sunday in the morning.

The 8/2025 Medication Administration Record (MAR), indicated the Levothyroxine was blank and not administered on 8/1, 8/9, 8/15, 8/16, 8/17, 8/21, and 8/25/25.

The 9/2025 MAR indicated Levothyroxine was blank and not administered on 9/15 and 9/16/25.

The 10/2025 MAR indicated the Trelegy, Amlodipine, Aspirin, and Omeprazole were blank and not administered on 10/17 and 10/19/25. The Levothyroxine was blank and not administered on 10/6 and 10/16/25 and Vitamin D 2 was

blank and not administered on 10/19/25.

During an interview on 10/23/25 at 3:30 p.m., the Assistant Director of Nursing indicated the all medications were to be signed out on the MAR after administration.

This citation relates to Intake IN00465317.

Based on record review and interview, the facility failed to ensure medications were signed out as being administered for 3 of 9 records reviewed. (Residents D, G, and H)

Findings include:

1. The record for Resident D was reviewed on 10/22/25 at 11:20 a.m. Diagnoses included, but were not limited to, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), and diabetes.

Physician's Orders, dated 9/12/25, indicated the resident was to receive Morphine (a pain medication) 100 milligrams (mg) per 5 milliliters (ml) give 0.25 ml's every 4 hours as needed (PRN) for shortness of breath or agitation and Lorazepam (an antianxiety medication) 0.5 mg every 4 hours PRN.

The Individual Resident Controlled Substance Count Sheet indicated the resident

	received the Morphine on 9/9/25 at 4:25 a.m., and on 9/30/25 at 8:30 p.m. and 10:30 p.m. The Lorazepam was administered on 9/30/25 at 10:22 a.m. and 6:30 p.m. The September 2025 Medication Administration Record (MAR), indicated the Morphine and Lorazepam for the above dates were signed out on the Controlled Substance Count Sheet but not on the MAR. Physician's Orders, dated 10/1/25, indicated the PRN Morphine and Lorazepam were to be given every two hours. The Individual Resident Controlled Substance Count Sheet indicated the resident received the Morphine on 10/1/25 at 7:45 p.m., 9:45 p.m., and 11:45 p.m. as well as on 10/2/25 at 1:45 a.m. The Lorazepam was given on 10/1/25 at 7:45 p.m., 9:45 p.m., and 11:45 p.m. as well as on 10/2/25 at 1:40 a.m. and 3:40 a.m. The October 2025 Medication Administration Record (MAR), indicated the Morphine and Lorazepam for the above dates were signed out on the Controlled Substance Count Sheet but not on the MAR. During an interview on 10/23/25 at 3:41 p.m., the Director of			

Nursing indicated the medications should have been signed out on the Controlled Substance Count Sheet and the MAR.

2. The record for Resident G was reviewed on 10/23/25 at 8:40 a.m. Diagnoses included, but were not limited to, altered mental status and hallucinations.

A Nurse's Note, dated 8/8/25 (no time), indicated the resident fell out of bed and an ambulance was called. The resident was admitted to the hospital.

A Nurse's Note, dated 8/11/25 at 3:15 p.m., indicated the resident returned from hospital with new orders for an antibiotic for an urinary tract infection (UTI).

A Physician's Order, dated 8/11/25, indicated Cefdinir (an antibiotic) 300 milligrams (mg) twice a day for five days.

The Medication Administration Record for 8/2025, indicated the antibiotic was not available on 8/12/25 and a handwritten note on the backside of MAR indicated "the a.m. and p.m. doses were not available med not passed."

The antibiotic was signed out as being administrated on 8/13, 8/14, 8/15, and 8/16 twice a

day, however, it was stopped after 8/16/25 and not administered for the full five days.

During an interview on 10/23/25 at 11:00 a.m., the Assistant Director of Nursing indicated the antibiotic should have administered as ordered by the Physician.

3. The record for Resident H was reviewed on 10/23/25 at 7:25 a.m. Diagnoses included, but were not limited to, dementia, chronic kidney disease, high blood pressure, and hypothyroidism.

Physician Orders, dated 6/2/25, indicated Levothyroxine (a medication used for the thyroid) 88 micrograms (mcg) upon rising. Aspirin 81 milligrams (mg) and Omeprazole 40 mg daily in the morning.

A Physician's Order, dated 6/4/25, indicated Trelegy 1 puff daily in the morning.

A Physician's Order, dated 8/1/25, indicated Amlodipine (a medication used to lower the blood pressure) 5 mg daily in the morning.

A Physician's Order, dated 8/25/25, indicated Vitamin D 2 1.25 mg/50,000 units take 1 capsule every Sunday in the morning.

	The 8/2025 Medication Administration Record (MAR), indicated the Levothyroxine was blank and not administered on 8/1, 8/9, 8/15, 8/16, 8/17, 8/21, and 8/25/25. The 9/2025 MAR indicated Levothyroxine was blank and not administered on 9/15 and 9/16/25. The 10/2025 MAR indicated the Trelegy, Amlodipine, Aspirin, and Omeprazole were blank and not administered on 10/17 and 10/19/25. The Levothyroxine was blank and not administered on 10/6 and 10/16/25 and Vitamin D 2 was blank and not administered on 10/19/25. During an interview on 10/23/25 at 3:30 p.m., the Assistant Director of Nursing indicated the all medications were to be signed out on the MAR after administration. This citation relates to Intake IN00465317. Based on record review and interview, the facility failed to ensure medications were signed out as being administered for 3 of 9 records reviewed. (Residents D, G, and H) Findings include: 1. The record for Resident D was reviewed on 10/22/25 at			

	11:20 a.m. Diagnoses included, but were not limited to, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), and diabetes. Physician's Orders, dated 9/12/25, indicated the resident was to receive Morphine (a pain medication) 100 milligrams (mg) per 5 milliliters (ml) give 0.25 ml's every 4 hours as needed (PRN) for shortness of breath or agitation and Lorazepam (an antianxiety medication) 0.5 mg every 4 hours PRN. The Individual Resident Controlled Substance Count Sheet indicated the resident received the Morphine on 9/9/25 at 4:25 a.m., and on 9/30/25 at 8:30 p.m. and 10:30 p.m. The Lorazepam was administered on 9/30/25 at 10:22 a.m. and 6:30 p.m. The September 2025 Medication Administration Record (MAR), indicated the Morphine and Lorazepam for the above dates were signed out on the Controlled Substance Count Sheet but not on the MAR. Physician's Orders, dated 10/1/25, indicated the PRN Morphine and Lorazepam were to be given every two hours. The Individual Resident Controlled Substance Count Sheet indicated the resident			

	received the Morphine on 10/1/25 at 7:45 p.m., 9:45 p.m., and 11:45 p.m. as well as on 10/2/25 at 1:45 a.m. The Lorazepam was given on 10/1/25 at 7:45 p.m., 9:45 p.m., and 11:45 p.m. as well as on 10/2/25 at 1:40 a.m. and 3:40 a.m. The October 2025 Medication Administration Record (MAR), indicated the Morphine and Lorazepam for the above dates were signed out on the Controlled Substance Count Sheet but not on the MAR. During an interview on 10/23/25 at 3:41 p.m., the Director of Nursing indicated the medications should have been signed out on the Controlled Substance Count Sheet and the MAR. 2. The record for Resident G was reviewed on 10/23/25 at 8:40 a.m. Diagnoses included, but were not limited to, altered mental status and hallucinations. A Nurse's Note, dated 8/8/25 (no time), indicated the resident fell out of bed and an ambulance was called. The resident was admitted to the hospital. A Nurse's Note, dated 8/11/25 at 3:15 p.m., indicated the resident returned from hospital with new orders for an antibiotic			

for an urinary tract infection (UTI).

A Physician's Order, dated 8/11/25, indicated Cefdinir (an antibiotic) 300 milligrams (mg) twice a day for five days.

The Medication Administration Record for 8/2025, indicated the antibiotic was not available on 8/12/25 and a handwritten note on the backside of MAR indicated "the a.m. and p.m. doses were not available med not passed."

The antibiotic was signed out as being administrated on 8/13, 8/14, 8/15, and 8/16 twice a day, however, it was stopped after 8/16/25 and not administered for the full five days.

During an interview on 10/23/25 at 11:00 a.m., the Assistant Director of Nursing indicated the antibiotic should have administered as ordered by the Physician.

3. The record for Resident H was reviewed on 10/23/25 at 7:25 a.m. Diagnoses included, but were not limited to, dementia, chronic kidney disease, high blood pressure, and hypothyroidism.

Physician Orders, dated 6/2/25, indicated Levothyroxine (a medication used for the thyroid) 88 micrograms (mcg) upon

rising. Aspirin 81 milligrams (mg) and Omeprazole 40 mg daily in the morning.

A Physician's Order, dated 6/4/25, indicated Trelegy 1 puff daily in the morning.

A Physician's Order, dated 8/1/25, indicated Amlodipine (a medication used to lower the blood pressure) 5 mg daily in the morning.

A Physician's Order, dated 8/25/25, indicated Vitamin D 2 1.25 mg/50,000 units take 1 capsule every Sunday in the morning.

The 8/2025 Medication Administration Record (MAR), indicated the Levothyroxine was blank and not administered on 8/1, 8/9, 8/15, 8/16, 8/17, 8/21, and 8/25/25.

The 9/2025 MAR indicated Levothyroxine was blank and not administered on 9/15 and 9/16/25.

The 10/2025 MAR indicated the Trelegy, Amlodipine, Aspirin, and Omeprazole were blank and not administered on 10/17 and 10/19/25. The Levothyroxine was blank and not administered on 10/6 and 10/16/25 and Vitamin D 2 was blank and not administered on 10/19/25.

During an interview on 10/23/25

at 3:30 p.m., the Assistant Director of Nursing indicated the all medications were to be signed out on the MAR after administration.

This citation relates to Intake IN00465317.

Based on record review and interview, the facility failed to ensure medications were signed out as being administered for 3 of 9 records reviewed. (Residents D, G, and H)

Findings include:

1. The record for Resident D was reviewed on 10/22/25 at 11:20 a.m. Diagnoses included, but were not limited to, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), and diabetes.

Physician's Orders, dated 9/12/25, indicated the resident was to receive Morphine (a pain medication) 100 milligrams (mg) per 5 milliliters (ml) give 0.25 ml's every 4 hours as needed (PRN) for shortness of breath or agitation and Lorazepam (an antianxiety medication) 0.5 mg every 4 hours PRN.

The Individual Resident Controlled Substance Count Sheet indicated the resident received the Morphine on 9/9/25 at 4:25 a.m., and on 9/30/25 at 8:30 p.m. and 10:30 p.m. The Lorazepam was administered

on 9/30/25 at 10:22 a.m. and 6:30 p.m.

The September 2025 Medication Administration Record (MAR), indicated the Morphine and Lorazepam for the above dates were signed out on the Controlled Substance Count Sheet but not on the MAR.

Physician's Orders, dated 10/1/25, indicated the PRN Morphine and Lorazepam were to be given every two hours.

The Individual Resident Controlled Substance Count Sheet indicated the resident received the Morphine on 10/1/25 at 7:45 p.m., 9:45 p.m., and 11:45 p.m. as well as on 10/2/25 at 1:45 a.m. The Lorazepam was given on 10/1/25 at 7:45 p.m., 9:45 p.m., and 11:45 p.m. as well as on 10/2/25 at 1:40 a.m. and 3:40 a.m.

The October 2025 Medication Administration Record (MAR), indicated the Morphine and Lorazepam for the above dates were signed out on the Controlled Substance Count Sheet but not on the MAR.

During an interview on 10/23/25 at 3:41 p.m., the Director of Nursing indicated the medications should have been signed out on the Controlled Substance Count Sheet and the

	MAR. 2. The record for Resident G was reviewed on 10/23/25 at 8:40 a.m. Diagnoses included, but were not limited to, altered mental status and hallucinations. A Nurse's Note, dated 8/8/25 (no time), indicated the resident fell out of bed and an ambulance was called. The resident was admitted to the hospital. A Nurse's Note, dated 8/11/25 at 3:15 p.m., indicated the resident returned from hospital with new orders for an antibiotic for an urinary tract infection (UTI). A Physician's Order, dated 8/11/25, indicated Cefdinir (an antibiotic) 300 milligrams (mg) twice a day for five days. The Medication Administration Record for 8/2025, indicated the antibiotic was not available on 8/12/25 and a handwritten note on the backside of MAR indicated "the a.m. and p.m. doses were not available med not passed."			

The antibiotic was signed out as being administrated on 8/13, 8/14, 8/15, and 8/16 twice a day, however, it was stopped after 8/16/25 and not administered for the full five days.

During an interview on 10/23/25 at 11:00 a.m., the Assistant Director of Nursing indicated the antibiotic should have administered as ordered by the Physician.

3. The record for Resident H was reviewed on 10/23/25 at 7:25 a.m. Diagnoses included, but were not limited to, dementia, chronic kidney disease, high blood pressure, and hypothyroidism.

Physician Orders, dated 6/2/25, indicated Levothyroxine (a medication used for the thyroid) 88 micrograms (mcg) upon rising. Aspirin 81 milligrams (mg) and Omeprazole 40 mg daily in the morning.

A Physician's Order, dated 6/4/25, indicated Trelegy 1 puff daily in the morning.

A Physician's Order, dated 8/1/25, indicated Amlodipine (a medication used to lower the blood pressure) 5 mg daily in the morning.

A Physician's Order, dated 8/25/25, indicated Vitamin D 2 1.25 mg/50,000 units take 1

	capsule every Sunday in the morning. The 8/2025 Medication Administration Record (MAR), indicated the Levothyroxine was blank and not administered on 8/1, 8/9, 8/15, 8/16, 8/17, 8/21, and 8/25/25. The 9/2025 MAR indicated Levothyroxine was blank and not administered on 9/15 and 9/16/25. The 10/2025 MAR indicated the Trelegy, Amlodipine, Aspirin, and Omeprazole were blank and not administered on 10/17 and 10/19/25. The Levothyroxine was blank and not administered on 10/6 and 10/16/25 and Vitamin D 2 was blank and not administered on 10/19/25. During an interview on 10/23/25 at 3:30 p.m., the Assistant Director of Nursing indicated the all medications were to be signed out on the MAR after administration. This citation relates to Intake IN00465317.			
R 0296	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(b) (b) The facility shall maintain clear written policies and procedures on	R 0296	R 296 Licensed Practical Nurse (LPN 1) and Qualified Medication	11/21/2025

	medication assistance. The facility shall provide for ongoing training to ensure competence of medication staff. Based on observation, record review, and interview, the facility failed to ensure offgoing facility nursing personnel completed a narcotic count with the oncoming nursing staff during each change of shift for 1 of 3 units. (The Assisted Living Unit) Finding includes: During an observation on 10/23/25 at 7:20 a.m., LPN 1 and LPN 2 were standing at the A/B nurses' station on the Assisted Living Unit. LPN 1 had worked the midnight shift and LPN 2 was the oncoming nurse. LPN 1 finished the report and told LPN 2 she was leaving. At 7:35 a.m., LPN 2 was asked to open the locked refrigerator inside the medication room. She indicated she would, however, she had not counted the narcotics that were inside. LPN 2 unlocked the refrigerator and inside were 2 baskets with pre-filled syringes of Morphine Sulfate and Lorazepam. During an interview at that time, LPN 2 indicated she did not count the narcotics with LPN 1 before she left. She indicated when she worked on the Independent Living Unit, the		Aide (QMA 1) received disciplinary coaching and education regarding failure to follow facility policy on narcotic counting. Facility-Wide Review: To determine if other staff or residents may have been affected by the deficient practice, the facility conducted a complete audit of all narcotics and narcotic logbook. The audit confirmed that no narcotics were missing and all were accounted for according to the narcotic logbook. Additionally, the Director of Nursing conducted individual interviews with relevant staff to reinforce the facility’s mandatory narcotic counting policy. An educational in-service will be completed on 11/10/2025 for all QMA and nursing staff to ensure compliance with narcotic counting procedures. Preventive Measures:	

	narcotics were counted before the offgoing nurse left. "Sometimes that was completed over here and sometimes it was not." At 7:41 a.m., LPN 2 sat down at the nurses' station and begun to count the pre-filled syringes of the Morphine Sulfate and the Lorazepam by herself. There were 55 Lorazepam pre-filled syringes and 60 pre-filled Morphine Sulfate syringes inside the baskets. After completing the count, she signed her name on the narcotic count form. LPN 1 had signed the form as well for 10/23/25, however, she was not present for the count. During an interview on 10/23/25 at 8:00 a.m., QMA 1 indicated she had counted the narcotics by herself before she started medication pass. She indicated sometimes the offgoing nurse will count and sometimes she will not. LPN 1's signature was observed on the narcotic form as counting with QMA 1 on 10/23/25. The QMA indicated she was aware that two staff members needed to count the narcotics together. During an interview on 10/23/25 at 11:00 a.m., the Assistant Director of Nursing indicated there should have been 2 nurses or the QMA counting the		To prevent recurrence, the Director of Nursing will conduct narcotic count audits three times per week for 6 months using a standardized audit tool. These audits will include both visual inspections and documentation reviews to verify compliance with facility policy. The corrective actions will be monitored by the Director of Nursing or designee using a quality assurance tool to ensure sustained compliance. Systemic Change Completion Date: All systemic changes will be fully implemented by November 21, 2025.	

narcotics together at the end/start of their shift.

The current and undated "Narcotic and Controlled Drug" policy, provided by the Medical Records Liaison on 10/23/25 at 2:45 p.m., indicated at each shift change, the narcotics count should be verified by the oncoming and previous shift. Each narcotic sheet should be verified with an actual count of the medications. The narcotic sheet should be signed by both the oncoming and previous shift employee partners.

Based on observation, record review, and interview, the facility failed to ensure offgoing facility nursing personnel completed a narcotic count with the oncoming nursing staff during each change of shift for 1 of 3 units. (The Assisted Living Unit)

Finding includes:

During an observation on 10/23/25 at 7:20 a.m., LPN 1 and LPN 2 were standing at the A/B nurses' station on the Assisted Living Unit. LPN 1 had worked the midnight shift and LPN 2 was the oncoming nurse. LPN 1 finished the report and told LPN 2 she was leaving.

At 7:35 a.m., LPN 2 was asked to open the locked refrigerator inside the medication room. She indicated she would, however, she had not counted the

narcotics that were inside. LPN 2 unlocked the refrigerator and inside were 2 baskets with pre-filled syringes of Morphine Sulfate and Lorazepam.

During an interview at that time, LPN 2 indicated she did not count the narcotics with LPN 1 before she left. She indicated when she worked on the Independent Living Unit, the narcotics were counted before the offgoing nurse left. "Sometimes that was completed over here and sometimes it was not."

At 7:41 a.m., LPN 2 sat down at the nurses' station and begun to count the pre-filled syringes of the Morphine Sulfate and the Lorazepam by herself. There were 55 Lorazepam pre-filled syringes and 60 pre-filled Morphine Sulfate syringes inside the baskets.

After completing the count, she signed her name on the narcotic count form. LPN 1 had signed the form as well for 10/23/25, however, she was not present for the count.

During an interview on 10/23/25 at 8:00 a.m., QMA 1 indicated she had counted the narcotics by herself before she started medication pass. She indicated sometimes the offgoing nurse will count and sometimes she will not. LPN 1's signature was

	observed on the narcotic form as counting with QMA 1 on 10/23/25. The QMA indicated she was aware that two staff members needed to count the narcotics together. During an interview on 10/23/25 at 11:00 a.m., the Assistant Director of Nursing indicated there should have been 2 nurses or the QMA counting the narcotics together at the end/start of their shift. The current and undated "Narcotic and Controlled Drug" policy, provided by the Medical Records Liaison on 10/23/25 at 2:45 p.m., indicated at each shift change, the narcotics count should be verified by the oncoming and previous shift. Each narcotic sheet should be verified with an actual count of the medications. The narcotic sheet should be signed by both the oncoming and previous shift employee partners.			
R 0300	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(4) (4) Over-the-counter medications, prescription drugs, and biologicals used in the facility must be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration	R 0300	R300 The expired medication was immediately discarded upon identification. Facility-Wide Review:	11/17/2025

	date. Based on observation, record review, and interview, the facility failed to ensure expired antianxiety medications were disposed of for 1 of 3 residents reviewed for hospice services. (Resident F) Finding includes: During a random observation on 10/23/25 at 12:40 p.m., 19 pre-filled syringes of Lorazepam (an antianxiety medication) for Resident F were noted in the Memory Care Unit medication refrigerator. The Lorazepam syringes were dispensed on 5/19/25 and expired on 7/29/25. There were 18 pre-filled syringes of Lorazepam that were dispensed on 5/30/25 and expired on 8/28/25. The record for Resident F was reviewed on 10/23/25 at 8:28 a.m. Diagnoses included, but were not limited to, dementia and anxiety. A Physician's Order, dated 4/26/25, indicated the resident was to receive Lorazepam 0.5 milligrams (mg) 0.25 milliliters (ml) every 2 hours as needed (PRN) for anxiety. The August, September, and October 2025 Medication Administration Records (MARs) indicated the resident had not		To determine if other residents may have been affected by the deficient practice, the facility conducted a comprehensive audit of all medications on hand from November 6 through November 11. Any expired medications identified during the audit were promptly discarded and reordered as necessary. No residents were noted to be affected at that time. Preventive Measures: To prevent recurrence, the Director of Nursing or designee will conduct weekly audits for 6 months of all medication cards and overflow medications using a standardized audit tool. These audits will ensure that all medications remain within their expiration dates and are stored in compliance with facility policy. In addition, all pertinent staff will receive an educational in-service by 11/16/2025 regarding medication and expiry practices. Monitoring and Follow-Up:	

	received the PRN Lorazepam. During an interview on 10/23/25 at 3:41 p.m., the Director of Nursing indicated the Lorazepam syringes would be disposed of. Based on observation, record review, and interview, the facility failed to ensure expired antianxiety medications were disposed of for 1 of 3 residents reviewed for hospice services. (Resident F) Finding includes: During a random observation on 10/23/25 at 12:40 p.m., 19 pre-filled syringes of Lorazepam (an antianxiety medication) for Resident F were noted in the Memory Care Unit medication refrigerator. The Lorazepam syringes were dispensed on 5/19/25 and expired on 7/29/25. There were 18 pre-filled syringes of Lorazepam that were dispensed on 5/30/25 and expired on 8/28/25. The record for Resident F was reviewed on 10/23/25 at 8:28 a.m. Diagnoses included, but were not limited to, dementia and anxiety.		The audit findings will be reviewed weekly for 6 months by the DON and/ or designee using an audit tool as part of the facility's quality assurance process to ensure continued compliance. Systemic Change Completion Date: All systemic changes will be fully implemented by November 17, 2025.	

	A Physician's Order, dated 4/26/25, indicated the resident was to receive Lorazepam 0.5 milligrams (mg) 0.25 milliliters (ml) every 2 hours as needed (PRN) for anxiety. The August, September, and October 2025 Medication Administration Records (MARs) indicated the resident had not received the PRN Lorazepam. During an interview on 10/23/25 at 3:41 p.m., the Director of Nursing indicated the Lorazepam syringes would be disposed of.			
R 0304	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(e) (e) Medicine or treatment cabinets or rooms shall be appropriately locked at all times except when authorized personnel are present. All Schedule II drugs administered by the facility shall be kept in individual containers under double lock and stored in a substantially constructed box, cabinet, or mobile drug storage unit. Based on observation, record review and interview, the facility failed to ensure Schedule 2 (opioid, sedative, and hypnotic) medications were secured under a double-lock system in 2 of 3 medication rooms throughout the facility. (The	R 0304	R304 1. Corrective actions accomplished for those residents found to have been affected by the deficient practice Upon identification of the deficiency, the medication room door was immediately secured to prevent unauthorized access. All medications stored within the medication refrigerator were verified, secured, and placed under double-lock protection in accordance with facility policy and state regulations. A complete	11/22/2025

	Memory Care and Assisted Living medication rooms) Findings include: 1. On 10/23/25 at 11:25 a.m., the door to the Medication Room on the Memory Care Unit was unlocked. There was a pad lock in use on the medication refrigerator. The nurse was off the unit at the time and had the keys to the lock. At 12:40 p.m., the door to the Medication Room on the Memory Care Unit remained unlocked. The LPN proceeded to unlock the pad lock on the refrigerator. Eighteen pre-filled syringes of Morphine (an opioid pain medication) and 37 pre-filled syringes of Lorazepam (an antianxiety medication) were observed in a basket inside of the refrigerator. The medications were not double-locked. During an interview on 10/23/25 at 3:41 p.m., the Director of Nursing indicated the door to the medication room should have been locked that way the medications would have been double-locked. 2. During an observation on 10/23/25 at 7:20 a.m. LPN 1 and LPN 2 were standing at the A/B nurses' station on the Assisted Living Unit. LPN 1 had worked the midnight shift and LPN 2 was the oncoming nurse.		inventory was conducted to ensure that no medications were missing or compromised. 2. Identification of other residents having the potential to be affected by the same deficient practice and corrective actions taken: All medication rooms and medication refrigerators throughout the community were inspected to ensure compliance with medication security requirements. Automatic locking mechanisms were installed on all medication room doors to ensure they remain locked when not in use. In addition, automatic locking mechanisms were installed on all medication doors containing medications. This ensures all residents' medications are safeguarded at all times. 3. Measures or systemic changes implemented to ensure the deficient practice does not recur: The facility maintenance department installed automatic door	

	At that time, the medication room door was wide open. LPN 1 finished the report and told LPN 2 she was leaving. At 7:23 a.m., LPN 2 indicated she had to go up front and drop off some papers, so she left the unit with the medication room door wide open. Inside the medication room were the resident's hard charts as well as a locked refrigerator. At 7:30 a.m., LPN 1 came back to the unit, walked inside the medication room and pulled the door shut, she walked out of the medication room and door closed behind her, however, the door was unlocked. At 7:35 a.m., LPN 2 came back to the unit and was asked to open the refrigerator. She unlocked the refrigerator and inside were 2 baskets with pre-filled syringes of Morphine Sulfate and Lorazepam. None of the syringes were in a locked container. During an interview on 10/23/25 at 7:37 a.m., LPN 2 was aware the medications were to be double locked. At 7:41 a.m., LPN 2 sat down at the nurses' station and begun to count the pre-filled syringes of the Morphine Sulfate and the Lorazepam by herself. There were 55 Lorazepam pre-filled syringes and 60 pre-filled Morphine Sulfate syringes		locks on all medication room doors. All medication refrigerators containing medications are now equipped with lock mechanisms. All licensed nurses and qualified medication aides received a documented re-education on the facility's Medication Storage and Security Policy, with emphasis on: The requirement that all medication rooms remain locked at all times when not actively in use. The requirement that all medications, including those stored in refrigerators, must be kept double locked. The Director of Nursing (DON) or designee will conduct audits of all medication rooms for four times per week for 6 months, followed by weekly audits for three months, to ensure compliance with the policy and state regulations. 4. Monitoring of corrective actions to ensure the deficient	

	inside the baskets. During an observation on 10/23/25 at 8:20 a.m., the medication room door on the A/B hall was still unlocked and there were no staff around. During an interview on 10/23/25 at 11:00 a.m., the Assistant Director of Nursing indicated the narcotics should have been double locked, however there was no lock on the medication room door. The Maintenance Director was just informed to put a lock on the door. The current and undated "Narcotic Storage" policy, provided by the Administrator on 10/23/25 at 3:35 p.m., indicated all narcotic medications must be stored behind two separate locking mechanisms at all times. The policy applied to all areas within the facility where narcotics were stored including medication carts, cabinets, and refrigerators. Based on observation, record review and interview, the facility failed to ensure Schedule 2 (opioid, sedative, and hypnotic) medications were secured under a double-lock system in 2 of 3 medication rooms throughout the facility. (The Memory Care and Assisted Living medication rooms) Findings include:		practice will not recur and quality assurance measures to be implemented: The DON or designee will utilize a Medication Room Security Audit Tool to verify that all medication room doors and medication refrigerators remain locked and secured as required four times per week for 6 months then weekly for 3 months. Any identified deficiencies will be corrected immediately, and additional staff education will be provided as necessary to ensure ongoing compliance. 5. Date of Completion: November 22, 2025	

	1. On 10/23/25 at 11:25 a.m., the door to the Medication Room on the Memory Care Unit was unlocked. There was a pad lock in use on the medication refrigerator. The nurse was off the unit at the time and had the keys to the lock. At 12:40 p.m., the door to the Medication Room on the Memory Care Unit remained unlocked. The LPN proceeded to unlock the pad lock on the refrigerator. Eighteen pre-filled syringes of Morphine (an opioid pain medication) and 37 pre-filled syringes of Lorazepam (an antianxiety medication) were observed in a basket inside of the refrigerator. The medications were not double-locked. During an interview on 10/23/25 at 3:41 p.m., the Director of Nursing indicated the door to the medication room should have been locked that way the medications would have been double-locked. 2. During an observation on 10/23/25 at 7:20 a.m. LPN 1 and LPN 2 were standing at the A/B nurses' station on the Assisted Living Unit. LPN 1 had worked the midnight shift and LPN 2 was the oncoming nurse. At that time, the medication room door was wide open. LPN 1 finished the report and told LPN 2 she was leaving. At 7:23			

	a.m., LPN 2 indicated she had to go up front and drop off some papers, so she left the unit with the medication room door wide open. Inside the medication room were the resident's hard charts as well as a locked refrigerator. At 7:30 a.m., LPN 1 came back to the unit, walked inside the medication room and pulled the door shut, she walked out of the medication room and door closed behind her, however, the door was unlocked. At 7:35 a.m., LPN 2 came back to the unit and was asked to open the refrigerator. She unlocked the refrigerator and inside were 2 baskets with pre-filled syringes of Morphine Sulfate and Lorazepam. None of the syringes were in a locked container. During an interview on 10/23/25 at 7:37 a.m., LPN 2 was aware the medications were to be double locked. At 7:41 a.m., LPN 2 sat down at the nurses' station and begun to count the pre-filled syringes of the Morphine Sulfate and the Lorazepam by herself. There were 55 Lorazepam pre-filled syringes and 60 pre-filled Morphine Sulfate syringes inside the baskets. During an observation on 10/23/25 at 8:20 a.m., the			

	medication room door on the A/B hall was still unlocked and there were no staff around. During an interview on 10/23/25 at 11:00 a.m., the Assistant Director of Nursing indicated the narcotics should have been double locked, however there was no lock on the medication room door. The Maintenance Director was just informed to put a lock on the door. The current and undated "Narcotic Storage" policy, provided by the Administrator on 10/23/25 at 3:35 p.m., indicated all narcotic medications must be stored behind two separate locking mechanisms at all times. The policy applied to all areas within the facility where narcotics were stored including medication carts, cabinets, and refrigerators. Based on observation, record review and interview, the facility failed to ensure Schedule 2 (opioid, sedative, and hypnotic) medications were secured under a double-lock system in 2 of 3 medication rooms throughout the facility. (The Memory Care and Assisted Living medication rooms) Findings include: 1. On 10/23/25 at 11:25 a.m., the door to the Medication Room on the Memory Care Unit was unlocked. There was a pad			

	lock in use on the medication refrigerator. The nurse was off the unit at the time and had the keys to the lock. At 12:40 p.m., the door to the Medication Room on the Memory Care Unit remained unlocked. The LPN proceeded to unlock the pad lock on the refrigerator. Eighteen pre-filled syringes of Morphine (an opioid pain medication) and 37 pre-filled syringes of Lorazepam (an antianxiety medication) were observed in a basket inside of the refrigerator. The medications were not double-locked. During an interview on 10/23/25 at 3:41 p.m., the Director of Nursing indicated the door to the medication room should have been locked that way the medications would have been double-locked. 2. During an observation on 10/23/25 at 7:20 a.m. LPN 1 and LPN 2 were standing at the A/B nurses' station on the Assisted Living Unit. LPN 1 had worked the midnight shift and LPN 2 was the oncoming nurse. At that time, the medication room door was wide open. LPN 1 finished the report and told LPN 2 she was leaving. At 7:23 a.m., LPN 2 indicated she had to go up front and drop off some papers, so she left the unit with the medication room door wide			

open. Inside the medication room were the resident's hard charts as well as a locked refrigerator.

At 7:30 a.m., LPN 1 came back to the unit, walked inside the medication room and pulled the door shut, she walked out of the medication room and door closed behind her, however, the door was unlocked. At 7:35 a.m., LPN 2 came back to the unit and was asked to open the refrigerator. She unlocked the refrigerator and inside were 2 baskets with pre-filled syringes of Morphine Sulfate and Lorazepam. None of the syringes were in a locked container.

During an interview on 10/23/25 at 7:37 a.m., LPN 2 was aware the medications were to be double locked.

At 7:41 a.m., LPN 2 sat down at the nurses' station and begun to count the pre-filled syringes of the Morphine Sulfate and the Lorazepam by herself. There were 55 Lorazepam pre-filled syringes and 60 pre-filled Morphine Sulfate syringes inside the baskets.

During an observation on 10/23/25 at 8:20 a.m., the medication room door on the A/B hall was still unlocked and there were no staff around.

During an interview on 10/23/25

at 11:00 a.m., the Assistant Director of Nursing indicated the narcotics should have been double locked, however there was no lock on the medication room door. The Maintenance Director was just informed to put a lock on the door.

The current and undated "Narcotic Storage" policy, provided by the Administrator on 10/23/25 at 3:35 p.m., indicated all narcotic medications must be stored behind two separate locking mechanisms at all times. The policy applied to all areas within the facility where narcotics were stored including medication carts, cabinets, and refrigerators.

Based on observation, record review and interview, the facility failed to ensure Schedule 2 (opioid, sedative, and hypnotic) medications were secured under a double-lock system in 2 of 3 medication rooms throughout the facility. (The Memory Care and Assisted Living medication rooms)

Findings include:

1. On 10/23/25 at 11:25 a.m., the door to the Medication Room on the Memory Care Unit was unlocked. There was a pad lock in use on the medication refrigerator. The nurse was off the unit at the time and had the keys to the lock.

	At 12:40 p.m., the door to the Medication Room on the Memory Care Unit remained unlocked. The LPN proceeded to unlock the pad lock on the refrigerator. Eighteen pre-filled syringes of Morphine (an opioid pain medication) and 37 pre-filled syringes of Lorazepam (an antianxiety medication) were observed in a basket inside of the refrigerator. The medications were not double-locked. During an interview on 10/23/25 at 3:41 p.m., the Director of Nursing indicated the door to the medication room should have been locked that way the medications would have been double-locked. 2. During an observation on 10/23/25 at 7:20 a.m. LPN 1 and LPN 2 were standing at the A/B nurses' station on the Assisted Living Unit. LPN 1 had worked the midnight shift and LPN 2 was the oncoming nurse. At that time, the medication room door was wide open. LPN 1 finished the report and told LPN 2 she was leaving. At 7:23 a.m., LPN 2 indicated she had to go up front and drop off some papers, so she left the unit with the medication room door wide open. Inside the medication room were the resident's hard charts as well as a locked refrigerator.			

	At 7:30 a.m., LPN 1 came back to the unit, walked inside the medication room and pulled the door shut, she walked out of the medication room and door closed behind her, however, the door was unlocked. At 7:35 a.m., LPN 2 came back to the unit and was asked to open the refrigerator. She unlocked the refrigerator and inside were 2 baskets with pre-filled syringes of Morphine Sulfate and Lorazepam. None of the syringes were in a locked container. During an interview on 10/23/25 at 7:37 a.m., LPN 2 was aware the medications were to be double locked. At 7:41 a.m., LPN 2 sat down at the nurses' station and begun to count the pre-filled syringes of the Morphine Sulfate and the Lorazepam by herself. There were 55 Lorazepam pre-filled syringes and 60 pre-filled Morphine Sulfate syringes inside the baskets. During an observation on 10/23/25 at 8:20 a.m., the medication room door on the A/B hall was still unlocked and there were no staff around. During an interview on 10/23/25 at 11:00 a.m., the Assistant Director of Nursing indicated the narcotics should have been double locked, however there			

	was no lock on the medication room door. The Maintenance Director was just informed to put a lock on the door. The current and undated "Narcotic Storage" policy, provided by the Administrator on 10/23/25 at 3:35 p.m., indicated all narcotic medications must be stored behind two separate locking mechanisms at all times. The policy applied to all areas within the facility where narcotics were stored including medication carts, cabinets, and refrigerators.			
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. 3. The record for Resident C was reviewed on 10/22/25 at 11:25 a.m. Diagnoses included, but were not limited to, high blood pressure.	R 0349	R349 1. Corrective actions accomplished for those residents found to have been affected by the deficient practice:	11/18/2025

A Physician's Order, dated 5/15/25, indicated Amlodipine (a medication used to lower blood pressure) 5 milligrams (mg) every morning and hold if the systolic (top number) blood pressure was less than 100.

The 7/2025, 8/2025, 9/2025, and 10/2025, Medication Administration Records (MAR) indicated there was no documentation of the resident's blood pressure prior to the administration of the Amlodipine.

There were no documented blood pressures in the clinical record except for monthly recordings.

During an interview on 10/23/25 at 8:08 a.m., QMA 1 indicated she checked the resident's blood pressure prior to administrating the Amlodipine, however, there was no place in the resident's record to document the result.

During an interview on 10/23/25 at 3:00 p.m., the Assistant Director of Nursing indicated she would expect nursing staff to document the blood pressure either on the MAR or on a blood pressure form that was currently in use.

This citation relates to Intake IN00465317.

Based on observation, record

The physician orders in question were immediately reviewed and corrected to ensure all medications were accurately transcribed onto the Medication Administration Record (MAR). Medication records were updated to reflect the current physician orders. No negative resident outcomes were identified as a result of this deficient practice.

2. Identification of other residents having the potential to be affected by the same deficient practice and corrective actions taken:

On 11/12/2025 through 11/14/2025, a comprehensive audit of all physician orders and corresponding Medication Administration Records (MARs) for the past 60 days was initiated to verify accuracy and ensure all orders have been properly transcribed.

3. Measures or systemic changes implemented to ensure the deficient practice does not recur:

All licensed nurses received a

review, and interview, the facility failed to ensure clinical records were complete and accurately documented related to pain medication orders and blood pressure results for 3 of 8 records reviewed. (Residents F, E, and C)

Findings include:

1. The record for Resident F was reviewed on 10/23/25 at 8:28 a.m. Diagnoses included, but were not limited to, dementia and anxiety.

A Physician's Order, dated 4/26/25, indicated the resident was to receive Lorazepam 0.5 milligrams (mg) 0.25 milliliters (ml) every 2 hours as needed (PRN) for anxiety.

The order was not listed on the August, September, and October 2025 Physician Order Summaries.

The August, September, and October 2025 Medication Administration Records (MARs) indicated the Lorazepam 0.5 mg was to be given PRN. There was no documented frequency of the medication and the indication for the use.

During an interview on 10/23/25 at 3:41 p.m., the Director of Nursing indicated the order should have been transcribed on the Physician Order Summaries and the frequency

re-education on proper transcription of physician orders and completion of monthly medication record recapulations.

A standardized Order Transcription Checklist has been
implemented to be used by nursing staff when processing all new and monthly
orders.

The Director of Nursing or designee will review all new physician orders utilizing the physician audit tool within 24 hours of entry to
ensure accuracy of transcription onto the MAR.

4. Monitoring of corrective actions and quality assurance measures:

Two times per week, the DON or designee will complete audits of new physician orders and corresponding MAR entries for 6 months, followed by
monthly audits for three months, to ensure ongoing compliance.

5. Date of Completion:
November 20, 2025

	and indication for the use of the medication should have been listed on the MARs. 2. The record for Resident E was reviewed on 10/23/25 at 9:12 a.m. Diagnoses included, but were not limited to, dementia and acute kidney failure. Physician Orders, dated 7/10/25, indicated the resident was to receive Morphine Sulfate (a pain medication) 20 milligrams (mg) per milliliter (ml), give 5 mg (0.25 ml) every 2 hours as needed (PRN) for pain or dyspnea (difficulty breathing). The resident was also to receive Lorazepam (an antianxiety medication) 2 mg/ml give 0.5 mg (0.25 ml) every 2 hours PRN for anxiety. The Morphine and Lorazepam orders were not listed on the Physician's Order Summaries or the Medication Administration Records (MARs) for the months of August 2025, September 2025, and October 2025. A Physician's Order, dated 10/16/25, indicated the resident was to receive Morphine Sulfate 20 mg/ml, give 5 mg (0.25 ml) every 2 hours PRN for pain or dyspnea. The resident was also to receive Lorazepam 2 mg/ml give 0.5 mg (0.25 ml) every 2 hours PRN for anxiety. The order was handwritten on		FAILURE TO DOCUMENT BLOOD PRESSURES 1. Corrective actions accomplished for those residents found to have been affected by the deficient practice: The staff member involved was counseled and re-educated on proper documentation requirements for vital signs. The missing blood pressure entries were obtained and documented as appropriate. No adverse resident outcomes were identified as a result of the deficient practice. 2. Identification of other residents having the potential to be affected by the same deficient practice and corrective actions taken: On 11/9/2025 through 11/10/2025, an audit was completed of all residents' medication records for the past 30 days were completed to ensure blood pressure monitoring and documentation were completed as ordered. Newly implemented blood pressure	

	the October 2025 Physician's Order Summary (POS) and the October 2025 MAR effective 10/16/25. During an interview on 10/23/25 at 3:41 p.m., the Director of Nursing indicated the orders should have been transcribed onto the August, September, and October 2025 Physician Order Summaries and the MARs. 3. The record for Resident C was reviewed on 10/22/25 at 11:25 a.m. Diagnoses included, but were not limited to, high blood pressure. A Physician's Order, dated 5/15/25, indicated Amlodipine (a medication used to lower blood pressure) 5 milligrams (mg) every morning and hold if the systolic (top number) blood pressure was less than 100. The 7/2025, 8/2025, 9/2025, and 10/2025, Medication Administration Records (MAR) indicated there was no documentation of the resident's blood pressure prior to the administration of the Amlodipine. There were no documented blood pressures in the clinical record except for monthly recordings. During an interview on 10/23/25 at 8:08 a.m., QMA 1 indicated		form was implemented for each resident at that time. 3. Measures or systemic changes implemented to ensure the deficient practice does not recur: A new Blood Pressure Monitoring Form was developed and implemented for all residents requiring routine or as-needed blood pressure checks. All nursing staff received documented in-service training on accurate and timely documentation of blood pressures, including the use of the new form The DON or designee will verify completion of blood pressure documentation during daily shift report reviews. 4. Monitoring of corrective actions and quality assurance measures:	

she checked the resident's blood pressure prior to administrating the Amlodipine, however, there was no place in the resident's record to document the result.

During an interview on 10/23/25 at 3:00 p.m., the Assistant Director of Nursing indicated she would expect nursing staff to document the blood pressure either on the MAR or on a blood pressure form that was currently in use.

This citation relates to Intake IN00465317.

Based on observation, record review, and interview, the facility failed to ensure clinical records were complete and accurately documented related to pain medication orders and blood pressure results for 3 of 8 records reviewed. (Residents F, E, and C)

Findings include:

1. The record for Resident F was reviewed on 10/23/25 at 8:28 a.m. Diagnoses included, but were not limited to, dementia and anxiety.

A Physician's Order, dated 4/26/25, indicated the resident was to receive Lorazepam 0.5 milligrams (mg) 0.25 milliliters (ml) every 2 hours as needed (PRN) for anxiety.

The DON or designee will conduct audits of blood pressure documentation twice weekly for four weeks, followed by weekly audits for three months, to ensure compliance with facility policy.

5. Date of Completion: November 18, 2025

The order was not listed on the August, September, and October 2025 Physician Order Summaries.

The August, September, and October 2025 Medication Administration Records (MARs) indicated the Lorazepam 0.5 mg was to be given PRN. There was no documented frequency of the medication and the indication for the use.

During an interview on 10/23/25 at 3:41 p.m., the Director of Nursing indicated the order should have been transcribed on the Physician Order Summaries and the frequency and indication for the use of the medication should have been listed on the MARs.

2. The record for Resident E was reviewed on 10/23/25 at 9:12 a.m. Diagnoses included, but were not limited to, dementia and acute kidney failure.

Physician Orders, dated 7/10/25, indicated the resident was to receive Morphine Sulfate (a pain medication) 20 milligrams (mg) per milliliter (ml), give 5 mg (0.25 ml) every 2 hours as needed (PRN) for pain or dyspnea (difficulty breathing). The resident was also to receive Lorazepam (an antianxiety medication) 2 mg/ml give 0.5 mg (0.25 ml) every 2 hours PRN

for anxiety.

The Morphine and Lorazepam orders were not listed on the Physician's Order Summaries or the Medication Administration Records (MARs) for the months of August 2025, September 2025, and October 2025.

A Physician's Order, dated 10/16/25, indicated the resident was to receive Morphine Sulfate 20 mg/ml, give 5 mg (0.25 ml) every 2 hours PRN for pain or dyspnea. The resident was also to receive Lorazepam 2 mg/ml give 0.5 mg (0.25 ml) every 2 hours PRN for anxiety.

The order was handwritten on the October 2025 Physician's Order Summary (POS) and the October 2025 MAR effective 10/16/25.

During an interview on 10/23/25 at 3:41 p.m., the Director of Nursing indicated the orders should have been transcribed onto the August, September, and October 2025 Physician Order Summaries and the MARs.

3. The record for Resident C was reviewed on 10/22/25 at 11:25 a.m. Diagnoses included, but were not limited to, high blood pressure.

A Physician's Order, dated 5/15/25, indicated Amlodipine (a medication used to lower blood

pressure) 5 milligrams (mg) every morning and hold if the systolic (top number) blood pressure was less than 100.

The 7/2025, 8/2025, 9/2025, and 10/2025, Medication Administration Records (MAR) indicated there was no documentation of the resident's blood pressure prior to the administration of the Amlodipine.

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During an interview on 10/23/25 at 8:08 a.m., QMA 1 indicated she checked the resident's blood pressure prior to administrating the Amlodipine, however, there was no place in the resident's record to document the result.

During an interview on 10/23/25 at 3:00 p.m., the Assistant Director of Nursing indicated she would expect nursing staff to document the blood pressure either on the MAR or on a blood pressure form that was currently in use.

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Based on observation, record review, and interview, the facility failed to ensure clinical records were complete and accurately

documented related to pain medication orders and blood pressure results for 3 of 8 records reviewed. (Residents F, E, and C)

Findings include:

1. The record for Resident F was reviewed on 10/23/25 at 8:28 a.m. Diagnoses included, but were not limited to, dementia and anxiety.

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2. The record for Resident E was reviewed on 10/23/25 at 9:12 a.m. Diagnoses included, but were not limited to, dementia and acute kidney failure.

Physician Orders, dated 7/10/25, indicated the resident was to receive Morphine Sulfate (a pain medication) 20 milligrams (mg) per milliliter (ml), give 5 mg (0.25 ml) every 2 hours as needed (PRN) for pain or dyspnea (difficulty breathing). The resident was also to receive Lorazepam (an antianxiety medication) 2 mg/ml give 0.5 mg (0.25 ml) every 2 hours PRN for anxiety.

The Morphine and Lorazepam orders were not listed on the Physician's Order Summaries or the Medication Administration Records (MARs) for the months of August 2025, September 2025, and October 2025.

A Physician's Order, dated 10/16/25, indicated the resident was to receive Morphine Sulfate 20 mg/ml, give 5 mg (0.25 ml)

every 2 hours PRN for pain or dyspnea. The resident was also to receive Lorazepam 2 mg/ml give 0.5 mg (0.25 ml) every 2 hours PRN for anxiety.

The order was handwritten on the October 2025 Physician's Order Summary (POS) and the October 2025 MAR effective 10/16/25.

During an interview on 10/23/25 at 3:41 p.m., the Director of Nursing indicated the orders should have been transcribed onto the August, September, and October 2025 Physician Order Summaries and the MARs.

3. The record for Resident C was reviewed on 10/22/25 at 11:25 a.m. Diagnoses included, but were not limited to, high blood pressure.

A Physician's Order, dated 5/15/25, indicated Amlodipine (a medication used to lower blood pressure) 5 milligrams (mg) every morning and hold if the systolic (top number) blood pressure was less than 100.

The 7/2025, 8/2025, 9/2025, and 10/2025, Medication Administration Records (MAR) indicated there was no documentation of the resident's blood pressure prior to the administration of the Amlodipine.

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During an interview on 10/23/25 at 3:41 p.m., the Director of Nursing indicated the order should have been transcribed on the Physician Order Summaries and the frequency and indication for the use of the medication should have been listed on the MARs.

2. The record for Resident E was reviewed on 10/23/25 at 9:12 a.m. Diagnoses included, but were not limited to, dementia and acute kidney failure.

Physician Orders, dated 7/10/25, indicated the resident was to receive Morphine Sulfate (a pain medication) 20 milligrams (mg) per milliliter (ml), give 5 mg (0.25 ml) every 2

hours as needed (PRN) for pain or dyspnea (difficulty breathing). The resident was also to receive Lorazepam (an antianxiety medication) 2 mg/ml give 0.5 mg (0.25 ml) every 2 hours PRN for anxiety.

The Morphine and Lorazepam orders were not listed on the Physician's Order Summaries or the Medication Administration Records (MARs) for the months of August 2025, September 2025, and October 2025.

A Physician's Order, dated 10/16/25, indicated the resident was to receive Morphine Sulfate 20 mg/ml, give 5 mg (0.25 ml) every 2 hours PRN for pain or dyspnea. The resident was also to receive Lorazepam 2 mg/ml give 0.5 mg (0.25 ml) every 2 hours PRN for anxiety.

The order was handwritten on the October 2025 Physician's Order Summary (POS) and the October 2025 MAR effective 10/16/25.

During an interview on 10/23/25 at 3:41 p.m., the Director of Nursing indicated the orders should have been transcribed onto the August, September, and October 2025 Physician Order Summaries and the MARs.

instructions.)		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURERikki Ford	TITLEFord	(X6) DATE11/10/2025