STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRENTWOOD AT HOBART	1420 ST MARYS CIRCLE, HOBART, , 46342

(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 Intakes IN00465152 and IN00465176. Intake IN00465152 - No deficiencies related to the allegations are cited. Intake IN00465176 - No deficiencies related to the allegations are cited. Survey dates: October 6 and 7, 2025 Facility number: 002627 Residential Census: 115 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 10/14/25.	R 0000	The submission of this plan of correction does not indicate an admission by Brentwood at Hobart that the findings and allegations contained herein are an accurate, true representation of the quality of care provided, and living environment provided to the residents of Brentwood at Hobart. The community hereby maintains it is in substantial compliance with the requirements of participation in residential care facilities. Please accept this plan of correction as the credible allegation of compliance with all state and federal requirements governing the management of this facility. Brentwood at Hobart respectfully request from the department a desk review/paper compliance for these tags.¿	
R 0045	Residents' Rights - Deficiency	R 0045	The transfer/discharge policy was	11/01/2025

	410 IAC 16.2-5-1.2(r)(6-9) (6) Before an interfacility transfer or discharge occurs, the facility must, on a form prescribed by the department, do the following: (A) Notify the resident of the transfer or discharge and the reasons for the move, in writing, and in a language and manner that the resident understands. The health facility must place a copy of the notice in the resident ' s clinical record and transmit a copy to the following: (i) The resident. (ii) A family member of the resident if known. (iii) The resident ' s legal representative if known. (iv) The local long term care ombudsman program (for involuntary relocations or discharges only). (v) The person or agency responsible for the resident ' s placement, maintenance, and care in the facility. (vi) In situations where the resident is developmentally disabled, the regional office of the division of disability, aging, and rehabilitative services, who may assist with placement decisions. (vii) The resident ' s physician when the transfer or discharge is necessary under subdivision (4)(C), (4)(D), (4)(E), or (4)(F).		reviewed. No other residents were affected by this deficient practice. No prolonged adverse effects were noted for the resident involved in this deficient practice. All staff were trained in the protocol for transfers/discharges. The transfer discharge binder has been updated for memory care. DON or designee will verify and maintain a copy of all transfer discharge packets. DON or designee will audit transfers/discharge records twice weekly for 2 months, then weekly for 1 month then once per month for 3 months. Any identified noncompliance will result in immediate documented re-training and placed in the employee’s file. Audits will be reviewed in	

	(B) Record the reasons in the resident ' s clinical record. (C) Include in the notice the items described in subdivision (9). (7) Except when specified in subdivision (8), the notice of transfer or discharge required under subdivision (6) must be made by the facility at least thirty (30) days before the resident is transferred or discharged. (8) Notice may be made as soon as practicable before transfer or discharge when: (A) the safety of individuals in the facility would be endangered; (B) the health of individuals in the facility would be endangered; (C) the resident ' s health improves sufficiently to allow a more immediate transfer or discharge; (D) an immediate transfer or discharge is required by the resident ' s urgent medical needs; or (E) a resident has not resided in the facility for thirty (30) days. (9) For health facilities, the written notice specified in subdivision (7) must include the following: (A) The reason for transfer or discharge. (B) The effective date of transfer or discharge. (C) The location to which the resident is transferred or			

	discharged. (D) A statement in not smaller than 12-point bold type that reads, " You have the right to appeal the health facility ' s decision to transfer you. If you think you should not have to leave this facility, you may file a written request for a hearing with the Indiana state department of health postmarked within ten (10) days after you receive this notice. If you request a hearing, it will be held within twenty-three (23) days after you receive this notice, and you will not be transferred from the facility earlier than thirty-four (34) days after you receive this notice of transfer or discharge unless the facility is authorized to transfer you under subdivision (8). If you wish to appeal this transfer or discharge, a form to appeal the health facility's decision and to request a hearing is attached. If you have any questions, call the Indiana state department of health at the number listed below. " . (E) The name of the director and the address, telephone number, and hours of operation of the division. (F) A hearing request form prescribed by the department. (G) The name, address, and telephone number of the state and local long term care ombudsman. (H) For health facility residents with developmental disabilities or who are mentally ill, the mailing address and telephone number of the protection and advocacy services commission.			

Based on record review and interview, the facility failed to ensure the State approved transfer and discharge form was completed prior to a transfer to the hospital for 1 of 8 records reviewed. (Resident 9)

Finding includes:

The closed record for Resident 9 was reviewed on 10/6/25 at 2:26 p.m. Diagnoses included, but were not limited to, Alzheimer's disease. The resident was admitted to the facility on 6/4/25.

A Progress Note, dated 6/11/25 at 7:27 a.m., indicated around 1:30 a.m. the resident had complained of pain to his left abdomen and left arm. The physician was notified.

A Progress Note, dated 6/11/25 at 9:28 a.m., indicated the resident had returned from the hospital at 6:30 a.m.

A Progress Note, dated 6/11/25 at 10:40 a.m., indicated the resident was bleeding when passing stool. The resident's daughter was present and refused transportation to the hospital as the resident already had an appointment with his physician at 1:30 p.m. and she would rather have him evaluated there.

	An Order Administration Note, dated 6/16/25 at 5:48 p.m., indicated the resident was hospitalized. There was no documentation that the resident had received a copy of the State approved transfer and discharge notice for either hospitalization. During an interview on 10/6/25 at 3:29 p.m., the Director of Nursing indicated she was unable to find any further documentation. Based on record review and interview, the facility failed to ensure the State approved transfer and discharge form was completed prior to a transfer to the hospital for 1 of 8 records reviewed. (Resident 9) Finding includes: The closed record for Resident 9 was reviewed on 10/6/25 at 2:26 p.m. Diagnoses included, but were not limited to, Alzheimer's disease. The resident was admitted to the facility on 6/4/25. A Progress Note, dated 6/11/25 at 7:27 a.m., indicated around 1:30 a.m. the resident had complained of pain to his left abdomen and left arm. The physician was notified. A Progress Note, dated 6/11/25 at 9:28 a.m., indicated the			

	resident had returned from the hospital at 6:30 a.m. A Progress Note, dated 6/11/25 at 10:40 a.m., indicated the resident was bleeding when passing stool. The resident's daughter was present and refused transportation to the hospital as the resident already had an appointment with his physician at 1:30 p.m. and she would rather have him evaluated there. An Order Administration Note, dated 6/16/25 at 5:48 p.m., indicated the resident was hospitalized. There was no documentation that the resident had received a copy of the State approved transfer and discharge notice for either hospitalization. During an interview on 10/6/25 at 3:29 p.m., the Director of Nursing indicated she was unable to find any further documentation.			
R 0090	Administration and Management - Deficiency 410 IAC 16.2-5-1.3(g)(1-6) (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following:	R 0090	It is the practice of this community to keep previous state surveys readily accessible to the public. All previous surveys were reviewed and placed in the front entrance binder, clearly visible and accessible to the public to ensure compliance. No residents were affected by this deficient practice. The ED or designee will audit the survey binder monthly to ensure	11/01/2025

	(1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during		compliance. Findings from the audits will be reviewed during monthly QA meetings to ensure compliance.	

	the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request Based on observation, record review, and interview, the facility failed to ensure the results of previous State Surveys were readily accessible. This had the potential to affect all 115 residents who resided in the facility. Finding includes: On 10/7/25 at 10:23 a.m., the State Survey Binder located near the Main Dining Room was reviewed. The most recent survey results in the binder were dated 1/31/25. There were no results available to review for complaint surveys completed on 6/2/25, 7/16/25, 7/31/25, and 9/4/25. During an interview on 10/7/25 at 11:30 a.m., the Director of			

	Nursing indicated she had printed off the survey results and given them to staff to update the binder, but they must not have placed them in the binder yet. Based on observation, record review, and interview, the facility failed to ensure the results of previous State Surveys were readily accessible. This had the potential to affect all 115 residents who resided in the facility. Finding includes: On 10/7/25 at 10:23 a.m., the State Survey Binder located near the Main Dining Room was reviewed. The most recent survey results in the binder were dated 1/31/25. There were no results available to review for complaint surveys completed on 6/2/25, 7/16/25, 7/31/25, and 9/4/25. During an interview on 10/7/25 at 11:30 a.m., the Director of Nursing indicated she had printed off the survey results and given them to staff to update the binder, but they must not have placed them in the binder yet.			
R 0120	Personnel - Noncompliance 410 IAC 16.2-5-1.4(e)(1-3)	R 0120	The QMA and who were found non-compliant, immediately completed both the annual	11/01/2025

	(e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor.		dementia training and annual resident's rights and service upon identification of the deficiency. Copies of the documented in-service training were placed in the employee’s file. The administrative assistant received in-service training on maintaining training compliance logs and ensuring all employees complete required annual training before the due date. All other staff files were audited with no negative results. The administrative assistant will audit all employee files monthly and discuss the findings in our monthly QA meeting.	

	(C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on record review and interview, the facility failed to ensure annual dementia training and an annual resident rights inservice was completed for 2 of 5 employee files reviewed. (QMA 1 and Lead Caregiver 1) Finding includes: The employee files were reviewed on 10/7/25 at 1:15 p.m. QMA 1, who was hired on 7/18/15, had no documentation of receiving her 3 hours of annual dementia training for 2024. There was also no documentation the QMA received her annual resident rights inservice. Lead Caregiver 1, who was hired on 8/22/23, had no documentation of receiving her 3 hours of annual dementia training for 2024. There was also no documentation the Lead Caregiver received her annual resident rights inservice. During an interview on 10/7/25 at 2:20 p.m., the Director of Nursing indicated dementia training and resident rights were			

not uploaded to the Relias training system for 2024. She indicated the last time the above employees completed their dementia and resident rights training was in 2023.

Based on record review and interview, the facility failed to ensure annual dementia training and an annual resident rights inservice was completed for 2 of 5 employee files reviewed. (QMA 1 and Lead Caregiver 1)

Finding includes:

The employee files were reviewed on 10/7/25 at 1:15 p.m. QMA 1, who was hired on 7/18/15, had no documentation of receiving her 3 hours of annual dementia training for 2024. There was also no documentation the QMA received her annual resident rights inservice.

Lead Caregiver 1, who was hired on 8/22/23, had no documentation of receiving her 3 hours of annual dementia training for 2024. There was also no documentation the Lead Caregiver received her annual resident rights inservice.

During an interview on 10/7/25 at 2:20 p.m., the Director of Nursing indicated dementia training and resident rights were not uploaded to the Relias training system for 2024. She indicated the last time the above

	employees completed their dementia and resident rights training was in 2023.			
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations	R 0217	An audit was completed, and service plans were updated and placed in residents' charts. Service plans will also be updated as needed based on any changes in care services. Residents and POA/representatives will be reminded during service plan meetings of their role in signing and approving service plans to ensure accuracy and compliance. No other residents were affected by this deficient practice. The DON or designee will audit all admission charts to ensure the service plans are complete and signed twice per month for 2 months, then monthly for 2 months, then quarterly indefinitely to ensure they are up to date and signed. Results will be reviewed in QA meetings monthly to ensure compliance.	11/01/2025

subsequent to the initial evaluation indicate no need for a change in services.

(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.

Based on record review and interview, the facility failed to ensure Service Plans were signed by the resident or the representative, and revised and updated for 5 of 8 residents reviewed for Service Plans. (Residents 2, 4, 5, 9, and 3)

Findings include:

1. The record for Resident 2 was reviewed on 10/6/25 at 1:27 p.m. Diagnoses included, but were not limited to, depression and osteoarthritis of the hips.

A Level of Care Assessment, dated 8/11/25, indicated the resident was cognitively intact.

A Service Plan, reviewed by the facility on 9/19/25, indicated the resident was receiving home health services for wound care.

Nurses' Notes, dated 1/10/25, indicated Home Health Services were discontinued on 1/10/25.

There was also no

documentation that the Service Plan had been signed by the resident.

During an interview on 10/7/25 at 11:23 a.m., the Director of Nursing (DON) indicated the resident's service plan was not signed and was also not updated related to home health services.

2. The record for Resident 4 was reviewed on 10/6/25 at 1:42 p.m. Diagnoses included, but were not limited to, dementia without behavior disturbance, anxiety, and type 2 diabetes.

A Level of Care Assessment, dated 8/11/25, indicated the resident was cognitively impaired for daily decision making.

A Service Plan was reviewed by the facility on 9/9/25. There was no documentation the service plan had been signed by the resident's representative.

During an interview on 10/7/25 at 11:23 a.m., the Director of Nursing (DON) indicated the resident's service plan had not been signed since 2/28/24.

3. The record for Resident 5 was reviewed on 10/6/25 at 11:29 a.m. Diagnoses included, but were not limited to, atrial fibrillation and osteoarthritis. The resident was admitted to

the facility on 9/16/25.

A Progress Note, dated 9/17/25 at 10:40 p.m., indicated the resident was receiving hospice services and the hospice nurse was scheduled to visit on 9/18/25.

A Level of Care Assessment/Individualized Service Plan was completed on 9/16/25. There was a lack of documentation to indicate the resident was receiving hospice services.

During an interview on 10/6/25 at 3:29 p.m., the Director of Nursing indicated hospice services should have been included on the service plan.

4. The closed record for Resident 9 was reviewed on 10/6/25 at 2:26 p.m. Diagnoses included, but were not limited to, Alzheimer's disease. The resident was admitted to the facility on 6/4/25.

A Level of Care Assessment/Individualized Service Plan was completed on 6/4/25. There was no signature of the resident and/or responsible party to indicate the Service Plan had been reviewed and accepted.

During an interview on 10/6/25 at 3:29 p.m., the Director of Nursing indicated she was unable to provide any further

	documentation. 5. The record for Resident 3 was reviewed on 10/6/25 at 10:45 a.m. Diagnoses included, but were not limited to, dementia, psychotic mood disturbance, and chronic kidney disease. The 9/9/25 Quarterly Level of Care Assessment indicated the resident was not cognitively intact for daily decision making and required set-up assistance with activities of daily living. The Service Plan, updated on 5/13/25, lacked a resident or responsible party's signature. During an interview on 10/7/25 at 10:00 a.m., the Director of Nursing (DON) indicated she did not have a signed service plan for the resident. Based on record review and interview, the facility failed to ensure Service Plans were signed by the resident or the representative, and revised and updated for 5 of 8 residents reviewed for Service Plans. (Residents 2, 4, 5, 9, and 3) Findings include:			

	1. The record for Resident 2 was reviewed on 10/6/25 at 1:27 p.m. Diagnoses included, but were not limited to, depression and osteoarthritis of the hips. A Level of Care Assessment, dated 8/11/25, indicated the resident was cognitively intact. A Service Plan, reviewed by the facility on 9/19/25, indicated the resident was receiving home health services for wound care. Nurses' Notes, dated 1/10/25, indicated Home Health Services were discontinued on 1/10/25. There was also no documentation that the Service Plan had been signed by the resident. During an interview on 10/7/25 at 11:23 a.m., the Director of Nursing (DON) indicated the resident's service plan was not signed and was also not updated related to home health services. 2. The record for Resident 4 was reviewed on 10/6/25 at 1:42 p.m. Diagnoses included, but were not limited to, dementia without behavior disturbance, anxiety, and type 2 diabetes. A Level of Care Assessment, dated 8/11/25, indicated the resident was cognitively			

impaired for daily decision making.

A Service Plan was reviewed by the facility on 9/9/25. There was no documentation the service plan had been signed by the resident's representative.

During an interview on 10/7/25 at 11:23 a.m., the Director of Nursing (DON) indicated the resident's service plan had not been signed since 2/28/24.

3. The record for Resident 5 was reviewed on 10/6/25 at 11:29 a.m. Diagnoses included, but were not limited to, atrial fibrillation and osteoarthritis. The resident was admitted to the facility on 9/16/25.

A Progress Note, dated 9/17/25 at 10:40 p.m., indicated the resident was receiving hospice services and the hospice nurse was scheduled to visit on 9/18/25.

A Level of Care Assessment/Individualized Service Plan was completed on 9/16/25. There was a lack of documentation to indicate the resident was receiving hospice services.

During an interview on 10/6/25 at 3:29 p.m., the Director of Nursing indicated hospice services should have been included on the service plan.

	4. The closed record for Resident 9 was reviewed on 10/6/25 at 2:26 p.m. Diagnoses included, but were not limited to, Alzheimer's disease. The resident was admitted to the facility on 6/4/25. A Level of Care Assessment/Individualized Service Plan was completed on 6/4/25. There was no signature of the resident and/or responsible party to indicate the Service Plan had been reviewed and accepted. During an interview on 10/6/25 at 3:29 p.m., the Director of Nursing indicated she was unable to provide any further documentation. 5. The record for Resident 3 was reviewed on 10/6/25 at 10:45 a.m. Diagnoses included, but were not limited to, dementia, psychotic mood disturbance, and chronic kidney disease. The 9/9/25 Quarterly Level of Care Assessment indicated the resident was not cognitively intact for daily decision making and required set-up assistance with activities of daily living. The Service Plan, updated on 5/13/25, lacked a resident or responsible party's signature. During an interview on 10/7/25 at 10:00 a.m., the Director of			

Nursing (DON) indicated she did not have a signed service plan for the resident.

Based on record review and interview, the facility failed to ensure Service Plans were signed by the resident or the representative, and revised and updated for 5 of 8 residents reviewed for Service Plans. (Residents 2, 4, 5, 9, and 3)

Findings include:

1. The record for Resident 2 was reviewed on 10/6/25 at 1:27 p.m. Diagnoses included, but were not limited to, depression and osteoarthritis of the hips.

A Level of Care Assessment, dated 8/11/25, indicated the resident was cognitively intact.

A Service Plan, reviewed by the facility on 9/19/25, indicated the resident was receiving home health services for wound care.

Nurses' Notes, dated 1/10/25, indicated Home Health Services were discontinued on 1/10/25.

There was also no documentation that the Service Plan had been signed by the resident.

During an interview on 10/7/25 at 11:23 a.m., the Director of Nursing (DON) indicated the resident's service plan was not

	signed and was also not updated related to home health services. 2. The record for Resident 4 was reviewed on 10/6/25 at 1:42 p.m. Diagnoses included, but were not limited to, dementia without behavior disturbance, anxiety, and type 2 diabetes. A Level of Care Assessment, dated 8/11/25, indicated the resident was cognitively impaired for daily decision making. A Service Plan was reviewed by the facility on 9/9/25. There was no documentation the service plan had been signed by the resident's representative. During an interview on 10/7/25 at 11:23 a.m., the Director of Nursing (DON) indicated the resident's service plan had not been signed since 2/28/24. 3. The record for Resident 5 was reviewed on 10/6/25 at 11:29 a.m. Diagnoses included, but were not limited to, atrial fibrillation and osteoarthritis. The resident was admitted to the facility on 9/16/25.			

	A Progress Note, dated 9/17/25 at 10:40 p.m., indicated the resident was receiving hospice services and the hospice nurse was scheduled to visit on 9/18/25. A Level of Care Assessment/Individualized Service Plan was completed on 9/16/25. There was a lack of documentation to indicate the resident was receiving hospice services. During an interview on 10/6/25 at 3:29 p.m., the Director of Nursing indicated hospice services should have been included on the service plan. 4. The closed record for Resident 9 was reviewed on 10/6/25 at 2:26 p.m. Diagnoses included, but were not limited to, Alzheimer's disease. The resident was admitted to the facility on 6/4/25. A Level of Care Assessment/Individualized Service Plan was completed on 6/4/25. There was no signature of the resident and/or responsible party to indicate the Service Plan had been reviewed and accepted. During an interview on 10/6/25 at 3:29 p.m., the Director of Nursing indicated she was unable to provide any further documentation.			

	5. The record for Resident 3 was reviewed on 10/6/25 at 10:45 a.m. Diagnoses included, but were not limited to, dementia, psychotic mood disturbance, and chronic kidney disease. The 9/9/25 Quarterly Level of Care Assessment indicated the resident was not cognitively intact for daily decision making and required set-up assistance with activities of daily living. The Service Plan, updated on 5/13/25, lacked a resident or responsible party's signature. During an interview on 10/7/25 at 10:00 a.m., the Director of Nursing (DON) indicated she did not have a signed service plan for the resident. Based on record review and interview, the facility failed to ensure Service Plans were signed by the resident or the representative, and revised and updated for 5 of 8 residents reviewed for Service Plans. (Residents 2, 4, 5, 9, and 3) Findings include: 1. The record for Resident 2 was reviewed on 10/6/25 at 1:27 p.m. Diagnoses included, but were not limited to, depression and osteoarthritis of the hips. A Level of Care Assessment,			

	dated 8/11/25, indicated the resident was cognitively intact. A Service Plan, reviewed by the facility on 9/19/25, indicated the resident was receiving home health services for wound care. Nurses' Notes, dated 1/10/25, indicated Home Health Services were discontinued on 1/10/25. There was also no documentation that the Service Plan had been signed by the resident. During an interview on 10/7/25 at 11:23 a.m., the Director of Nursing (DON) indicated the resident's service plan was not signed and was also not updated related to home health services. 2. The record for Resident 4 was reviewed on 10/6/25 at 1:42 p.m. Diagnoses included, but were not limited to, dementia without behavior disturbance, anxiety, and type 2 diabetes. A Level of Care Assessment, dated 8/11/25, indicated the resident was cognitively impaired for daily decision making.			

	A Service Plan was reviewed by the facility on 9/9/25. There was no documentation the service plan had been signed by the resident's representative. During an interview on 10/7/25 at 11:23 a.m., the Director of Nursing (DON) indicated the resident's service plan had not been signed since 2/28/24. 3. The record for Resident 5 was reviewed on 10/6/25 at 11:29 a.m. Diagnoses included, but were not limited to, atrial fibrillation and osteoarthritis. The resident was admitted to the facility on 9/16/25. A Progress Note, dated 9/17/25 at 10:40 p.m., indicated the resident was receiving hospice services and the hospice nurse was scheduled to visit on 9/18/25. A Level of Care Assessment/Individualized Service Plan was completed on 9/16/25. There was a lack of documentation to indicate the resident was receiving hospice services. During an interview on 10/6/25 at 3:29 p.m., the Director of Nursing indicated hospice services should have been included on the service plan. 4. The closed record for Resident 9 was reviewed on 10/6/25 at 2:26 p.m. Diagnoses			

	included, but were not limited to, Alzheimer's disease. The resident was admitted to the facility on 6/4/25. A Level of Care Assessment/Individualized Service Plan was completed on 6/4/25. There was no signature of the resident and/or responsible party to indicate the Service Plan had been reviewed and accepted. During an interview on 10/6/25 at 3:29 p.m., the Director of Nursing indicated she was unable to provide any further documentation. 5. The record for Resident 3 was reviewed on 10/6/25 at 10:45 a.m. Diagnoses included, but were not limited to, dementia, psychotic mood disturbance, and chronic kidney disease. The 9/9/25 Quarterly Level of Care Assessment indicated the resident was not cognitively intact for daily decision making and required set-up assistance with activities of daily living. The Service Plan, updated on 5/13/25, lacked a resident or responsible party's signature.			

During an interview on 10/7/25 at 10:00 a.m., the Director of Nursing (DON) indicated she did not have a signed service plan for the resident.

Based on record review and interview, the facility failed to ensure Service Plans were signed by the resident or the representative, and revised and updated for 5 of 8 residents reviewed for Service Plans. (Residents 2, 4, 5, 9, and 3)

Findings include:

1. The record for Resident 2 was reviewed on 10/6/25 at 1:27 p.m. Diagnoses included, but were not limited to, depression and osteoarthritis of the hips.

A Level of Care Assessment, dated 8/11/25, indicated the resident was cognitively intact.

A Service Plan, reviewed by the facility on 9/19/25, indicated the resident was receiving home health services for wound care.

Nurses' Notes, dated 1/10/25, indicated Home Health Services were discontinued on 1/10/25.

There was also no documentation that the Service Plan had been signed by the resident.

During an interview on 10/7/25 at 11:23 a.m., the Director of

Nursing (DON) indicated the resident's service plan was not signed and was also not updated related to home health services.

2. The record for Resident 4 was reviewed on 10/6/25 at 1:42 p.m. Diagnoses included, but were not limited to, dementia without behavior disturbance, anxiety, and type 2 diabetes.

A Level of Care Assessment, dated 8/11/25, indicated the resident was cognitively impaired for daily decision making.

A Service Plan was reviewed by the facility on 9/9/25. There was no documentation the service plan had been signed by the resident's representative.

During an interview on 10/7/25 at 11:23 a.m., the Director of Nursing (DON) indicated the resident's service plan had not been signed since 2/28/24.

3. The record for Resident 5 was reviewed on 10/6/25 at 11:29 a.m. Diagnoses included, but were not limited to, atrial fibrillation and osteoarthritis. The resident was admitted to the facility on 9/16/25.

A Progress Note, dated 9/17/25 at 10:40 p.m., indicated the resident was receiving hospice services and the hospice nurse

was scheduled to visit on 9/18/25.

A Level of Care Assessment/Individualized Service Plan was completed on 9/16/25. There was a lack of documentation to indicate the resident was receiving hospice services.

During an interview on 10/6/25 at 3:29 p.m., the Director of Nursing indicated hospice services should have been included on the service plan.

4. The closed record for Resident 9 was reviewed on 10/6/25 at 2:26 p.m. Diagnoses included, but were not limited to, Alzheimer's disease. The resident was admitted to the facility on 6/4/25.

A Level of Care Assessment/Individualized Service Plan was completed on 6/4/25. There was no signature of the resident and/or responsible party to indicate the Service Plan had been reviewed and accepted.

During an interview on 10/6/25 at 3:29 p.m., the Director of Nursing indicated she was unable to provide any further documentation.

5. The record for Resident 3 was reviewed on 10/6/25 at 10:45 a.m. Diagnoses included, but were not limited to,

dementia, psychotic mood disturbance, and chronic kidney disease.

The 9/9/25 Quarterly Level of Care Assessment indicated the resident was not cognitively intact for daily decision making and required set-up assistance with activities of daily living.

The Service Plan, updated on 5/13/25, lacked a resident or responsible party's signature.

During an interview on 10/7/25 at 10:00 a.m., the Director of Nursing (DON) indicated she did not have a signed service plan for the resident.

Based on record review and interview, the facility failed to ensure Service Plans were signed by the resident or the representative, and revised and updated for 5 of 8 residents reviewed for Service Plans. (Residents 2, 4, 5, 9, and 3)

Findings include:

1. The record for Resident 2 was reviewed on 10/6/25 at 1:27 p.m. Diagnoses included, but were not limited to, depression and osteoarthritis of the hips.

A Level of Care Assessment, dated 8/11/25, indicated the resident was cognitively intact.

A Service Plan, reviewed by the

facility on 9/19/25, indicated the resident was receiving home health services for wound care.

Nurses' Notes, dated 1/10/25, indicated Home Health Services were discontinued on 1/10/25.

There was also no documentation that the Service Plan had been signed by the resident.

During an interview on 10/7/25 at 11:23 a.m., the Director of Nursing (DON) indicated the resident's service plan was not signed and was also not updated related to home health services.

2. The record for Resident 4 was reviewed on 10/6/25 at 1:42 p.m. Diagnoses included, but were not limited to, dementia without behavior disturbance, anxiety, and type 2 diabetes.

A Level of Care Assessment, dated 8/11/25, indicated the resident was cognitively impaired for daily decision making.

A Service Plan was reviewed by the facility on 9/9/25. There was no documentation the service plan had been signed by the resident's representative.

During an interview on 10/7/25 at 11:23 a.m., the Director of Nursing (DON) indicated the

resident's service plan had not been signed since 2/28/24.

3. The record for Resident 5 was reviewed on 10/6/25 at 11:29 a.m. Diagnoses included, but were not limited to, atrial fibrillation and osteoarthritis. The resident was admitted to the facility on 9/16/25.

A Progress Note, dated 9/17/25 at 10:40 p.m., indicated the resident was receiving hospice services and the hospice nurse was scheduled to visit on 9/18/25.

A Level of Care Assessment/Individualized Service Plan was completed on 9/16/25. There was a lack of documentation to indicate the resident was receiving hospice services.

During an interview on 10/6/25 at 3:29 p.m., the Director of Nursing indicated hospice services should have been included on the service plan.

4. The closed record for Resident 9 was reviewed on 10/6/25 at 2:26 p.m. Diagnoses included, but were not limited to, Alzheimer's disease. The resident was admitted to the facility on 6/4/25.

A Level of Care Assessment/Individualized Service Plan was completed on 6/4/25. There was no signature

	of the resident and/or responsible party to indicate the Service Plan had been reviewed and accepted. During an interview on 10/6/25 at 3:29 p.m., the Director of Nursing indicated she was unable to provide any further documentation. 5. The record for Resident 3 was reviewed on 10/6/25 at 10:45 a.m. Diagnoses included, but were not limited to, dementia, psychotic mood disturbance, and chronic kidney disease. The 9/9/25 Quarterly Level of Care Assessment indicated the resident was not cognitively intact for daily decision making and required set-up assistance with activities of daily living. The Service Plan, updated on 5/13/25, lacked a resident or responsible party's signature. During an interview on 10/7/25 at 10:00 a.m., the Director of Nursing (DON) indicated she did not have a signed service plan for the resident.			
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	R 0241	All affected residents with active wound care orders were immediately evaluated by the DON to ensure orders were in place, and treatment needs were being met. Any delays were communicated to the attending physician for further	11/01/2025

	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 observation, record review, and interview, the facility failed to provide care as ordered related to the delay in home health services for 1 of 2 residents reviewed for wounds. (Resident 3) Finding includes: During a random observation on 10/6/25 at 2:50 p.m., Resident 3 was observed sitting in a common area of the memory care unit. The resident was wearing shoes without socks, and bandage tape was visible on top of the resident's left foot. On 10/6/25 at 3:05 p.m., the Memory Care Director (MCD) indicated the resident had a nickel-sized open area to the bottom of her left foot. She removed the resident's shoe, and a soiled dressing with yellow drainage bleeding through was observed. The MCD indicated it was the same dressing that had been applied by the nurse practitioner on 10/3/25. The record for Resident 3 was		instruction and to ensure continuity of care. No other residents were affected by this deficient practice. No long-term adverse effects were identified for the affected residents. Nursing staff were re-educated on the requirements to ensure compliance. The DON/designee will read 24hr reports daily to identify any changes in conditions. DON/designee will complete the change in condition audit form twice weekly for 2 months, then weekly for 2 months, then once per month for 2 months to ensure all new orders are completed. Findings will be reviewed during monthly QA meetings to ensure compliance.	

	reviewed on 10/6/25 at 10:45 a.m. Diagnoses included, but were not limited to, dementia, psychotic mood disturbance, and chronic kidney disease. The 9/9/25 Quarterly Level of Care Assessment indicated the resident was not cognitively intact for daily decision making and required set-up assistance with activities of daily living. A Health Status Note, dated 9/30/25 at 1:39 p.m., indicated an open area was observed to bottom of the resident's left foot. The area was cleansed and a bandage was applied. A Progress Note, dated 10/1/25 at 1:55 p.m., indicated the nurse practitioner assessed the resident's foot, applied a new dressing, and put in a referral for home health. The Service Plan, updated on 5/13/25, lacked home health or wound care. During an interview on 10/6/25 at 3:05 p.m., the Memory Care Director indicated they were supposed to get home health to treat the resident's wound, but no one had come yet.			

During an interview on 10/7/25 at 10:00 a.m., the Director of Nursing indicated they were working on getting home health services that would be covered by the resident's insurance.

Based on observation, record review, and interview, the facility failed to provide care as ordered related to the delay in home health services for 1 of 2 residents reviewed for wounds. (Resident 3)

Finding includes:

During a random observation on 10/6/25 at 2:50 p.m., Resident 3 was observed sitting in a common area of the memory care unit. The resident was wearing shoes without socks, and bandage tape was visible on top of the resident's left foot.

On 10/6/25 at 3:05 p.m., the Memory Care Director (MCD) indicated the resident had a nickel-sized open area to the bottom of her left foot. She removed the resident's shoe, and a soiled dressing with yellow drainage bleeding through was observed. The MCD indicated it was the same dressing that had been applied by the nurse practitioner on 10/3/25.

The record for Resident 3 was reviewed on 10/6/25 at 10:45 a.m. Diagnoses included, but were not limited to, dementia,

	psychotic mood disturbance, and chronic kidney disease. The 9/9/25 Quarterly Level of Care Assessment indicated the resident was not cognitively intact for daily decision making and required set-up assistance with activities of daily living. A Health Status Note, dated 9/30/25 at 1:39 p.m., indicated an open area was observed to bottom of the resident's left foot. The area was cleansed and a bandage was applied. A Progress Note, dated 10/1/25 at 1:55 p.m., indicated the nurse practitioner assessed the resident's foot, applied a new dressing, and put in a referral for home health. The Service Plan, updated on 5/13/25, lacked home health or wound care. During an interview on 10/6/25 at 3:05 p.m., the Memory Care Director indicated they were supposed to get home health to treat the resident's wound, but no one had come yet. During an interview on 10/7/25 at 10:00 a.m., the Director of Nursing indicated they were working on getting home health services that would be covered by the resident's insurance.			

R 0246	Health Services - Deficiency 410 IAC 16.2-5-4(e)(6) (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. 3. The record for Resident 5 was reviewed on 10/6/25 at 11:29 a.m. Diagnoses included, but were not limited to, atrial fibrillation and osteoarthritis. The Physician's Order Summary, dated 10/2025, indicated an order for lorazepam (an anti-anxiety medication) 2 mg/ml (milligrams/milliliter), give 0.5 ml every hour PRN (as needed) for anxiety, restlessness or insomnia. The Medication Administration Record, dated 9/2025, indicated the PRN lorazepam was signed off as administered by a QMA (Qualified Medication Aide) on 9/19/25 at 2:33 p.m. There was a lack of documentation to indicate the reason why the medication was administered or that the QMA had received	R 0246	The QMA’s involved were immediately re-educated on the requirements to obtain nurse authorization before administering any PRN medication. Documentation of training was placed in the personnel files for the employees. An audit was completed, and no other residents were affected by this deficient practice. Nursing staff were educated on protocol and policies for PRN medication administration. DON or designee will audit all medication administrations to ensure state regulations are followed for PRN medications. The DON or designee will audit medication administration in point click care twice weekly for 2 months, then weekly for 2 months, then monthly for 2 months.Any non-compliance will result in immediate retraining and disciplinary action as necessary. Findings will be reviewed during monthly QA meetings to ensure compliance.	11/01/2025

	authorization from a licensed nurse prior to administering the medication. During an interview on 10/6/25 at 2:20 p.m., the Director of Nursing indicated a QMA should receive and document prior authorization from a licensed nurse before administering any PRN medication. Based on record review and interview, the facility failed to ensure QMAs received authorization from a licensed nurse prior to administering as needed (PRN) medications for 3 of 8 records reviewed. (Residents 4, 7, and 5) Findings include: 1. The record for Resident 4 was reviewed on 10/6/25 at 1:42 p.m. Diagnoses included, but were not limited to, dementia without behavior disturbance, anxiety, and type 2 diabetes. A Level of Care Assessment, dated 8/11/25, indicated the resident was cognitively impaired for daily decision making. A Physician's Order, dated 9/3/25, indicated the resident was to receive Xanax (an anti-anxiety medication) 0.25 milligrams (mg) daily as needed (PRN) for anxiety.			

	The September 2025 Medication Administration Record (MAR) indicated the resident received the PRN Xanax on 9/30/25 at 8:13 p.m. The medication was administered by QMA 2. There was no documentation of authorization from a licensed nurse prior to giving the medication. During an interview on 10/7/25 at 11:23 a.m., the Director of Nursing (DON) indicated the QMA should have received prior authorization from the nurse before giving the resident her PRN Xanax. 2. The record for Resident 7 was reviewed on 10/7/25 at 10:45 a.m. Diagnoses included, but were not limited to, depression and spondylosis (arthritis of the spine). A Level of Care Assessment, dated 10/5/25, indicated the resident was cognitively intact. A Physician's Order, dated 7/17/25 and identified as current on the October 2025 Physician's Order Summary (POS), indicated the resident was to receive Hydrocodone/APAP (a pain medication) 10-325 milligrams (mg), 1 tablet every 4 hours as needed (PRN) for pain. The September 2025 Medication Administration Record (MAR) indicated QMA 3			

	administered the resident's PRN Hydrocodone/APAP without authorization from a licensed nurse on the following dates and times: - 9/4/25 at 5:31 p.m. - 9/8/25 at 2:23 p.m. and 9:00 p.m. - 9/13/25 at 5:15 p.m. and 9:47 p.m. - 9/14/25 at 10:28 p.m. The October 2025 MAR indicated QMA 3 administered the resident's PRN Hydrocodone/APAP without authorization from a licensed nurse on 10/6/25 at 5:05 p.m. and 10:45 p.m. During an interview on 10/7/25 at 2:00 p.m., the Director of Nursing (DON) indicated the QMA should have received authorization from the nurse before giving the resident his PRN Hydrocodone. 3. The record for Resident 5 was reviewed on 10/6/25 at 11:29 a.m. Diagnoses included, but were not limited to, atrial fibrillation and osteoarthritis. The Physician's Order Summary, dated 10/2025, indicated an order for lorazepam (an anti-anxiety medication) 2 mg/ml (milligrams/milliliter), give 0.5 ml every hour PRN (as			

needed) for anxiety, restlessness or insomnia.

The Medication Administration Record, dated 9/2025, indicated the PRN lorazepam was signed off as administered by a QMA (Qualified Medication Aide) on 9/19/25 at 2:33 p.m. There was a lack of documentation to indicate the reason why the medication was administered or that the QMA had received authorization from a licensed nurse prior to administering the medication.

During an interview on 10/6/25 at 2:20 p.m., the Director of Nursing indicated a QMA should receive and document prior authorization from a licensed nurse before administering any PRN medication.

Based on record review and interview, the facility failed to ensure QMAs received authorization from a licensed nurse prior to administering as needed (PRN) medications for 3 of 8 records reviewed. (Residents 4, 7, and 5)

Findings include:

1. The record for Resident 4 was reviewed on 10/6/25 at 1:42 p.m. Diagnoses included, but were not limited to, dementia without behavior disturbance, anxiety, and type 2 diabetes.

A Level of Care Assessment, dated 8/11/25, indicated the resident was cognitively impaired for daily decision making.

A Physician's Order, dated 9/3/25, indicated the resident was to receive Xanax (an anti-anxiety medication) 0.25 milligrams (mg) daily as needed (PRN) for anxiety.

The September 2025 Medication Administration Record (MAR) indicated the resident received the PRN Xanax on 9/30/25 at 8:13 p.m. The medication was administered by QMA 2. There was no documentation of authorization from a licensed nurse prior to giving the medication.

During an interview on 10/7/25 at 11:23 a.m., the Director of Nursing (DON) indicated the QMA should have received prior authorization from the nurse before giving the resident her PRN Xanax.

2. The record for Resident 7 was reviewed on 10/7/25 at 10:45 a.m. Diagnoses included, but were not limited to, depression and spondylosis (arthritis of the spine).

A Level of Care Assessment, dated 10/5/25, indicated the resident was cognitively intact.

	A Physician's Order, dated 7/17/25 and identified as current on the October 2025 Physician's Order Summary (POS), indicated the resident was to receive Hydrocodone/APAP (a pain medication) 10-325 milligrams (mg), 1 tablet every 4 hours as needed (PRN) for pain. The September 2025 Medication Administration Record (MAR) indicated QMA 3 administered the resident's PRN Hydrocodone/APAP without authorization from a licensed nurse on the following dates and times: - 9/4/25 at 5:31 p.m. - 9/8/25 at 2:23 p.m. and 9:00 p.m. - 9/13/25 at 5:15 p.m. and 9:47 p.m. - 9/14/25 at 10:28 p.m. The October 2025 MAR indicated QMA 3 administered the resident's PRN Hydrocodone/APAP without authorization from a licensed nurse on 10/6/25 at 5:05 p.m. and 10:45 p.m.			

	During an interview on 10/7/25 at 2:00 p.m., the Director of Nursing (DON) indicated the QMA should have received authorization from the nurse before giving the resident his PRN Hydrocodone. 3. The record for Resident 5 was reviewed on 10/6/25 at 11:29 a.m. Diagnoses included, but were not limited to, atrial fibrillation and osteoarthritis. The Physician's Order Summary, dated 10/2025, indicated an order for lorazepam (an anti-anxiety medication) 2 mg/ml (milligrams/milliliter), give 0.5 ml every hour PRN (as needed) for anxiety, restlessness or insomnia. The Medication Administration Record, dated 9/2025, indicated the PRN lorazepam was signed off as administered by a QMA (Qualified Medication Aide) on 9/19/25 at 2:33 p.m. There was a lack of documentation to indicate the reason why the medication was administered or that the QMA had received authorization from a licensed nurse prior to administering the medication. During an interview on 10/6/25 at 2:20 p.m., the Director of Nursing indicated a QMA should receive and document prior authorization from a licensed nurse before administering any			

PRN medication.

Based on record review and interview, the facility failed to ensure QMAs received authorization from a licensed nurse prior to administering as needed (PRN) medications for 3 of 8 records reviewed. (Residents 4, 7, and 5)

Findings include:

1. The record for Resident 4 was reviewed on 10/6/25 at 1:42 p.m. Diagnoses included, but were not limited to, dementia without behavior disturbance, anxiety, and type 2 diabetes.

A Level of Care Assessment, dated 8/11/25, indicated the resident was cognitively impaired for daily decision making.

A Physician's Order, dated 9/3/25, indicated the resident was to receive Xanax (an anti-anxiety medication) 0.25 milligrams (mg) daily as needed (PRN) for anxiety.

The September 2025 Medication Administration Record (MAR) indicated the resident received the PRN Xanax on 9/30/25 at 8:13 p.m. The medication was administered by QMA 2. There was no documentation of authorization from a licensed nurse prior to giving the

	medication. During an interview on 10/7/25 at 11:23 a.m., the Director of Nursing (DON) indicated the QMA should have received prior authorization from the nurse before giving the resident her PRN Xanax. 2. The record for Resident 7 was reviewed on 10/7/25 at 10:45 a.m. Diagnoses included, but were not limited to, depression and spondylosis (arthritis of the spine). A Level of Care Assessment, dated 10/5/25, indicated the resident was cognitively intact. A Physician's Order, dated 7/17/25 and identified as current on the October 2025 Physician's Order Summary (POS), indicated the resident was to receive Hydrocodone/APAP (a pain medication) 10-325 milligrams (mg), 1 tablet every 4 hours as needed (PRN) for pain. The September 2025 Medication Administration Record (MAR) indicated QMA 3 administered the resident's PRN Hydrocodone/APAP without authorization from a licensed nurse on the following dates and times: - 9/4/25 at 5:31 p.m.			

	- 9/8/25 at 2:23 p.m. and 9:00 p.m. - 9/13/25 at 5:15 p.m. and 9:47 p.m. - 9/14/25 at 10:28 p.m. The October 2025 MAR indicated QMA 3 administered the resident's PRN Hydrocodone/APAP without authorization from a licensed nurse on 10/6/25 at 5:05 p.m. and 10:45 p.m. During an interview on 10/7/25 at 2:00 p.m., the Director of Nursing (DON) indicated the QMA should have received authorization from the nurse before giving the resident his PRN Hydrocodone. 3. The record for Resident 5 was reviewed on 10/6/25 at 11:29 a.m. Diagnoses included, but were not limited to, atrial fibrillation and osteoarthritis. The Physician's Order Summary, dated 10/2025, indicated an order for lorazepam (an anti-anxiety medication) 2 mg/ml (milligrams/milliliter), give 0.5 ml every hour PRN (as needed) for anxiety, restlessness or insomnia. The Medication Administration Record, dated 9/2025, indicated the PRN lorazepam was signed off as administered by a QMA (Qualified Medication Aide) on			

9/19/25 at 2:33 p.m. There was a lack of documentation to indicate the reason why the medication was administered or that the QMA had received authorization from a licensed nurse prior to administering the medication.

During an interview on 10/6/25 at 2:20 p.m., the Director of Nursing indicated a QMA should receive and document prior authorization from a licensed nurse before administering any PRN medication.

Based on record review and interview, the facility failed to ensure QMAs received authorization from a licensed nurse prior to administering as needed (PRN) medications for 3 of 8 records reviewed. (Residents 4, 7, and 5)

Findings include:

1. The record for Resident 4 was reviewed on 10/6/25 at 1:42 p.m. Diagnoses included, but were not limited to, dementia without behavior disturbance, anxiety, and type 2 diabetes.

A Level of Care Assessment, dated 8/11/25, indicated the resident was cognitively impaired for daily decision making.

A Physician's Order, dated 9/3/25, indicated the resident

was to receive Xanax (an anti-anxiety medication) 0.25 milligrams (mg) daily as needed (PRN) for anxiety.

The September 2025 Medication Administration Record (MAR) indicated the resident received the PRN Xanax on 9/30/25 at 8:13 p.m. The medication was administered by QMA 2. There was no documentation of authorization from a licensed nurse prior to giving the medication.

During an interview on 10/7/25 at 11:23 a.m., the Director of Nursing (DON) indicated the QMA should have received prior authorization from the nurse before giving the resident her PRN Xanax.

2. The record for Resident 7 was reviewed on 10/7/25 at 10:45 a.m. Diagnoses included, but were not limited to, depression and spondylosis (arthritis of the spine).

A Level of Care Assessment, dated 10/5/25, indicated the resident was cognitively intact.

A Physician's Order, dated 7/17/25 and identified as current on the October 2025 Physician's Order Summary (POS), indicated the resident was to receive Hydrocodone/APAP (a pain medication) 10-325 milligrams (mg), 1 tablet every 4

	hours as needed (PRN) for pain. The September 2025 Medication Administration Record (MAR) indicated QMA 3 administered the resident's PRN Hydrocodone/APAP without authorization from a licensed nurse on the following dates and times: - 9/4/25 at 5:31 p.m. - 9/8/25 at 2:23 p.m. and 9:00 p.m. - 9/13/25 at 5:15 p.m. and 9:47 p.m. - 9/14/25 at 10:28 p.m. The October 2025 MAR indicated QMA 3 administered the resident's PRN Hydrocodone/APAP without authorization from a licensed nurse on 10/6/25 at 5:05 p.m. and 10:45 p.m. During an interview on 10/7/25 at 2:00 p.m., the Director of Nursing (DON) indicated the QMA should have received authorization from the nurse before giving the resident his PRN Hydrocodone.			
R 0297	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(c)(1) (c) If the facility controls, handles,	R 0297	All nurses and QMAs were re-educated on the importance of ensuring timely medication availability, particularly pain medications. Staff were educated immediately regarding notifying the	11/01/2025

	and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on record review and interview, the facility failed to ensure pain medications were available as ordered for 1 of 8 records reviewed. (Resident 2) Finding includes: During an interview on 10/6/25 at 9:45 a.m., Resident 2 indicated that she went 4-5 days without her pain medication a few months ago. The record for Resident 2 was reviewed on 10/6/25 at 1:27 p.m. Diagnoses included, but were not limited to, depression and osteoarthritis of the hips. A Level of Care Assessment, dated 8/11/25, indicated the resident was cognitively intact. The assessment also indicated nursing staff administered the resident's medications. A Physician's Order, dated 5/3/25 and listed as current on the October 2025 Physician's Order Summary (POS), indicated the resident was to receive Hydrocodone/APAP (a		nurse or pharmacy if any medications including pain medications are not received as expected. Any delays in receipt of medications will be documented in the resident chart, and MD will be notified for further instruction. An audit was completed, and no other residents were affected by this deficient practice. The DON or designee will audit all medication administration to ensure pain medications are given as ordered. The DON or designee will conduct the audits in point click care twice weekly for 2 months, then weekly for 2 months, then monthly for 2 months. Any deficiencies identified will result in immediate correction and staff training up to and including disciplinary action. Findings will be reviewed during monthly QA meetings to ensure compliance.	

pain medication) 5-325 milligrams (mg), give 1 tablet by mouth at bedtime.

The July 2025 Medication Administration Record (MAR) indicated the resident's Hydrocodone/APAP was signed out as "NA" for July 10 through July 14, 2025.

There was no documentation in the nursing progress notes regarding why the medication was not available for the above dates.

During an interview on 10/7/25 at 11:23 a.m., the Director of Nursing (DON) indicated the resident's Hydrocodone should not have been documented as "NA" on the MAR and there should have been documentation in the nursing progress notes indicating why the medication was not available.

Based on record review and interview, the facility failed to ensure pain medications were available as ordered for 1 of 8 records reviewed. (Resident 2)

Finding includes:

During an interview on 10/6/25 at 9:45 a.m., Resident 2 indicated that she went 4-5 days without her pain medication a few months ago.

The record for Resident 2 was

reviewed on 10/6/25 at 1:27 p.m. Diagnoses included, but were not limited to, depression and osteoarthritis of the hips.

A Level of Care Assessment, dated 8/11/25, indicated the resident was cognitively intact. The assessment also indicated nursing staff administered the resident's medications.

A Physician's Order, dated 5/3/25 and listed as current on the October 2025 Physician's Order Summary (POS), indicated the resident was to receive Hydrocodone/APAP (a pain medication) 5-325 milligrams (mg), give 1 tablet by mouth at bedtime.

The July 2025 Medication Administration Record (MAR) indicated the resident's Hydrocodone/APAP was signed out as "NA" for July 10 through July 14, 2025.

There was no documentation in the nursing progress notes regarding why the medication was not available for the above dates.

During an interview on 10/7/25 at 11:23 a.m., the Director of Nursing (DON) indicated the resident's Hydrocodone should not have been documented as "NA" on the MAR and there should have been documentation in the nursing progress notes indicating why

	the medication was not available.			
R 0298	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(2) (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. 3. The record for Resident 3 was reviewed on 10/6/25 at 10:45 a.m. Diagnoses included, but were not limited to, dementia, psychotic mood disturbance, and chronic kidney disease. The 9/9/25 Quarterly Level of Care Assessment indicated the	R 0298	The consulting pharmacist was immediately notified to complete overdue medication reviews for all affected residents. All identified resident medication profiles were reviewed, and any recommendations from the pharmacist were addressed and documented in each resident chart. No other residents were affected by this deficient practice. No long-term adverse effects were identified for the affected residents. The DON or designee will audit pharmacy recommendations every 60 days indefinitely to ensure orders are being carried out as written by MD. Findings will be reviewed during monthly QA meetings to ensure compliance.	11/01/2025

	resident was not cognitively intact for daily decision making and required set-up assistance with activities of daily living. The Service Plan, updated on 5/13/25, indicated the facility managed and provided the resident's medications. The record lacked pharmacy reviews from 12/16/24 to 8/9/25. During an interview on 10/7/25 at 11:28 a.m., the Director of Nursing (DON) indicated she did not have pharmacy reviews from 12/16/24 to 8/9/25. Based on record review and interview, the facility failed to ensure each resident's drug regimen was reviewed at least once every 60 days by the Consulting Pharmacist for 3 of 8 records reviewed. (Residents 2, 4, and 3) Findings include: 1. The record for Resident 2 was reviewed on 10/6/25 at 1:27 p.m. Diagnoses included, but were not limited to, depression and osteoarthritis of the hips.			

	A Level of Care Assessment, dated 8/11/25, indicated the resident was cognitively intact. The assessment also indicated nursing staff administered and provided the resident's medications. The record lacked pharmacy reviews from 12/16/24 to 8/9/25. During an interview on 10/7/25 at 11:28 a.m., the Director of Nursing (DON) indicated she did not have pharmacy reviews from 12/16/24 to 8/9/25. 2. The record for Resident 4 was reviewed on 10/6/25 at 1:42 p.m. Diagnoses included, but were not limited to, dementia without behavior disturbance, anxiety, and type 2 diabetes. A Level of Care Assessment, dated 8/11/25, indicated the resident was cognitively impaired for daily decision making. The assessment also indicated nursing staff administered and provided the resident's medications. The record lacked pharmacy reviews from 12/16/24 to 8/9/25. During an interview on 10/7/25 at 11:28 a.m., the Director of Nursing (DON) indicated she did not have pharmacy reviews from 12/16/24 to 8/9/25. 3. The record for Resident 3			

	was reviewed on 10/6/25 at 10:45 a.m. Diagnoses included, but were not limited to, dementia, psychotic mood disturbance, and chronic kidney disease. The 9/9/25 Quarterly Level of Care Assessment indicated the resident was not cognitively intact for daily decision making and required set-up assistance with activities of daily living. The Service Plan, updated on 5/13/25, indicated the facility managed and provided the resident's medications. The record lacked pharmacy reviews from 12/16/24 to 8/9/25. During an interview on 10/7/25 at 11:28 a.m., the Director of Nursing (DON) indicated she did not have pharmacy reviews from 12/16/24 to 8/9/25. Based on record review and interview, the facility failed to ensure each resident's drug regimen was reviewed at least once every 60 days by the Consulting Pharmacist for 3 of 8 records reviewed. (Residents 2, 4, and 3) Findings include: 1. The record for Resident 2 was reviewed on 10/6/25 at 1:27 p.m. Diagnoses included, but were not limited to, depression and osteoarthritis of			

	the hips. A Level of Care Assessment, dated 8/11/25, indicated the resident was cognitively intact. The assessment also indicated nursing staff administered and provided the resident's medications. The record lacked pharmacy reviews from 12/16/24 to 8/9/25. During an interview on 10/7/25 at 11:28 a.m., the Director of Nursing (DON) indicated she did not have pharmacy reviews from 12/16/24 to 8/9/25. 2. The record for Resident 4 was reviewed on 10/6/25 at 1:42 p.m. Diagnoses included, but were not limited to, dementia without behavior disturbance, anxiety, and type 2 diabetes. A Level of Care Assessment, dated 8/11/25, indicated the resident was cognitively impaired for daily decision making. The assessment also indicated nursing staff administered and provided the resident's medications. The record lacked pharmacy reviews from 12/16/24 to 8/9/25.			

	During an interview on 10/7/25 at 11:28 a.m., the Director of Nursing (DON) indicated she did not have pharmacy reviews from 12/16/24 to 8/9/25. 3. The record for Resident 3 was reviewed on 10/6/25 at 10:45 a.m. Diagnoses included, but were not limited to, dementia, psychotic mood disturbance, and chronic kidney disease. The 9/9/25 Quarterly Level of Care Assessment indicated the resident was not cognitively intact for daily decision making and required set-up assistance with activities of daily living. The Service Plan, updated on 5/13/25, indicated the facility managed and provided the resident's medications. The record lacked pharmacy reviews from 12/16/24 to 8/9/25. During an interview on 10/7/25 at 11:28 a.m., the Director of Nursing (DON) indicated she did not have pharmacy reviews from 12/16/24 to 8/9/25. Based on record review and interview, the facility failed to ensure each resident's drug regimen was reviewed at least once every 60 days by the Consulting Pharmacist for 3 of 8 records reviewed. (Residents 2, 4, and 3)			

Findings include:

1. The record for Resident 2 was reviewed on 10/6/25 at 1:27 p.m. Diagnoses included, but were not limited to, depression and osteoarthritis of the hips.

A Level of Care Assessment, dated 8/11/25, indicated the resident was cognitively intact. The assessment also indicated nursing staff administered and provided the resident's medications.

The record lacked pharmacy reviews from 12/16/24 to 8/9/25.

During an interview on 10/7/25 at 11:28 a.m., the Director of Nursing (DON) indicated she did not have pharmacy reviews from 12/16/24 to 8/9/25.

2. The record for Resident 4 was reviewed on 10/6/25 at 1:42 p.m. Diagnoses included, but were not limited to, dementia without behavior disturbance, anxiety, and type 2 diabetes.

A Level of Care Assessment, dated 8/11/25, indicated the resident was cognitively impaired for daily decision making. The assessment also indicated nursing staff administered and provided the resident's medications.

The record lacked pharmacy

reviews from 12/16/24 to 8/9/25.

During an interview on 10/7/25 at 11:28 a.m., the Director of Nursing (DON) indicated she did not have pharmacy reviews from 12/16/24 to 8/9/25.

3. The record for Resident 3 was reviewed on 10/6/25 at 10:45 a.m. Diagnoses included, but were not limited to, dementia, psychotic mood disturbance, and chronic kidney disease.

The 9/9/25 Quarterly Level of Care Assessment indicated the resident was not cognitively intact for daily decision making and required set-up assistance with activities of daily living.

The Service Plan, updated on 5/13/25, indicated the facility managed and provided the resident's medications.

The record lacked pharmacy reviews from 12/16/24 to 8/9/25.

During an interview on 10/7/25 at 11:28 a.m., the Director of Nursing (DON) indicated she did not have pharmacy reviews from 12/16/24 to 8/9/25.

Based on record review and interview, the facility failed to ensure each resident's drug regimen was reviewed at least once every 60 days by the Consulting Pharmacist for 3 of 8 records reviewed. (Residents 2,

	4, and 3) Findings include: 1. The record for Resident 2 was reviewed on 10/6/25 at 1:27 p.m. Diagnoses included, but were not limited to, depression and osteoarthritis of the hips. A Level of Care Assessment, dated 8/11/25, indicated the resident was cognitively intact. The assessment also indicated nursing staff administered and provided the resident's medications. The record lacked pharmacy reviews from 12/16/24 to 8/9/25. During an interview on 10/7/25 at 11:28 a.m., the Director of Nursing (DON) indicated she did not have pharmacy reviews from 12/16/24 to 8/9/25. 2. The record for Resident 4 was reviewed on 10/6/25 at 1:42 p.m. Diagnoses included, but were not limited to, dementia without behavior disturbance, anxiety, and type 2 diabetes.			

	A Level of Care Assessment, dated 8/11/25, indicated the resident was cognitively impaired for daily decision making. The assessment also indicated nursing staff administered and provided the resident's medications. The record lacked pharmacy reviews from 12/16/24 to 8/9/25. During an interview on 10/7/25 at 11:28 a.m., the Director of Nursing (DON) indicated she did not have pharmacy reviews from 12/16/24 to 8/9/25.			
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. 4. The closed record for Resident 8 was reviewed on 10/6/25 at 11:40 a.m. Diagnoses included, but were not limited to, malignant neoplasm (cancer) of the brain,	R 0349	Each identified residents' clinical record was immediately reviewed and corrected to ensure all required documentation was present and accurate. An audit was completed for all residents, and no other residents were affected by this deficient practice. No long-term adverse effects were identified for the affected residents. All nursing staff were educated in proper charting and documentation including post-resident to resident altercations, changes in conditions, and fall charting.The DON or designee will read the 24hr report in point click care daily to identify proper charting. The DON or designee will audit notes twice weekly for 2 months, then weekly for 2 months, then monthly for 2 months. Any deficiencies will result in immediate re-education, training, and disciplinary action as needed. Findings will be reviewed during monthly QA meetings to ensure	11/01/2025

	and traumatic brain injury. The Quarterly Level of Care Assessment/Individualized Service Plan, dated 6/6/25, indicated the resident was a full code status and was receiving hospice care. The Hospice nurse's notes from 6/13/25 through 7/10/25 indicated the resident had a Do Not Resuscitate (DNR) order. The facility's clinical record for the resident lacked documentation of a DNR. During an interview on 10/7/25 at 11:28 a.m., the Director of Nursing (DON) indicated they did not have a DNR form for the resident. The Medication Administration Record (MAR) for July 2025 indicated Ketoconazole Cream 2% (an anti-fungal) was administered to the resident on 7/12/25 and 7/16/25. The resident's fluid restriction was signed out on 7/11/25, 7/12/25, 7/13/25, 7/14/25, 7/15/25, 7/16/25, and 7/17/25. The clinical record indicated the resident expired on 7/10/25. During an interview on 10/7/25 at 11:28 a.m., the DON was informed of the findings and offered no further information. 3. The record for Resident 5		compliance.	

was reviewed on 10/6/25 at 11:29 a.m. Diagnoses included, but were not limited to, atrial fibrillation and osteoarthritis.

A Physician's Order, dated 9/18/25 and discontinued on 9/26/25, indicated lorazepam (an anti-anxiety medication) 0.5 mg (milligrams) twice daily.

A Physician's Order, dated 9/19/25 and discontinued on 9/26/25, indicated lorazepam 1 mg every 6 hours.

The Medication Administration Record (MAR), dated 9/2025, indicated the 0.5 mg lorazepam order was signed off as administered 13 times. The 1 mg lorazepam order was signed off as administered 19 times.

During an interview on 10/6/25 at 2:58 p.m., the Director of Nursing indicated there was some confusion with the resident's lorazepam orders upon admission. He had not received both lorazepam orders at the same time, the documentation on the MAR was incorrect.

Based on record review and interview, the facility failed to ensure clinical records were complete and accurately documented related to the indication for the use of an anti-anxiety medication, follow up documentation after a resident to resident altercation

	and a non-pressure skin condition, lack of documentation of medication administration, clarification of medication orders, documentation of advance directives, and inaccurate documentation related to a fluid restriction and a treatment for 4 of 8 sampled residents. (Residents 4, 7, 5, and 8) Findings include: 1. The record for Resident 4 was reviewed on 10/6/25 at 1:42 p.m. Diagnoses included, but were not limited to, dementia without behavior disturbance, anxiety, and type 2 diabetes. A Level of Care Assessment, dated 8/11/25, indicated the resident was cognitively impaired for daily decision making. A Physician's Order, dated 9/3/25, indicated the resident was to receive Xanax (an anti-anxiety medication) 0.25 milligrams (mg) daily as needed (PRN) for anxiety.			

	The September 2025 Medication Administration Record (MAR) indicated LPN 1 administered the PRN Xanax on 9/22/25 at 10:53 p.m. There was no documentation on the MAR or in the nursing progress notes related to why the medication was given. An Incident Note, dated 9/28/25 at 8:50 p.m., indicated Resident 4 had been slapped by another resident. Resident 4 was reportedly standing close to the other resident's face and she was trying to take her walker. Upon arrival of the nurse, the resident was observed with slight redness to the left cheek. The resident denied pain or discomfort. The residents were separated and redirected to their respective rooms. Both residents calmed down with staff support. Their families were notified and both residents remained under close supervision, no further behavioral issues were noted at that time. The next documented entry was a Health Status Note, dated 9/29/25 at 1:50 p.m., which indicated the resident was sitting in the common area with no behaviors or signs and symptoms of distress. There were no reported or expressed issues related to the most recent resident to resident altercation. The resident			

remained separated from the co-resident. No obvious or visible injuries were observed at that time.

There was no further documentation regarding the resident to resident altercation.

A Health Status Note, dated 10/1/25 at 2:10 p.m., indicated the resident had a small scratch observed to the left side of her face near her ear. The resident stated she bumped it on the towel bar in her bathroom after washing her face. The area was scabbed over and no complaints of pain were voiced.

There was no further documentation regarding the scratch to the resident's face.

During an interview on 10/7/25 at 11:23 a.m., the Director of Nursing (DON) indicated the LPN should have documented the reason why the Xanax was being given when it was administered on 9/22/25. The DON also indicated documentation should have been completed once a shift for 72 hours after the resident to resident altercation and the scratch to the resident's face.

2. The record for Resident 7 was reviewed on 10/7/25 at 10:45 a.m. Diagnoses included, but were not limited to, type 2 diabetes, depression, and spondylosis (arthritis of the

spine).

A Level of Care Assessment, dated 10/5/25, indicated the resident was cognitively intact.

Physician's Orders, dated 9/9/25, indicated the resident was to receive Humalog insulin 46 units subcutaneously (sq) three times a day and Toujeo (a long acting insulin) 70 units sq twice a day.

The September 2025 Medication Administration Record (MAR) indicated the Humalog insulin was not signed out as being administered on 9/14/25 at 12:00 p.m. and on 9/12/25, 9/13/25, and 9/14/25 at 5:00 p.m.

The resident's Toujeo insulin was not signed out as being administered on 9/12/25, 9/13/25, and 9/14/25 at 7:00 p.m.

During an interview on 10/7/25 at 2:00 p.m., the Director of Nursing (DON) indicated the insulin should have been signed out as ordered.

4. The closed record for Resident 8 was reviewed on 10/6/25 at 11:40 a.m. Diagnoses included, but were not limited to, malignant neoplasm (cancer) of the brain, and traumatic brain injury.

The Quarterly Level of Care

	Assessment/Individualized Service Plan, dated 6/6/25, indicated the resident was a full code status and was receiving hospice care. The Hospice nurse's notes from 6/13/25 through 7/10/25 indicated the resident had a Do Not Resuscitate (DNR) order. The facility's clinical record for the resident lacked documentation of a DNR. During an interview on 10/7/25 at 11:28 a.m., the Director of Nursing (DON) indicated they did not have a DNR form for the resident. The Medication Administration Record (MAR) for July 2025 indicated Ketoconazole Cream 2% (an anti-fungal) was administered to the resident on 7/12/25 and 7/16/25. The resident's fluid restriction was signed out on 7/11/25, 7/12/25, 7/13/25, 7/14/25, 7/15/25, 7/16/25, and 7/17/25. The clinical record indicated the resident expired on 7/10/25. During an interview on 10/7/25 at 11:28 a.m., the DON was informed of the findings and offered no further information. 3. The record for Resident 5 was reviewed on 10/6/25 at 11:29 a.m. Diagnoses included, but were not limited to, atrial			

fibrillation and osteoarthritis.

A Physician's Order, dated 9/18/25 and discontinued on 9/26/25, indicated lorazepam (an anti-anxiety medication) 0.5 mg (milligrams) twice daily.

A Physician's Order, dated 9/19/25 and discontinued on 9/26/25, indicated lorazepam 1 mg every 6 hours.

The Medication Administration Record (MAR), dated 9/2025, indicated the 0.5 mg lorazepam order was signed off as administered 13 times. The 1 mg lorazepam order was signed off as administered 19 times.

During an interview on 10/6/25 at 2:58 p.m., the Director of Nursing indicated there was some confusion with the resident's lorazepam orders upon admission. He had not received both lorazepam orders at the same time, the documentation on the MAR was incorrect.

Based on record review and interview, the facility failed to ensure clinical records were complete and accurately documented related to the indication for the use of an anti-anxiety medication, follow up documentation after a resident to resident altercation and a non-pressure skin condition, lack of documentation of medication administration,

clarification of medication orders, documentation of advance directives, and inaccurate documentation related to a fluid restriction and a treatment for 4 of 8 sampled residents. (Residents 4, 7, 5, and 8)

Findings include:

1. The record for Resident 4 was reviewed on 10/6/25 at 1:42 p.m. Diagnoses included, but were not limited to, dementia without behavior disturbance, anxiety, and type 2 diabetes.

A Level of Care Assessment, dated 8/11/25, indicated the resident was cognitively impaired for daily decision making.

A Physician's Order, dated 9/3/25, indicated the resident was to receive Xanax (an anti-anxiety medication) 0.25 milligrams (mg) daily as needed (PRN) for anxiety.

The September 2025 Medication Administration Record (MAR) indicated LPN 1 administered the PRN Xanax on 9/22/25 at 10:53 p.m. There was no documentation on the MAR or in the nursing progress notes related to why the medication was given.

An Incident Note, dated 9/28/25 at 8:50 p.m., indicated Resident

	4 had been slapped by another resident. Resident 4 was reportedly standing close to the other resident's face and she was trying to take her walker. Upon arrival of the nurse, the resident was observed with slight redness to the left cheek. The resident denied pain or discomfort. The residents were separated and redirected to their respective rooms. Both residents calmed down with staff support. Their families were notified and both residents remained under close supervision, no further behavioral issues were noted at that time. The next documented entry was a Health Status Note, dated 9/29/25 at 1:50 p.m., which indicated the resident was sitting in the common area with no behaviors or signs and symptoms of distress. There were no reported or expressed issues related to the most recent resident to resident altercation. The resident remained separated from the co-resident. No obvious or visible injuries were observed at that time. There was no further documentation regarding the resident to resident altercation. A Health Status Note, dated 10/1/25 at 2:10 p.m., indicated the resident had a small scratch			

observed to the left side of her face near her ear. The resident stated she bumped it on the towel bar in her bathroom after washing her face. The area was scabbed over and no complaints of pain were voiced.

There was no further documentation regarding the scratch to the resident's face.

During an interview on 10/7/25 at 11:23 a.m., the Director of Nursing (DON) indicated the LPN should have documented the reason why the Xanax was being given when it was administered on 9/22/25. The DON also indicated documentation should have been completed once a shift for 72 hours after the resident to resident altercation and the scratch to the resident's face.

2. The record for Resident 7 was reviewed on 10/7/25 at 10:45 a.m. Diagnoses included, but were not limited to, type 2 diabetes, depression, and spondylosis (arthritis of the spine).

A Level of Care Assessment, dated 10/5/25, indicated the resident was cognitively intact.

Physician's Orders, dated 9/9/25, indicated the resident was to receive Humalog insulin 46 units subcutaneously (sq) three times a day and Toujeo (a long acting insulin) 70 units sq

twice a day.

The September 2025 Medication Administration Record (MAR) indicated the Humalog insulin was not signed out as being administered on 9/14/25 at 12:00 p.m. and on 9/12/25, 9/13/25, and 9/14/25 at 5:00 p.m.

The resident's Toujeo insulin was not signed out as being administered on 9/12/25, 9/13/25, and 9/14/25 at 7:00 p.m.

During an interview on 10/7/25 at 2:00 p.m., the Director of Nursing (DON) indicated the insulin should have been signed out as ordered.

4. The closed record for Resident 8 was reviewed on 10/6/25 at 11:40 a.m. Diagnoses included, but were not limited to, malignant neoplasm (cancer) of the brain, and traumatic brain injury.

The Quarterly Level of Care Assessment/Individualized Service Plan, dated 6/6/25, indicated the resident was a full code status and was receiving hospice care.

The Hospice nurse's notes from 6/13/25 through 7/10/25 indicated the resident had a Do Not Resuscitate (DNR) order.

The facility's clinical record for

	the resident lacked documentation of a DNR. During an interview on 10/7/25 at 11:28 a.m., the Director of Nursing (DON) indicated they did not have a DNR form for the resident. The Medication Administration Record (MAR) for July 2025 indicated Ketoconazole Cream 2% (an anti-fungal) was administered to the resident on 7/12/25 and 7/16/25. The resident's fluid restriction was signed out on 7/11/25, 7/12/25, 7/13/25, 7/14/25, 7/15/25, 7/16/25, and 7/17/25. The clinical record indicated the resident expired on 7/10/25. During an interview on 10/7/25 at 11:28 a.m., the DON was informed of the findings and offered no further information. 3. The record for Resident 5 was reviewed on 10/6/25 at 11:29 a.m. Diagnoses included, but were not limited to, atrial fibrillation and osteoarthritis. A Physician's Order, dated 9/18/25 and discontinued on 9/26/25, indicated lorazepam (an anti-anxiety medication) 0.5 mg (milligrams) twice daily.			

	A Physician's Order, dated 9/19/25 and discontinued on 9/26/25, indicated lorazepam 1 mg every 6 hours. The Medication Administration Record (MAR), dated 9/2025, indicated the 0.5 mg lorazepam order was signed off as administered 13 times. The 1 mg lorazepam order was signed off as administered 19 times. During an interview on 10/6/25 at 2:58 p.m., the Director of Nursing indicated there was some confusion with the resident's lorazepam orders upon admission. He had not received both lorazepam orders at the same time, the documentation on the MAR was incorrect. Based on record review and interview, the facility failed to ensure clinical records were complete and accurately documented related to the indication for the use of an anti-anxiety medication, follow up documentation after a resident to resident altercation and a non-pressure skin condition, lack of documentation of medication administration, clarification of medication orders, documentation of advance directives, and inaccurate documentation related to a fluid restriction and a treatment for 4 of 8 sampled residents. (Residents 4, 7, 5,			

and 8)

Findings include:

1. The record for Resident 4 was reviewed on 10/6/25 at 1:42 p.m. Diagnoses included, but were not limited to, dementia without behavior disturbance, anxiety, and type 2 diabetes.

A Level of Care Assessment, dated 8/11/25, indicated the resident was cognitively impaired for daily decision making.

A Physician's Order, dated 9/3/25, indicated the resident was to receive Xanax (an anti-anxiety medication) 0.25 milligrams (mg) daily as needed (PRN) for anxiety.

The September 2025 Medication Administration Record (MAR) indicated LPN 1 administered the PRN Xanax on 9/22/25 at 10:53 p.m. There was no documentation on the MAR or in the nursing progress notes related to why the medication was given.

An Incident Note, dated 9/28/25 at 8:50 p.m., indicated Resident 4 had been slapped by another resident. Resident 4 was reportedly standing close to the other resident's face and she was trying to take her walker. Upon arrival of the nurse, the resident was observed with

	slight redness to the left cheek. The resident denied pain or discomfort. The residents were separated and redirected to their respective rooms. Both residents calmed down with staff support. Their families were notified and both residents remained under close supervision, no further behavioral issues were noted at that time. The next documented entry was a Health Status Note, dated 9/29/25 at 1:50 p.m., which indicated the resident was sitting in the common area with no behaviors or signs and symptoms of distress. There were no reported or expressed issues related to the most recent resident to resident altercation. The resident remained separated from the co-resident. No obvious or visible injuries were observed at that time. There was no further documentation regarding the resident to resident altercation.			

	A Health Status Note, dated 10/1/25 at 2:10 p.m., indicated the resident had a small scratch observed to the left side of her face near her ear. The resident stated she bumped it on the towel bar in her bathroom after washing her face. The area was scabbed over and no complaints of pain were voiced. There was no further documentation regarding the scratch to the resident's face. During an interview on 10/7/25 at 11:23 a.m., the Director of Nursing (DON) indicated the LPN should have documented the reason why the Xanax was being given when it was administered on 9/22/25. The DON also indicated documentation should have been completed once a shift for 72 hours after the resident to resident altercation and the scratch to the resident's face. 2. The record for Resident 7 was reviewed on 10/7/25 at 10:45 a.m. Diagnoses included, but were not limited to, type 2 diabetes, depression, and spondylosis (arthritis of the spine). A Level of Care Assessment, dated 10/5/25, indicated the resident was cognitively intact. Physician's Orders, dated 9/9/25, indicated the resident was to receive Humalog insulin			

	46 units subcutaneously (sq) three times a day and Toujeo (a long acting insulin) 70 units sq twice a day. The September 2025 Medication Administration Record (MAR) indicated the Humalog insulin was not signed out as being administered on 9/14/25 at 12:00 p.m. and on 9/12/25, 9/13/25, and 9/14/25 at 5:00 p.m. The resident's Toujeo insulin was not signed out as being administered on 9/12/25, 9/13/25, and 9/14/25 at 7:00 p.m. During an interview on 10/7/25 at 2:00 p.m., the Director of Nursing (DON) indicated the insulin should have been signed out as ordered. 4. The closed record for Resident 8 was reviewed on 10/6/25 at 11:40 a.m. Diagnoses included, but were not limited to, malignant neoplasm (cancer) of the brain, and traumatic brain injury. The Quarterly Level of Care Assessment/Individualized Service Plan, dated 6/6/25, indicated the resident was a full code status and was receiving hospice care. The Hospice nurse's notes from 6/13/25 through 7/10/25 indicated the resident had a Do			

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	9/19/25 and discontinued on 9/26/25, indicated lorazepam 1 mg every 6 hours. The Medication Administration Record (MAR), dated 9/2025, indicated the 0.5 mg lorazepam order was signed off as administered 13 times. The 1 mg lorazepam order was signed off as administered 19 times. During an interview on 10/6/25 at 2:58 p.m., the Director of Nursing indicated there was some confusion with the resident's lorazepam orders upon admission. He had not received both lorazepam orders at the same time, the documentation on the MAR was incorrect.			

Based on record review and interview, the facility failed to ensure clinical records were complete and accurately documented related to the indication for the use of an anti-anxiety medication, follow up documentation after a resident to resident altercation and a non-pressure skin condition, lack of documentation of medication administration, clarification of medication orders, documentation of advance directives, and inaccurate documentation related to a fluid restriction and a treatment for 4 of 8 sampled residents. (Residents 4, 7, 5, and 8)

Findings include:

1. The record for Resident 4 was reviewed on 10/6/25 at 1:42 p.m. Diagnoses included, but were not limited to, dementia without behavior disturbance, anxiety, and type 2 diabetes.

A Level of Care Assessment, dated 8/11/25, indicated the resident was cognitively impaired for daily decision making.

A Physician's Order, dated 9/3/25, indicated the resident was to receive Xanax (an anti-anxiety medication) 0.25 milligrams (mg) daily as needed (PRN) for anxiety.

	The September 2025 Medication Administration Record (MAR) indicated LPN 1 administered the PRN Xanax on 9/22/25 at 10:53 p.m. There was no documentation on the MAR or in the nursing progress notes related to why the medication was given. An Incident Note, dated 9/28/25 at 8:50 p.m., indicated Resident 4 had been slapped by another resident. Resident 4 was reportedly standing close to the other resident's face and she was trying to take her walker. Upon arrival of the nurse, the resident was observed with slight redness to the left cheek. The resident denied pain or discomfort. The residents were separated and redirected to their respective rooms. Both residents calmed down with staff support. Their families were notified and both residents remained under close supervision, no further behavioral issues were noted at that time. The next documented entry was a Health Status Note, dated 9/29/25 at 1:50 p.m., which indicated the resident was sitting in the common area with no behaviors or signs and symptoms of distress. There were no reported or expressed issues related to the most recent resident to resident altercation. The resident			

remained separated from the co-resident. No obvious or visible injuries were observed at that time.

There was no further documentation regarding the resident to resident altercation.

A Health Status Note, dated 10/1/25 at 2:10 p.m., indicated the resident had a small scratch observed to the left side of her face near her ear. The resident stated she bumped it on the towel bar in her bathroom after washing her face. The area was scabbed over and no complaints of pain were voiced.

There was no further documentation regarding the scratch to the resident's face.

During an interview on 10/7/25 at 11:23 a.m., the Director of Nursing (DON) indicated the LPN should have documented the reason why the Xanax was being given when it was administered on 9/22/25. The DON also indicated documentation should have been completed once a shift for 72 hours after the resident to resident altercation and the scratch to the resident's face.

2. The record for Resident 7 was reviewed on 10/7/25 at 10:45 a.m. Diagnoses included, but were not limited to, type 2 diabetes, depression, and spondylosis (arthritis of the

spine).

A Level of Care Assessment, dated 10/5/25, indicated the resident was cognitively intact.

Physician's Orders, dated 9/9/25, indicated the resident was to receive Humalog insulin 46 units subcutaneously (sq) three times a day and Toujeo (a long acting insulin) 70 units sq twice a day.

The September 2025 Medication Administration Record (MAR) indicated the Humalog insulin was not signed out as being administered on 9/14/25 at 12:00 p.m. and on 9/12/25, 9/13/25, and 9/14/25 at 5:00 p.m.

The resident's Toujeo insulin was not signed out as being administered on 9/12/25, 9/13/25, and 9/14/25 at 7:00 p.m.

During an interview on 10/7/25 at 2:00 p.m., the Director of Nursing (DON) indicated the insulin should have been signed out as ordered.

4. The closed record for Resident 8 was reviewed on 10/6/25 at 11:40 a.m. Diagnoses included, but were not limited to, malignant neoplasm (cancer) of the brain, and traumatic brain injury.

The Quarterly Level of Care

	Assessment/Individualized Service Plan, dated 6/6/25, indicated the resident was a full code status and was receiving hospice care. The Hospice nurse's notes from 6/13/25 through 7/10/25 indicated the resident had a Do Not Resuscitate (DNR) order. The facility's clinical record for the resident lacked documentation of a DNR. During an interview on 10/7/25 at 11:28 a.m., the Director of Nursing (DON) indicated they did not have a DNR form for the resident. The Medication Administration Record (MAR) for July 2025 indicated Ketoconazole Cream 2% (an anti-fungal) was administered to the resident on 7/12/25 and 7/16/25. The resident's fluid restriction was signed out on 7/11/25, 7/12/25, 7/13/25, 7/14/25, 7/15/25, 7/16/25, and 7/17/25. The clinical record indicated the resident expired on 7/10/25. During an interview on 10/7/25 at 11:28 a.m., the DON was informed of the findings and offered no further information. 3. The record for Resident 5 was reviewed on 10/6/25 at 11:29 a.m. Diagnoses included, but were not limited to, atrial			

fibrillation and osteoarthritis.

A Physician's Order, dated 9/18/25 and discontinued on 9/26/25, indicated lorazepam (an anti-anxiety medication) 0.5 mg (milligrams) twice daily.

A Physician's Order, dated 9/19/25 and discontinued on 9/26/25, indicated lorazepam 1 mg every 6 hours.

The Medication Administration Record (MAR), dated 9/2025, indicated the 0.5 mg lorazepam order was signed off as administered 13 times. The 1 mg lorazepam order was signed off as administered 19 times.

During an interview on 10/6/25 at 2:58 p.m., the Director of Nursing indicated there was some confusion with the resident's lorazepam orders upon admission. He had not received both lorazepam orders at the same time, the documentation on the MAR was incorrect.

Based on record review and interview, the facility failed to ensure clinical records were complete and accurately documented related to the indication for the use of an anti-anxiety medication, follow up documentation after a resident to resident altercation and a non-pressure skin condition, lack of documentation of medication administration,

clarification of medication orders, documentation of advance directives, and inaccurate documentation related to a fluid restriction and a treatment for 4 of 8 sampled residents. (Residents 4, 7, 5, and 8)

Findings include:

1. The record for Resident 4 was reviewed on 10/6/25 at 1:42 p.m. Diagnoses included, but were not limited to, dementia without behavior disturbance, anxiety, and type 2 diabetes.

A Level of Care Assessment, dated 8/11/25, indicated the resident was cognitively impaired for daily decision making.

A Physician's Order, dated 9/3/25, indicated the resident was to receive Xanax (an anti-anxiety medication) 0.25 milligrams (mg) daily as needed (PRN) for anxiety.

The September 2025 Medication Administration Record (MAR) indicated LPN 1 administered the PRN Xanax on 9/22/25 at 10:53 p.m. There was no documentation on the MAR or in the nursing progress notes related to why the medication was given.

An Incident Note, dated 9/28/25 at 8:50 p.m., indicated Resident

	4 had been slapped by another resident. Resident 4 was reportedly standing close to the other resident's face and she was trying to take her walker. Upon arrival of the nurse, the resident was observed with slight redness to the left cheek. The resident denied pain or discomfort. The residents were separated and redirected to their respective rooms. Both residents calmed down with staff support. Their families were notified and both residents remained under close supervision, no further behavioral issues were noted at that time. The next documented entry was a Health Status Note, dated 9/29/25 at 1:50 p.m., which indicated the resident was sitting in the common area with no behaviors or signs and symptoms of distress. There were no reported or expressed issues related to the most recent resident to resident altercation. The resident remained separated from the co-resident. No obvious or visible injuries were observed at that time. There was no further documentation regarding the resident to resident altercation. A Health Status Note, dated 10/1/25 at 2:10 p.m., indicated the resident had a small scratch			

observed to the left side of her face near her ear. The resident stated she bumped it on the towel bar in her bathroom after washing her face. The area was scabbed over and no complaints of pain were voiced.

There was no further documentation regarding the scratch to the resident's face.

During an interview on 10/7/25 at 11:23 a.m., the Director of Nursing (DON) indicated the LPN should have documented the reason why the Xanax was being given when it was administered on 9/22/25. The DON also indicated documentation should have been completed once a shift for 72 hours after the resident to resident altercation and the scratch to the resident's face.

2. The record for Resident 7 was reviewed on 10/7/25 at 10:45 a.m. Diagnoses included, but were not limited to, type 2 diabetes, depression, and spondylosis (arthritis of the spine).

A Level of Care Assessment, dated 10/5/25, indicated the resident was cognitively intact.

Physician's Orders, dated 9/9/25, indicated the resident was to receive Humalog insulin 46 units subcutaneously (sq) three times a day and Toujeo (a long acting insulin) 70 units sq

twice a day.

The September 2025 Medication Administration Record (MAR) indicated the Humalog insulin was not signed out as being administered on 9/14/25 at 12:00 p.m. and on 9/12/25, 9/13/25, and 9/14/25 at 5:00 p.m.

The resident's Toujeo insulin was not signed out as being administered on 9/12/25, 9/13/25, and 9/14/25 at 7:00 p.m.

During an interview on 10/7/25 at 2:00 p.m., the Director of Nursing (DON) indicated the insulin should have been signed out as ordered.

4. The closed record for Resident 8 was reviewed on 10/6/25 at 11:40 a.m. Diagnoses included, but were not limited to, malignant neoplasm (cancer) of the brain, and traumatic brain injury.

The Quarterly Level of Care Assessment/Individualized Service Plan, dated 6/6/25, indicated the resident was a full code status and was receiving hospice care.

The Hospice nurse's notes from 6/13/25 through 7/10/25 indicated the resident had a Do Not Resuscitate (DNR) order.

The facility's clinical record for

	the resident lacked documentation of a DNR. During an interview on 10/7/25 at 11:28 a.m., the Director of Nursing (DON) indicated they did not have a DNR form for the resident. The Medication Administration Record (MAR) for July 2025 indicated Ketoconazole Cream 2% (an anti-fungal) was administered to the resident on 7/12/25 and 7/16/25. The resident's fluid restriction was signed out on 7/11/25, 7/12/25, 7/13/25, 7/14/25, 7/15/25, 7/16/25, and 7/17/25. The clinical record indicated the resident expired on 7/10/25. During an interview on 10/7/25 at 11:28 a.m., the DON was informed of the findings and offered no further information. 3. The record for Resident 5 was reviewed on 10/6/25 at 11:29 a.m. Diagnoses included, but were not limited to, atrial fibrillation and osteoarthritis. A Physician's Order, dated 9/18/25 and discontinued on 9/26/25, indicated lorazepam (an anti-anxiety medication) 0.5 mg (milligrams) twice daily.			

	A Physician's Order, dated 9/19/25 and discontinued on 9/26/25, indicated lorazepam 1 mg every 6 hours. The Medication Administration Record (MAR), dated 9/2025, indicated the 0.5 mg lorazepam order was signed off as administered 13 times. The 1 mg lorazepam order was signed off as administered 19 times. During an interview on 10/6/25 at 2:58 p.m., the Director of Nursing indicated there was some confusion with the resident's lorazepam orders upon admission. He had not received both lorazepam orders at the same time, the documentation on the MAR was incorrect. Based on record review and interview, the facility failed to ensure clinical records were complete and accurately documented related to the indication for the use of an anti-anxiety medication, follow up documentation after a resident to resident altercation and a non-pressure skin condition, lack of documentation of medication administration, clarification of medication orders, documentation of advance directives, and inaccurate documentation related to a fluid restriction and a treatment for 4 of 8 sampled residents. (Residents 4, 7, 5,			

and 8)

Findings include:

1. The record for Resident 4 was reviewed on 10/6/25 at 1:42 p.m. Diagnoses included, but were not limited to, dementia without behavior disturbance, anxiety, and type 2 diabetes.

A Level of Care Assessment, dated 8/11/25, indicated the resident was cognitively impaired for daily decision making.

A Physician's Order, dated 9/3/25, indicated the resident was to receive Xanax (an anti-anxiety medication) 0.25 milligrams (mg) daily as needed (PRN) for anxiety.

The September 2025 Medication Administration Record (MAR) indicated LPN 1 administered the PRN Xanax on 9/22/25 at 10:53 p.m. There was no documentation on the MAR or in the nursing progress notes related to why the medication was given.

An Incident Note, dated 9/28/25 at 8:50 p.m., indicated Resident 4 had been slapped by another resident. Resident 4 was reportedly standing close to the other resident's face and she was trying to take her walker. Upon arrival of the nurse, the resident was observed with

	slight redness to the left cheek. The resident denied pain or discomfort. The residents were separated and redirected to their respective rooms. Both residents calmed down with staff support. Their families were notified and both residents remained under close supervision, no further behavioral issues were noted at that time. The next documented entry was a Health Status Note, dated 9/29/25 at 1:50 p.m., which indicated the resident was sitting in the common area with no behaviors or signs and symptoms of distress. There were no reported or expressed issues related to the most recent resident to resident altercation. The resident remained separated from the co-resident. No obvious or visible injuries were observed at that time. There was no further documentation regarding the resident to resident altercation.			

	A Health Status Note, dated 10/1/25 at 2:10 p.m., indicated the resident had a small scratch observed to the left side of her face near her ear. The resident stated she bumped it on the towel bar in her bathroom after washing her face. The area was scabbed over and no complaints of pain were voiced. There was no further documentation regarding the scratch to the resident's face. During an interview on 10/7/25 at 11:23 a.m., the Director of Nursing (DON) indicated the LPN should have documented the reason why the Xanax was being given when it was administered on 9/22/25. The DON also indicated documentation should have been completed once a shift for 72 hours after the resident to resident altercation and the scratch to the resident's face. 2. The record for Resident 7 was reviewed on 10/7/25 at 10:45 a.m. Diagnoses included, but were not limited to, type 2 diabetes, depression, and spondylosis (arthritis of the spine). A Level of Care Assessment, dated 10/5/25, indicated the resident was cognitively intact. Physician's Orders, dated 9/9/25, indicated the resident was to receive Humalog insulin			

	46 units subcutaneously (sq) three times a day and Toujeo (a long acting insulin) 70 units sq twice a day. The September 2025 Medication Administration Record (MAR) indicated the Humalog insulin was not signed out as being administered on 9/14/25 at 12:00 p.m. and on 9/12/25, 9/13/25, and 9/14/25 at 5:00 p.m. The resident's Toujeo insulin was not signed out as being administered on 9/12/25, 9/13/25, and 9/14/25 at 7:00 p.m. During an interview on 10/7/25 at 2:00 p.m., the Director of Nursing (DON) indicated the insulin should have been signed out as ordered.			
R 0356	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(i)(1-8) (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number	R 0356	All resident emergency information files were immediately reviewed and updated to ensure completeness and accuracy. Any missing or outdated information was corrected immediately. No long-term adverse effects were identified for the affected residents. Emergency binders were updated for the entire facility. DON or designee will update all emergency binders during the first week of each month to ensure accuracy. The DON or designee will audit emergency binders Monthly for 6 months to ensure the binders are updated with each new admit or	11/01/2025

	of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on record review and interview, the facility failed to ensure a current emergency information file was complete for 4 of 8 records reviewed. (Residents 2, 4, 5, and 3) Findings include: 1. The record for Resident 2 was reviewed on 10/6/25 at 1:27 p.m. Diagnoses included, but were not limited to, depression and osteoarthritis of the hips. The Director of Nursing was asked for the Emergency Binder on 10/7/25 at 10:55 a.m. During an interview on 10/7/25 at 11:30 a.m., the DON indicated the Emergency Binder		discharge. Findings will be reviewed during monthly QA meetings to ensure compliance.	

for Assisted Living was in the process of being updated and not all forms were in the binder. She indicated there was no information in the binder for Resident 2 but if she did have to be sent out, they would print up a transfer/discharge face sheet which contained the resident's preferences and medication list as well as the State transfer and discharge form.

2. The Memory Care Unit Emergency Binder was reviewed on 10/7/25 at 10:59 a.m.

The emergency file for Resident 4 did not contain a photograph of the resident.

During an interview on 10/7/25 at 11:30 a.m., the Director of Nursing indicated she would update the Emergency Binder.

4. The record for Resident 3 was reviewed on 10/6/25 at 10:45 a.m. Diagnoses included, but were not limited to, dementia, psychotic mood disturbance, and chronic kidney disease.

The 9/9/25 Quarterly Level of Care Assessment indicated the resident was not cognitively intact for daily decision making and required set-up assistance with activities of daily living.

The resident's emergency file lacked the resident's hospital

	preference and a copy of her advanced directive. During an interview on 10/7/25 at 11:28 a.m., the Director of Nursing (DON) indicated the emergency files needed to be updated to include all necessary information. 3. The Memory Care Unit Emergency Binder was reviewed on 10/7/25 at 10:59 a.m. There was no emergency file for Resident 5. During an interview on 10/7/25 at 11:30 a.m., the Director of Nursing indicated she would update the Emergency Binder. Based on record review and interview, the facility failed to ensure a current emergency information file was complete for 4 of 8 records reviewed. (Residents 2, 4, 5, and 3) Findings include: 1. The record for Resident 2 was reviewed on 10/6/25 at 1:27 p.m. Diagnoses included, but were not limited to, depression and osteoarthritis of the hips. The Director of Nursing was asked for the Emergency Binder on 10/7/25 at 10:55 a.m. During an interview on 10/7/25			

at 11:30 a.m., the DON indicated the Emergency Binder for Assisted Living was in the process of being updated and not all forms were in the binder. She indicated there was no information in the binder for Resident 2 but if she did have to be sent out, they would print up a transfer/discharge face sheet which contained the resident's preferences and medication list as well as the State transfer and discharge form.

2. The Memory Care Unit Emergency Binder was reviewed on 10/7/25 at 10:59 a.m.

The emergency file for Resident 4 did not contain a photograph of the resident.

During an interview on 10/7/25 at 11:30 a.m., the Director of Nursing indicated she would update the Emergency Binder.

4. The record for Resident 3 was reviewed on 10/6/25 at 10:45 a.m. Diagnoses included, but were not limited to, dementia, psychotic mood disturbance, and chronic kidney disease.

The 9/9/25 Quarterly Level of Care Assessment indicated the resident was not cognitively intact for daily decision making and required set-up assistance with activities of daily living.

	The resident's emergency file lacked the resident's hospital preference and a copy of her advanced directive. During an interview on 10/7/25 at 11:28 a.m., the Director of Nursing (DON) indicated the emergency files needed to be updated to include all necessary information. 3. The Memory Care Unit Emergency Binder was reviewed on 10/7/25 at 10:59 a.m. There was no emergency file for Resident 5. During an interview on 10/7/25 at 11:30 a.m., the Director of Nursing indicated she would update the Emergency Binder. Based on record review and interview, the facility failed to ensure a current emergency information file was complete for 4 of 8 records reviewed. (Residents 2, 4, 5, and 3) Findings include: 1. The record for Resident 2 was reviewed on 10/6/25 at 1:27 p.m. Diagnoses included, but were not limited to, depression and osteoarthritis of the hips.			

	The Director of Nursing was asked for the Emergency Binder on 10/7/25 at 10:55 a.m. During an interview on 10/7/25 at 11:30 a.m., the DON indicated the Emergency Binder for Assisted Living was in the process of being updated and not all forms were in the binder. She indicated there was no information in the binder for Resident 2 but if she did have to be sent out, they would print up a transfer/discharge face sheet which contained the resident's preferences and medication list as well as the State transfer and discharge form. 2. The Memory Care Unit Emergency Binder was reviewed on 10/7/25 at 10:59 a.m. The emergency file for Resident 4 did not contain a photograph of the resident. During an interview on 10/7/25 at 11:30 a.m., the Director of Nursing indicated she would update the Emergency Binder. 4. The record for Resident 3 was reviewed on 10/6/25 at 10:45 a.m. Diagnoses included, but were not limited to, dementia, psychotic mood disturbance, and chronic kidney disease. The 9/9/25 Quarterly Level of Care Assessment indicated the			

resident was not cognitively intact for daily decision making and required set-up assistance with activities of daily living.

The resident's emergency file lacked the resident's hospital preference and a copy of her advanced directive.

During an interview on 10/7/25 at 11:28 a.m., the Director of Nursing (DON) indicated the emergency files needed to be updated to include all necessary information.

3. The Memory Care Unit Emergency Binder was reviewed on 10/7/25 at 10:59 a.m.

There was no emergency file for Resident 5.

During an interview on 10/7/25 at 11:30 a.m., the Director of Nursing indicated she would update the Emergency Binder.

Based on record review and interview, the facility failed to ensure a current emergency information file was complete for 4 of 8 records reviewed. (Residents 2, 4, 5, and 3)

Findings include:

1. The record for Resident 2 was reviewed on 10/6/25 at 1:27 p.m. Diagnoses included, but were not limited to, depression and osteoarthritis of

	the hips. The Director of Nursing was asked for the Emergency Binder on 10/7/25 at 10:55 a.m. During an interview on 10/7/25 at 11:30 a.m., the DON indicated the Emergency Binder for Assisted Living was in the process of being updated and not all forms were in the binder. She indicated there was no information in the binder for Resident 2 but if she did have to be sent out, they would print up a transfer/discharge face sheet which contained the resident's preferences and medication list as well as the State transfer and discharge form. 2. The Memory Care Unit Emergency Binder was reviewed on 10/7/25 at 10:59 a.m. The emergency file for Resident 4 did not contain a photograph of the resident. During an interview on 10/7/25 at 11:30 a.m., the Director of Nursing indicated she would update the Emergency Binder. 4. The record for Resident 3 was reviewed on 10/6/25 at 10:45 a.m. Diagnoses included, but were not limited to, dementia, psychotic mood disturbance, and chronic kidney disease.			

	The 9/9/25 Quarterly Level of Care Assessment indicated the resident was not cognitively intact for daily decision making and required set-up assistance with activities of daily living. The resident's emergency file lacked the resident's hospital preference and a copy of her advanced directive. During an interview on 10/7/25 at 11:28 a.m., the Director of Nursing (DON) indicated the emergency files needed to be updated to include all necessary information. 3. The Memory Care Unit Emergency Binder was reviewed on 10/7/25 at 10:59 a.m. There was no emergency file for Resident 5. During an interview on 10/7/25 at 11:30 a.m., the Director of Nursing indicated she would update the Emergency Binder. Based on record review and interview, the facility failed to ensure a current emergency information file was complete for 4 of 8 records reviewed. (Residents 2, 4, 5, and 3) Findings include: 1. The record for Resident 2 was reviewed on 10/6/25 at 1:27 p.m. Diagnoses included,			

but were not limited to, depression and osteoarthritis of the hips.

The Director of Nursing was asked for the Emergency Binder on 10/7/25 at 10:55 a.m.

During an interview on 10/7/25 at 11:30 a.m., the DON indicated the Emergency Binder for Assisted Living was in the process of being updated and not all forms were in the binder. She indicated there was no information in the binder for Resident 2 but if she did have to be sent out, they would print up a transfer/discharge face sheet which contained the resident's preferences and medication list as well as the State transfer and discharge form.

2. The Memory Care Unit Emergency Binder was reviewed on 10/7/25 at 10:59 a.m.

The emergency file for Resident 4 did not contain a photograph of the resident.

During an interview on 10/7/25 at 11:30 a.m., the Director of Nursing indicated she would update the Emergency Binder.

4. The record for Resident 3 was reviewed on 10/6/25 at 10:45 a.m. Diagnoses included, but were not limited to, dementia, psychotic mood disturbance, and chronic kidney

disease.

The 9/9/25 Quarterly Level of Care Assessment indicated the resident was not cognitively intact for daily decision making and required set-up assistance with activities of daily living.

The resident's emergency file lacked the resident's hospital preference and a copy of her advanced directive.

During an interview on 10/7/25 at 11:28 a.m., the Director of Nursing (DON) indicated the emergency files needed to be updated to include all necessary information.

3. The Memory Care Unit Emergency Binder was reviewed on 10/7/25 at 10:59 a.m.

There was no emergency file for Resident 5.

During an interview on 10/7/25 at 11:30 a.m., the Director of Nursing indicated she would update the Emergency Binder.

Based on record review and interview, the facility failed to ensure a current emergency information file was complete for 4 of 8 records reviewed. (Residents 2, 4, 5, and 3)

Findings include:

1. The record for Resident 2

	was reviewed on 10/6/25 at 1:27 p.m. Diagnoses included, but were not limited to, depression and osteoarthritis of the hips. The Director of Nursing was asked for the Emergency Binder on 10/7/25 at 10:55 a.m. During an interview on 10/7/25 at 11:30 a.m., the DON indicated the Emergency Binder for Assisted Living was in the process of being updated and not all forms were in the binder. She indicated there was no information in the binder for Resident 2 but if she did have to be sent out, they would print up a transfer/discharge face sheet which contained the resident's preferences and medication list as well as the State transfer and discharge form. 2. The Memory Care Unit Emergency Binder was reviewed on 10/7/25 at 10:59 a.m. The emergency file for Resident 4 did not contain a photograph of the resident. During an interview on 10/7/25 at 11:30 a.m., the Director of Nursing indicated she would update the Emergency Binder. 4. The record for Resident 3 was reviewed on 10/6/25 at 10:45 a.m. Diagnoses included, but were not limited to,			

	dementia, psychotic mood disturbance, and chronic kidney disease. The 9/9/25 Quarterly Level of Care Assessment indicated the resident was not cognitively intact for daily decision making and required set-up assistance with activities of daily living. The resident's emergency file lacked the resident's hospital preference and a copy of her advanced directive. During an interview on 10/7/25 at 11:28 a.m., the Director of Nursing (DON) indicated the emergency files needed to be updated to include all necessary information. 3. The Memory Care Unit Emergency Binder was reviewed on 10/7/25 at 10:59 a.m. There was no emergency file for Resident 5. During an interview on 10/7/25 at 11:30 a.m., the Director of Nursing indicated she would update the Emergency Binder.			
R 0410	Infection Control - Noncompliance 410 IAC 16.2-5-12(e)(f)(g) (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or	R 0410	All residents admitted without documentation of TB testing were immediately identified and tested for TB. Results of TB testing were documented in the resident's chart. No long-term adverse effects were identified for the affected residents.	11/05/2025

	upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on record review and interview, the facility failed to ensure infection control measures were in place related to not testing residents for tuberculosis (TB) on or prior to admission for 1 of 8 residents reviewed. (Resident 9) Finding includes:		All nursing staff were re-educated on the requirements for TB testing to be completed per Indiana state guidelines. The DON or designee will audit all admission charts to ensure the two step PPD testing is completed. DON or designee will audit TB documentation in the immunizations tab twice weekly for 2 months, then weekly for 2 months, then monthly for 2 months. Any discrepancies found during audits will be corrected immediately, and responsible staff will receive retraining and disciplinary action as needed. Findings will be reviewed during monthly QA meetings to ensure compliance.	

	The closed record for Resident 9 was reviewed on 10/6/25 at 2:26 p.m. Diagnoses included, but were not limited to, Alzheimer's disease. The resident was admitted to the facility on 6/4/25. There was lack of documentation to indicate any two-step Mantoux test (TB test) had been completed upon admission. During an interview on 10/6/25 at 3:29 p.m., the Director of Nursing indicated she was unable to find any admission TB test documentation. Based on record review and interview, the facility failed to ensure infection control measures were in place related to not testing residents for tuberculosis (TB) on or prior to admission for 1 of 8 residents reviewed. (Resident 9) Finding includes: The closed record for Resident 9 was reviewed on 10/6/25 at 2:26 p.m. Diagnoses included, but were not limited to, Alzheimer's disease. The resident was admitted to the facility on 6/4/25.			

	There was lack of documentation to indicate any two-step Mantoux test (TB test) had been completed upon admission. During an interview on 10/6/25 at 3:29 p.m., the Director of Nursing indicated she was unable to find any admission TB test documentation.			
R 0412	Infection Control - Noncompliance 410 IAC 16.2-5-12(i) (i) Persons with a documented history of a positive tuberculin skin test, adequate treatment for disease, or preventive therapy for infection shall be exempt from further skin testing. In lieu of a tuberculin skin test, these persons should have an annual risk assessment for the development of symptoms suggestive of tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss. If symptoms are present, the individual shall be evaluated immediately with a chest x-ray. 2. The record for Resident 3 was reviewed on 10/6/25 at 10:45 a.m. Diagnoses included, but were not limited to, dementia, psychotic mood disturbance, and chronic kidney disease. The resident was admitted to the facility on 8/30/24. Their	R 0412	All residents without current annual TB screening were immediately identified and scheduled for TB screens as appropriate. No long-term adverse effects were identified for the affected residents. Nursing staff were educated on Indiana state regulations for annual screenings. The DON or designee will audit all charts to ensure the annual screening is completed. DON or designee will complete annual PPD screening for all residents every November.Any missed or overdue screenings will be corrected immediately and reviewed with the responsible staff member for education or disciplinary action as needed. Findings will be reviewed during monthly QA meetings to ensure compliance.	11/05/2025

record lacked an annual TB screening.

During an interview on 10/7/25 at 10:00 a.m., the Director of Nursing (DON) indicated she did not have documentation of an annual TB screening for the resident.

Based on record review and interview, the facility failed to ensure infection control measures were in place related to completing annual tuberculin (TB) screening for 2 of 8 records reviewed. (Residents 4 and 3)

Findings include:

1. The record for Resident 4 was reviewed on 10/6/25 at 1:42 p.m. Diagnoses included, but were not limited to, dementia without behavior disturbance, anxiety, and type 2 diabetes.

The resident was admitted to the facility on 12/1/23. Their record lacked an annual TB screening.

During an interview on 10/7/25 at 11:23 a.m., the Director of Nursing (DON) indicated she did not have documentation of an annual TB screening for the resident.

2. The record for Resident 3 was reviewed on 10/6/25 at 10:45 a.m. Diagnoses included, but were not limited to,

dementia, psychotic mood disturbance, and chronic kidney disease.

The resident was admitted to the facility on 8/30/24. Their record lacked an annual TB screening.

During an interview on 10/7/25 at 10:00 a.m., the Director of Nursing (DON) indicated she did not have documentation of an annual TB screening for the resident.

Based on record review and interview, the facility failed to ensure infection control measures were in place related to completing annual tuberculin (TB) screening for 2 of 8 records reviewed. (Residents 4 and 3)

Findings include:

1. The record for Resident 4 was reviewed on 10/6/25 at 1:42 p.m. Diagnoses included, but were not limited to, dementia without behavior disturbance, anxiety, and type 2 diabetes.

The resident was admitted to the facility on 12/1/23. Their record lacked an annual TB screening.

During an interview on 10/7/25 at 11:23 a.m., the Director of Nursing (DON) indicated she did not have documentation of an annual TB screening for the

resident.

2. The record for Resident 3 was reviewed on 10/6/25 at 10:45 a.m. Diagnoses included, but were not limited to, dementia, psychotic mood disturbance, and chronic kidney disease.

The resident was admitted to the facility on 8/30/24. Their record lacked an annual TB screening.

During an interview on 10/7/25 at 10:00 a.m., the Director of Nursing (DON) indicated she did not have documentation of an annual TB screening for the resident.

Based on record review and interview, the facility failed to ensure infection control measures were in place related to completing annual tuberculin (TB) screening for 2 of 8 records reviewed. (Residents 4 and 3)

Findings include:

1. The record for Resident 4 was reviewed on 10/6/25 at 1:42 p.m. Diagnoses included, but were not limited to, dementia without behavior disturbance, anxiety, and type 2 diabetes.

The resident was admitted to the facility on 12/1/23. Their record lacked an annual TB screening.

During an interview on 10/7/25 at 11:23 a.m., the Director of Nursing (DON) indicated she did not have documentation of an annual TB screening for the resident.

2. The record for Resident 3 was reviewed on 10/6/25 at 10:45 a.m. Diagnoses included, but were not limited to, dementia, psychotic mood disturbance, and chronic kidney disease.

The resident was admitted to the facility on 8/30/24. Their record lacked an annual TB screening.

During an interview on 10/7/25 at 10:00 a.m., the Director of Nursing (DON) indicated she did not have documentation of an annual TB screening for the resident.

Based on record review and interview, the facility failed to ensure infection control measures were in place related to completing annual tuberculin (TB) screening for 2 of 8 records reviewed. (Residents 4 and 3)

Findings include:

1. The record for Resident 4 was reviewed on 10/6/25 at

	1:42 p.m. Diagnoses included, but were not limited to, dementia without behavior disturbance, anxiety, and type 2 diabetes. The resident was admitted to the facility on 12/1/23. Their record lacked an annual TB screening. During an interview on 10/7/25 at 11:23 a.m., the Director of Nursing (DON) indicated she did not have documentation of an annual TB screening for the resident.			

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 SIGNATURESearfeeair Sutherland	TITLEDON	(X6) DATE10/27/2025