STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER PLACE	2216 N RILEY HWY, SHELBYVILLE, , 46176

(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. Survey Dates: October 2 and 3, 2025 Facility Number: 004444 Residential Census: 28 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-5. Quality review completed on October 7, 2025.	R 0000	.	
R 0297	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(c)(1) (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with	R 0297	**R297 Pharmaceutical services** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.***	10/21/2025

	prescribed medications in accordance with applicable laws of Indiana. Based on interview and record review, the facility failed to have medications available for 2 of 5 residents reviewed for medication compliance. (Resident 2 and Resident 6) Findings include: 1. The clinical record for Resident 2 was reviewed on 10/3/2025 at 11:50 a.m. The medical diagnoses included chronic kidney disease and falls. An individualized service plan, revised 8/8/2025, indicated staff assisted Resident 2 with medication administration. Physician orders were provided by the Director of Health and Wellness on 10/3/2025 at 1:04 p.m. The orders indicated to administer gabapentin and Eliquis twice a day to Resident 2. Review of the September 2025 medication administration record (MAR) for Resident 2 indicated two missed doses of gabapentin (a medication used for neuropathy) and Eliquis (a blood thinner) with the reason of medications not being available. During an interview on 10/3/2025 at 12:05 p.m., the Director of Health and Wellness		***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:*** Resident 2 and Resident 6 medication were verified for availability and pharmacy was notified to refill any missing medications.MD was notified as per policy. ***2)How the facility identified other residents:*** Any resident residing in the facility has the potential to be affected. Audit was completed by DSW/Designee to verify if any residents have any missing medication. None noted.	

	was unsure why these medications were not available. 2. The clinical record for Resident 6 was reviewed on 10/3/25 at 12:15 p.m. His diagnoses included, but were not limited to, gastroesophageal reflux disease and hypertension. The 9/16/25 Resident Assessment indicated he required assistance with medication administration up to three times per day with four or fewer medications and assistance for reordering medications. He did not use an outside pharmacy. The physician's order indicated he was to be administered one 10 milligram (mg) tablet of amlodipine at bedtime and one 20 mg tablet of omeprazole at bedtime. The September 2025 MAR indicated he was in the hospital through 9/5/25. The amlodipine was not administered on the following dates for the following reasons: 9/6/25 due to unavailability; 9/7/25 due to waiting on pharmacy delivery; and 9/9/25 due to unavailability. The omeprazole was not administered on the following dates for the following reasons: 9/6/25 due to unavailability; 9/7/25 due to waiting on pharmacy delivery; and 9/8/25 due to unavailability.		**3)Measures put into place/ System changes:** Inservice provided to all licensed nurses and QMA on policy on missed medication administration. DSW/Designee will review 3 residents 3 times weekly x 4 weeks, then 2 residents 2 times weekly x 4 weeks and then 1 resident 1 time weekly for 4 months for any missing medications and will inform pharmacy and MD immediately. **4)How the corrective actions will be monitored:** ED/Designee will be responsible for this plan of correction and Audit findings will be presented to the department head’s meeting once a month x 6 months. The results of these audits will be reviewed in Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months.	

	An interview was conducted with the Director of Health and Wellness on 10/3/25 at 12:21 p.m. She indicated that the amlodipine and omeprazole may not have come in from the pharmacy yet on the above days, after Resident 6 returned from the hospital. Their process was to fax over orders to the pharmacy upon return from the hospital. The pharmacy would then deliver the medications to the facility. She was unsure what happened with Resident 6's amlodipine and omeprazole, but he should have been administered both medications daily upon return from the hospital. The Missed or Refused Medications policy was provided by ED (Executive Director) 1 on 10/3/25 at 2:14 p.m. It indicated, "Steps will be taken to avoid missed or refused doses of medications and related adverse reactions." Based on interview and record review, the facility failed to have medications available for 2 of 5 residents reviewed for medication compliance. (Resident 2 and Resident 6) Findings include: 1. The clinical record for Resident 2 was reviewed on 10/3/2025 at 11:50 a.m. The medical diagnoses included		**5)Date of compliance: 10/21/25**	

chronic kidney disease and falls.

An individualized service plan, revised 8/8/2025, indicated staff assisted Resident 2 with medication administration.

Physician orders were provided by the Director of Health and Wellness on 10/3/2025 at 1:04 p.m. The orders indicated to administer gabapentin and Eliquis twice a day to Resident 2.

Review of the September 2025 medication administration record (MAR) for Resident 2 indicated two missed doses of gabapentin (a medication used for neuropathy) and Eliquis (a blood thinner) with the reason of medications not being available.

During an interview on 10/3/2025 at 12:05 p.m., the Director of Health and Wellness was unsure why these medications were not available.

2. The clinical record for Resident 6 was reviewed on 10/3/25 at 12:15 p.m. His diagnoses included, but were not limited to, gastroesophageal reflux disease and hypertension.

The 9/16/25 Resident Assessment indicated he required assistance with medication administration up to three times per day with four or fewer medications and assistance for reordering

	medications. He did not use an outside pharmacy. The physician's order indicated he was to be administered one 10 milligram (mg) tablet of amlodipine at bedtime and one 20 mg tablet of omeprazole at bedtime. The September 2025 MAR indicated he was in the hospital through 9/5/25. The amlodipine was not administered on the following dates for the following reasons: 9/6/25 due to unavailability; 9/7/25 due to waiting on pharmacy delivery; and 9/9/25 due to unavailability. The omeprazole was not administered on the following dates for the following reasons: 9/6/25 due to unavailability; 9/7/25 due to waiting on pharmacy delivery; and 9/8/25 due to unavailability. An interview was conducted with the Director of Health and Wellness on 10/3/25 at 12:21 p.m. She indicated that the amlodipine and omeprazole may not have come in from the pharmacy yet on the above days, after Resident 6 returned from the hospital. Their process was to fax over orders to the pharmacy upon return from the hospital. The pharmacy would then deliver the medications to the facility. She was unsure what happened with Resident 6's amlodipine and omeprazole,			

but he should have been administered both medications daily upon return from the hospital.

The Missed or Refused Medications policy was provided by ED (Executive Director) 1 on 10/3/25 at 2:14 p.m. It indicated, "Steps will be taken to avoid missed or refused doses of medications and related adverse reactions."

Based on interview and record review, the facility failed to have medications available for 2 of 5 residents reviewed for medication compliance. (Resident 2 and Resident 6)

Findings include:

1. The clinical record for Resident 2 was reviewed on 10/3/2025 at 11:50 a.m. The medical diagnoses included chronic kidney disease and falls.

An individualized service plan, revised 8/8/2025, indicated staff assisted Resident 2 with medication administration.

Physician orders were provided by the Director of Health and Wellness on 10/3/2025 at 1:04 p.m. The orders indicated to administer gabapentin and Eliquis twice a day to Resident 2.

Review of the September 2025 medication administration

record (MAR) for Resident 2 indicated two missed doses of gabapentin (a medication used for neuropathy) and Eliquis (a blood thinner) with the reason of medications not being available.

During an interview on 10/3/2025 at 12:05 p.m., the Director of Health and Wellness was unsure why these medications were not available.

2. The clinical record for Resident 6 was reviewed on 10/3/25 at 12:15 p.m. His diagnoses included, but were not limited to, gastroesophageal reflux disease and hypertension.

The 9/16/25 Resident Assessment indicated he required assistance with medication administration up to three times per day with four or fewer medications and assistance for reordering medications. He did not use an outside pharmacy.

The physician's order indicated he was to be administered one 10 milligram (mg) tablet of amlodipine at bedtime and one 20 mg tablet of omeprazole at bedtime.

The September 2025 MAR indicated he was in the hospital through 9/5/25. The amlodipine was not administered on the following dates for the following reasons: 9/6/25 due to unavailability; 9/7/25 due to

	waiting on pharmacy delivery; and 9/9/25 due to unavailability. The omeprazole was not administered on the following dates for the following reasons: 9/6/25 due to unavailability; 9/7/25 due to waiting on pharmacy delivery; and 9/8/25 due to unavailability. An interview was conducted with the Director of Health and Wellness on 10/3/25 at 12:21 p.m. She indicated that the amlodipine and omeprazole may not have come in from the pharmacy yet on the above days, after Resident 6 returned from the hospital. Their process was to fax over orders to the pharmacy upon return from the hospital. The pharmacy would then deliver the medications to the facility. She was unsure what happened with Resident 6's amlodipine and omeprazole, but he should have been administered both medications daily upon return from the hospital. The Missed or Refused Medications policy was provided by ED (Executive Director) 1 on 10/3/25 at 2:14 p.m. It indicated, "Steps will be taken to avoid missed or refused doses of medications and related adverse reactions." Based on interview and record review, the facility failed to have medications available for 2 of 5			

residents reviewed for medication compliance. (Resident 2 and Resident 6)

Findings include:

1. The clinical record for Resident 2 was reviewed on 10/3/2025 at 11:50 a.m. The medical diagnoses included chronic kidney disease and falls.

An individualized service plan, revised 8/8/2025, indicated staff assisted Resident 2 with medication administration.

Physician orders were provided by the Director of Health and Wellness on 10/3/2025 at 1:04 p.m. The orders indicated to administer gabapentin and Eliquis twice a day to Resident 2.

Review of the September 2025 medication administration record (MAR) for Resident 2 indicated two missed doses of gabapentin (a medication used for neuropathy) and Eliquis (a blood thinner) with the reason of medications not being available.

During an interview on 10/3/2025 at 12:05 p.m., the Director of Health and Wellness was unsure why these medications were not available.

2. The clinical record for Resident 6 was reviewed on 10/3/25 at 12:15 p.m. His diagnoses included, but were

	not limited to, gastroesophageal reflux disease and hypertension. The 9/16/25 Resident Assessment indicated he required assistance with medication administration up to three times per day with four or fewer medications and assistance for reordering medications. He did not use an outside pharmacy. The physician's order indicated he was to be administered one 10 milligram (mg) tablet of amlodipine at bedtime and one 20 mg tablet of omeprazole at bedtime. The September 2025 MAR indicated he was in the hospital through 9/5/25. The amlodipine was not administered on the following dates for the following reasons: 9/6/25 due to unavailability; 9/7/25 due to waiting on pharmacy delivery; and 9/9/25 due to unavailability. The omeprazole was not administered on the following dates for the following reasons: 9/6/25 due to unavailability; 9/7/25 due to waiting on pharmacy delivery; and 9/8/25 due to unavailability. An interview was conducted with the Director of Health and Wellness on 10/3/25 at 12:21 p.m. She indicated that the amlodipine and omeprazole may not have come in from the			

	pharmacy yet on the above days, after Resident 6 returned from the hospital. Their process was to fax over orders to the pharmacy upon return from the hospital. The pharmacy would then deliver the medications to the facility. She was unsure what happened with Resident 6's amlodipine and omeprazole, but he should have been administered both medications daily upon return from the hospital. The Missed or Refused Medications policy was provided by ED (Executive Director) 1 on 10/3/25 at 2:14 p.m. It indicated, "Steps will be taken to avoid missed or refused doses of medications and related adverse reactions."			

R 0349	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(a)(1-4) (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on interview and record review, the facility failed to accurately document the administration of medications for 2 of 5 residents reviewed for medication administration. (Resident 2 and Resident 4) Findings include: 1. The clinical record for Resident 2 was reviewed on 10/3/2025 at 11:50 a.m. The medical diagnoses included chronic kidney disease and falls. An individualized service plan, revised 8/8/2025, indicated staff assisted Resident 2 with medication administration. During an observation on 10/3/2025 at 12:30 p.m., Resident 2's medications were reviewed to be in pharmacy	R 0349	**R349 Clinical records** **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:*** Resident 2 and Resident 4 orders were reviewed by DSW/designee, and any duplicate orders were D/C and MD was notified. ***2)How the facility identified other residents:***	10/21/2025

	preset packages which contained exact dosing for each date and time administration. No overflow or missing sodium bicarbonate was noted in the cart. During an interview on 10/3/2025 at 12:35 p.m., Licensed Practical Nurse (LPN) 2 indicated Resident 2's order was for sodium bicarbonate three times a day. Review of the September 2025 medication administration record (MAR) for Resident 2 indicated multiple orders for sodium bicarbonate. During September, there were 12 duplicated administrations of sodium bicarbonate and two administrations held for duplicate order. During an interview on 10/3/2025 at 12:05 p.m., the Director of Health and Wellness verified sodium bicarbonate had been duplicated. 2. The clinical record for Resident 4 was reviewed on 10/3/2025 at 1:50 p.m. The medical diagnoses included osteoporosis and dysphagia. An individualized service plan, revised 8/1/2025, indicated staff assisted Resident 4 with medication administration. During an observation on 10/3/2025 at 12:30 p.m.,		Any resident residing in the facility has the potential to be affected and none noted. Audit was completed by DSW/Designee on all current residents' orders to verify any duplicate orders. Any duplicate orders were D/C and MD was notified. **3)Measures put into place/ System changes:** Inservice provided to all licensed nurses and QMA on medication administration. DSW/Designee will review 3 residents 3 times weekly x 4 weeks, then 2 residents 2 times weekly x 4 weeks and then 1 resident 1 weekly for 4 months for accuracy of medications orders. **4)How the corrective actions will be monitored:** ED/Designee will be responsible for this plan of correction and Audit findings will be presented to the	

	Resident 4's medications were reviewed to be in pharmacy preset packages which contained exact dosing for each date and time administration. No overflow or missing doses of ropinirole were noted in the cart. Review of the September 2025 MAR for Resident 4 indicated multiple orders for ropinirole. During September, there were 3 duplicated administrations of ropinirole, and two administrations held for duplicate order. During an interview on 10/3/2025 at 12:05 p.m., the Director of Health and Wellness verified ropinirole had been duplicated. Resident 4 should have been receiving ropinirole three times a day with 1.5 milligrams (mg) in the morning and at bedtime, and a dose of 1 mg at noon. The electronic medical record had recently migrated to a new system and when new orders were added, or orders changed, the system would send one copy to the nurses for review and one to the pharmacy. When pharmacy was doing their side, the system would sometimes duplicate the order. It was the expectation the nursing staff should be catching duplicate orders and sending notifications to the pharmacy for clarification. Based on interview and record		department head's meeting once a month x 6 months. The results of these audits will be reviewed in Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. **5)Date of compliance: 10/21/25**	

review, the facility failed to accurately document the administration of medications for 2 of 5 residents reviewed for medication administration. (Resident 2 and Resident 4)

Findings include:

1. The clinical record for Resident 2 was reviewed on 10/3/2025 at 11:50 a.m. The medical diagnoses included chronic kidney disease and falls.

An individualized service plan, revised 8/8/2025, indicated staff assisted Resident 2 with medication administration.

During an observation on 10/3/2025 at 12:30 p.m., Resident 2's medications were reviewed to be in pharmacy preset packages which contained exact dosing for each date and time administration. No overflow or missing sodium bicarbonate was noted in the cart.

During an interview on 10/3/2025 at 12:35 p.m., Licensed Practical Nurse (LPN) 2 indicated Resident 2's order was for sodium bicarbonate three times a day.

Review of the September 2025 medication administration record (MAR) for Resident 2 indicated multiple orders for sodium bicarbonate. During September, there were 12

duplicated administrations of sodium bicarbonate and two administrations held for duplicate order.

During an interview on 10/3/2025 at 12:05 p.m., the Director of Health and Wellness verified sodium bicarbonate had been duplicated.

2. The clinical record for Resident 4 was reviewed on 10/3/2025 at 1:50 p.m. The medical diagnoses included osteoporosis and dysphagia.

An individualized service plan, revised 8/1/2025, indicated staff assisted Resident 4 with medication administration.

During an observation on 10/3/2025 at 12:30 p.m., Resident 4's medications were reviewed to be in pharmacy preset packages which contained exact dosing for each date and time administration. No overflow or missing doses of ropinirole were noted in the cart.

Review of the September 2025 MAR for Resident 4 indicated multiple orders for ropinirole. During September, there were 3 duplicated administrations of ropinirole, and two administrations held for duplicate order.

During an interview on 10/3/2025 at 12:05 p.m., the Director of Health and Wellness

	verified ropinirole had been duplicated. Resident 4 should have been receiving ropinirole three times a day with 1.5 milligrams (mg) in the morning and at bedtime, and a dose of 1 mg at noon. The electronic medical record had recently migrated to a new system and when new orders were added, or orders changed, the system would send one copy to the nurses for review and one to the pharmacy. When pharmacy was doing their side, the system would sometimes duplicate the order. It was the expectation the nursing staff should be catching duplicate orders and sending notifications to the pharmacy for clarification.			

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	(X6) DATE10/24/2025