STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITLOCK PLACE	1719 S ELM ST, CRAWFORDSVILLE, , 47933

(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 Intake IN00465461. Intake IN00465461 - State deficiencies related to the allegations are cited at R0245. Survey dates: October 14, 15, 16, and 17, 2025. Facility number: 004419 Residential Census: 55 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on October 30, 2025.	R 0000	**The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.*** ***The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.***	
R 0088	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(c)(1-2)(d)(1-2) c) The licensee shall:	R 0088	**R088- Administration and management** **The facility requests paper**	11/24/2025

	(1) appoint an administrator with either a: (A) comprehensive care facility administrator license as required by IC 25-19-1-5(c); or (B) residential care facility administrator license as required by IC 25-19-1-5(d); and (2) delegate to that administrator the authority to organize and implement the day-to-day operations of the facility. (d) The licensee shall notify the director: (1) within three (3) working days of a vacancy in the administrator's position; and (2) of the name and license number of the replacement administrator Based on observation, record review, and interview, the facility failed to ensure a change in the facility's Administrator was reported to the Indiana Department of Health (IDOH) within three days. This deficient practice had the potential to affect 55 out of 55 residents who resided at the facility. Findings include: On 10/14/25 at 10:15 a.m., upon entrance to the facility, an unidentified employee indicated she was in sales, and there was no Administrator at the facility.		**compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.*** ***The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** **1)Immediate actions taken for those residents identified:** **State Department of Health immediately notified of interim ED.** **2)How the facility identified other residents:** **All residents have the ablility to be affected** **3)Measures put into place/**	

	The employee indicated there was an Administrator from another campus that helped them sometimes, so she would call her. This Administrator's building was about 2.5 hours away from the facility. The Indiana Department of Health (IDOH) pre-survey report, current at the start of the survey, indicated Administrator 15 was the Administrator at the facility. During an interview, on 10/14/25 at 11:10 a.m., Executive Director (ED) 2 indicated she was not sure when Administrator 15 stopped coming into the facility. ED 2 filled in as the Administrator, from 8/31/25 to 9/28/25, however, she continued to be the Administrator at her current building during that time as well. She came into the facility two days a week during that month. ED 2 thought Administrator 15 returned to the facility on 9/29/25, but she never actually saw Administrator 15 in the facility. ED 2 was not aware Administrator 15 remained out of the facility until today. Another employee asked ED 2 to come in and help today because the employee was 2.5 hours away from the facility. She was not sure if IDOH was notified Administrator 15 was no longer the acting facility Administrator. A Float ED		**System changes:** **New ED starts 11/24. Will notify the dept. of Health within 3 business days.** **4)How the corrective actions will be monitored:** **RDO or designee to notify the department of any future ED openings within 3 days.** **5)Date of compliance:11/24/25**	

	helped ED 2 cover the facility during the month of September, but she was not physically at the building. The Float ED was also the Administrator at another campus. ED 2 came into the facility twice a week, and the Float ED helped with tasks that could be completed off-site and on the computer. ED 2 thought Administrator 15 was on Family Medical Leave of Absence (FMLA) during the month of September due to a surgery, but she was not sure. During an interview, on 10/16/25 at 11:21 a.m., the Float ED indicated she would try to find out Administrator 15's exact dates of employment. Administrator 15 was off related to a workman's compensation claim during September and part of October, but she was not sure of the exact dates. She thought she returned for at least part of October but then left again. During an interview, on 10/16/25 at 12:10 p.m., the Float ED indicated she verified with Human Resources (HR), and Administrator 15 was off on a workman's compensation claim from 9/1/25 to 9/30/25. Administrator 15's last day being employed by the facility was 9/30/25. As of 9/30/25, Administrator 15 transferred to another facility within the corporation. Administrator 15			

	never returned to the facility once the workman's compensation clam began on 9/1/25. In September, ED 2 assisted with covering Administrator 15's absence, however, ED 2 was still an ED in her own facility during that time. In October 2025, the Float ED started to come into the facility to assist with covering Administrator 15's absence. During an interview, on 10/16/25 at 12:22 p.m., the Float ED indicated she would not be responsible for the IDOH notification of the change in Administrator. The Regional Director of Operations (RDO) should have made the notification. IDOH was not notified of the change in Administrator or delegation of the Administrator's duties. The Float ED indicated there was no facility policy for when to notify IDOH of a change in Administrator, but they would follow the state rule the notification was to be made within three business days.			

	Based on observation, record review, and interview, the facility failed to ensure a change in the facility's Administrator was reported to the Indiana Department of Health (IDOH) within three days. This deficient practice had the potential to affect 55 out of 55 residents who resided at the facility. Findings include: On 10/14/25 at 10:15 a.m., upon entrance to the facility, an unidentified employee indicated she was in sales, and there was no Administrator at the facility. The employee indicated there was an Administrator from another campus that helped them sometimes, so she would call her. This Administrator's building was about 2.5 hours away from the facility. The Indiana Department of Health (IDOH) pre-survey report, current at the start of the survey, indicated Administrator 15 was the Administrator at the facility. During an interview, on 10/14/25 at 11:10 a.m., Executive Director (ED) 2 indicated she was not sure when Administrator 15 stopped coming into the facility. ED 2 filled in as the Administrator, from 8/31/25 to 9/28/25, however, she continued to be the Administrator at her current			

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	Float ED indicated there was no facility policy for when to notify IDOH of a change in Administrator, but they would follow the state rule the notification was to be made within three business days.			
R 0089	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(e)(1-2)(f) (e) An administrator shall be employed to work in each licensed health facility. For purposes of this subsection, an individual can only be employed as an administrator in one (1): (1) health facility; or (2) hospital-based long-term care unit; at a time. (f) In the administrator's absence, an individual shall be authorized, in writing, to act on the administrator's behalf. Based on observation, record review, and interview, the facility failed to ensure an Administrator was employed by the facility, and an individual was authorized, in writing, to act on the Administrator's behalf in their absence. This deficient practice had the potential to affect 55 out of 55 residents who resided at the facility.	R 0089	**R089- Administration and management** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.*** ***The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** **1)Immediate actions taken for those residents identified:**	11/24/2025

	Findings include: On 10/14/25 at 10:15 a.m., upon entrance to the facility, an unidentified employee indicated she was in sales, and there was no Administrator at the facility. The employee indicated there was an Administrator from another campus that helped them sometimes, so she would call her. This Administrator's building was about 2.5 hours away from the facility. The Indiana Department of Health (IDOH) pre-survey report, current at the start of the survey, indicated Administrator 15 was the Administrator at the facility. During an interview, on 10/14/25 at 11:10 a.m., Executive Director (ED) 2 indicated she was not sure when Administrator 15 stopped coming into the facility. ED 2 filled in as the Administrator, from 8/31/25 to 9/28/25, however, she continued to be the Administrator at her current building during that time as well. She came into the facility two days a week during that month. ED 2 thought Administrator 15 returned to the facility on 9/29/25, but she never actually saw Administrator 14 in the facility. ED 2 was not aware Administrator 15 remained out of the facility until today. Another employee asked ED 2		**State Department of Health immediately notified of interim ED.** **2)How the facility identified other residents:** **All residents have the ablility to be affected** **3)Measures put into place/ System changes:** **New ED starts 11/24. Will notify the dept. of Health within 3 business days.** **4)How the corrective actions will be monitored:** **RDO or designee to notify the department of any future ED openings within 3 days.** **5)Date of compliance:11/24/25**	

	to come in and help today because the employee was 2.5 hours away from the facility. A Float ED helped ED 2 cover the facility during the month of September, but she was not physically at the building. The Float ED was also the Administrator at another campus. ED 2 came into the facility twice a week, and the Float ED helped with tasks that could be completed off-site and on the computer. ED 2 thought Administrator 15 was on Family Medical Leave of Absence (FMLA) during the month of September due to a surgery, but she was not sure. There was nothing provided in writing, that she was aware of, regarding Administrator 15's absence or authorization to act on Administrator 15's behalf. During an interview, on 10/16/25 at 11:21 a.m., the Float ED indicated she would try to find out Administrator 15's exact dates of employment. Administrator 15 was off related to a workman's compensation claim during September and part of October, but she was not sure of the exact dates. She thought she returned for at least part of October but then left again. During an interview, on 10/16/25 at 12:10 p.m., the Float ED indicated she verified with Human Resources (HR), and			

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	review, and interview, the facility failed to ensure an Administrator was employed by the facility, and an individual was authorized, in writing, to act on the Administrator's behalf in their absence. This deficient practice had the potential to affect 55 out of 55 residents who resided at the facility. Findings include: On 10/14/25 at 10:15 a.m., upon entrance to the facility, an unidentified employee indicated she was in sales, and there was no Administrator at the facility. The employee indicated there was an Administrator from another campus that helped them sometimes, so she would call her. This Administrator's building was about 2.5 hours away from the facility. The Indiana Department of Health (IDOH) pre-survey report, current at the start of the survey, indicated Administrator 15 was the Administrator at the facility. During an interview, on 10/14/25 at 11:10 a.m., Executive Director (ED) 2 indicated she was not sure when Administrator 15 stopped coming into the facility. ED 2 filled in as the Administrator, from 8/31/25 to 9/28/25, however, she continued to be the Administrator at her current			

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	or written authorization to act on the Administrator's behalf in their absence, but they would follow the state rules. The Float ED indicated she was also the Administrator at her own facility during the time she assisted with covering Administrator duties at this facility.			
R 0092	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(i)(1-2) (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall	R 0092	**R092 Administration and Management** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.*** ***The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** ***1)Immediate actions taken for those residents identified:***	12/01/2025

	be documented with the names and signatures of the personnel present. Based on observation and record review, the facility failed to ensure a monthly fire drill was completed for 1of 10 fire drills and failed to ensure the local fire department participated in a disaster drill plan. Findings include: On 10/14/25 the facility fire drill and disaster drill records were reviewed. The records lacked documentation of a fire drill for the month of September 2025. The record lacked documentation of a disaster drill or coordination with the local fire department by invitation or participation in disaster preparedness. On 10/14/25 at 2:00 p.m., during an interview the Float Administrator indicated she could not verify a disaster preparedness drill or presentation had been completed since the last annual survey. The Administrator verified a fire drill had not been completed for September 2025. On 10/16/25 at 12:50 p.m., the Float Administrator provided a document, titled, "Fire, wildfire, explosion, natural gas leak, hazardous spill," dated 2022, and indicated it was the policy		ED called to schedule drill with fire department ASAP ***2)How the facility identified other residents:*** Any resident residing in the facility has the potential to be affected and none noted. **3)Measures put into place/ System changes:** Drill with Fire Department pending. To be completed by 12/1/25 **4)How the corrective actions will be monitored:** ED/Designee will be responsible for this plan of correction and will audit monthly indefinitely to ensure that a drill has been held in conjuction with the fire department in at least 6 months.	

	currently being used by the facility. The policy indicated, "...8.3 Active Response Plan ...The executive Director and Facilities Director are Responsible for ...Management and enforcement of the fire safety program. Establishing liaison with the state fire inspector and with the local fire department to ensure compliance with all codes ...." Based on observation and record review, the facility failed to ensure a monthly fire drill was completed for 1of 10 fire drills and failed to ensure the local fire department participated in a disaster drill plan. Findings include: On 10/14/25 the facility fire drill and disaster drill records were reviewed. The records lacked documentation of a fire drill for the month of September 2025. The record lacked documentation of a disaster drill or coordination with the local fire department by invitation or participation in disaster preparedness. On 10/14/25 at 2:00 p.m., during an interview the Float Administrator indicated she could not verify a disaster preparedness drill or presentation had been completed since the last annual survey. The Administrator		**5)Date of compliance:12/1/25**	

	verified a fire drill had not been completed for September 2025. On 10/16/25 at 12:50 p.m., the Float Administrator provided a document, titled, "Fire, wildfire, explosion, natural gas leak, hazardous spill," dated 2022, and indicated it was the policy currently being used by the facility. The policy indicated, "...8.3 Active Response Plan ...The executive Director and Facilities Director are Responsible for ...Management and enforcement of the fire safety program. Establishing liaison with the state fire inspector and with the local fire department to ensure compliance with all codes ...."			
R 0117	Personnel - Deficiency 410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or	R 0117	**R117 Personnel** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of***	11/15/2025

	both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure employees were certified in CPR and emergency first aide and failed to ensure a certified employee was on site at all times for 1 of 1 week of staffing reviewed for CPR and emergency first aide. Findings include: On 10/15/25 staffing CPR and First side certifications were reviewed. The records lacked evidence of scheduled staff having current CPR/First aide certification. The staff schedule was reviewed for the week of 9/21/25 to 9/27/25. Employees 16, 17, 18, 19, and 13 were scheduled. The schedule indicated 6 shifts lacked coverage by a CPR certified staff member. The record lacked evidence of coverage for 16		***deficiencies.*** ***The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** ***1)Immediate actions taken for those residents identified:*** Future schedules reviewed by ED to always ensure that at least 1 CPR/First aid certified staff member on staff at all times. ***2)How the facility identified other residents:*** All residents have the potential to be affected. **3)Measures put into place/ System changes:** CPR/First aid classes to be provided to direct care staff to ensure at least 1 staff member per shift is CPR/First aid certified. **4)How the corrective actions will be monitored:**	

	shifts by a staff member certified in emergency first aide. On 10/15/25 at 2:45 p.m., during an interview, the Float Administrator indicated the staff did not have current or updated CPR and First aide certifications. On 10/16/25 at 12:40 p.m., the Float Administrator provided a document, titled, "GP12-Staffing, Emergency Training, Cardiopulmonary Resuscitation (CPR) and First Aide Training ," dated 6/10/2024, and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedure ...5. Each community must have at least one (1) staff member trained in CPR and First Aide on-duty and on the premises at all times ..." Based on record review and interview, the facility failed to ensure employees were certified in CPR and emergency first aide and failed to ensure a certified employee was on site at all times for 1 of 1 week of staffing reviewed for CPR and emergency first aide. Findings include: On 10/15/25 staffing CPR and First side certifications were reviewed. The records lacked evidence of scheduled staff having current CPR/First aide		ED/Designee will be responsible for this plan of correction and will audit schedules weekly indefinitely to ensure compliance. **5)Date of compliance:11/15/25**	

	certification. The staff schedule was reviewed for the week of 9/21/25 to 9/27/25. Employees 16, 17, 18, 19, and 13 were scheduled. The schedule indicated 6 shifts lacked coverage by a CPR certified staff member. The record lacked evidence of coverage for 16 shifts by a staff member certified in emergency first aide. On 10/15/25 at 2:45 p.m., during an interview, the Float Administrator indicated the staff did not have current or updated CPR and First aide certifications. On 10/16/25 at 12:40 p.m., the Float Administrator provided a document, titled, "GP12-Staffing, Emergency Training, Cardiopulmonary Resuscitation (CPR) and First Aide Training ," dated 6/10/2024, and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedure ...5. Each community must have at least one (1) staff member trained in CPR and First Aide on-duty and on the premises at all times ..."			
R 0121	Personnel - Noncompliance 410 IAC 16.2-5-1.4(f)(1-4) (f) A health screen shall be	R 0121	**R121 Personnel** **The facility requests paper**	12/01/2025

	required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers 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 one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings.		**compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.*** ***The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** ***1)Immediate actions taken for those residents identified:*** Interim ED audited all employee records to ensure all TB tests/screening were complete and up to date. ***2)How the facility identified other residents:*** All residents have the potential to be affected. None identified	

	(4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on record review and interview, the facility failed to ensure employees were administered a PPD (purified protein derivative) a skin test that checks if you have been exposed to the (TB) tuberculosis bacteria prior to hire and annually after hire for 5 of 5 employee records reviewed. Findings include: On 10/26/25 the employee file review indicated employees 5, 7, and 12 lacked documentation of initial 2 step PPD administration at hire. Employees 11 and 14 lacked documentation of an annual PPD or health assessment. On 10/26/25 at 1:30 p.m., the Float Administrator indicated she was unable to verify the employees were administered a PPD or were given a TB risk assessment and screening annually. On 10/16/25 at 1:30 p.m., the float Administrator provided a document, titled, "Infection Control," dated 2/1/22, and indicated it was the policy currently being used by the		**3)Measures put into place/ System changes:** Tracking form created to track TB testing and annual screens **4)How the corrective actions will be monitored:** ED/Designee will be responsible for this plan of correction. ED to audit tracking form weekly x6 weeks, then monthly indefinitely to ensure that all training is completed and current and all current staff are accounted for on form. **5)Date of compliance:12/1/25**	

facility. The policy indicated, "...Procedure ...Ensure the employees, prior to placement obtain a TB test (or chest Xray, if appropriate and complete a TB risk assessment and TB screening ...."

Based on record review and interview, the facility failed to ensure employees were administered a PPD (purified protein derivative) a skin test that checks if you have been exposed to the (TB) tuberculosis bacteria prior to hire and annually after hire for 5 of 5 employee records reviewed.

Findings include:

On 10/26/25 the employee file review indicated employees 5, 7, and 12 lacked documentation of initial 2 step PPD administration at hire. Employees 11 and 14 lacked documentation of an annual PPD or health assessment.

On 10/26/25 at 1:30 p.m., the Float Administrator indicated she was unable to verify the employees were administered a PPD or were given a TB risk assessment and screening annually.

On 10/16/25 at 1:30 p.m., the float Administrator provided a document, titled, "Infection Control," dated 2/1/22, and indicated it was the policy currently being used by the

	facility. The policy indicated, "...Procedure ...Ensure the employees, prior to placement obtain a TB test (or chest Xray, if appropriate and complete a TB risk assessment and TB screening ...."			
R 0148	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(e)(1-4) (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on record review and interview, the facility failed to	R 0148	**R148 Sanitation and Safety Standards** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.*** ***The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** ***1)Immediate actions taken for those residents identified:***	12/01/2025

	ensure the heating and ventilation system had been inspected at least yearly for 12 of 12 months reviewed. Findings include: On 10/14/25 the facility fire safety and heating ventilation records were reviewed. The facility lacked documentation of annual inspection of heating and ventilation systems of the facility. On 10/15/25 at 2:00 p.m., during an interview, the Float Administrator indicated she could not verify the system had been inspected. She indicated the facility did not have a specific policy and they follow the state guidelines for annual inspections. Based on record review and interview, the facility failed to ensure the heating and ventilation system had been inspected at least yearly for 12 of 12 months reviewed. Findings include: On 10/14/25 the facility fire safety and heating ventilation records were reviewed. The facility lacked documentation of annual inspection of heating and ventilation systems of the facility. On 10/15/25 at 2:00 p.m., during an interview, the Float		Maintenance Director called to scheduled system inspection. ***2)How the facility identified other residents:*** All residents have the potential to be affected. None identified **3)Measures put into place/ System changes:** Tracking Form created to track when last inspection completed. **4)How the corrective actions will be monitored:** ED/Designee will be responsible for this plan of correction. ED to audit tracking form weekly x6 weeks, then monthly indefinitely to ensure annual inspection of the heating and ventilation system. **5)Date of compliance:12/1/25**	

	Administrator indicated she could not verify the system had been inspected. She indicated the facility did not have a specific policy and they follow the state guidelines for annual inspections.			
R 0216	Evaluation - Noncompliance 410 IAC 16.2-5-2(c)(1-4)(d) (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on record review and interview, the facility failed to ensure an admission weight was obtained for 1 of 7 residents' records reviewed (Resident 230).	R 0216	**R216 Evaluation** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.*** ***The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** ***1)Immediate actions taken for those residents identified:*** Weights were immediately	12/01/2025

	Findings include: On 10/15/25 the clinical record of Resident 230 was reviewed. The resident entered the facility on 9/26/25. Admission diagnosis included but were not limited to, anxiety (a feeling of fear, dread, and uneasiness. It might cause you to sweat, feel restless and tense, and have a rapid heartbeat. It can be a normal reaction to stress), chronic pain (persistent or recurring pain that lasts for an extended period, typically more than three months), and focal traumatic brain injury (damage to a specific, localized area of the brain). The clinical record lacked verification of admission weight. During an interview, the Unit Manager indicated they could not verify if a weight had been obtained since admission to the facility. On10/16/25 at 12:40 p.m., the Float Administrator provided an undated document, titled, "AS01-Resident Assessments," and indicated it was the policy currently being used by the facility. The policy indicated, "...The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an		obtained for all residents in the community. ***2)How the facility identified other residents:*** All residents have the potential to be affected. None identified. **3)Measures put into place/ System changes:** All residents will be weighed monthly **4)How the corrective actions will be monitored:** ED/ DHW/ Designee will be responsible for this plan of correction. ED or designee will audit weights monthly indefinitely to ensure compliance	

	evaluation of the following ...c. The resident's weight taken on admission and semiannually thereafter ...." Based on record review and interview, the facility failed to ensure an admission weight was obtained for 1 of 7 residents' records reviewed (Resident 230). Findings include: On 10/15/25 the clinical record of Resident 230 was reviewed. The resident entered the facility on 9/26/25. Admission diagnosis included but were not limited to, anxiety (a feeling of fear, dread, and uneasiness. It might cause you to sweat, feel restless and tense, and have a rapid heartbeat. It can be a normal reaction to stress), chronic pain (persistent or recurring pain that lasts for an extended period, typically more than three months), and focal traumatic brain injury (damage to a specific, localized area of the brain). The clinical record lacked verification of admission weight. During an interview, the Unit Manager indicated they could not verify if a weight had been obtained since admission to the facility. On10/16/25 at 12:40 p.m., the		**5)Date of compliance:12/1/25**	

	Float Administrator provided an undated document, titled, "AS01-Resident Assessments," and indicated it was the policy currently being used by the facility. The policy indicated, "...The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following ...c. The resident's weight taken on admission and semiannually thereafter ...."			
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	R 0217	**R217 Evaluation** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.***	12/15/2025

	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 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. 3. On 10/15/25 the clinical record of Resident 230 was reviewed. The resident entered the facility on 9/26/25.		***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.*** ***The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** ***1)Immediate actions taken for those residents identified:*** Care Plan meetings immediately arranged for all residents to coordinate care with res/families and obtain care plan signatures. ***2)How the facility identified other residents:*** All residents have the potential to be affected. None identified. **3)Measures put into place/ System changes:** Care Plan signatures to be obtained upon admission and with any change in	

	Admission diagnosis included but were not limited to, anxiety (a feeling of fear, dread, and uneasiness. It might cause you to sweat, feel restless and tense, and have a rapid heartbeat. It can be a normal reaction to stress), chronic pain (persistent or recurring pain that lasts for an extended period, typically more than three months), and focal traumatic brain injury (damage to a specific, localized area of the brain). The record indicated a service plan was generated but was not signed by the resident upon admission. On 10/16/25 at 12:40 p.m.. the Float Administrator provided a document titled, "Service Plans," dated 6/10/24, and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy: Assessments and Service Plans will be developed and updated as frequently as necessary to ensure they reflect current resident needs and preferences. Individualized Service Plans are used to plan for and meet resident needs using an interdisciplinary approach. Procedure...8. The Director of Health and Wellness ensures the Service Plan is signed and dated by the Community representative and the resident and/or responsible		condition **4)How the corrective actions will be monitored:** ED/ DHW/ Designee will be responsible for this plan of correction. ED/DHW/Designee to audit 5 random residents to ensure care plans are signed weekly x6 weeks, bi-weekly x3 weeks and monthly indefinitely. **5)Date of compliance:12/15/25**	

	party as appropriate. A copy is given to the family/responsible party. 9. A signed copy of the Service Plan is kept in the resident's record...." Based on record review and interview, the facility failed to ensure service plans were created and signed for 3 of 7 residents reviewed for service plans (Resident 261, 214, and 230). Findings include: 1. Resident 261's record was reviewed on 10/16/25 at 11:40 a.m. Census information indicated the resident was admitted to the facility on 1/15/25. A change in condition resident assessment and service plan was completed on 7/3/25. The signature spaces for the resident/resident representative were blank. The resident's closed record lacked documentation of a service plan completed upon admission to the facility.			

During an interview, on 10/16/25 at 12:32 p.m., the Regional Director of Resident Care indicated the resident's service plan should have been signed by the resident/resident representative. There was a service plan completed at admission, but it was not signed either.

2. Resident 214's record was reviewed on 10/15/25 at 11:00 a.m. The profile indicated the resident diagnoses included, but were not limited to, type 2 diabetes (a chronic condition characterized by high blood sugar levels), stroke (occurs when the blood flow to a particular area of the brain is blocked or cut off), and hyperlipidemia (elevated cholesterol levels).

Facility census information indicated Resident 214 moved into the facility on 4/22/25.

Resident 214's record lacked documentation of a signed completed service plan.

During an interview, on 10/15/25 at 12:20 p.m., the Unit Manager indicated she was not aware of where the signed service plans for the residents were kept. She indicated the service plans were not a part of her duties to be completed.

During an interview, on 10/25/25 at 2:00 p.m., the float Executive

	Director indicated she was not aware of where the signed service plans for the residents were kept, she was unable to locate them. 3. On 10/15/25 the clinical record of Resident 230 was reviewed. The resident entered the facility on 9/26/25. Admission diagnosis included but were not limited to, anxiety (a feeling of fear, dread, and uneasiness. It might cause you to sweat, feel restless and tense, and have a rapid heartbeat. It can be a normal reaction to stress), chronic pain (persistent or recurring pain that lasts for an extended period, typically more than three months), and focal traumatic brain injury (damage to a specific, localized area of the brain). The record indicated a service plan was generated but was not signed by the resident upon admission. On 10/16/25 at 12:40 p.m.. the Float Administrator provided a document titled, "Service Plans," dated 6/10/24, and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy: Assessments and Service Plans will be developed and updated as frequently as necessary to ensure they reflect			

current resident needs and preferences. Individualized Service Plans are used to plan for and meet resident needs using an interdisciplinary approach. Procedure...8. The Director of Health and Wellness ensures the Service Plan is signed and dated by the Community representative and the resident and/or responsible party as appropriate. A copy is given to the family/responsible party. 9. A signed copy of the Service Plan is kept in the resident's record...."

Based on record review and interview, the facility failed to ensure service plans were created and signed for 3 of 7 residents reviewed for service plans (Resident 261, 214, and 230).

Findings include:

1. Resident 261's record was reviewed on 10/16/25 at 11:40 a.m. Census information indicated the resident was admitted to the facility on 1/15/25.

A change in condition resident assessment and service plan was completed on 7/3/25. The signature spaces for the resident/resident representative were blank. The resident's closed record lacked documentation of a service plan completed upon admission to

the facility.

During an interview, on 10/16/25 at 12:32 p.m., the Regional Director of Resident Care indicated the resident's service plan should have been signed by the resident/resident representative. There was a service plan completed at admission, but it was not signed either.

2. Resident 214's record was reviewed on 10/15/25 at 11:00 a.m. The profile indicated the resident diagnoses included, but were not limited to, type 2 diabetes (a chronic condition characterized by high blood sugar levels), stroke (occurs when the blood flow to a particular area of the brain is blocked or cut off), and hyperlipidemia (elevated cholesterol levels).

Facility census information indicated Resident 214 moved into the facility on 4/22/25.

Resident 214's record lacked documentation of a signed completed service plan.

During an interview, on 10/15/25 at 12:20 p.m., the Unit Manager indicated she was not aware of where the signed service plans for the residents were kept. She indicated the service plans were not a part of her duties to be completed.

	During an interview, on 10/25/25 at 2:00 p.m., the float Executive Director indicated she was not aware of where the signed service plans for the residents were kept, she was unable to locate them. 3. On 10/15/25 the clinical record of Resident 230 was reviewed. The resident entered the facility on 9/26/25. Admission diagnosis included but were not limited to, anxiety (a feeling of fear, dread, and uneasiness. It might cause you to sweat, feel restless and tense, and have a rapid heartbeat. It can be a normal reaction to stress), chronic pain (persistent or recurring pain that lasts for an extended period, typically more than three months), and focal traumatic brain injury (damage to a specific, localized area of the brain). The record indicated a service plan was generated but was not signed by the resident upon admission. On 10/16/25 at 12:40 p.m.. the Float Administrator provided a document titled, "Service Plans," dated 6/10/24, and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy: Assessments and Service Plans will be developed			

	and updated as frequently as necessary to ensure they reflect current resident needs and preferences. Individualized Service Plans are used to plan for and meet resident needs using an interdisciplinary approach. Procedure...8. The Director of Health and Wellness ensures the Service Plan is signed and dated by the Community representative and the resident and/or responsible party as appropriate. A copy is given to the family/responsible party. 9. A signed copy of the Service Plan is kept in the resident's record...." Based on record review and interview, the facility failed to ensure service plans were created and signed for 3 of 7 residents reviewed for service plans (Resident 261, 214, and 230). Findings include: 1. Resident 261's record was reviewed on 10/16/25 at 11:40 a.m. Census information indicated the resident was admitted to the facility on 1/15/25. A change in condition resident assessment and service plan was completed on 7/3/25. The signature spaces for the resident/resident representative were blank. The resident's closed record lacked			

documentation of a service plan completed upon admission to the facility.

During an interview, on 10/16/25 at 12:32 p.m., the Regional Director of Resident Care indicated the resident's service plan should have been signed by the resident/resident representative. There was a service plan completed at admission, but it was not signed either.

2. Resident 214's record was reviewed on 10/15/25 at 11:00 a.m. The profile indicated the resident diagnoses included, but were not limited to, type 2 diabetes (a chronic condition characterized by high blood sugar levels), stroke (occurs when the blood flow to a particular area of the brain is blocked or cut off), and hyperlipidemia (elevated cholesterol levels).

Facility census information indicated Resident 214 moved into the facility on 4/22/25.

Resident 214's record lacked documentation of a signed completed service plan.

During an interview, on 10/15/25 at 12:20 p.m., the Unit Manager indicated she was not aware of where the signed service plans for the residents were kept. She indicated the service plans were not a part of her duties to be

completed.

During an interview, on 10/25/25 at 2:00 p.m., the float Executive Director indicated she was not aware of where the signed service plans for the residents were kept, she was unable to locate them.

3. On 10/15/25 the clinical record of Resident 230 was reviewed. The resident entered the facility on 9/26/25.

Admission diagnosis included but were not limited to, anxiety (a feeling of fear, dread, and uneasiness. It might cause you to sweat, feel restless and tense, and have a rapid heartbeat. It can be a normal reaction to stress), chronic pain (persistent or recurring pain that lasts for an extended period, typically more than three months), and focal traumatic brain injury (damage to a specific, localized area of the brain).

The record indicated a service plan was generated but was not signed by the resident upon admission.

On 10/16/25 at 12:40 p.m.. the Float Administrator provided a document titled, "Service Plans," dated 6/10/24, and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy: Assessments and

	Service Plans will be developed and updated as frequently as necessary to ensure they reflect current resident needs and preferences. Individualized Service Plans are used to plan for and meet resident needs using an interdisciplinary approach. Procedure...8. The Director of Health and Wellness ensures the Service Plan is signed and dated by the Community representative and the resident and/or responsible party as appropriate. A copy is given to the family/responsible party. 9. A signed copy of the Service Plan is kept in the resident's record...." Based on record review and interview, the facility failed to ensure service plans were created and signed for 3 of 7 residents reviewed for service plans (Resident 261, 214, and 230). Findings include: 1. Resident 261's record was reviewed on 10/16/25 at 11:40 a.m. Census information indicated the resident was admitted to the facility on 1/15/25. A change in condition resident assessment and service plan was completed on 7/3/25. The signature spaces for the resident/resident representative were blank. The resident's			

closed record lacked documentation of a service plan completed upon admission to the facility.

During an interview, on 10/16/25 at 12:32 p.m., the Regional Director of Resident Care indicated the resident's service plan should have been signed by the resident/resident representative. There was a service plan completed at admission, but it was not signed either.

2. Resident 214's record was reviewed on 10/15/25 at 11:00 a.m. The profile indicated the resident diagnoses included, but were not limited to, type 2 diabetes (a chronic condition characterized by high blood sugar levels), stroke (occurs when the blood flow to a particular area of the brain is blocked or cut off), and hyperlipidemia (elevated cholesterol levels).

Facility census information indicated Resident 214 moved into the facility on 4/22/25.

Resident 214's record lacked documentation of a signed completed service plan.

During an interview, on 10/15/25 at 12:20 p.m., the Unit Manager indicated she was not aware of where the signed service plans for the residents were kept. She indicated the service plans were

not a part of her duties to be completed.

During an interview, on 10/25/25 at 2:00 p.m., the float Executive Director indicated she was not aware of where the signed service plans for the residents were kept, she was unable to locate them.

3. On 10/15/25 the clinical record of Resident 230 was reviewed. The resident entered the facility on 9/26/25.

Admission diagnosis included but were not limited to, anxiety (a feeling of fear, dread, and uneasiness. It might cause you to sweat, feel restless and tense, and have a rapid heartbeat. It can be a normal reaction to stress), chronic pain (persistent or recurring pain that lasts for an extended period, typically more than three months), and focal traumatic brain injury (damage to a specific, localized area of the brain).

The record indicated a service plan was generated but was not signed by the resident upon admission.

On 10/16/25 at 12:40 p.m.. the Float Administrator provided a document titled, "Service Plans," dated 6/10/24, and indicated it was the policy currently being used by the facility. The policy indicated,

	"...Policy: Assessments and Service Plans will be developed and updated as frequently as necessary to ensure they reflect current resident needs and preferences. Individualized Service Plans are used to plan for and meet resident needs using an interdisciplinary approach. Procedure...8. The Director of Health and Wellness ensures the Service Plan is signed and dated by the Community representative and the resident and/or responsible party as appropriate. A copy is given to the family/responsible party. 9. A signed copy of the Service Plan is kept in the resident's record...." Based on record review and interview, the facility failed to ensure service plans were created and signed for 3 of 7 residents reviewed for service plans (Resident 261, 214, and 230). Findings include: 1. Resident 261's record was reviewed on 10/16/25 at 11:40 a.m. Census information indicated the resident was admitted to the facility on 1/15/25. A change in condition resident assessment and service plan was completed on 7/3/25. The signature spaces for the resident/resident representative			

were blank. The resident's closed record lacked documentation of a service plan completed upon admission to the facility.

During an interview, on 10/16/25 at 12:32 p.m., the Regional Director of Resident Care indicated the resident's service plan should have been signed by the resident/resident representative. There was a service plan completed at admission, but it was not signed either.

2. Resident 214's record was reviewed on 10/15/25 at 11:00 a.m. The profile indicated the resident diagnoses included, but were not limited to, type 2 diabetes (a chronic condition characterized by high blood sugar levels), stroke (occurs when the blood flow to a particular area of the brain is blocked or cut off), and hyperlipidemia (elevated cholesterol levels).

Facility census information indicated Resident 214 moved into the facility on 4/22/25.

Resident 214's record lacked documentation of a signed completed service plan.

During an interview, on 10/15/25 at 12:20 p.m., the Unit Manager indicated she was not aware of where the signed service plans for the residents were kept. She

indicated the service plans were not a part of her duties to be completed.

During an interview, on 10/25/25 at 2:00 p.m., the float Executive Director indicated she was not aware of where the signed service plans for the residents were kept, she was unable to locate them.

3. On 10/15/25 the clinical record of Resident 230 was reviewed. The resident entered the facility on 9/26/25.

Admission diagnosis included but were not limited to, anxiety (a feeling of fear, dread, and uneasiness. It might cause you to sweat, feel restless and tense, and have a rapid heartbeat. It can be a normal reaction to stress), chronic pain (persistent or recurring pain that lasts for an extended period, typically more than three months), and focal traumatic brain injury (damage to a specific, localized area of the brain).

The record indicated a service plan was generated but was not signed by the resident upon admission.

On 10/16/25 at 12:40 p.m.. the Float Administrator provided a document titled, "Service Plans," dated 6/10/24, and indicated it was the policy currently being used by the

	facility. The policy indicated, "...Policy: Assessments and Service Plans will be developed and updated as frequently as necessary to ensure they reflect current resident needs and preferences. Individualized Service Plans are used to plan for and meet resident needs using an interdisciplinary approach. Procedure...8. The Director of Health and Wellness ensures the Service Plan is signed and dated by the Community representative and the resident and/or responsible party as appropriate. A copy is given to the family/responsible party. 9. A signed copy of the Service Plan is kept in the resident's record...." Based on record review and interview, the facility failed to ensure service plans were created and signed for 3 of 7 residents reviewed for service plans (Resident 261, 214, and 230). Findings include: 1. Resident 261's record was reviewed on 10/16/25 at 11:40 a.m. Census information indicated the resident was admitted to the facility on 1/15/25. A change in condition resident assessment and service plan was completed on 7/3/25. The signature spaces for the			

resident/resident representative were blank. The resident's closed record lacked documentation of a service plan completed upon admission to the facility.

During an interview, on 10/16/25 at 12:32 p.m., the Regional Director of Resident Care indicated the resident's service plan should have been signed by the resident/resident representative. There was a service plan completed at admission, but it was not signed either.

2. Resident 214's record was reviewed on 10/15/25 at 11:00 a.m. The profile indicated the resident diagnoses included, but were not limited to, type 2 diabetes (a chronic condition characterized by high blood sugar levels), stroke (occurs when the blood flow to a particular area of the brain is blocked or cut off), and hyperlipidemia (elevated cholesterol levels).

Facility census information indicated Resident 214 moved into the facility on 4/22/25.

Resident 214's record lacked documentation of a signed completed service plan.

During an interview, on 10/15/25 at 12:20 p.m., the Unit Manager indicated she was not aware of where the signed service plans

	for the residents were kept. She indicated the service plans were not a part of her duties to be completed. During an interview, on 10/25/25 at 2:00 p.m., the float Executive Director indicated she was not aware of where the signed service plans for the residents were kept, she was unable to locate them.			
R 0241	Health Services - Offense 410 IAC 16.2-5-4(e)(1) (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. 2. On 10/15/25 the clinical record of Resident 210 was reviewed. The resident entered the facility on 5/9/25. Admission diagnosis included but was not limited to Diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high) and Hypertension (High blood pressure). The record indicated the	R 0241	**R241 Health Services** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.*** ***The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** ***1)Immediate actions taken for***	12/01/2025

	physician orders were not signed or reviewed by the attending physician. 3. Resident 218's record was reviewed on 10/15/25 at 10:20 a.m. The profile indicated the resident diagnoses included, but were not limited to, hypertension (elevated blood pressure) and glaucoma (an eye condition that damages the optic nerve. This damage can lead to vision loss or blindness). Facility census information indicated Resident 218 moved into the facility on 11/17/24. Resident 218's health record lacked documentation of physician orders for medications. The record indicated the resident self-administers her medication, but the record lacked documentation of what medications the resident was taking. 4. Resident 214's record was reviewed on 10/15/25 at 11:00 a.m. The profile indicated the resident diagnoses included, but were not limited to, type 2 diabetes (a chronic condition characterized by high blood sugar levels), stroke (occurs when the blood flow to a particular area of the brain is blocked or cut off), and hyperlipidemia (elevated cholesterol levels).		***those residents identified:*** Physicians notified of late administrations by LPN ***2)How the facility identified other residents:*** All residents have the potential to be affected. No others identified. **3)Measures put into place/ System changes:** Inservice completed with all Nurses/QMA's regarding medication administration. MAR audits intitiated **4)How the corrective actions will be monitored:** DHW/ Designee will be responsible for this plan of correction. DHW/Designee to audit MAR to ensure all medications have	

	Facility census information indicated Resident 214 moved into the facility on 4/22/25. Resident 214's health record lacked documentation of signed physician orders for medications. The record indicated that the resident does not self-administer her medications. During an interview on 10/15/25 at 12:24 p.m., the Unit Manager indicated each resident should have physician orders for medications even if they self-administer. On 10/16/25 at 12:40 p.m., the float Executive Director provided an undated document, titled, " ...Medication Reconciliation/Order Renewal," and indicated it was the current policy being used by the facility. The policy indicated, " ...Medication orders will be renewed and reconciled to ensure the accuracy of orders ...1. All medication orders will be verified every 6 months ...2. When a resident is readmitted to the Community, such as after a hospitalization, all orders will be reviewed ...." 1. Based on observation, record review, and interview, the facility failed to ensure medications were administered in a timely manner as ordered by the physician for 5 of 5 medication		been given at the appropriate time and will rectify any issues and notify providers 5 days a week for 6 weeks, then 3 days a week x3 weeks, then monthly indefinitely. **5)Date of compliance:12/1/25**	

pass observations (Resident 221, 222, 225, 224, and 223).

2. Based on record review and interview, the facility failed to ensure signed physician's orders were in place for medications for 3 of 7 residents reviewed for physician's orders (Resident 210, 218, and 214).

Findings include:

1a. On 10/15/25 at 10:01 a.m., Licensed Practical Nurse (LPN) 3 administered carvedilol (blood pressure medication) 6.25 milligrams (mg), furosemide (diuretic) 20 mg, losartan (blood pressure medication) 50 mg, metformin (treats diabetes mellitus) 500 mg, levothyroxine (thyroid medication) 137 micrograms (mcg), vitamin D3 400 units (u), and pravastatin (cholesterol medication) 40 mg to Resident 221. At the same time, LPN 3 indicated the facility obtained permission from the resident's physician to administer the levothyroxine with the other morning medications instead of before breakfast because the resident refused early medications. LPN 3 did not provide documentation the physician was notified.

Resident 221's record was reviewed on 10/15/25 at 10:54 a.m. The record lacked documentation the resident's physician was notified of the

	levothyroxine administration time. A Medication Administration Record (MAR), dated October 2025, indicated levothyroxine was scheduled for administration daily at 6:00 a.m. Carvedilol, furosemide, losartan, metformin, vitamin D3, and pravastatin were scheduled for administration daily at 8:00 a.m. 1b. On 10/15/25 at 10:05 a.m., LPN 3 administered amlodipine (blood pressure medication) 5 mg, aripiprazole (antipsychotic medication) 2 mg, carvedilol 12.5 mg, Eliquis (blood thinner) 2.5 mg, folic acid (supplement) 1 mg, levitracetam (anti-seizure medication) 125 mg, sertraline (antidepressant) 50 mg, and torsemide (diuretic) 10 mg to Resident 222. Resident 222's record was reviewed on 10/15/25 at 11:00 a.m. A MAR, dated October 2025, indicated amlodipine, aripiprazole, carvedilol, Eliquis, folic acid, levitracetam, sertraline, and torsemide were scheduled for administration daily at 8:00 a.m. 1c. On 10/15/25 at 10:10 a.m., LPN 3 administered atorvastatin (cholesterol medication) 40 mg, escitalopram (antidepressant) 20 mg, finasteride (treats enlarged prostate) 5 mg, furosemide 20 mg, memantine			

	(dementia medication) 10 mg, tamsulosin (treats enlarged prostate) 0.4 mg, and vitamin B-12 1,000 mcg to Resident 225. Resident 225's record was reviewed on 10/15/25 at 11:05 a.m. A MAR, dated October 2025, indicated atorvastatin, escitalopram, finasteride, furosemide, memantine, tamsulosin, and vitamin B-12 were scheduled for administration daily at 8:00 a.m. 1d. On 10/15/25 at 10:17 a.m., LPN 3 administered atorvastatin 10 mg, levothyroxine 25 mcg, hydrochlorothiazide (diuretic) 25 mg, losartan 25 mg, metoprolol (blood pressure medication) 25 mg, and nabumetone (nonsteroidal anti-inflammatory drug) 500 mg to Resident 224. At the same time, LPN 3 indicated Resident 224 had severe dementia and would not take the levothyroxine early in the morning, so it was administered with the other morning medications. Resident 224's record was reviewed on 10/15/25 at 11:12 a.m. The record lacked documentation the physician was notified the levothyroxine was administered with the rest of the resident's morning medications, instead of before breakfast.			

	A MAR, dated October 2025, indicated the levothyroxine was scheduled for administration daily at 6:00 a.m. The atorvastatin, hydrochlorothiazide, losartan, metoprolol, and nabumetone were scheduled for administration daily at 8:00 a.m. 1e. On 10/15/25 at 10:26 a.m., LPN 3 administered aspirin (blood thinner) 81 mg, calcium (supplement) 600 mg, desvenlafaxine extended release (ER) (antidepressant) 50 mg, fish oil (supplement) 1,200 mg, lisinopril (blood pressure medication) 20 mg, omeprazole (treats excess stomach acid) 20 mg, potassium chloride ER (supplement) 10 milliequivalent (mEq), vitamin D3 2,000 u, and evening primrose oil supplement 1 tablet to Resident 223. Resident 223's record was reviewed on 10/15/25 at 11:30 a.m. A MAR, dated October 2025, indicated aspirin 81 mg, calcium 600 mg, desvenlafaxine ER 50 mg, fish oil 1,200 mg, lisinopril 20 mg, omeprazole 20 mg, potassium chloride ER 10 mEq, vitamin D3 2,000 u, and evening primrose oil supplement 1 tablet were scheduled for administration daily at 8:00 a.m. During an interview, on 10/15/25 at 11:45 a.m., LPN 3 indicated morning medications were able			

	to be passed from 7:00 a.m. to 11:59 a.m. There were some issues with the medication times in the computer because they were generated from the pharmacy. She was not sure why they were scheduled on the MAR the way that they were, but she thought she had a window of time to pass the morning medications. On 10/15/25 at 1:41 p.m., the Float Executive Director (ED) provided a document titled, "Medication Services," dated 6/10/24, and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy: The Community provides medication ordering and medication assistance/administration services. Procedure...12. Medications may be given up to one (1) hour before and up to one (1) hour after the prescribed time to accommodate the resident's schedule unless otherwise indicated by the resident's physician...."			

	2. On 10/15/25 the clinical record of Resident 210 was reviewed. The resident entered the facility on 5/9/25. Admission diagnosis included but was not limited to Diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high) and Hypertension (High blood pressure). The record indicated the physician orders were not signed or reviewed by the attending physician. 3. Resident 218's record was reviewed on 10/15/25 at 10:20 a.m. The profile indicated the resident diagnoses included, but were not limited to, hypertension (elevated blood pressure) and glaucoma (an eye condition that damages the optic nerve. This damage can lead to vision loss or blindness). Facility census information indicated Resident 218 moved into the facility on 11/17/24. Resident 218's health record lacked documentation of physician orders for medications. The record indicated the resident self-administers her medication, but the record lacked documentation of what medications the resident was taking. 4. Resident 214's record was			

	reviewed on 10/15/25 at 11:00 a.m. The profile indicated the resident diagnoses included, but were not limited to, type 2 diabetes (a chronic condition characterized by high blood sugar levels), stroke (occurs when the blood flow to a particular area of the brain is blocked or cut off), and hyperlipidemia (elevated cholesterol levels). Facility census information indicated Resident 214 moved into the facility on 4/22/25. Resident 214's health record lacked documentation of signed physician orders for medications. The record indicated that the resident does not self-administer her medications. During an interview on 10/15/25 at 12:24 p.m., the Unit Manager indicated each resident should have physician orders for medications even if they self-administer. On 10/16/25 at 12:40 p.m., the float Executive Director provided an undated document, titled, " ...Medication Reconciliation/Order Renewal," and indicated it was the current policy being used by the facility. The policy indicated, " ...Medication orders will be renewed and reconciled to ensure the accuracy of orders			

	...1. All medication orders will be verified every 6 months ...2. When a resident is readmitted to the Community, such as after a hospitalization, all orders will be reviewed ...." 1. Based on observation, record review, and interview, the facility failed to ensure medications were administered in a timely manner as ordered by the physician for 5 of 5 medication pass observations (Resident 221, 222, 225, 224, and 223). 2. Based on record review and interview, the facility failed to ensure signed physician's orders were in place for medications for 3 of 7 residents reviewed for physician's orders (Resident 210, 218, and 214). Findings include: 1a. On 10/15/25 at 10:01 a.m., Licensed Practical Nurse (LPN) 3 administered carvedilol (blood pressure medication) 6.25 milligrams (mg), furosemide (diuretic) 20 mg, losartan (blood pressure medication) 50 mg, metformin (treats diabetes mellitus) 500 mg, levothyroxine (thyroid medication) 137 micrograms (mcg), vitamin D3 400 units (u), and pravastatin (cholesterol medication) 40 mg to Resident 221. At the same time, LPN 3 indicated the facility obtained permission from the resident's physician to			

	administer the levothyroxine with the other morning medications instead of before breakfast because the resident refused early medications. LPN 3 did not provide documentation the physician was notified. Resident 221's record was reviewed on 10/15/25 at 10:54 a.m. The record lacked documentation the resident's physician was notified of the levothyroxine administration time. A Medication Administration Record (MAR), dated October 2025, indicated levothyroxine was scheduled for administration daily at 6:00 a.m. Carvedilol, furosemide, losartan, metformin, vitamin D3, and pravastatin were scheduled for administration daily at 8:00 a.m. 1b. On 10/15/25 at 10:05 a.m., LPN 3 administered amlodipine (blood pressure medication) 5 mg, aripiprazole (antipsychotic medication) 2 mg, carvedilol 12.5 mg, Eliquis (blood thinner) 2.5 mg, folic acid (supplement) 1 mg, levitracetam (anti-seizure medication) 125 mg, sertraline (antidepressant) 50 mg, and torsemide (diuretic) 10 mg to Resident 222. Resident 222's record was reviewed on 10/15/25 at 11:00 a.m. A MAR, dated October 2025, indicated amlodipine,			

	aripiprazole, carvedilol, Eliquis, folic acid, levitracetam, sertraline, and torsemide were scheduled for administration daily at 8:00 a.m. 1c. On 10/15/25 at 10:10 a.m., LPN 3 administered atorvastatin (cholesterol medication) 40 mg, escitalopram (antidepressant) 20 mg, finasteride (treats enlarged prostate) 5 mg, furosemide 20 mg, memantine (dementia medication) 10 mg, tamsulosin (treats enlarged prostate) 0.4 mg, and vitamin B-12 1,000 mcg to Resident 225. Resident 225's record was reviewed on 10/15/25 at 11:05 a.m. A MAR, dated October 2025, indicated atorvastatin, escitalopram, finasteride, furosemide, memantine, tamsulosin, and vitamin B-12 were scheduled for administration daily at 8:00 a.m. 1d. On 10/15/25 at 10:17 a.m., LPN 3 administered atorvastatin 10 mg, levothyroxine 25 mcg, hydrochlorothiazide (diuretic) 25 mg, losartan 25 mg, metoprolol (blood pressure medication) 25 mg, and nabumetone (nonsteroidal anti-inflammatory drug) 500 mg to Resident 224. At the same time, LPN 3 indicated Resident 224 had severe dementia and would not take the levothyroxine early in the morning, so it was			

	administered with the other morning medications. Resident 224's record was reviewed on 10/15/25 at 11:12 a.m. The record lacked documentation the physician was notified the levothyroxine was administered with the rest of the resident's morning medications, instead of before breakfast. A MAR, dated October 2025, indicated the levothyroxine was scheduled for administration daily at 6:00 a.m. The atorvastatin, hydrochlorothiazide, losartan, metoprolol, and nabumetone were scheduled for administration daily at 8:00 a.m. 1e. On 10/15/25 at 10:26 a.m., LPN 3 administered aspirin (blood thinner) 81 mg, calcium (supplement) 600 mg, desvenlafaxine extended release (ER) (antidepressant) 50 mg, fish oil (supplement) 1,200 mg, lisinopril (blood pressure medication) 20 mg, omeprazole (treats excess stomach acid) 20 mg, potassium chloride ER (supplement) 10 milliequivalent (mEq), vitamin D3 2,000 u, and evening primrose oil supplement 1 tablet to Resident 223. Resident 223's record was reviewed on 10/15/25 at 11:30 a.m. A MAR, dated October			

	2025, indicated aspirin 81 mg, calcium 600 mg, desvenlafaxine ER 50 mg, fish oil 1,200 mg, lisinopril 20 mg, omeprazole 20 mg, potassium chloride ER 10 mEq, vitamin D3 2,000 u, and evening primrose oil supplement 1 tablet were scheduled for administration daily at 8:00 a.m. During an interview, on 10/15/25 at 11:45 a.m., LPN 3 indicated morning medications were able to be passed from 7:00 a.m. to 11:59 a.m. There were some issues with the medication times in the computer because they were generated from the pharmacy. She was not sure why they were scheduled on the MAR the way that they were, but she thought she had a window of time to pass the morning medications. On 10/15/25 at 1:41 p.m., the Float Executive Director (ED) provided a document titled, "Medication Services," dated 6/10/24, and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy: The Community provides medication ordering and medication assistance/administration services. Procedure...12. Medications may be given up to one (1) hour before and up to one (1) hour after the prescribed time to accommodate the resident's schedule unless otherwise indicated by the			

	resident's physician...." 2. On 10/15/25 the clinical record of Resident 210 was reviewed. The resident entered the facility on 5/9/25. Admission diagnosis included but was not limited to Diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high) and Hypertension (High blood pressure). The record indicated the physician orders were not signed or reviewed by the attending physician. 3. Resident 218's record was reviewed on 10/15/25 at 10:20 a.m. The profile indicated the resident diagnoses included, but were not limited to, hypertension (elevated blood pressure) and glaucoma (an eye condition that damages the optic nerve. This damage can lead to vision loss or blindness). Facility census information indicated Resident 218 moved into the facility on 11/17/24.			

Resident 218's health record lacked documentation of physician orders for medications. The record indicated the resident self-administers her medication, but the record lacked documentation of what medications the resident was taking.

4. Resident 214's record was reviewed on 10/15/25 at 11:00 a.m. The profile indicated the resident diagnoses included, but were not limited to, type 2 diabetes (a chronic condition characterized by high blood sugar levels), stroke (occurs when the blood flow to a particular area of the brain is blocked or cut off), and hyperlipidemia (elevated cholesterol levels).

Facility census information indicated Resident 214 moved into the facility on 4/22/25.

Resident 214's health record lacked documentation of signed physician orders for medications. The record indicated that the resident does not self-administer her medications.

During an interview on 10/15/25 at 12:24 p.m., the Unit Manager indicated each resident should have physician orders for medications even if they self-administer.

	On 10/16/25 at 12:40 p.m., the float Executive Director provided an undated document, titled, " ...Medication Reconciliation/Order Renewal," and indicated it was the current policy being used by the facility. The policy indicated, " ...Medication orders will be renewed and reconciled to ensure the accuracy of orders ...1. All medication orders will be verified every 6 months ...2. When a resident is readmitted to the Community, such as after a hospitalization, all orders will be reviewed ...." 1. Based on observation, record review, and interview, the facility failed to ensure medications were administered in a timely manner as ordered by the physician for 5 of 5 medication pass observations (Resident 221, 222, 225, 224, and 223). 2. Based on record review and interview, the facility failed to ensure signed physician's orders were in place for medications for 3 of 7 residents reviewed for physician's orders (Resident 210, 218, and 214). Findings include: 1a. On 10/15/25 at 10:01 a.m., Licensed Practical Nurse (LPN) 3 administered carvedilol (blood pressure medication) 6.25 milligrams (mg), furosemide (diuretic) 20 mg, losartan (blood			

	pressure medication) 50 mg, metformin (treats diabetes mellitus) 500 mg, levothyroxine (thyroid medication) 137 micrograms (mcg), vitamin D3 400 units (u), and pravastatin (cholesterol medication) 40 mg to Resident 221. At the same time, LPN 3 indicated the facility obtained permission from the resident's physician to administer the levothyroxine with the other morning medications instead of before breakfast because the resident refused early medications. LPN 3 did not provide documentation the physician was notified. Resident 221's record was reviewed on 10/15/25 at 10:54 a.m. The record lacked documentation the resident's physician was notified of the levothyroxine administration time. A Medication Administration Record (MAR), dated October 2025, indicated levothyroxine was scheduled for administration daily at 6:00 a.m. Carvedilol, furosemide, losartan, metformin, vitamin D3, and pravastatin were scheduled for administration daily at 8:00 a.m. 1b. On 10/15/25 at 10:05 a.m., LPN 3 administered amlodipine (blood pressure medication) 5 mg, aripiprazole (antipsychotic medication) 2 mg, carvedilol 12.5 mg, Eliquis (blood thinner)			

	2.5 mg, folic acid (supplement) 1 mg, levitracetam (anti-seizure medication) 125 mg, sertraline (antidepressant) 50 mg, and torsemide (diuretic) 10 mg to Resident 222. Resident 222's record was reviewed on 10/15/25 at 11:00 a.m. A MAR, dated October 2025, indicated amlodipine, aripiprazole, carvedilol, Eliquis, folic acid, levitracetam, sertraline, and torsemide were scheduled for administration daily at 8:00 a.m. 1c. On 10/15/25 at 10:10 a.m., LPN 3 administered atorvastatin (cholesterol medication) 40 mg, escitalopram (antidepressant) 20 mg, finasteride (treats enlarged prostate) 5 mg, furosemide 20 mg, memantine (dementia medication) 10 mg, tamsulosin (treats enlarged prostate) 0.4 mg, and vitamin B-12 1,000 mcg to Resident 225. Resident 225's record was reviewed on 10/15/25 at 11:05 a.m. A MAR, dated October 2025, indicated atorvastatin, escitalopram, finasteride, furosemide, memantine, tamsulosin, and vitamin B-12 were scheduled for administration daily at 8:00 a.m. 1d. On 10/15/25 at 10:17 a.m., LPN 3 administered atorvastatin 10 mg, levothyroxine 25 mcg,			

	hydrochlorothiazide (diuretic) 25 mg, losartan 25 mg, metoprolol (blood pressure medication) 25 mg, and nabumetone (nonsteroidal anti-inflammatory drug) 500 mg to Resident 224. At the same time, LPN 3 indicated Resident 224 had severe dementia and would not take the levothyroxine early in the morning, so it was administered with the other morning medications. Resident 224's record was reviewed on 10/15/25 at 11:12 a.m. The record lacked documentation the physician was notified the levothyroxine was administered with the rest of the resident's morning medications, instead of before breakfast. A MAR, dated October 2025, indicated the levothyroxine was scheduled for administration daily at 6:00 a.m. The atorvastatin, hydrochlorothiazide, losartan, metoprolol, and nabumetone were scheduled for administration daily at 8:00 a.m. 1e. On 10/15/25 at 10:26 a.m., LPN 3 administered aspirin (blood thinner) 81 mg, calcium (supplement) 600 mg, desvenlafaxine extended release (ER) (antidepressant) 50 mg, fish oil (supplement) 1,200 mg, lisinopril (blood pressure medication) 20 mg,			

	omeprazole (treats excess stomach acid) 20 mg, potassium chloride ER (supplement) 10 milliequivalent (mEq), vitamin D3 2,000 u, and evening primrose oil supplement 1 tablet to Resident 223. Resident 223's record was reviewed on 10/15/25 at 11:30 a.m. A MAR, dated October 2025, indicated aspirin 81 mg, calcium 600 mg, desvenlafaxine ER 50 mg, fish oil 1,200 mg, lisinopril 20 mg, omeprazole 20 mg, potassium chloride ER 10 mEq, vitamin D3 2,000 u, and evening primrose oil supplement 1 tablet were scheduled for administration daily at 8:00 a.m. During an interview, on 10/15/25 at 11:45 a.m., LPN 3 indicated morning medications were able to be passed from 7:00 a.m. to 11:59 a.m. There were some issues with the medication times in the computer because they were generated from the pharmacy. She was not sure why they were scheduled on the MAR the way that they were, but she thought she had a window of time to pass the morning medications. On 10/15/25 at 1:41 p.m., the Float Executive Director (ED) provided a document titled, "Medication Services," dated 6/10/24, and indicated it was the policy currently being used by the facility. The policy indicated,			

	"...Policy: The Community provides medication ordering and medication assistance/administration services. Procedure...12. Medications may be given up to one (1) hour before and up to one (1) hour after the prescribed time to accommodate the resident's schedule unless otherwise indicated by the resident's physician...." 2. On 10/15/25 the clinical record of Resident 210 was reviewed. The resident entered the facility on 5/9/25. Admission diagnosis included but was not limited to Diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high) and Hypertension (High blood pressure). The record indicated the physician orders were not signed or reviewed by the attending physician. 3. Resident 218's record was reviewed on 10/15/25 at 10:20 a.m. The profile indicated the resident diagnoses included, but were not limited to, hypertension (elevated blood pressure) and glaucoma (an eye condition that damages the optic nerve. This damage can lead to vision loss or blindness). Facility census information indicated Resident 218 moved			

into the facility on 11/17/24.

Resident 218's health record lacked documentation of physician orders for medications. The record indicated the resident self-administers her medication, but the record lacked documentation of what medications the resident was taking.

4. Resident 214's record was reviewed on 10/15/25 at 11:00 a.m. The profile indicated the resident diagnoses included, but were not limited to, type 2 diabetes (a chronic condition characterized by high blood sugar levels), stroke (occurs when the blood flow to a particular area of the brain is blocked or cut off), and hyperlipidemia (elevated cholesterol levels).

Facility census information indicated Resident 214 moved into the facility on 4/22/25.

Resident 214's health record lacked documentation of signed physician orders for medications. The record indicated that the resident does not self-administer her medications.

During an interview on 10/15/25 at 12:24 p.m., the Unit Manager indicated each resident should have physician orders for medications even if they

self-administer.

On 10/16/25 at 12:40 p.m., the float Executive Director provided an undated document, titled, " ...Medication Reconciliation/Order Renewal," and indicated it was the current policy being used by the facility. The policy indicated, " ...Medication orders will be renewed and reconciled to ensure the accuracy of orders ...1. All medication orders will be verified every 6 months ...2. When a resident is readmitted to the Community, such as after a hospitalization, all orders will be reviewed ...."

1. Based on observation, record review, and interview, the facility failed to ensure medications were administered in a timely manner as ordered by the physician for 5 of 5 medication pass observations (Resident 221, 222, 225, 224, and 223).

2. Based on record review and interview, the facility failed to ensure signed physician's orders were in place for medications for 3 of 7 residents reviewed for physician's orders (Resident 210, 218, and 214).

Findings include:

1a. On 10/15/25 at 10:01 a.m., Licensed Practical Nurse (LPN) 3 administered carvedilol (blood pressure medication) 6.25 milligrams (mg), furosemide

	(diuretic) 20 mg, losartan (blood pressure medication) 50 mg, metformin (treats diabetes mellitus) 500 mg, levothyroxine (thyroid medication) 137 micrograms (mcg), vitamin D3 400 units (u), and pravastatin (cholesterol medication) 40 mg to Resident 221. At the same time, LPN 3 indicated the facility obtained permission from the resident's physician to administer the levothyroxine with the other morning medications instead of before breakfast because the resident refused early medications. LPN 3 did not provide documentation the physician was notified. Resident 221's record was reviewed on 10/15/25 at 10:54 a.m. The record lacked documentation the resident's physician was notified of the levothyroxine administration time. A Medication Administration Record (MAR), dated October 2025, indicated levothyroxine was scheduled for administration daily at 6:00 a.m. Carvedilol, furosemide, losartan, metformin, vitamin D3, and pravastatin were scheduled for administration daily at 8:00 a.m. 1b. On 10/15/25 at 10:05 a.m., LPN 3 administered amlodipine (blood pressure medication) 5 mg, aripiprazole (antipsychotic medication) 2 mg, carvedilol			

	12.5 mg, Eliquis (blood thinner) 2.5 mg, folic acid (supplement) 1 mg, levitracetam (anti-seizure medication) 125 mg, sertraline (antidepressant) 50 mg, and torsemide (diuretic) 10 mg to Resident 222. Resident 222's record was reviewed on 10/15/25 at 11:00 a.m. A MAR, dated October 2025, indicated amlodipine, aripiprazole, carvedilol, Eliquis, folic acid, levitracetam, sertraline, and torsemide were scheduled for administration daily at 8:00 a.m. 1c. On 10/15/25 at 10:10 a.m., LPN 3 administered atorvastatin (cholesterol medication) 40 mg, escitalopram (antidepressant) 20 mg, finasteride (treats enlarged prostate) 5 mg, furosemide 20 mg, memantine (dementia medication) 10 mg, tamsulosin (treats enlarged prostate) 0.4 mg, and vitamin B-12 1,000 mcg to Resident 225. Resident 225's record was reviewed on 10/15/25 at 11:05 a.m. A MAR, dated October 2025, indicated atorvastatin, escitalopram, finasteride, furosemide, memantine, tamsulosin, and vitamin B-12 were scheduled for administration daily at 8:00 a.m. 1d. On 10/15/25 at 10:17 a.m., LPN 3 administered atorvastatin			

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	pressure medication) 20 mg, omeprazole (treats excess stomach acid) 20 mg, potassium chloride ER (supplement) 10 milliequivalent (mEq), vitamin D3 2,000 u, and evening primrose oil supplement 1 tablet to Resident 223. Resident 223's record was reviewed on 10/15/25 at 11:30 a.m. A MAR, dated October 2025, indicated aspirin 81 mg, calcium 600 mg, desvenlafaxine ER 50 mg, fish oil 1,200 mg, lisinopril 20 mg, omeprazole 20 mg, potassium chloride ER 10 mEq, vitamin D3 2,000 u, and evening primrose oil supplement 1 tablet were scheduled for administration daily at 8:00 a.m. During an interview, on 10/15/25 at 11:45 a.m., LPN 3 indicated morning medications were able to be passed from 7:00 a.m. to 11:59 a.m. There were some issues with the medication times in the computer because they were generated from the pharmacy. She was not sure why they were scheduled on the MAR the way that they were, but she thought she had a window of time to pass the morning medications. On 10/15/25 at 1:41 p.m., the Float Executive Director (ED) provided a document titled, "Medication Services," dated 6/10/24, and indicated it was the policy currently being used by			

	the facility. The policy indicated, "...Policy: The Community provides medication ordering and medication assistance/administration services. Procedure...12. Medications may be given up to one (1) hour before and up to one (1) hour after the prescribed time to accommodate the resident's schedule unless otherwise indicated by the resident's physician...." 2. On 10/15/25 the clinical record of Resident 210 was reviewed. The resident entered the facility on 5/9/25. Admission diagnosis included but was not limited to Diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high) and Hypertension (High blood pressure). The record indicated the physician orders were not signed or reviewed by the attending physician. 3. Resident 218's record was reviewed on 10/15/25 at 10:20 a.m. The profile indicated the resident diagnoses included, but were not limited to, hypertension (elevated blood pressure) and glaucoma (an eye condition that damages the optic nerve. This damage can lead to vision loss or blindness). Facility census information			

indicated Resident 218 moved into the facility on 11/17/24.

Resident 218's health record lacked documentation of physician orders for medications. The record indicated the resident self-administers her medication, but the record lacked documentation of what medications the resident was taking.

4. Resident 214's record was reviewed on 10/15/25 at 11:00 a.m. The profile indicated the resident diagnoses included, but were not limited to, type 2 diabetes (a chronic condition characterized by high blood sugar levels), stroke (occurs when the blood flow to a particular area of the brain is blocked or cut off), and hyperlipidemia (elevated cholesterol levels).

Facility census information indicated Resident 214 moved into the facility on 4/22/25.

Resident 214's health record lacked documentation of signed physician orders for medications. The record indicated that the resident does not self-administer her medications.

During an interview on 10/15/25 at 12:24 p.m., the Unit Manager indicated each resident should have physician orders for

medications even if they self-administer.

On 10/16/25 at 12:40 p.m., the float Executive Director provided an undated document, titled, " ...Medication Reconciliation/Order Renewal," and indicated it was the current policy being used by the facility. The policy indicated, " ...Medication orders will be renewed and reconciled to ensure the accuracy of orders ...1. All medication orders will be verified every 6 months ...2. When a resident is readmitted to the Community, such as after a hospitalization, all orders will be reviewed ...."

1. Based on observation, record review, and interview, the facility failed to ensure medications were administered in a timely manner as ordered by the physician for 5 of 5 medication pass observations (Resident 221, 222, 225, 224, and 223).

2. Based on record review and interview, the facility failed to ensure signed physician's orders were in place for medications for 3 of 7 residents reviewed for physician's orders (Resident 210, 218, and 214).

Findings include:

1a. On 10/15/25 at 10:01 a.m., Licensed Practical Nurse (LPN) 3 administered carvedilol (blood pressure medication) 6.25

	milligrams (mg), furosemide (diuretic) 20 mg, losartan (blood pressure medication) 50 mg, metformin (treats diabetes mellitus) 500 mg, levothyroxine (thyroid medication) 137 micrograms (mcg), vitamin D3 400 units (u), and pravastatin (cholesterol medication) 40 mg to Resident 221. At the same time, LPN 3 indicated the facility obtained permission from the resident's physician to administer the levothyroxine with the other morning medications instead of before breakfast because the resident refused early medications. LPN 3 did not provide documentation the physician was notified. Resident 221's record was reviewed on 10/15/25 at 10:54 a.m. The record lacked documentation the resident's physician was notified of the levothyroxine administration time. A Medication Administration Record (MAR), dated October 2025, indicated levothyroxine was scheduled for administration daily at 6:00 a.m. Carvedilol, furosemide, losartan, metformin, vitamin D3, and pravastatin were scheduled for administration daily at 8:00 a.m. 1b. On 10/15/25 at 10:05 a.m., LPN 3 administered amlodipine (blood pressure medication) 5 mg, aripiprazole (antipsychotic			

	medication) 2 mg, carvedilol 12.5 mg, Eliquis (blood thinner) 2.5 mg, folic acid (supplement) 1 mg, levitracetam (anti-seizure medication) 125 mg, sertraline (antidepressant) 50 mg, and torsemide (diuretic) 10 mg to Resident 222. Resident 222's record was reviewed on 10/15/25 at 11:00 a.m. A MAR, dated October 2025, indicated amlodipine, aripiprazole, carvedilol, Eliquis, folic acid, levitracetam, sertraline, and torsemide were scheduled for administration daily at 8:00 a.m. 1c. On 10/15/25 at 10:10 a.m., LPN 3 administered atorvastatin (cholesterol medication) 40 mg, escitalopram (antidepressant) 20 mg, finasteride (treats enlarged prostate) 5 mg, furosemide 20 mg, memantine (dementia medication) 10 mg, tamsulosin (treats enlarged prostate) 0.4 mg, and vitamin B-12 1,000 mcg to Resident 225. Resident 225's record was reviewed on 10/15/25 at 11:05 a.m. A MAR, dated October 2025, indicated atorvastatin, escitalopram, finasteride, furosemide, memantine, tamsulosin, and vitamin B-12 were scheduled for administration daily at 8:00 a.m. 1d. On 10/15/25 at 10:17 a.m.,			

	LPN 3 administered atorvastatin 10 mg, levothyroxine 25 mcg, hydrochlorothiazide (diuretic) 25 mg, losartan 25 mg, metoprolol (blood pressure medication) 25 mg, and nabumetone (nonsteroidal anti-inflammatory drug) 500 mg to Resident 224. At the same time, LPN 3 indicated Resident 224 had severe dementia and would not take the levothyroxine early in the morning, so it was administered with the other morning medications. Resident 224's record was reviewed on 10/15/25 at 11:12 a.m. The record lacked documentation the physician was notified the levothyroxine was administered with the rest of the resident's morning medications, instead of before breakfast. A MAR, dated October 2025, indicated the levothyroxine was scheduled for administration daily at 6:00 a.m. The atorvastatin, hydrochlorothiazide, losartan, metoprolol, and nabumetone were scheduled for administration daily at 8:00 a.m. 1e. On 10/15/25 at 10:26 a.m., LPN 3 administered aspirin (blood thinner) 81 mg, calcium (supplement) 600 mg, desvenlafaxine extended release (ER) (antidepressant) 50 mg, fish oil (supplement)			

	1,200 mg, lisinopril (blood pressure medication) 20 mg, omeprazole (treats excess stomach acid) 20 mg, potassium chloride ER (supplement) 10 milliequivalent (mEq), vitamin D3 2,000 u, and evening primrose oil supplement 1 tablet to Resident 223. Resident 223's record was reviewed on 10/15/25 at 11:30 a.m. A MAR, dated October 2025, indicated aspirin 81 mg, calcium 600 mg, desvenlafaxine ER 50 mg, fish oil 1,200 mg, lisinopril 20 mg, omeprazole 20 mg, potassium chloride ER 10 mEq, vitamin D3 2,000 u, and evening primrose oil supplement 1 tablet were scheduled for administration daily at 8:00 a.m. During an interview, on 10/15/25 at 11:45 a.m., LPN 3 indicated morning medications were able to be passed from 7:00 a.m. to 11:59 a.m. There were some issues with the medication times in the computer because they were generated from the pharmacy. She was not sure why they were scheduled on the MAR the way that they were, but she thought she had a window of time to pass the morning medications. On 10/15/25 at 1:41 p.m., the Float Executive Director (ED) provided a document titled, "Medication Services," dated 6/10/24, and indicated it was the			

	policy currently being used by the facility. The policy indicated, "...Policy: The Community provides medication ordering and medication assistance/administration services. Procedure...12. Medications may be given up to one (1) hour before and up to one (1) hour after the prescribed time to accommodate the resident's schedule unless otherwise indicated by the resident's physician...." 2. On 10/15/25 the clinical record of Resident 210 was reviewed. The resident entered the facility on 5/9/25. Admission diagnosis included but was not limited to Diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high) and Hypertension (High blood pressure). The record indicated the physician orders were not signed or reviewed by the attending physician. 3. Resident 218's record was reviewed on 10/15/25 at 10:20 a.m. The profile indicated the resident diagnoses included, but were not limited to, hypertension (elevated blood pressure) and glaucoma (an eye condition that damages the optic nerve. This damage can lead to vision loss or blindness).			

Facility census information indicated Resident 218 moved into the facility on 11/17/24.

Resident 218's health record lacked documentation of physician orders for medications. The record indicated the resident self-administers her medication, but the record lacked documentation of what medications the resident was taking.

4. Resident 214's record was reviewed on 10/15/25 at 11:00 a.m. The profile indicated the resident diagnoses included, but were not limited to, type 2 diabetes (a chronic condition characterized by high blood sugar levels), stroke (occurs when the blood flow to a particular area of the brain is blocked or cut off), and hyperlipidemia (elevated cholesterol levels).

Facility census information indicated Resident 214 moved into the facility on 4/22/25.

Resident 214's health record lacked documentation of signed physician orders for medications. The record indicated that the resident does not self-administer her medications.

During an interview on 10/15/25 at 12:24 p.m., the Unit Manager indicated each resident should

	have physician orders for medications even if they self-administer. On 10/16/25 at 12:40 p.m., the float Executive Director provided an undated document, titled, " ...Medication Reconciliation/Order Renewal," and indicated it was the current policy being used by the facility. The policy indicated, " ...Medication orders will be renewed and reconciled to ensure the accuracy of orders ...1. All medication orders will be verified every 6 months ...2. When a resident is readmitted to the Community, such as after a hospitalization, all orders will be reviewed ...." 1. Based on observation, record review, and interview, the facility failed to ensure medications were administered in a timely manner as ordered by the physician for 5 of 5 medication pass observations (Resident 221, 222, 225, 224, and 223). 2. Based on record review and interview, the facility failed to ensure signed physician's orders were in place for medications for 3 of 7 residents reviewed for physician's orders (Resident 210, 218, and 214). Findings include: 1a. On 10/15/25 at 10:01 a.m., Licensed Practical Nurse (LPN) 3 administered carvedilol (blood			

	pressure medication) 6.25 milligrams (mg), furosemide (diuretic) 20 mg, losartan (blood pressure medication) 50 mg, metformin (treats diabetes mellitus) 500 mg, levothyroxine (thyroid medication) 137 micrograms (mcg), vitamin D3 400 units (u), and pravastatin (cholesterol medication) 40 mg to Resident 221. At the same time, LPN 3 indicated the facility obtained permission from the resident's physician to administer the levothyroxine with the other morning medications instead of before breakfast because the resident refused early medications. LPN 3 did not provide documentation the physician was notified. Resident 221's record was reviewed on 10/15/25 at 10:54 a.m. The record lacked documentation the resident's physician was notified of the levothyroxine administration time. A Medication Administration Record (MAR), dated October 2025, indicated levothyroxine was scheduled for administration daily at 6:00 a.m. Carvedilol, furosemide, losartan, metformin, vitamin D3, and pravastatin were scheduled for administration daily at 8:00 a.m. 1b. On 10/15/25 at 10:05 a.m., LPN 3 administered amlodipine (blood pressure medication) 5			

	mg, aripiprazole (antipsychotic medication) 2 mg, carvedilol 12.5 mg, Eliquis (blood thinner) 2.5 mg, folic acid (supplement) 1 mg, levitracetam (anti-seizure medication) 125 mg, sertraline (antidepressant) 50 mg, and torsemide (diuretic) 10 mg to Resident 222. Resident 222's record was reviewed on 10/15/25 at 11:00 a.m. A MAR, dated October 2025, indicated amlodipine, aripiprazole, carvedilol, Eliquis, folic acid, levitracetam, sertraline, and torsemide were scheduled for administration daily at 8:00 a.m. 1c. On 10/15/25 at 10:10 a.m., LPN 3 administered atorvastatin (cholesterol medication) 40 mg, escitalopram (antidepressant) 20 mg, finasteride (treats enlarged prostate) 5 mg, furosemide 20 mg, memantine (dementia medication) 10 mg, tamsulosin (treats enlarged prostate) 0.4 mg, and vitamin B-12 1,000 mcg to Resident 225. Resident 225's record was reviewed on 10/15/25 at 11:05 a.m. A MAR, dated October 2025, indicated atorvastatin, escitalopram, finasteride, furosemide, memantine, tamsulosin, and vitamin B-12 were scheduled for administration daily at 8:00 a.m.			

	1d. On 10/15/25 at 10:17 a.m., LPN 3 administered atorvastatin 10 mg, levothyroxine 25 mcg, hydrochlorothiazide (diuretic) 25 mg, losartan 25 mg, metoprolol (blood pressure medication) 25 mg, and nabumetone (nonsteroidal anti-inflammatory drug) 500 mg to Resident 224. At the same time, LPN 3 indicated Resident 224 had severe dementia and would not take the levothyroxine early in the morning, so it was administered with the other morning medications. Resident 224's record was reviewed on 10/15/25 at 11:12 a.m. The record lacked documentation the physician was notified the levothyroxine was administered with the rest of the resident's morning medications, instead of before breakfast. A MAR, dated October 2025, indicated the levothyroxine was scheduled for administration daily at 6:00 a.m. The atorvastatin, hydrochlorothiazide, losartan, metoprolol, and nabumetone were scheduled for administration daily at 8:00 a.m. 1e. On 10/15/25 at 10:26 a.m., LPN 3 administered aspirin (blood thinner) 81 mg, calcium (supplement) 600 mg, desvenlafaxine extended release (ER) (antidepressant)			

	50 mg, fish oil (supplement) 1,200 mg, lisinopril (blood pressure medication) 20 mg, omeprazole (treats excess stomach acid) 20 mg, potassium chloride ER (supplement) 10 milliequivalent (mEq), vitamin D3 2,000 u, and evening primrose oil supplement 1 tablet to Resident 223. Resident 223's record was reviewed on 10/15/25 at 11:30 a.m. A MAR, dated October 2025, indicated aspirin 81 mg, calcium 600 mg, desvenlafaxine ER 50 mg, fish oil 1,200 mg, lisinopril 20 mg, omeprazole 20 mg, potassium chloride ER 10 mEq, vitamin D3 2,000 u, and evening primrose oil supplement 1 tablet were scheduled for administration daily at 8:00 a.m. During an interview, on 10/15/25 at 11:45 a.m., LPN 3 indicated morning medications were able to be passed from 7:00 a.m. to 11:59 a.m. There were some issues with the medication times in the computer because they were generated from the pharmacy. She was not sure why they were scheduled on the MAR the way that they were, but she thought she had a window of time to pass the morning medications. On 10/15/25 at 1:41 p.m., the Float Executive Director (ED) provided a document titled, "Medication Services," dated			

	6/10/24, and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy: The Community provides medication ordering and medication assistance/administration services. Procedure...12. Medications may be given up to one (1) hour before and up to one (1) hour after the prescribed time to accommodate the resident's schedule unless otherwise indicated by the resident's physician...."			
R 0245	Health Services - Offense 410 IAC 16.2-5-4(e)(5) (5) Injectable medications shall be given only by licensed personnel. Based on interview and record review, the facility failed to ensure only licensed nurses or appropriately certified Qualified Medication Aides (QMAs) administered insulin for 1 of 1 residents reviewed for insulin (Resident B). Findings include:	R 0245	**R245 Health Services** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.***	12/01/2025

	During an interview, on 10/15/25 at 3:41 p.m., Resident B's family member indicated they witnessed Qualified Medication Aide (QMA) 7 administer insulin to Resident B, and they did not think QMA 7 was supposed to administer insulin. Resident B's record was reviewed on 10/15/25 at 10:00 a.m. A Medication Administration Record (MAR), dated October 2025, indicated Lantus (long-acting insulin) 100 units (u)/milliliters (ml), inject 20 u subcutaneously (SQ) (fatty layer underneath skin) at bedtime. The MAR indicated QMA 7 signed off the medication as administered on 10/1/25, 10/2/25, 10/6/25, 10/7/25, and 10/14/25. A MAR, dated October 2025, indicated Novolin (fast-acting insulin) R 100 u/ml, inject six u SQ three times daily. The MAR indicated QMA 7 signed off the medication as administered twice on 10/1/25, and once on 10/2/25, 10/6/25, 10/7/25, 10/9/25, and 10/14/25. License information indicated QMA 7 was certified as a QMA, with an expiration of 12/13/26. The license information lacked documentation QMA 7 was a certified insulin administrator. During an interview, on 10/16/25 at 9:58 a.m., Licensed Practical		***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.*** ***The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** ***1)Immediate actions taken for those residents identified:*** ED immediately reviewed all future schedules to ensure insulin certified staff present to administer insulin when scheduled. ***2)How the facility identified other residents:*** All insulin dependent residents have the ability to be affected. **3)Measures put into place/ System changes:** At least 1 insulin certified QMA/nurse to be on staff at times when insulin	

	Nurse (LPN) 3 indicated when the Director of Health and Wellness (DHW) was still employed at the facility, QMA 7 was completing clinical hours to become an insulin administrator. QMA 7 was allowed to administer insulin, under the supervision of the DHW, for the completion of her clinical hours during that time. The DHW's last day of employment was around 9/28/25, so QMA 7 should not have administered insulin in October. There were some other QMAs at the facility who were certified insulin administrators. Either the certified QMAs, or a licensed nurse, came into the facility to administer insulin when QMA 7 worked. LPN 3 indicated she did not think QMA 7 administered insulin in October, but maybe another staff member administered it and QMA 7 signed it off on the MAR. LPN 3 indicated if she came in to give insulin she always signed it off herself on the MAR. If someone else gave the insulin and QMA 7 signed it off, it should have been documented somewhere who actually administered the medication. On 10/15/25 at 1:41 p.m., the Float ED provided a document titled, "Qualified Medication Aides (QMAs)," dated 6/10/24, and indicated it was the policy currently being used by the facility. The policy indicated,		is scheduled for administration. **4)How the corrective actions will be monitored:** ED/Designee will be responsible for this plan of correction and will audit schedules weekly indefinitely to ensure compliance. **5)Date of compliance:12/1/25**	

	"...Policy: Medications are administered by licensed personnel or QMAs per state regulations...Procedure...3. The administration of medications and the provision of residential nursing care shall be as ordered by the resident's physician and shall be supervised by a licensed nurse on the premises or on call as follows...iii. Administer regularly prescribed medication which the QMA has been trained to administer only after personally preparing (setting up) the medication to be administered. 1. The QMA shall document in a resident's clinical record all medications that the QMA personally administered. 2. The QMA shall not document in a resident's clinical record any medication that was administered by another person or not administered at all...." On 10/16/25 at 11:54 a.m., the Float ED provided a document titled, "Administering and Assisting with Injections," dated 6/10/24, and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy: [Corporation Name] allows injectable medications to be self-administered by the resident or an appropriately licensed healthcare professional. Procedure: 1. Injectable medications will only be self-administered by the resident or by a licensed medical professional in			

accordance with their licensure...."

This citation is related to Intake IN00465461.

Based on interview and record review, the facility failed to ensure only licensed nurses or appropriately certified Qualified Medication Aides (QMAs) administered insulin for 1 of 1 residents reviewed for insulin (Resident B).

Findings include:

During an interview, on 10/15/25 at 3:41 p.m., Resident B's family member indicated they witnessed Qualified Medication Aide (QMA) 7 administer insulin to Resident B, and they did not think QMA 7 was supposed to administer insulin.

Resident B's record was reviewed on 10/15/25 at 10:00 a.m. A Medication Administration Record (MAR), dated October 2025, indicated Lantus (long-acting insulin) 100 units (u)/milliliters (ml), inject 20 u subcutaneously (SQ) (fatty layer underneath skin) at bedtime. The MAR indicated QMA 7 signed off the medication as administered on 10/1/25, 10/2/25, 10/6/25, 10/7/25, and 10/14/25.

A MAR, dated October 2025, indicated Novolin (fast-acting insulin) R 100 u/ml, inject six u

	SQ three times daily. The MAR indicated QMA 7 signed off the medication as administered twice on 10/1/25, and once on 10/2/25, 10/6/25, 10/7/25, 10/9/25, and 10/14/25. License information indicated QMA 7 was certified as a QMA, with an expiration of 12/13/26. The license information lacked documentation QMA 7 was a certified insulin administrator. During an interview, on 10/16/25 at 9:58 a.m., Licensed Practical Nurse (LPN) 3 indicated when the Director of Health and Wellness (DHW) was still employed at the facility, QMA 7 was completing clinical hours to become an insulin administrator. QMA 7 was allowed to administer insulin, under the supervision of the DHW, for the completion of her clinical hours during that time. The DHW's last day of employment was around 9/28/25, so QMA 7 should not have administered insulin in October. There were some other QMAs at the facility who were certified insulin administrators. Either the certified QMAs, or a licensed nurse, came into the facility to administer insulin when QMA 7 worked. LPN 3 indicated she did not think QMA 7 administered insulin in October, but maybe another staff member administered it and QMA 7 signed it off on the MAR. LPN 3			

	indicated if she came in to give insulin she always signed it off herself on the MAR. If someone else gave the insulin and QMA 7 signed it off, it should have been documented somewhere who actually administered the medication. On 10/15/25 at 1:41 p.m., the Float ED provided a document titled, "Qualified Medication Aides (QMAs)," dated 6/10/24, and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy: Medications are administered by licensed personnel or QMAs per state regulations...Procedure...3. The administration of medications and the provision of residential nursing care shall be as ordered by the resident's physician and shall be supervised by a licensed nurse on the premises or on call as follows...iii. Administer regularly prescribed medication which the QMA has been trained to administer only after personally preparing (setting up) the medication to be administered. 1. The QMA shall document in a resident's clinical record all medications that the QMA personally administered. 2. The QMA shall not document in a resident's clinical record any medication that was administered by another person or not administered at all...." On 10/16/25 at 11:54 a.m., the			

	Float ED provided a document titled, "Administering and Assisting with Injections," dated 6/10/24, and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy: [Corporation Name] allows injectable medications to be self-administered by the resident or an appropriately licensed healthcare professional. Procedure: 1. Injectable medications will only be self-administered by the resident or by a licensed medical professional in accordance with their licensure...." This citation is related to Intake IN00465461.			
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. Based on interview and record review, the facility failed to	R 0246	**R246 Health Services** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of***	12/01/2025

	ensure Qualified Medication Aides (QMAs) obtained approval from a licensed nurse prior to the administration of as needed (PRN) medications. Findings include: During an interview, on 10/15/25 at 11:45 a.m., Licensed Practical Nurse (LPN) 3 indicated if Qualified Medication Aides (QMAs) needed to administer as needed (PRN) medications they documented the administration in the narcotic book with the reason the medication was administered. QMAs did not call the nurse to obtain approval to administer PRN medications that she was aware of. QMAs used to call the Director of Health and Wellness (DHW), but the DHW had not worked at the facility since the end of September 2025. A review of the facility's narcotic books included a notice on the cover which indicated, "Please check with DHW/DON [Director of Nursing] or the nurse on duty...before giving PRN narcotics-must get approval before administering...." The notice did not indicate approval was required for PRN medications other than narcotics. The narcotic books included a QMA log of nurse notification document for July, August,		***deficiencies.*** ***The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** ***1)Immediate actions taken for those residents identified:*** QMA PRN admnistration log immediately put in place to track to PRN's given by QMA's along with symptoms and nurse reported to along with signature line for nurse to sign prior to end of shift or after her on call tour of duty on her next shift in facility. ***2)How the facility identified other residents:*** All residents who receive PRN medications by the facility have the potential to be affected. **3)Measures put into place/ System changes:** QMA PRN administration log initiated.	

	September, and October 2025. The logs included the date, time of notification, name of resident, name of QMA initiating PRN, licensed nurse or physician consulted, and comments which included the medication administered. In July 2025, 67 PRN medications were administered by QMAs, and 47 administrations included documentation of the nurse consultation. The remaining 20 administrations lacked documentation a licensed nurse was consulted prior to the administration of the PRN medication. A QMA log of nurse notification document, dated August 2025, indicated 127 PRN medications were administered by QMAs. The PRN administrations lacked documentation a nurse was consulted prior to administration of the PRN medications. A QMA log of nurse notification document, dated September 2025, indicated 79 PRN medications were administered by QMAs. The PRN administrations lacked documentation a nurse was consulted prior to administration of the PRN medications. A QMA log of nurse notification document, dated October 2025, indicated 6 PRN medications were administered by QMAs. The PRN administrations lacked		All QMAs educated on use of log and obtaining consent prior to administering a PRN. **4)How the corrective actions will be monitored:** DHW/Designee will be responsible for this plan of correction and will audit PRN's 5x week x6 weeks, then 3x week x3 weeks, then weekly indefinitely to ensure compliance **5)Date of compliance:12/1/25**	

	documentation a nurse was consulted prior to administration of the PRN medications. During an interview, on 10/15/25 at 11:56 a.m., QMA 7 indicated when the DHW worked at the facility previously, she told the QMAs they should administer PRN medications if they felt it was necessary because a lot of residents took the same PRN medications all the time. The QMAs were told to document the PRN medications on the log in the narcotic books, and the nurse would review what was administered when they arrived at the facility. Since the DHW no longer worked at the facility, there was no nurse available to notify about PRN medication administrations, so she did not call anyone prior to administering PRNs. During an interview, on 10/15/25 at 12:19 p.m., the Float Executive Director (ED) indicated QMAs should have contacted a nurse prior to PRN medication administrations. The DHW was usually contacted, but if there was no DHW the corporate support nurse should have been contacted. On 10/15/25 at 1:41 p.m., the Float ED provided a document titled, "Qualified Medication Aides (QMAs)," dated 6/10/24, and indicated it was the policy currently being used by the			

	facility. The policy indicated, "...Policy: Medications are administered by licensed nursing personnel or QMAs per state regulations...Procedure...2. QMAs must work under the direct supervision of a registered nurse (RN) or licensed practical nurse (LPN). a. QMAs will only perform procedures defined within the QMA scope of practice...f. PRN medications can be administered by a QMA only upon authorization by a licensed nurse or physician. i. The QMA must receive appropriate authorization for each administration of a PRN mediation. ii. 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...." Based on interview and record review, the facility failed to ensure Qualified Medication Aides (QMAs) obtained approval from a licensed nurse prior to the administration of as needed (PRN) medications. Findings include: During an interview, on 10/15/25 at 11:45 a.m., Licensed Practical Nurse (LPN) 3 indicated if Qualified Medication Aides (QMAs) needed to			

	administer as needed (PRN) medications they documented the administration in the narcotic book with the reason the medication was administered. QMAs did not call the nurse to obtain approval to administer PRN medications that she was aware of. QMAs used to call the Director of Health and Wellness (DHW), but the DHW had not worked at the facility since the end of September 2025. A review of the facility's narcotic books included a notice on the cover which indicated, "Please check with DHW/DON [Director of Nursing] or the nurse on duty...before giving PRN narcotics-must get approval before administering...." The notice did not indicate approval was required for PRN medications other than narcotics. The narcotic books included a QMA log of nurse notification document for July, August, September, and October 2025. The logs included the date, time of notification, name of resident, name of QMA initiating PRN, licensed nurse or physician consulted, and comments which included the medication administered. In July 2025, 67 PRN medications were administered by QMAs, and 47 administrations included documentation of the nurse consultation. The remaining 20			

	administrations lacked documentation a licensed nurse was consulted prior to the administration of the PRN medication. A QMA log of nurse notification document, dated August 2025, indicated 127 PRN medications were administered by QMAs. The PRN administrations lacked documentation a nurse was consulted prior to administration of the PRN medications. A QMA log of nurse notification document, dated September 2025, indicated 79 PRN medications were administered by QMAs. The PRN administrations lacked documentation a nurse was consulted prior to administration of the PRN medications. A QMA log of nurse notification document, dated October 2025, indicated 6 PRN medications were administered by QMAs. The PRN administrations lacked documentation a nurse was consulted prior to administration of the PRN medications. During an interview, on 10/15/25 at 11:56 a.m., QMA 7 indicated when the DHW worked at the facility previously, she told the QMAs they should administer PRN medications if they felt it was necessary because a lot of residents took the same PRN medications all the time. The			

	QMAs were told to document the PRN medications on the log in the narcotic books, and the nurse would review what was administered when they arrived at the facility. Since the DHW no longer worked at the facility, there was no nurse available to notify about PRN medication administrations, so she did not call anyone prior to administering PRNs. During an interview, on 10/15/25 at 12:19 p.m., the Float Executive Director (ED) indicated QMAs should have contacted a nurse prior to PRN medication administrations. The DHW was usually contacted, but if there was no DHW the corporate support nurse should have been contacted. On 10/15/25 at 1:41 p.m., the Float ED provided a document titled, "Qualified Medication Aides (QMAs)," dated 6/10/24, and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy: Medications are administered by licensed nursing personnel or QMAs per state regulations...Procedure...2. QMAs must work under the direct supervision of a registered nurse (RN) or licensed practical nurse (LPN). a. QMAs will only perform procedures defined within the QMA scope of practice...f. PRN			

	medications can be administered by a QMA only upon authorization by a licensed nurse or physician. i. The QMA must receive appropriate authorization for each administration of a PRN mediation. ii. 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...."			
R 0273	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(f) (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to ensure food was labeled properly and they failed to dispose of expired foods properly during 1 of 3 kitchen observations. The facility further failed to ensure beard restraints were worn in the kitchen during 2 of 3 kitchen observations. This deficient practice had the potential to affect 55 out of 55 residents who ate out of the kitchen.	R 0273	**R273 Food and Nutritional Services** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.***	12/01/2025

	Findings include: 1. During the initial tour of the kitchen, on 10/14/25 at 10:38 a.m., Cook 5 was present in the kitchen and not wearing a beard restraint at this time. Cook 5 indicated the dietary manager was not currently in the facility but was on her way. Initial tour was initiated with Cook 5, and the following was observed in the refrigerator: a. A used container of cottage cheese with no open date. Cook 5 indicated food should be labeled when in the refrigerator. b. A used container of vanilla yogurt with no open date. c. A Ziploc bag with pepperoni slices and had a date of 6/20 on the bag. Cook 5 was unaware of when the pepperoni was placed in the refrigerator and how old it was. d. A secondary container of shredded cheese with an open date of 9/28. e. A small bowl covered with foil and contained no open date or a label that identified what the food item was. Cook 5 indicated it was a side salad and should have a label on it. f. 4 side salads with plastic warp covering the bowls, there was no prepared date on the salads. Cook 5 removed the salads		***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.*** ***The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** ***1)Immediate actions taken for those residents identified:*** ED and kitchen manager audited all food storage to ensure proper labeling and dating. Beard Covers provided for all staff with facial hair ***2)How the facility identified other residents:*** All residents have the potential to be affected. None noted **3)Measures put into place/ System changes:**	

	from the refrigerator to discard, and he was noted to not have on a beard restraint. g. A prepared side salad with a date of 10/10. h. 3 plastic serving bowls with fruit and had no prepared dates on them. i. A pitcher of tomato juice with no prepared date on the pitcher. j. A secondary container of bell peppers with a prepared date of 10/7. k. A secondary container of applesauce with a prepared date of 10/3. l. A secondary container of prepared chopped onions with a date of 10/10. m. A secondary container of prepared lettuce with a date of 10/10. n. A secondary container of peaches with a prepared date of 9/28. o. A secondary container of pineapple with a prepared date of 9/28. Upon finishing the initial tour, the dietary manager arrived at the facility. During an interview with the dietary manager, on 10/14/25 at 11:00 a.m., she indicated food should be labeled		Education provided to all staff about labeling/dating food stores and head/facial hair covering while in kitchen or serving food. **4)How the corrective actions will be monitored:** ED/Kitchen Manager will be responsible for this plan of correction and will audit food storage and proper hair covering 5 days a week for 6 weeks, then 3 days a week for 3 weeks, then weekly indefinitely to ensure compliance **5)Date of compliance:12/1/25**	

	in the refrigerator with an open date or prepared by date. She was not sure how long prepared food was good for, but thought it was around 5 days. She was new to being the dietary manager and was active in classes learning all the regulations. 2. During a second kitchen observation, on 10/14/25 at 11:53 a.m. Cook 5 was cooking chicken on the grill, he was noted not to be wearing a bread restraint while cooking the chicken. During an interview, on 10/14/25 at 11:55 a.m., the Dietary Manager indicated she was not aware that the cook should be wearing a beard restraint while he was in the kitchen. She further indicated she had not gotten any guidance from the former administrator on that. She would have to order some beard restraints for Cook 5 and it would take a few days; in the meantime, he would have to wear a hair net as a beard restraint. During an interview, on 10/14/25 at 11:57 a.m., Cook 5 indicated he was not aware that he needed to wear the beard restraint while in the kitchen, no one had ever mentioned it to him before. During an interview, on 10/15/25			

	at 9:45 a.m., the float Executive Director indicated staff should wear beard restraints when in the kitchen. On 10/14/25 at 11:37 a.m., the Dietary Manager provided an undated document, titled, "Food Storage Guidelines," and indicated it was the current policy being used by the facility. The policy indicated, " ...All food items must be labeled using food storage labels ...Prepared food items must be labeled with common name, prepared date and use by date ...3 days from preparation for prepared foods. Preparation day counts as Day 1 ...7 days from opening canned items like pudding, fruits, and vegetables ...Left over foods that cannot be frozen must be discarded after 3 days from the refrigerator if not used ...." On 10/15/25 at 12:18 p.m., the float Executive Director provided a document, dated 4/17/17, titled, "Infection Control and DNH (dining, nutrition, hospitality) Dress Code," and indicated it was the currently policy being used by the facility. The policy indicated, " ... DNH employees with facial hair must wear beard/mustache restraints ...." Based on observation, interview, and record review, the facility failed to ensure food was labeled properly and they failed			

	to dispose of expired foods properly during 1 of 3 kitchen observations. The facility further failed to ensure beard restraints were worn in the kitchen during 2 of 3 kitchen observations. This deficient practice had the potential to affect 55 out of 55 residents who ate out of the kitchen. Findings include: 1. During the initial tour of the kitchen, on 10/14/25 at 10:38 a.m., Cook 5 was present in the kitchen and not wearing a beard restraint at this time. Cook 5 indicated the dietary manager was not currently in the facility but was on her way. Initial tour was initiated with Cook 5, and the following was observed in the refrigerator: a. A used container of cottage cheese with no open date. Cook 5 indicated food should be labeled when in the refrigerator. b. A used container of vanilla yogurt with no open date. c. A Ziploc bag with pepperoni slices and had a date of 6/20 on the bag. Cook 5 was unaware of when the pepperoni was placed in the refrigerator and how old it was. d. A secondary container of shredded cheese with an open date of 9/28.			

	e. A small bowl covered with foil and contained no open date or a label that identified what the food item was. Cook 5 indicated it was a side salad and should have a label on it. f. 4 side salads with plastic warp covering the bowls, there was no prepared date on the salads. Cook 5 removed the salads from the refrigerator to discard, and he was noted to not have on a beard restraint. g. A prepared side salad with a date of 10/10. h. 3 plastic serving bowls with fruit and had no prepared dates on them. i. A pitcher of tomato juice with no prepared date on the pitcher. j. A secondary container of bell peppers with a prepared date of 10/7. k. A secondary container of applesauce with a prepared date of 10/3. l. A secondary container of prepared chopped onions with a date of 10/10. m. A secondary container of prepared lettuce with a date of 10/10.			

	n. A secondary container of peaches with a prepared date of 9/28. o. A secondary container of pineapple with a prepared date of 9/28. Upon finishing the initial tour, the dietary manager arrived at the facility. During an interview with the dietary manager, on 10/14/25 at 11:00 a.m., she indicated food should be labeled in the refrigerator with an open date or prepared by date. She was not sure how long prepared food was good for, but thought it was around 5 days. She was new to being the dietary manager and was active in classes learning all the regulations. 2. During a second kitchen observation, on 10/14/25 at 11:53 a.m. Cook 5 was cooking chicken on the grill, he was noted not to be wearing a bread restraint while cooking the chicken. During an interview, on 10/14/25 at 11:55 a.m., the Dietary Manager indicated she was not aware that the cook should be wearing a beard restraint while he was in the kitchen. She further indicated she had not gotten any guidance from the former administrator on that. She would have to order some beard restraints for Cook 5 and			

	it would take a few days; in the meantime, he would have to wear a hair net as a beard restraint. During an interview, on 10/14/25 at 11:57 a.m., Cook 5 indicated he was not aware that he needed to wear the beard restraint while in the kitchen, no one had ever mentioned it to him before. During an interview, on 10/15/25 at 9:45 a.m., the float Executive Director indicated staff should wear beard restraints when in the kitchen. On 10/14/25 at 11:37 a.m., the Dietary Manager provided an undated document, titled, "Food Storage Guidelines," and indicated it was the current policy being used by the facility. The policy indicated, " ...All food items must be labeled using food storage labels ...Prepared food items must be labeled with common name, prepared date and use by date ...3 days from preparation for prepared foods. Preparation day counts as Day 1 ...7 days from opening canned items like pudding, fruits, and vegetables ...Left over foods that cannot be frozen must be discarded after 3 days from the refrigerator if not used ...." On 10/15/25 at 12:18 p.m., the float Executive Director provided a document, dated 4/17/17,			

	titled, "Infection Control and DNH (dining, nutrition, hospitality) Dress Code," and indicated it was the currently policy being used by the facility. The policy indicated, " ... DNH employees with facial hair must wear beard/mustache restraints ...."			
R 0300	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(4) (4) Over-the-counter medications, prescription drugs, and biologicals used in the facility must be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date. Based on observation, interview, and record review, the facility failed to ensure expired insulin was removed from the medication room for 1 of 1 medication rooms reviewed (Resident B). Findings include: On 10/15/25 at 11:30 a.m., the medication room was observed with Qualified Medication Aide (QMA) 7. An unopened vial of Novolin R (rapid-acting insulin) for Resident B was observed in the refrigerator. The label indicated the vial was dispensed	R 0300	**R300 Pharmaceutical Services** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.*** ***The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** ***1)Immediate actions taken for those residents identified:***	12/01/2025

	from the pharmacy on 9/27/24 and should have been discarded by 9/27/25. At the same time, QMA 7 indicated the insulin should have been discarded before 9/27/25 and should not have remained in the facility. QMA 7 indicated she usually went through the medication room weekly and removed items if needed and a pharmacy representative completed audits periodically and also removed items when needed. The vial must have been missed. Resident B's record was reviewed on 10/15/25 at 10:00 a.m. A Medication Administration Record (MAR), dated October 2025, indicated Novolin R 100 units (u)/milliliter (ml), inject six u subcutaneously three times daily.		Medication audit complete by LPN to ensure no expired medications were in facility. ***2)How the facility identified other residents:*** All residents have the potential to be affected. **3)Measures put into place/ System changes:** Audit log created to audit medications in facility for labeling and expiration dates. **4)How the corrective actions will be monitored:** DHW/designee will be responsible for this plan of correction. DHW/Designee will audit medications in facility weekly x6 weeks. Then bi-weekly x6 weeks, then monthly indefinitely to ensure all medications are properly labeled and that	

	On 10/15/25 at 1:41 p.m., the Float Executive Director (ED) provided a document titled, "Medication Storage-Centrally Stored Medications," dated 6/10/24, and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy: Medications will be stored in a manner that ensures the maintenance of the medication's integrity and safety of all residents residing in the Community. Procedure...3. All medications must be stored in accordance with the label instructions...." Based on observation, interview, and record review, the facility failed to ensure expired insulin was removed from the medication room for 1 of 1 medication rooms reviewed (Resident B). Findings include: On 10/15/25 at 11:30 a.m., the medication room was observed with Qualified Medication Aide (QMA) 7. An unopened vial of Novolin R (rapid-acting insulin) for Resident B was observed in the refrigerator. The label indicated the vial was dispensed from the pharmacy on 9/27/24 and should have been discarded by 9/27/25. At the same time, QMA 7 indicated the insulin should have been discarded before 9/27/25 and should not have remained in the		expired medications are not available for administration. **5)Date of compliance:12/1/25**	

	facility. QMA 7 indicated she usually went through the medication room weekly and removed items if needed and a pharmacy representative completed audits periodically and also removed items when needed. The vial must have been missed. Resident B's record was reviewed on 10/15/25 at 10:00 a.m. A Medication Administration Record (MAR), dated October 2025, indicated Novolin R 100 units (u)/milliliter (ml), inject six u subcutaneously three times daily. On 10/15/25 at 1:41 p.m., the Float Executive Director (ED) provided a document titled, "Medication Storage-Centrally Stored Medications," dated 6/10/24, and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy: Medications will be stored in a manner that ensures the maintenance of the medication's integrity and safety of all residents residing in the Community. Procedure...3. All medications must be stored in accordance with the label instructions...."			
R 0406	Infection Control - Offense 410 IAC 16.2-5-12(a) (a) The facility must establish and maintain an infection control	R 0406	**R407 Infection Control**	12/01/2025

	practice designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of diseases and infection. Based on observation, record review, and interview, the facility failed to ensure vital sign equipment was cleaned between uses for 2 of 2 blood pressure observations (Resident 222 and 223). Findings include: 1. On 10/15/25 at 10:05 a.m., Licensed Practical Nurse (LPN) 3 used a wrist blood pressure cuff and obtained Resident 222's blood pressure. The wrist cuff was not cleaned before or after use and was placed back on the medication cart after use. Resident 222's record was reviewed on 10/15/25 at 11:00 a.m. A Medication Administration Record (MAR), dated October 2025 indicated the resident's blood pressure was checked related to the administration of amlodipine (blood pressure medication), carvedilol (blood pressure medication), and torsemide (diuretic). 2. On 10/15/25 at 10:26 a.m., Licensed Practical Nurse (LPN) 3 used the same wrist blood pressure cuff used on Resident 222 and checked Resident		**The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.*** ***The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** ***1)Immediate actions taken for those residents identified:*** All equipment immediately cleaned and staff educated on cleaning reusable equipment between residents. ***2)How the facility identified other residents:*** All residents have the potential to be affected.	

	223's blood pressure. The wrist cuff was not cleaned before or after use and was placed back on the medication cart after use. Resident 223's record was reviewed on 10/15/25 at 11:30 a.m. A Medication Administration Record (MAR), dated October 2025, included a physician's order to check the resident's blood pressure weekly. During an interview, on 10/15/25 at 11:45 a.m., LPN 3 indicated the wrist cuff was hard to clean because it was cloth. The facility had other vital sign equipment available, but it was difficult to use. On 10/15/25 at 1:41 p.m., the Float Executive Director (ED) provided a document titled, "Disposal and Disinfection of Care Equipment," dated 6/10/24, and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy: Procedures are followed to ensure proper handling of disposable and reusable care equipment...Procedure: 1. All medical equipment used by care staff is either disposable (one-time use) or requires proper disinfection prior to next use...." Based on observation, record review, and interview, the facility		**3)Measures put into place/ System changes:** All staff educated on sanitizing equipment in between resident contact. **4)How the corrective actions will be monitored:** ED/DHW will randomly audit 5 care acts involving re-usable equipment to ensure proper santiation after use weekly x6 weeks then bi-weekly x3 weeks, then monthly indefinitely. **5)Date of compliance:12/1/25**	

failed to ensure vital sign equipment was cleaned between uses for 2 of 2 blood pressure observations (Resident 222 and 223).

Findings include:

1. On 10/15/25 at 10:05 a.m., Licensed Practical Nurse (LPN) 3 used a wrist blood pressure cuff and obtained Resident 222's blood pressure. The wrist cuff was not cleaned before or after use and was placed back on the medication cart after use.

Resident 222's record was reviewed on 10/15/25 at 11:00 a.m. A Medication Administration Record (MAR), dated October 2025 indicated the resident's blood pressure was checked related to the administration of amlodipine (blood pressure medication), carvedilol (blood pressure medication), and torsemide (diuretic).

2. On 10/15/25 at 10:26 a.m., Licensed Practical Nurse (LPN) 3 used the same wrist blood pressure cuff used on Resident 222 and checked Resident 223's blood pressure. The wrist cuff was not cleaned before or after use and was placed back on the medication cart after use.

Resident 223's record was reviewed on 10/15/25 at 11:30 a.m. A Medication Administration Record (MAR),

	dated October 2025, included a physician's order to check the resident's blood pressure weekly. During an interview, on 10/15/25 at 11:45 a.m., LPN 3 indicated the wrist cuff was hard to clean because it was cloth. The facility had other vital sign equipment available, but it was difficult to use. On 10/15/25 at 1:41 p.m., the Float Executive Director (ED) provided a document titled, "Disposal and Disinfection of Care Equipment," dated 6/10/24, and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy: Procedures are followed to ensure proper handling of disposable and reusable care equipment...Procedure: 1. All medical equipment used by care staff is either disposable (one-time use) or requires proper disinfection prior to next use...."			
R 0407	Infection Control - Noncompliance 410 IAC 16.2-5-12(b)(1-4) (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms.	R 0407	**R407 Infection Control** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible***	12/01/2025

	(2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on record review and interview, the facility failed to ensure information for the influenza vaccine was provided to 1 of 3 residents reviewed for infection control (Resident B). Findings include: Resident B's record was reviewed on 10/15/25 at 10:00 a.m. The record lacked documentation the resident was offered, provided, or refused an influenza vaccine in 2024. The resident's record lacked documentation the resident, or the resident's representative, was provided information or education regarding the influenza vaccine for the 2024 influenza season. During an interview, on 10/16/25 at 9:58 a.m., Licensed Practical Nurse (LPN) 3 indicated she was not employed at the facility during the 2024 influenza season so she was not sure if		***allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.*** ***The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** ***1)Immediate actions taken for those residents identified:*** All resident records audited to make sure they were offered/refused the flu vaccine for the 2025 flu season ***2)How the facility identified other residents:*** All residents have the potential to be affected. **3)Measures put into place/ System changes:** ED to audit during 2026 flu	

	there was information about Resident B's influenza vaccine information. During an interview, on 10/16/25 at 10:25 a.m., the Float Executive Director (ED) indicated she was unable to find documentation of Resident B's influenza vaccine information for the 2024 influenza season. Influenza vaccines should have been documented in the residents' record if they were accepted or refused. A third party came into the facility and administered vaccines. A consent or declination should have been signed for each resident to show they were provided information regarding the influenza vaccine. On 10/16/25 at 11:54 a.m., the Float ED provided a document titled, "Immunization of Residents," dated 6/10/24, and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy: All residents will receive vaccinations according to physician's orders. Procedure: 1. [Company name] should contract with an outside agency to provide influenza and other vaccines as needed. a. Residents will be encouraged to receive the following vaccines as ordered by their physician: i Annual influenza vaccine...b. Documentation of vaccine availability and resident refusal		season to ensure all residents are offered a flu vaccine **4)How the corrective actions will be monitored:** ED to audit all vaccines yearly **5)Date of compliance:12/1/25**	

on a yearly basis are retained in the resident's record...."

Based on record review and interview, the facility failed to ensure information for the influenza vaccine was provided to 1 of 3 residents reviewed for infection control (Resident B).

Findings include:

Resident B's record was reviewed on 10/15/25 at 10:00 a.m. The record lacked documentation the resident was offered, provided, or refused an influenza vaccine in 2024.

The resident's record lacked documentation the resident, or the resident's representative, was provided information or education regarding the influenza vaccine for the 2024 influenza season.

During an interview, on 10/16/25 at 9:58 a.m., Licensed Practical Nurse (LPN) 3 indicated she was not employed at the facility during the 2024 influenza season so she was not sure if there was information about Resident B's influenza vaccine information.

During an interview, on 10/16/25 at 10:25 a.m., the Float Executive Director (ED) indicated she was unable to find documentation of Resident B's influenza vaccine information for the 2024 influenza season.

	Influenza vaccines should have been documented in the residents' record if they were accepted or refused. A third party came into the facility and administered vaccines. A consent or declination should have been signed for each resident to show they were provided information regarding the influenza vaccine. On 10/16/25 at 11:54 a.m., the Float ED provided a document titled, "Immunization of Residents," dated 6/10/24, and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy: All residents will receive vaccinations according to physician's orders. Procedure: 1. [Company name] should contract with an outside agency to provide influenza and other vaccines as needed. a. Residents will be encouraged to receive the following vaccines as ordered by their physician: i Annual influenza vaccine...b. Documentation of vaccine availability and resident refusal on a yearly basis are retained in the resident's record...."			
R 0409	Infection Control - Noncompliance 410 IAC 16.2-5-12(d) (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or	R 0409	**R409 Infection Control** **The facility requests paper compliance for this citation.**	12/01/2025

	present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. 2. On 10/15/25 the clinical record of Resident 210 was reviewed. The resident entered the facility on 5/9/25. Admission diagnosis included but was not limited to Diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high) and Hypertension (High blood pressure). Review of the clinical record indicated the record lacked a health statement signed by the physician indicating the resident was free of communicable diseases including TB (Tuberculosis) (an infectious disease caused by bacteria called Mycobacterium tuberculosis. Based on record review and interview, the facility failed to ensure residents had an annual health statement up to date in their health record for 4 of 7 residents reviewed for an annual health statement (Residents 218, 214, 210, and B). Findings include: 1a. Resident 218's record was reviewed on 10/15/25 at 10:20		***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.*** ***The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** ***1)Immediate actions taken for those residents identified:*** Annual Health Statements immediately sent to providers for completion. ***2)How the facility identified other residents:*** All residents have the potential to be affected. **3)Measures put into place/ System changes:**	

	a.m. The profile indicated the resident diagnoses included, but were not limited to, hypertension (elevated blood pressure) and glaucoma (an eye condition that damages the optic nerve. This damage can lead to vision loss or blindness). Facility census information indicated Resident 218 moved into the facility on 11/17/24. Resident 218's record lacked documentation of an annual health statement from the physician indicating the resident was free of communicable diseases including TB (Tuberculosis) (an infectious disease caused by bacteria called Mycobacterium tuberculosis. It primarily affects the lungs but can also spread to other parts of the body). During an interview, on 10/15/25 at 12:24 p.m., the Unit Manager indicated she was unaware of where the annual health statements were kept from the physician for the residents. She indicated it was considered an ancillary service (support functions in healthcare that enable primary services and ensure reliability) order and should be in their health records. 1b. Resident 214's record was reviewed on 10/15/25 at 11:00 a.m. The profile indicated the		All resident records were immediately reviewed and any annual health statements needed were sent for completion. **4)How the corrective actions will be monitored:** DHW/Designee will develop tracking system for when annual health assessments are due and will update with all new admissions. ED to audit tracking system monthly to ensure compliance and that all new residents are present. **5)Date of compliance:12/1/25**	

	resident diagnoses included, but were not limited to, type 2 diabetes (a chronic condition characterized by high blood sugar levels), stroke (occurs when the blood flow to a particular area of the brain is blocked or cut off), and hyperlipidemia (elevated cholesterol levels). Facility census information indicated Resident 214 moved into the facility on 4/22/25. Resident 214's record lacked documentation of an annual health statement from the physician indicating the resident was free of communicable diseases including TB (Tuberculosis) (an infectious disease caused by bacteria called Mycobacterium tuberculosis. It primarily affects the lungs but can also spread to other parts of the body). During an interview, on 10/15/25 at 2:00 p.m., the float Executive Director indicated she was not aware of where the facility kept the annual health statements from the physicians for each resident, she was not able to locate them. She further indicated each resident should have an annual health statement in their health record. 3. Resident B's record was reviewed on 10/15/25 at 10:00 a.m. A review of the resident's			

	electronic and paper medical record lacked documentation of an annual health statement to indicate the resident showed no evidence of tuberculosis (chronic bacterial infection that primarily affects the lungs) in an infectious stage. During an interview, on 10/16/25 at 10:25 a.m., the Float Executive Director (ED) indicated there was no annual health statement on the resident's chart.			

	On 10/16/25 at 11:54 a.m., the Float ED provided a document titled, "Medical Assessment/Physician Report," dated 6/10/24, and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy: A medical assessment is obtained and evaluated prior to move-in and updated upon significant changes in condition. Procedure...3. The verification of absence of tuberculosis (TB) within the last six (6) months...State Regulation References...Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter...." 2. On 10/15/25 the clinical record of Resident 210 was reviewed. The resident entered the facility on 5/9/25. Admission diagnosis included but was not limited to Diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high) and Hypertension (High blood pressure). Review of the clinical record indicated the record lacked a			

	health statement signed by the physician indicating the resident was free of communicable diseases including TB (Tuberculosis) (an infectious disease caused by bacteria called Mycobacterium tuberculosis. Based on record review and interview, the facility failed to ensure residents had an annual health statement up to date in their health record for 4 of 7 residents reviewed for an annual health statement (Residents 218, 214, 210, and B). Findings include: 1a. Resident 218's record was reviewed on 10/15/25 at 10:20 a.m. The profile indicated the resident diagnoses included, but were not limited to, hypertension (elevated blood pressure) and glaucoma (an eye condition that damages the optic nerve. This damage can lead to vision loss or blindness). Facility census information indicated Resident 218 moved into the facility on 11/17/24. Resident 218's record lacked documentation of an annual health statement from the physician indicating the resident was free of communicable diseases including TB (Tuberculosis) (an infectious disease caused by bacteria			

	called Mycobacterium tuberculosis. It primarily affects the lungs but can also spread to other parts of the body). During an interview, on 10/15/25 at 12:24 p.m., the Unit Manager indicated she was unaware of where the annual health statements were kept from the physician for the residents. She indicated it was considered an ancillary service (support functions in healthcare that enable primary services and ensure reliability) order and should be in their health records. 1b. Resident 214's record was reviewed on 10/15/25 at 11:00 a.m. The profile indicated the resident diagnoses included, but were not limited to, type 2 diabetes (a chronic condition characterized by high blood sugar levels), stroke (occurs when the blood flow to a particular area of the brain is blocked or cut off), and hyperlipidemia (elevated cholesterol levels). Facility census information indicated Resident 214 moved into the facility on 4/22/25. Resident 214's record lacked documentation of an annual health statement from the physician indicating the resident was free of communicable diseases including TB			

	(Tuberculosis) (an infectious disease caused by bacteria called Mycobacterium tuberculosis. It primarily affects the lungs but can also spread to other parts of the body). During an interview, on 10/15/25 at 2:00 p.m., the float Executive Director indicated she was not aware of where the facility kept the annual health statements from the physicians for each resident, she was not able to locate them. She further indicated each resident should have an annual health statement in their health record. 3. Resident B's record was reviewed on 10/15/25 at 10:00 a.m. A review of the resident's electronic and paper medical record lacked documentation of an annual health statement to indicate the resident showed no evidence of tuberculosis (chronic bacterial infection that primarily affects the lungs) in an infectious stage. During an interview, on 10/16/25 at 10:25 a.m., the Float Executive Director (ED) indicated there was no annual health statement on the resident's chart. On 10/16/25 at 11:54 a.m., the Float ED provided a document titled, "Medical Assessment/Physician Report," dated 6/10/24, and indicated it			

	was the policy currently being used by the facility. The policy indicated, "...Policy: A medical assessment is obtained and evaluated prior to move-in and updated upon significant changes in condition. Procedure...3. The verification of absence of tuberculosis (TB) within the last six (6) months...State Regulation References...Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter...." 2. On 10/15/25 the clinical record of Resident 210 was reviewed. The resident entered the facility on 5/9/25. Admission diagnosis included but was not limited to Diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high) and Hypertension (High blood pressure). Review of the clinical record indicated the record lacked a health statement signed by the physician indicating the resident was free of communicable diseases including TB (Tuberculosis) (an infectious			

disease caused by bacteria called Mycobacterium tuberculosis.

Based on record review and interview, the facility failed to ensure residents had an annual health statement up to date in their health record for 4 of 7 residents reviewed for an annual health statement (Residents 218, 214, 210, and B).

Findings include:

1a. Resident 218's record was reviewed on 10/15/25 at 10:20 a.m. The profile indicated the resident diagnoses included, but were not limited to, hypertension (elevated blood pressure) and glaucoma (an eye condition that damages the optic nerve. This damage can lead to vision loss or blindness).

Facility census information indicated Resident 218 moved into the facility on 11/17/24.

Resident 218's record lacked documentation of an annual health statement from the physician indicating the resident was free of communicable diseases including TB (Tuberculosis) (an infectious disease caused by bacteria called Mycobacterium tuberculosis. It primarily affects the lungs but can also spread to other parts of the body).

	During an interview, on 10/15/25 at 12:24 p.m., the Unit Manager indicated she was unaware of where the annual health statements were kept from the physician for the residents. She indicated it was considered an ancillary service (support functions in healthcare that enable primary services and ensure reliability) order and should be in their health records. 1b. Resident 214's record was reviewed on 10/15/25 at 11:00 a.m. The profile indicated the resident diagnoses included, but were not limited to, type 2 diabetes (a chronic condition characterized by high blood sugar levels), stroke (occurs when the blood flow to a particular area of the brain is blocked or cut off), and hyperlipidemia (elevated cholesterol levels). Facility census information indicated Resident 214 moved into the facility on 4/22/25. Resident 214's record lacked documentation of an annual health statement from the physician indicating the resident was free of communicable diseases including TB (Tuberculosis) (an infectious disease caused by bacteria called Mycobacterium tuberculosis. It primarily affects the lungs but can also spread to			

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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 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 a resident received a two-step purified protein derivative (PPD) test (screening test for latent tuberculosis) at admission for 1 of 7 residents	R 0410	**R410 Infection Control** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.*** ***The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** ***1)Immediate actions taken for those residents identified:*** TB test immediately administered to residents identified. ***2)How the facility identified***	12/15/2025

reviewed for PPD tests (Resident 261).

Findings include:

Resident 261's record was reviewed on 10/16/25 at 11:40 a.m. Census information indicated the resident was admitted to the facility on 1/15/25.

The record lacked documentation the resident received a two-step PPD at admission.

During an interview, on 10/16/25 at 12:45 p.m., the Float Executive Director (ED) indicated Resident 261 had not received a two-step PPD upon admission to the facility. The two-step PPD should have been completed upon admission.

On 10/14/25 at 2:00 p.m., ED 2 provided a document titled, "Infection Control Communicable Diseases," dated 2/1/22, and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedure: The Community will: Perform a Health Questionnaire, or other TB [tuberculosis] Screening, or ensure the Resident obtains a Tuberculosis...test [or Chest Xray...if appropriate] and a statement from the Medical Provider that the Resident is free of TB/Communicable Disease prior to Move

other residents:

All residents have the potential to be affected.

Full audit completed of all residents and staff to ensure compliance

3)Measures put into place/ System changes:

Full audit completed for all residents/staff to ensure compliance

Nursing staff educated on TB during admission/hire process

4)How the corrective actions will be monitored:

DHW/Designee will develop tracking system for when TB assessments are due
and will update with all new admissions/hires.

ED to audit tracking system monthly to ensure compliance and that all new
residents are present.

	In...Ensure Employees, prior to placement, obtain a TB test...and complete a TB Risk Assessment and TB Screening...." Based on record review and interview, the facility failed to ensure a resident received a two-step purified protein derivative (PPD) test (screening test for latent tuberculosis) at admission for 1 of 7 residents reviewed for PPD tests (Resident 261). Findings include: Resident 261's record was reviewed on 10/16/25 at 11:40 a.m. Census information indicated the resident was admitted to the facility on 1/15/25. The record lacked documentation the resident received a two-step PPD at admission. During an interview, on 10/16/25 at 12:45 p.m., the Float Executive Director (ED) indicated Resident 261 had not received a two-step PPD upon admission to the facility. The two-step PPD should have been completed upon admission. On 10/14/25 at 2:00 p.m., ED 2 provided a document titled, "Infection Control Communicable Diseases," dated 2/1/22, and indicated it		ED/DHW to audit all new residents/hires weekly x5 weeks, then bi-weekly x3 weeks, then monthly indefinitely to ensure compliance. **5)Date of compliance:12/15/25**	

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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 SIGNATURESteffani Dranchak	TITLERN, RDRC	(X6) DATE11/15/2025