STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROWNPOINTE OF INDIANAPOLIS	7365 E 16TH ST, INDIANAPOLIS, , 46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00462735. Complaint IN00462735 - State deficiencies related to the allegations are cited at R0240, R0245, R0246, R0349, and R0414. Survey date: July 8, 2025 Facility number: 005729 Residential Census: 27 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on July 9, 2025.	R 0000	Preparation and or execution of This Plan of Correction in general or any correct set forth herein, in particular, does not constituent admission or agreement by CrownPointe of the facts alleged or the conclusion set forth in the statement of deficiencies. The Plan of Correction and specific corrective actions are prepared and/or executed solely because the provisions of the Federal and State/laws. CrownPointe desires the Plan of Correction to be considered the facility's allegation of compliance.	
R 0240	Health Services - Deficiency 410 IAC 16.2-5-4(d) (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences.	R 0240	. Nurse manager/designee will monitor daily that all medications are available. When there are unavailable	07/28/2025

	Based on interview and record review, the facility failed to administer insulin as ordered for 1 of 4 residents reviewed for insulin administration. (Resident D) Findings include: The clinical record for Resident D was reviewed on 7/8/25 at 10:30 a.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus. A Mini Mental Status Exam (MMSE), dated 6/26/25, indicated Resident D was cognitively intact. A physician's order, dated 6/9/25, indicated to inject 22 units of Lantus (long-acting insulin) Solostar 100 unit/milliliter (ml) subcutaneously once daily in the morning for type 2 diabetes mellitus without complications. A record review of the Medication Administration Record (MAR) for Resident D was conducted on 7/8/25 at 11:40 a.m. On the following days, Resident D's order for 22 units of Lantus Solostar long-acting insulin was documented as "not administered" with an additional note of "not available" or "medication on hold":		medications Nurse Manager/designee will place those medications on hold and contact pharmacy immediately to address the timely delivery of medications. . All residents requiring insulin have the potential to be affected. Nurse Manager will reeducate all nursing staff on ensuring unavailable medications are communicated to the Nurse Manager/ designee to prevent ongoing unavailability of medications. . Nurse Manager/designee will monitor the Medication Summary in Accuflo daily to ensure that unavailable medications are placed on hold, and notify prescribing physician and pharmacy immediately. . Nurse manager will report any concerns to the Quality Assurance committee and will follow recommendations to ensure compliance. Nurse Manager will in-service all nursing staff on communication with Nurse Manager/ designee on	

	6/11/25 at 8:00 a.m. - Lantus Solostar (not available), 6/12/25 at 8:00 a.m. - not available, 6/13/25 at 8:00 a.m. - medication not available, 6/14/25 at 8:00 a.m. - medication on hold, 6/15/25 at 8:00 a.m. - medication on hold, 6/16/25 at 8:00 a.m. - not available, 6/17/25 at 8:00 a.m. - not available, 6/18/25 at 8:00 a.m. - medication not available, 6/19/25 at 8:00 a.m. - medication on hold, 6/20/25 at 8:00 a.m. - medication on hold, 6/21/25 at 8:00 a.m. - not available, 6/22/25 at 8:00 a.m. - not available, 6/23/25 at 8:00 a.m. - not available, 6/24/25 at 8:00 a.m. - medication not available, 6/25/25 at 8:00 a.m. - medication not available,		when a medication has not been refilled by the pharmacy to ensure that medications are placed on hold until they are available	

6/26/25 at 8:00 a.m. - medication not available, and

6/28/25 at 8:00 a.m. - medication not available.

During an interview on 7/8/25 at 4:00 p.m., the facility Nurse Consultant (NC) indicated she was unsure if Resident D received her order for Lantus Solostar long-acting insulin from 6/11/25 to 6/28/25. She indicated there were issues with Resident D's insurance when the order was initially placed for Lantus long-acting insulin, and she did not believe the pharmacy was sending it in June for that reason.

The clinical record for Resident D did not include an order to hold the medication Lantus Solostar 100 unit/ml.

A Medication Self-Administration/Administration/Storage Policy, last revised January 2024, was provided by the NC on 7/8/25 at 2:00 p.m. It indicated "Residents of the facility shall receive medications as ordered by their physician to treat specific medical conditions".

This citation is related to Complaint IN00462735.

Based on interview and record review, the facility failed to administer insulin as ordered for 1 of 4 residents reviewed for

insulin administration. (Resident D)

Findings include:

The clinical record for Resident D was reviewed on 7/8/25 at 10:30 a.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus.

A Mini Mental Status Exam (MMSE), dated 6/26/25, indicated Resident D was cognitively intact.

A physician's order, dated 6/9/25, indicated to inject 22 units of Lantus (long-acting insulin) Solostar 100 unit/milliliter (ml) subcutaneously once daily in the morning for type 2 diabetes mellitus without complications.

A record review of the Medication Administration Record (MAR) for Resident D was conducted on 7/8/25 at 11:40 a.m. On the following days, Resident D's order for 22 units of Lantus Solostar long-acting insulin was documented as "not administered" with an additional note of "not available" or "medication on hold":

6/11/25 at 8:00 a.m. - Lantus Solostar (not available),

6/12/25 at 8:00 a.m. - not available,

	6/13/25 at 8:00 a.m. - medication not available, 6/14/25 at 8:00 a.m. - medication on hold, 6/15/25 at 8:00 a.m. - medication on hold, 6/16/25 at 8:00 a.m. - not available, 6/17/25 at 8:00 a.m. - not available, 6/18/25 at 8:00 a.m. - medication not available, 6/19/25 at 8:00 a.m. - medication on hold, 6/20/25 at 8:00 a.m. - medication on hold, 6/21/25 at 8:00 a.m. - not available, 6/22/25 at 8:00 a.m. - not available, 6/23/25 at 8:00 a.m. - not available, 6/24/25 at 8:00 a.m. - medication not available, 6/25/25 at 8:00 a.m. - medication not available, 6/26/25 at 8:00 a.m. - medication not available, and 6/28/25 at 8:00 a.m. - medication not available.			

	During an interview on 7/8/25 at 4:00 p.m., the facility Nurse Consultant (NC) indicated she was unsure if Resident D received her order for Lantus Solostar long-acting insulin from 6/11/25 to 6/28/25. She indicated there were issues with Resident D's insurance when the order was initially placed for Lantus long-acting insulin, and she did not believe the pharmacy was sending it in June for that reason. The clinical record for Resident D did not include an order to hold the medication Lantus Solostar 100 unit/ml. A Medication Self-Administration/Administration/Storage Policy, last revised January 2024, was provided by the NC on 7/8/25 at 2:00 p.m. It indicated "Residents of the facility shall receive medications as ordered by their physician to treat specific medical conditions". This citation is related to Complaint IN00462735.			
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 observation,	R 0245	. QMA 1 will receive disciplinary action for administering insulin without the proper certification.	07/28/2025

	interview, and record review, the facility failed to ensure staff administering insulin was a nurse or Qualified Medication Aide (QMA) that was certified to administer insulin for 1 of 2 residents observed for blood sugars obtained and insulin administrations. (Resident E) Findings include: The clinical record for Resident E was reviewed on 7/8/25 at 11:30 a.m. The diagnoses included, but were not limited to, diabetes mellitus type 2. A service plan, dated 5/2/25, indicated Resident E's medications were to be administered by a staff member. A self-administration of medication assessment, dated 5/2/25, indicated Resident E was able to self-administer insulin only. A physician order, dated 8/24/24, indicated Resident E was to receive a sliding scale of lispro insulin (fast acting insulin) before meals and nightly. The sliding scale was the following: 101 - 150 blood sugar reading = 1 unit of insulin, 151-200 blood sugar reading = 2 units of insulin, 201-250 blood sugar reading = 3 units of insulin, 251-300 blood sugar reading = 4 units of insulin, 301-350 blood sugar reading = 5 units of insulin, 351-400 blood sugar		. All QMAs who are not insulin certified will go through an insulin certification class on July 21st, 2025. QMAs without insulin certification have until August 21st, 2025 to obtain their insulin certification. Any QMA without insulin certification will work in the capacity of a CAN until insulin certification is obtained. . Nurse Manager will in service all nursing staff on their scope of practice and job functions.	

	reading = 6 units of insulin, 401-450 blood sugar reading = 7 units of insulin, if the blood sugar readings were greater than 450, the staff were to notify the medical provider. An observation was conducted of an insulin administration with Qualified Medication Aide (QMA) 1 for Resident E on 7/8/25 at 11:17 a.m. QMA 1 was observed preparing to obtain Resident E's blood sugar reading. QMA 1 obtained the resident's blood sugar utilizing a glucometer. The blood sugar reading was 145. After, QMA 1 returned to her cart and pulled up the physician's order. She indicated at that time; the resident was to receive one unit of lispro insulin per the sliding scale. She then pulled the lispro insulin flex pen from the container. QMA 1 was observed holding the insulin flex pen in the air and tapping the pen. Then, attached a needle to the rubber tip of the flex pen. After, she dialed up one unit of lispro insulin on the dial. QMA 1 returned to the resident's room; handed an alcohol wipe and the insulin flex pen to the resident. The resident administered one unit of insulin in her abdomen. QMA 1 was not observed disinfecting the insulin flex pen rubber tip prior to attaching the needle nor did she prime the flex pen with two units of insulin prior to dialing the dosage to be			

	given. An interview was conducted with QMA 1 on 7/8/25 at 11:19 a.m. QMA 1 indicated she was unable to administer insulin to the residents, because she was not certified to administer insulin. She could set the insulin flex pens up by dialing up the insulin amount based on the blood sugar readings. The residents would then administer the insulin to themselves. The QMA staff that were certified in insulin administration administers insulin to Resident E. An interview was conducted with the Nurse Consultant (NC) on 7/8/25 at 1:00 p.m. She indicated QMA 1 should not be setting up the insulin flex pens. She was not certified in insulin administration. The insulin flex pens should be primed with two units of insulin before dialing up the dosage.			

	A medication self-administration policy was provided by the NC on 7/8/25 at 2:00 p.m. It indicated the following, "...Injectable medications/insulin... Insulin may be administered by a licensed nurse or QMA who has been certified by a program recognized by ISDH [Indiana State Department of Health]. Insulin pens are to be used per manufacturers' guidelines." A manufacture instruction insulin flex pen usage policy was provided by the NC on 7/8/25 at 2:00 p.m. It indicated, "...Step 1: ...wipe the rubber seal with an alcohol swab...Step 3: Select a needle...Step 5: ...Prime before each injection. Priming your pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. Step 6: To prime your pen, turn the dose knob to select 2 units. Step 7: Hold your pen with the needle pointing up. Tap the cartridge holder gently to collect air bubbles at the top. Step 8: Continue holding your pen with the needle pointing up. Push the dose knob in until it stops and "0" is seen in the dose window...If you do not see insulin, repeat priming..."			

An Indiana Department of Health QMA Insulin Administration Education Module was reviewed on 7/8/25 at 3:00 p.m. The module indicated the following, "...PREPARING AN INSULIN PEN AND ADMINISTERING INSULIN BY SUBQ [subcutaneous] INJECTION... 5. Wipe the pen tip with an alcohol wipe... 8. Dial a dose of 2 units to prime the pen... 9. Hold the pen with the needle pointing straight up and tap lightly so the bubbles will rise to the top... 10. Press the injection button all the way in and check to see that insulin comes out of the needle. (If no insulin comes out, repeat the test)...."

This citation is related to Complaint IN00462735.

Based on observation, interview, and record review, the facility failed to ensure staff administering insulin was a nurse or Qualified Medication Aide (QMA) that was certified to administer insulin for 1 of 2 residents observed for blood sugars obtained and insulin administrations. (Resident E)

Findings include:

The clinical record for Resident E was reviewed on 7/8/25 at 11:30 a.m. The diagnoses included, but were not limited to, diabetes mellitus type 2.

	A service plan, dated 5/2/25, indicated Resident E's medications were to be administered by a staff member. A self-administration of medication assessment, dated 5/2/25, indicated Resident E was able to self-administer insulin only. A physician order, dated 8/24/24, indicated Resident E was to receive a sliding scale of lispro insulin (fast acting insulin) before meals and nightly. The sliding scale was the following: 101 - 150 blood sugar reading = 1 unit of insulin, 151-200 blood sugar reading = 2 units of insulin, 201-250 blood sugar reading = 3 units of insulin, 251-300 blood sugar reading = 4 units of insulin, 301-350 blood sugar reading = 5 units of insulin, 351-400 blood sugar reading = 6 units of insulin, 401-450 blood sugar reading = 7 units of insulin, if the blood sugar readings were greater than 450, the staff were to notify the medical provider. An observation was conducted of an insulin administration with Qualified Medication Aide (QMA) 1 for Resident E on 7/8/25 at 11:17 a.m. QMA 1 was observed preparing to obtain Resident E's blood sugar reading. QMA 1 obtained the resident's blood sugar utilizing a glucometer. The blood sugar			

	reading was 145. After, QMA 1 returned to her cart and pulled up the physician's order. She indicated at that time; the resident was to receive one unit of lispro insulin per the sliding scale. She then pulled the lispro insulin flex pen from the container. QMA 1 was observed holding the insulin flex pen in the air and tapping the pen. Then, attached a needle to the rubber tip of the flex pen. After, she dialed up one unit of lispro insulin on the dial. QMA 1 returned to the resident's room; handed an alcohol wipe and the insulin flex pen to the resident. The resident administered one unit of insulin in her abdomen. QMA 1 was not observed disinfecting the insulin flex pen rubber tip prior to attaching the needle nor did she prime the flex pen with two units of insulin prior to dialing the dosage to be given. An interview was conducted with QMA 1 on 7/8/25 at 11:19 a.m. QMA 1 indicated she was unable to administer insulin to the residents, because she was not certified to administer insulin. She could set the insulin flex pens up by dialing up the insulin amount based on the blood sugar readings. The residents would then administer the insulin to themselves. The QMA staff that were certified in insulin administration administers insulin to Resident			

	E. An interview was conducted with the Nurse Consultant (NC) on 7/8/25 at 1:00 p.m. She indicated QMA 1 should not be setting up the insulin flex pens. She was not certified in insulin administration. The insulin flex pens should be primed with two units of insulin before dialing up the dosage. A medication self-administration policy was provided by the NC on 7/8/25 at 2:00 p.m. It indicated the following, "...Injectable medications/insulin... Insulin may be administered by a licensed nurse or QMA who has been certified by a program recognized by ISDH [Indiana State Department of Health]. Insulin pens are to be used per manufacturers' guidelines." A manufacture instruction insulin flex pen usage policy was provided by the NC on 7/8/25 at 2:00 p.m. It indicated, "...Step 1: ...wipe the rubber seal with an alcohol swab...Step 3: Select a needle...Step 5: ...Prime before each injection. Priming your pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. Step 6: To			

	prime your pen, turn the dose knob to select 2 units. Step 7: Hold your pen with the needle pointing up. Tap the cartridge holder gently to collect air bubbles at the top. Step 8: Continue holding your pen with the needle pointing up. Push the dose knob in until it stops and "0" is seen in the dose window...If you do not see insulin, repeat priming..." An Indiana Department of Health QMA Insulin Administration Education Module was reviewed on 7/8/25 at 3:00 p.m. The module indicated the following, "...PREPARING AN INSULIN PEN AND ADMINISTERING INSULIN BY SUBQ [subcutaneous] INJECTION... 5. Wipe the pen tip with an alcohol wipe... 8. Dial a dose of 2 units to prime the pen... 9. Hold the pen with the needle pointing straight up and tap lightly so the bubbles will rise to the top... 10. Press the injection button all the way in and check to see that insulin comes out of the needle. (If no insulin comes out, repeat the test)...." This citation is related to Complaint IN00462735.			
R 0246	Health Services - Deficiency 410 IAC 16.2-5-4(e)(6)	R 0246	. Nurse Manager immediately in	07/28/2025

	(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. 2. The clinical record for Resident B was reviewed on 7/8/25 at 11:30 a.m. The diagnoses included, but were not limited, chronic respiratory failure. A physician's order, dated 4/4/25, indicated to administer one tablet of morphine sulfate extended release 15 milligrams (mg) every four hours as needed for pain/shortness of breath. Resident B's MAR was reviewed on 7/8/25 at 11:35 a.m. It indicated QMA 4 administered one tablet of morphine sulfate extended release 15 mg, on 6/28/25 at 1:25 p.m., for pain, and documented the medication administered was effective. The clinical record did not contain documentation that a licensed nurse had been notified or had authorized the		serviced nursing staff on obtaining authorization prior to administering PRN medication. . All resident has the potential to be affected by this deficiency. Nurse Manager/designee will monitor all administered PRN medications to ensure that authorization was obtained prior to the administration of PRN medications. . Nurse manager/designee will monitor administered PRN medications twice weekly for six months to ensure ongoing compliance. . Nurse manager will report any concerns to the Quality Assurance committee and will follow recommendations to ensure compliance. Nurse manager/designee will monitor administered PRN medications twice weekly for six months to ensure ongoing compliance.	

administration of morphine administered by QMA 4.

3. The clinical record for Resident D was reviewed on 7/8/25 at 10:30 a.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus.

A physician's order, dated 3/17/25, indicated to administer two tablets of acetaminophen (Tylenol) 325 mg for headache/fever greater than 100 degrees/pain.

A physician's order, dated 1/23/24, indicated to administer two tablets of acetaminophen (Tylenol) 500 mg every six hours as needed for pain.

Resident D's MAR was reviewed on 7/8/25 at 11:40 a.m. It indicated QMA 4 administered two tablets of acetaminophen 325 mg for a headache, on 6/1/25 at 10:56 a.m., and documented the medication administered was effective.

The clinical record did not contain documentation that a licensed nurse had been notified or had authorized the administration of acetaminophen administered by QMA 4.

Resident D's MAR was reviewed on 7/8/25 at 11:40 a.m. It indicated, on 6/7/25 at

	7:35 p.m., QMA 2 administered two tablets of acetaminophen 500 mg for discomfort, and documented the medication administered was effective. The clinical record did not contain documentation that a licensed nurse had been notified or had authorized the administration of acetaminophen given by QMA 2. During an interview on 7/8/25 at 2:05 p.m., the facility Nurse Consultant (NC) indicated if a resident requests a PRN medication, the staff were to call her to obtain approval. She indicated staff do not document in the resident's chart when authorization has been received, and QMAs are not to assess effectiveness. The NC indicated she documented effectiveness of medications administered in the residents' charts afterward. An undated PRN Medication Administration Policy was provided by the NC on 7/8/25 at 3:45 p.m. It indicated "When a resident requests a PRN medication while a QMA is on staff, the QMA shall contact the nurse on call for approval to give the PRN medication. It will then be the nurse's responsibility to assess the efficacy of the PRN medication and sign it off as 'effective' or			

'ineffective' in Accuflo".

This citation is related to Complaint IN00462735.

Based on interview and record review, the facility failed to ensure Qualified Medication Aide (QMA) staff members received authorization by a nurse prior to administering an as needed (PRN) medications for 3 of 6 residents records reviewed. (Resident B, Resident C, and Resident D)

Findings include:

1. The clinical record for Resident C was reviewed on 7/8/25 at 1:30 p.m. The diagnoses included, but were not limited to, hypertension.

A physician's order, dated 4/20/25, indicated the resident was to receive 2.5 milliliters of chest congestion relief every four hours PRN for cough.

A physician's order, dated 10/30/24, indicated the resident was to receive 17 grams of polyethylene glycol powder once a day PRN for constipation.

The June 2024 Medication Administration Record (MAR) for Resident C indicated the following days and times the resident received PRN medications by a QMA:

	2.5 milliliters of chest congestion relief: 6/7/25 at 8:51 p.m. - QMA 2 administered, 6/14/25 at 8:49 p.m. - QMA 2 administered, 6/15/25 at 6:36 a.m. - QMA 2 administered, 6/15/25 at 9:13 p.m. - QMA 2 administered, 6/16/25 at 5:00 a.m. - QMA 2 administered, and 6/17/25 at 4:56 a.m. - QMA 3 administered. 17 grams of polyethylene glycol: 6/6/25 at 8:47 p.m. - QMA 2 administered, 6/14/25 at 8:49 p.m. - QMA 2 administered, and 6/25/25 at 7:29 p.m. - QMA 2 administered. There was no documentation of prior authorization being obtained from a nurse before the QMA staff administrated the PRN medication of chest congestion relief and/or polyethylene glycol to Resident C. An interview was conducted with QMA 1 on 7/8/25 at 11:11 a.m. She indicated the QMA staff were to document in the MAR if he or she contacted the nurse to receive prior			

authorization before administering PRN medications.

2. The clinical record for Resident B was reviewed on 7/8/25 at 11:30 a.m. The diagnoses included, but were not limited, chronic respiratory failure.

A physician's order, dated 4/4/25, indicated to administer one tablet of morphine sulfate extended release 15 milligrams (mg) every four hours as needed for pain/shortness of breath.

Resident B's MAR was reviewed on 7/8/25 at 11:35 a.m. It indicated QMA 4 administered one tablet of morphine sulfate extended release 15 mg, on 6/28/25 at 1:25 p.m., for pain, and documented the medication administered was effective.

The clinical record did not contain documentation that a licensed nurse had been notified or had authorized the administration of morphine administered by QMA 4.

3. The clinical record for Resident D was reviewed on 7/8/25 at 10:30 a.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus.

A physician's order, dated 3/17/25, indicated to administer

two tablets of acetaminophen (Tylenol) 325 mg for headache/fever greater than 100 degrees/pain.

A physician's order, dated 1/23/24, indicated to administer two tablets of acetaminophen (Tylenol) 500 mg every six hours as needed for pain.

Resident D's MAR was reviewed on 7/8/25 at 11:40 a.m. It indicated QMA 4 administered two tablets of acetaminophen 325 mg for a headache, on 6/1/25 at 10:56 a.m., and documented the medication administered was effective.

The clinical record did not contain documentation that a licensed nurse had been notified or had authorized the administration of acetaminophen administered by QMA 4.

Resident D's MAR was reviewed on 7/8/25 at 11:40 a.m. It indicated, on 6/7/25 at 7:35 p.m., QMA 2 administered two tablets of acetaminophen 500 mg for discomfort, and documented the medication administered was effective.

The clinical record did not contain documentation that a licensed nurse had been notified or had authorized the administration of acetaminophen given by QMA

	2. During an interview on 7/8/25 at 2:05 p.m., the facility Nurse Consultant (NC) indicated if a resident requests a PRN medication, the staff were to call her to obtain approval. She indicated staff do not document in the resident's chart when authorization has been received, and QMAs are not to assess effectiveness. The NC indicated she documented effectiveness of medications administered in the residents' charts afterward. An undated PRN Medication Administration Policy was provided by the NC on 7/8/25 at 3:45 p.m. It indicated "When a resident requests a PRN medication while a QMA is on staff, the QMA shall contact the nurse on call for approval to give the PRN medication. It will then be the nurse's responsibility to assess the efficacy of the PRN medication and sign it off as 'effective' or 'ineffective' in Accuflo". This citation is related to Complaint IN00462735. Based on interview and record review, the facility failed to ensure Qualified Medication Aide (QMA) staff members received authorization by a nurse prior to administering an as needed (PRN) medications			

for 3 of 6 residents records reviewed. (Resident B, Resident C, and Resident D)

Findings include:

1. The clinical record for Resident C was reviewed on 7/8/25 at 1:30 p.m. The diagnoses included, but were not limited to, hypertension.

A physician's order, dated 4/20/25, indicated the resident was to receive 2.5 milliliters of chest congestion relief every four hours PRN for cough.

A physician's order, dated 10/30/24, indicated the resident was to receive 17 grams of polyethylene glycol powder once a day PRN for constipation.

The June 2024 Medication Administration Record (MAR) for Resident C indicated the following days and times the resident received PRN medications by a QMA:

2.5 milliliters of chest congestion relief: 6/7/25 at 8:51 p.m. - QMA 2 administered,

6/14/25 at 8:49 p.m. - QMA 2 administered,

6/15/25 at 6:36 a.m. - QMA 2 administered,

	6/15/25 at 9:13 p.m. - QMA 2 administered, 6/16/25 at 5:00 a.m. - QMA 2 administered, and 6/17/25 at 4:56 a.m. - QMA 3 administered. 17 grams of polyethylene glycol: 6/6/25 at 8:47 p.m. - QMA 2 administered, 6/14/25 at 8:49 p.m. - QMA 2 administered, and 6/25/25 at 7:29 p.m. - QMA 2 administered. There was no documentation of prior authorization being obtained from a nurse before the QMA staff administrated the PRN medication of chest congestion relief and/or polyethylene glycol to Resident C. An interview was conducted with QMA 1 on 7/8/25 at 11:11 a.m. She indicated the QMA staff were to document in the MAR if he or she contacted the nurse to receive prior authorization before administering PRN medications. 2. The clinical record for Resident B was reviewed on 7/8/25 at 11:30 a.m. The diagnoses included, but were not limited, chronic respiratory failure.			

	A physician's order, dated 4/4/25, indicated to administer one tablet of morphine sulfate extended release 15 milligrams (mg) every four hours as needed for pain/shortness of breath. Resident B's MAR was reviewed on 7/8/25 at 11:35 a.m. It indicated QMA 4 administered one tablet of morphine sulfate extended release 15 mg, on 6/28/25 at 1:25 p.m., for pain, and documented the medication administered was effective. The clinical record did not contain documentation that a licensed nurse had been notified or had authorized the administration of morphine administered by QMA 4. 3. The clinical record for Resident D was reviewed on 7/8/25 at 10:30 a.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus. A physician's order, dated 3/17/25, indicated to administer two tablets of acetaminophen (Tylenol) 325 mg for headache/fever greater than 100 degrees/pain.			

A physician's order, dated 1/23/24, indicated to administer two tablets of acetaminophen (Tylenol) 500 mg every six hours as needed for pain.

Resident D's MAR was reviewed on 7/8/25 at 11:40 a.m. It indicated QMA 4 administered two tablets of acetaminophen 325 mg for a headache, on 6/1/25 at 10:56 a.m., and documented the medication administered was effective.

The clinical record did not contain documentation that a licensed nurse had been notified or had authorized the administration of acetaminophen administered by QMA 4.

Resident D's MAR was reviewed on 7/8/25 at 11:40 a.m. It indicated, on 6/7/25 at 7:35 p.m., QMA 2 administered two tablets of acetaminophen 500 mg for discomfort, and documented the medication administered was effective.

The clinical record did not contain documentation that a licensed nurse had been notified or had authorized the administration of acetaminophen given by QMA 2.

During an interview on 7/8/25 at 2:05 p.m., the facility Nurse Consultant (NC) indicated if a

resident requests a PRN medication, the staff were to call her to obtain approval. She indicated staff do not document in the resident's chart when authorization has been received, and QMAs are not to assess effectiveness. The NC indicated she documented effectiveness of medications administered in the residents' charts afterward.

An undated PRN Medication Administration Policy was provided by the NC on 7/8/25 at 3:45 p.m. It indicated "When a resident requests a PRN medication while a QMA is on staff, the QMA shall contact the nurse on call for approval to give the PRN medication. It will then be the nurse's responsibility to assess the efficacy of the PRN medication and sign it off as 'effective' or 'ineffective' in Accuflo".

This citation is related to Complaint IN00462735.

Based on interview and record review, the facility failed to ensure Qualified Medication Aide (QMA) staff members received authorization by a nurse prior to administering an as needed (PRN) medications for 3 of 6 residents records reviewed. (Resident B, Resident C, and Resident D)

Findings include:

	1. The clinical record for Resident C was reviewed on 7/8/25 at 1:30 p.m. The diagnoses included, but were not limited to, hypertension. A physician's order, dated 4/20/25, indicated the resident was to receive 2.5 milliliters of chest congestion relief every four hours PRN for cough. A physician's order, dated 10/30/24, indicated the resident was to receive 17 grams of polyethylene glycol powder once a day PRN for constipation. The June 2024 Medication Administration Record (MAR) for Resident C indicated the following days and times the resident received PRN medications by a QMA: 2.5 milliliters of chest congestion relief: 6/7/25 at 8:51 p.m. - QMA 2 administered, 6/14/25 at 8:49 p.m. - QMA 2 administered, 6/15/25 at 6:36 a.m. - QMA 2 administered, 6/15/25 at 9:13 p.m. - QMA 2 administered, 6/16/25 at 5:00 a.m. - QMA 2 administered, and			

	6/17/25 at 4:56 a.m. - QMA 3 administered. 17 grams of polyethylene glycol: 6/6/25 at 8:47 p.m. - QMA 2 administered, 6/14/25 at 8:49 p.m. - QMA 2 administered, and 6/25/25 at 7:29 p.m. - QMA 2 administered. There was no documentation of prior authorization being obtained from a nurse before the QMA staff administrated the PRN medication of chest congestion relief and/or polyethylene glycol to Resident C. An interview was conducted with QMA 1 on 7/8/25 at 11:11 a.m. She indicated the QMA staff were to document in the MAR if he or she contacted the nurse to receive prior authorization before administering PRN medications. 2. The clinical record for Resident B was reviewed on 7/8/25 at 11:30 a.m. The diagnoses included, but were not limited, chronic respiratory failure. A physician's order, dated 4/4/25, indicated to administer one tablet of morphine sulfate extended release 15 milligrams (mg) every four hours as needed for pain/shortness of			

breath.

Resident B's MAR was reviewed on 7/8/25 at 11:35 a.m. It indicated QMA 4 administered one tablet of morphine sulfate extended release 15 mg, on 6/28/25 at 1:25 p.m., for pain, and documented the medication administered was effective.

The clinical record did not contain documentation that a licensed nurse had been notified or had authorized the administration of morphine administered by QMA 4.

3. The clinical record for Resident D was reviewed on 7/8/25 at 10:30 a.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus.

A physician's order, dated 3/17/25, indicated to administer two tablets of acetaminophen (Tylenol) 325 mg for headache/fever greater than 100 degrees/pain.

A physician's order, dated 1/23/24, indicated to administer two tablets of acetaminophen (Tylenol) 500 mg every six hours as needed for pain.

Resident D's MAR was reviewed on 7/8/25 at 11:40 a.m. It indicated QMA 4 administered two tablets of acetaminophen 325 mg for a

	headache, on 6/1/25 at 10:56 a.m., and documented the medication administered was effective. The clinical record did not contain documentation that a licensed nurse had been notified or had authorized the administration of acetaminophen administered by QMA 4. Resident D's MAR was reviewed on 7/8/25 at 11:40 a.m. It indicated, on 6/7/25 at 7:35 p.m., QMA 2 administered two tablets of acetaminophen 500 mg for discomfort, and documented the medication administered was effective. The clinical record did not contain documentation that a licensed nurse had been notified or had authorized the administration of acetaminophen given by QMA 2. During an interview on 7/8/25 at 2:05 p.m., the facility Nurse Consultant (NC) indicated if a resident requests a PRN medication, the staff were to call her to obtain approval. She indicated staff do not document in the resident's chart when authorization has been received, and QMAs are not to assess effectiveness. The NC indicated she documented effectiveness of medications			

administered in the residents' charts afterward.

An undated PRN Medication Administration Policy was provided by the NC on 7/8/25 at 3:45 p.m. It indicated "When a resident requests a PRN medication while a QMA is on staff, the QMA shall contact the nurse on call for approval to give the PRN medication. It will then be the nurse's responsibility to assess the efficacy of the PRN medication and sign it off as 'effective' or 'ineffective' in Accuflo".

This citation is related to Complaint IN00462735.

Based on interview and record review, the facility failed to ensure Qualified Medication Aide (QMA) staff members received authorization by a nurse prior to administering an as needed (PRN) medications for 3 of 6 residents records reviewed. (Resident B, Resident C, and Resident D)

Findings include:

1. The clinical record for Resident C was reviewed on 7/8/25 at 1:30 p.m. The diagnoses included, but were not limited to, hypertension.

A physician's order, dated 4/20/25, indicated the resident was to receive 2.5 milliliters of chest congestion relief every

four hours PRN for cough.

A physician's order, dated 10/30/24, indicated the resident was to receive 17 grams of polyethylene glycol powder once a day PRN for constipation.

The June 2024 Medication Administration Record (MAR) for Resident C indicated the following days and times the resident received PRN medications by a QMA:

2.5 milliliters of chest congestion relief: 6/7/25 at 8:51 p.m. - QMA 2 administered,

6/14/25 at 8:49 p.m. - QMA 2 administered,

6/15/25 at 6:36 a.m. - QMA 2 administered,

6/15/25 at 9:13 p.m. - QMA 2 administered,

6/16/25 at 5:00 a.m. - QMA 2 administered, and

6/17/25 at 4:56 a.m. - QMA 3 administered.

17 grams of polyethylene glycol: 6/6/25 at 8:47 p.m. - QMA 2 administered,

6/14/25 at 8:49 p.m. - QMA 2 administered, and

	6/25/25 at 7:29 p.m. - QMA 2 administered. There was no documentation of prior authorization being obtained from a nurse before the QMA staff administrated the PRN medication of chest congestion relief and/or polyethylene glycol to Resident C. An interview was conducted with QMA 1 on 7/8/25 at 11:11 a.m. She indicated the QMA staff were to document in the MAR if he or she contacted the nurse to receive prior authorization before administering PRN medications.			
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. 2. The clinical record for Resident D was reviewed on 7/8/25 at 10:30 a.m. The	R 0349	. Nurse Manager immediately pulled the Medication Summary from the Accuflo system and reconciled the medications in the cart to ensure that the medications that were unavailable were communicated to pharmacy for distribution, reviewed medical charts for accuracy for all residents who are administered insulin including Resident D and Resident E. Nurse Manager in serviced/ reeducated staff on how to communicate with Nuse Manager when a medication	07/28/2025

	diagnoses included, but were not limited to, type 2 diabetes mellitus. A Mini Mental Status Exam (MMSE), dated 6/26/25, indicated Resident D was cognitively intact. A service plan, dated 6/26/25, indicated Resident D was unable to take medications unless administered by someone else. Special instructions indicated the resident may self-administer insulin. A physician's order, dated 6/9/25, indicated to inject 22 units of Lantus Solostar 100 unit/milliliter (ml) (long-acting insulin) subcutaneously once daily in the morning for type 2 diabetes mellitus without complications. A record review of the MAR for Resident D was conducted on 7/8/25 at 11:40 a.m. It indicated, on 6/30/25, Resident D self-administered 22 units of Lantus Solostar long-acting insulin. On the following days and times in July, Resident D's order for 22 units of Lantus Solostar long-acting insulin was documented as "self-administered": 7/01/25 at 8:00 a.m.,		has not been delivered from pharmacy so they can place the medication on hold until the medication is available. . All residents have the potential to be affected by this deficiency. Nurse Manager/ designee will monitor all medical charts, , physician's orders, assessments and service plans for residents who receive insulin, once a week for the next six months to ensure ongoing compliance. . Nurse manager will in-service Nursing Staff on the correct way to document within their scope of practice.Executive Director will in-service/ educate Nurse Manager/ designee on ensuring that medical charts, physician's orders, assessments and service plans are complete and accurate by overlooking the Medication Summary daily to ensure ongoing compliance. . Nurse Manager/designee will	

	7/02/25 at 8:00 a.m., 7/03/25 at 8:00 a.m., 7/05/25 at 8:00 a.m., 7/06/25 at 8:00 a.m., and 7/08/25 at 8:00 a.m. During an interview on 7/8/25 at 2:55 p.m., Resident D indicated the facility staff store and administered all her medications including her long-acting insulin, and she had never self-injected her insulin. During an interview on 7/8/25 at 4:00 p.m., the facility NC indicated she did not know why documentation in Resident D's MAR reflected that the resident had self-administered her medication when the resident confirmed she had not. This citation is related to Complaint IN00462735. Based on observation, interview, and record review, the facility failed to ensure residents' medical charts were complete and accurately documented with insulin administrations for 2 of 6 residents' records reviewed. (Resident D and Resident E) Findings include: 1. The clinical record for Resident E was reviewed on		monitor the administration of all residents who receive insulin administration daily for six months to ensure that insulin is administered by qualified nursing staff and charted correctly. Nursing Staff who were not previously insulin certified have taken the class and is awaiting testing date to ensure that insulin is prepared and administered by qualified personnel. Nurse manager will report any concerns to the Quality Assurance committee and will follow recommendations to ensure compliance.	

	7/8/25 at 11:30 a.m. The diagnoses included, but were not limited to, diabetes mellitus type 2. A service plan, dated 5/2/25, indicated Resident E's medications were to be administered by a staff member. A self-administration of medication assessment, dated 5/2/25, indicated Resident E was able to self-administer insulin only. A physician's order, dated 8/24/24, indicated Resident E was to receive a sliding scale of lispro insulin (fast acting insulin) before meals and nightly. The sliding scale was the following: 101 - 150 blood sugar reading = 1 unit of insulin, 151-200 blood sugar reading = 2 units of insulin, 201-250 blood sugar reading = 3 units of insulin, 251-300 blood sugar reading = 4 units of insulin, 301-350 blood sugar reading = 5 units of insulin, 351-400 blood sugar reading = 6 units of insulin, 401-450 blood sugar reading = 7 units of insulin, if the blood sugar reading were greater than 450, the staff was to notify the medical provider. The July 2025 Medication Administration Record (MAR) indicated the resident was on a sliding scale of lispro insulin before meals. The following			

	days and times; the blood sugar readings, injection site, and administration notes documentation were not consistent, complete or accurate: 7/1/25 at 7:00 a.m. - symbol used for not administered, blood sugar reading 157, site administration was abdomen - documented notes indicated - self-administered; 11:00 a.m. - symbol used for self-administered, symbol used for not recorded (NR) for injection site and blood sugar reading, 7/2/25 at 7:00 a.m. - symbol used for self-administered, symbol used for not recorded (NR) for injection site and blood sugar reading; 11:00 a.m. - symbol used for self-administered, symbol used for not recorded (NR) for injection site and blood sugar reading, 7/3/25 at 7:00 a.m. - symbol used for self-administered, symbol used for not recorded (NR) for injection site and blood sugar reading; 5:00 p.m. - symbol used for self-administered, symbol used for not recorded (NR) for injection site and blood sugar reading, 7/4/25 at 7:00 a.m. - symbol used for not administered, blood			

	sugar reading 145, injection site NR, documented as resident refused; 11:00 a.m. - symbol used for not administered, blood sugar reading 169, injection site abdomen, documented as self-administered; 5:00 p.m. - symbol used for not administered, symbol used for not recorded (NR) for injection site and blood sugar reading, documented as refused medication, and 7/8/25 at 11:00 a.m. - symbol used for not administered, blood sugar reading 315, and injection site abdomen, documented as self-administered. The July 2025 MAR did not include the amount of insulin administered by staff nor the resident utilizing the lispro insulin sliding scale. An observation was conducted of an insulin administration for Resident E with Qualified Medication Aide (QMA) 1 on 7/8/25 at 11:17 a.m. QMA 1 was observed preparing to obtain Resident E's blood sugar reading. QMA 1 obtained the resident's blood sugar utilizing a glucometer. She indicated the blood sugar reading was 145. After, QMA 1 returned to her cart and pulled up the physician's order. She indicated at that time; the resident was to receive one unit of lispro insulin per the sliding scale. QMA 1			

	dialed up one unit of lispro insulin on the flex pen dial. QMA 1 returned to the resident's room; handed an alcohol wipe, and the lispro insulin flex pen to the resident. The resident administered one unit of lispro insulin into her abdomen. An interview was conducted with QMA 1 on 7/8/25 at 11:19 a.m. QMA 1 indicated she was unable to administer insulin to the residents, because she was not certified to administered insulin. She could set the insulin flex pens up by dialing up the insulin amount based on the blood sugar readings. The residents would then administer the insulin to themselves. The QMA staff that were certified in insulin administration do administer insulin to Resident E. An interview was conducted with the Nurse Consultant (NC) on 7/8/25 at 1:00 p.m. She indicated the staff's documentation was not consistent with Resident E's sliding scale of lispro insulin. Education needed to be provided to the staff. 2. The clinical record for Resident D was reviewed on 7/8/25 at 10:30 a.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus. A Mini Mental Status Exam			

	(MMSE), dated 6/26/25, indicated Resident D was cognitively intact. A service plan, dated 6/26/25, indicated Resident D was unable to take medications unless administered by someone else. Special instructions indicated the resident may self-administer insulin. A physician's order, dated 6/9/25, indicated to inject 22 units of Lantus Solostar 100 unit/milliliter (ml) (long-acting insulin) subcutaneously once daily in the morning for type 2 diabetes mellitus without complications. A record review of the MAR for Resident D was conducted on 7/8/25 at 11:40 a.m. It indicated, on 6/30/25, Resident D self-administered 22 units of Lantus Solostar long-acting insulin. On the following days and times in July, Resident D's order for 22 units of Lantus Solostar long-acting insulin was documented as "self-administered": 7/01/25 at 8:00 a.m., 7/02/25 at 8:00 a.m., 7/03/25 at 8:00 a.m.,			

	7/05/25 at 8:00 a.m., 7/06/25 at 8:00 a.m., and 7/08/25 at 8:00 a.m. During an interview on 7/8/25 at 2:55 p.m., Resident D indicated the facility staff store and administered all her medications including her long-acting insulin, and she had never self-injected her insulin. During an interview on 7/8/25 at 4:00 p.m., the facility NC indicated she did not know why documentation in Resident D's MAR reflected that the resident had self-administered her medication when the resident confirmed she had not. This citation is related to Complaint IN00462735. Based on observation, interview, and record review, the facility failed to ensure residents' medical charts were complete and accurately documented with insulin administrations for 2 of 6 residents' records reviewed. (Resident D and Resident E) Findings include:			

	1. The clinical record for Resident E was reviewed on 7/8/25 at 11:30 a.m. The diagnoses included, but were not limited to, diabetes mellitus type 2. A service plan, dated 5/2/25, indicated Resident E's medications were to be administered by a staff member. A self-administration of medication assessment, dated 5/2/25, indicated Resident E was able to self-administer insulin only. A physician's order, dated 8/24/24, indicated Resident E was to receive a sliding scale of lispro insulin (fast acting insulin) before meals and nightly. The sliding scale was the following: 101 - 150 blood sugar reading = 1 unit of insulin, 151-200 blood sugar reading = 2 units of insulin, 201-250 blood sugar reading = 3 units of insulin, 251-300 blood sugar reading = 4 units of insulin, 301-350 blood sugar reading = 5 units of insulin, 351-400 blood sugar reading = 6 units of insulin, 401-450 blood sugar reading = 7 units of insulin, if the blood sugar reading were greater than 450, the staff was to notify the medical provider. The July 2025 Medication Administration Record (MAR) indicated the resident was on a			

	sliding scale of lispro insulin before meals. The following days and times; the blood sugar readings, injection site, and administration notes documentation were not consistent, complete or accurate: 7/1/25 at 7:00 a.m. - symbol used for not administered, blood sugar reading 157, site administration was abdomen - documented notes indicated - self-administered; 11:00 a.m. - symbol used for self-administered, symbol used for not recorded (NR) for injection site and blood sugar reading, 7/2/25 at 7:00 a.m. - symbol used for self-administered, symbol used for not recorded (NR) for injection site and blood sugar reading; 11:00 a.m. - symbol used for self-administered, symbol used for not recorded (NR) for injection site and blood sugar reading, 7/3/25 at 7:00 a.m. - symbol used for self-administered, symbol used for not recorded (NR) for injection site and blood sugar reading; 5:00 p.m. - symbol used for self-administered, symbol used for not recorded (NR) for injection site and blood sugar reading,			

	7/4/25 at 7:00 a.m. - symbol used for not administered, blood sugar reading 145, injection site NR, documented as resident refused; 11:00 a.m. - symbol used for not administered, blood sugar reading 169, injection site abdomen, documented as self-administered; 5:00 p.m. - symbol used for not administered, symbol used for not recorded (NR) for injection site and blood sugar reading, documented as refused medication, and 7/8/25 at 11:00 a.m. - symbol used for not administered, blood sugar reading 315, and injection site abdomen, documented as self-administered. The July 2025 MAR did not include the amount of insulin administered by staff nor the resident utilizing the lispro insulin sliding scale. An observation was conducted of an insulin administration for Resident E with Qualified Medication Aide (QMA) 1 on 7/8/25 at 11:17 a.m. QMA 1 was observed preparing to obtain Resident E's blood sugar reading. QMA 1 obtained the resident's blood sugar utilizing a glucometer. She indicated the blood sugar reading was 145. After, QMA 1 returned to her cart and pulled up the physician's order. She indicated at that time; the resident was to			

	receive one unit of lispro insulin per the sliding scale. QMA 1 dialed up one unit of lispro insulin on the flex pen dial. QMA 1 returned to the resident's room; handed an alcohol wipe, and the lispro insulin flex pen to the resident. The resident administered one unit of lispro insulin into her abdomen. An interview was conducted with QMA 1 on 7/8/25 at 11:19 a.m. QMA 1 indicated she was unable to administer insulin to the residents, because she was not certified to administered insulin. She could set the insulin flex pens up by dialing up the insulin amount based on the blood sugar readings. The residents would then administer the insulin to themselves. The QMA staff that were certified in insulin administration do administer insulin to Resident E. An interview was conducted with the Nurse Consultant (NC) on 7/8/25 at 1:00 p.m. She indicated the staff's documentation was not consistent with Resident E's sliding scale of lispro insulin. Education needed to be provided to the staff.			

	2. The clinical record for Resident D was reviewed on 7/8/25 at 10:30 a.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus. A Mini Mental Status Exam (MMSE), dated 6/26/25, indicated Resident D was cognitively intact. A service plan, dated 6/26/25, indicated Resident D was unable to take medications unless administered by someone else. Special instructions indicated the resident may self-administer insulin. A physician's order, dated 6/9/25, indicated to inject 22 units of Lantus Solostar 100 unit/milliliter (ml) (long-acting insulin) subcutaneously once daily in the morning for type 2 diabetes mellitus without complications. A record review of the MAR for Resident D was conducted on 7/8/25 at 11:40 a.m. It indicated, on 6/30/25, Resident D self-administered 22 units of Lantus Solostar long-acting insulin.			

	On the following days and times in July, Resident D's order for 22 units of Lantus Solostar long-acting insulin was documented as "self-administered": 7/01/25 at 8:00 a.m., 7/02/25 at 8:00 a.m., 7/03/25 at 8:00 a.m., 7/05/25 at 8:00 a.m., 7/06/25 at 8:00 a.m., and 7/08/25 at 8:00 a.m. During an interview on 7/8/25 at 2:55 p.m., Resident D indicated the facility staff store and administered all her medications including her long-acting insulin, and she had never self-injected her insulin. During an interview on 7/8/25 at 4:00 p.m., the facility NC indicated she did not know why documentation in Resident D's MAR reflected that the resident had self-administered her medication when the resident confirmed she had not. This citation is related to Complaint IN00462735. Based on observation, interview, and record review, the facility failed to ensure residents' medical charts were complete and accurately			

documented with insulin administrations for 2 of 6 residents' records reviewed. (Resident D and Resident E)

Findings include:

1. The clinical record for Resident E was reviewed on 7/8/25 at 11:30 a.m. The diagnoses included, but were not limited to, diabetes mellitus type 2.

A service plan, dated 5/2/25, indicated Resident E's medications were to be administered by a staff member.

A self-administration of medication assessment, dated 5/2/25, indicated Resident E was able to self-administer insulin only.

A physician's order, dated 8/24/24, indicated Resident E was to receive a sliding scale of lispro insulin (fast acting insulin) before meals and nightly. The sliding scale was the following: 101 - 150 blood sugar reading = 1 unit of insulin, 151-200 blood sugar reading = 2 units of insulin, 201-250 blood sugar reading = 3 units of insulin, 251-300 blood sugar reading = 4 units of insulin, 301-350 blood sugar reading = 5 units of insulin, 351-400 blood sugar reading = 6 units of insulin, 401-450 blood sugar reading = 7 units of insulin, if the blood sugar reading were greater than

	450, the staff was to notify the medical provider. The July 2025 Medication Administration Record (MAR) indicated the resident was on a sliding scale of lispro insulin before meals. The following days and times; the blood sugar readings, injection site, and administration notes documentation were not consistent, complete or accurate: 7/1/25 at 7:00 a.m. - symbol used for not administered, blood sugar reading 157, site administration was abdomen - documented notes indicated - self-administered; 11:00 a.m. - symbol used for self-administered, symbol used for not recorded (NR) for injection site and blood sugar reading, 7/2/25 at 7:00 a.m. - symbol used for self-administered, symbol used for not recorded (NR) for injection site and blood sugar reading; 11:00 a.m. - symbol used for self-administered, symbol used for not recorded (NR) for injection site and blood sugar reading, 7/3/25 at 7:00 a.m. - symbol used for self-administered, symbol used for not recorded (NR) for injection site and blood sugar reading; 5:00 p.m. -			

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	glucometer. She indicated the blood sugar reading was 145. After, QMA 1 returned to her cart and pulled up the physician's order. She indicated at that time; the resident was to receive one unit of lispro insulin per the sliding scale. QMA 1 dialed up one unit of lispro insulin on the flex pen dial. QMA 1 returned to the resident's room; handed an alcohol wipe, and the lispro insulin flex pen to the resident. The resident administered one unit of lispro insulin into her abdomen. An interview was conducted with QMA 1 on 7/8/25 at 11:19 a.m. QMA 1 indicated she was unable to administer insulin to the residents, because she was not certified to administered insulin. She could set the insulin flex pens up by dialing up the insulin amount based on the blood sugar readings. The residents would then administer the insulin to themselves. The QMA staff that were certified in insulin administration do administer insulin to Resident E. An interview was conducted with the Nurse Consultant (NC) on 7/8/25 at 1:00 p.m. She indicated the staff's documentation was not consistent with Resident E's sliding scale of lispro insulin. Education needed to be provided to the staff.			

	2. The clinical record for Resident D was reviewed on 7/8/25 at 10:30 a.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus. A Mini Mental Status Exam (MMSE), dated 6/26/25, indicated Resident D was cognitively intact. A service plan, dated 6/26/25, indicated Resident D was unable to take medications unless administered by someone else. Special instructions indicated the resident may self-administer insulin. A physician's order, dated 6/9/25, indicated to inject 22 units of Lantus Solostar 100 unit/milliliter (ml) (long-acting insulin) subcutaneously once daily in the morning for type 2 diabetes mellitus without complications. A record review of the MAR for Resident D was conducted on 7/8/25 at 11:40 a.m. It indicated, on 6/30/25, Resident D self-administered 22 units of Lantus Solostar long-acting insulin.			

	On the following days and times in July, Resident D's order for 22 units of Lantus Solostar long-acting insulin was documented as "self-administered": 7/01/25 at 8:00 a.m., 7/02/25 at 8:00 a.m., 7/03/25 at 8:00 a.m., 7/05/25 at 8:00 a.m., 7/06/25 at 8:00 a.m., and 7/08/25 at 8:00 a.m. During an interview on 7/8/25 at 2:55 p.m., Resident D indicated the facility staff store and administered all her medications including her long-acting insulin, and she had never self-injected her insulin. During an interview on 7/8/25 at 4:00 p.m., the facility NC indicated she did not know why documentation in Resident D's MAR reflected that the resident had self-administered her medication when the resident confirmed she had not. This citation is related to Complaint IN00462735. Based on observation, interview, and record review, the facility failed to ensure residents' medical charts were complete and accurately			

documented with insulin administrations for 2 of 6 residents' records reviewed. (Resident D and Resident E)

Findings include:

1. The clinical record for Resident E was reviewed on 7/8/25 at 11:30 a.m. The diagnoses included, but were not limited to, diabetes mellitus type 2.

A service plan, dated 5/2/25, indicated Resident E's medications were to be administered by a staff member.

A self-administration of medication assessment, dated 5/2/25, indicated Resident E was able to self-administer insulin only.

A physician's order, dated 8/24/24, indicated Resident E was to receive a sliding scale of lispro insulin (fast acting insulin) before meals and nightly. The sliding scale was the following: 101 - 150 blood sugar reading = 1 unit of insulin, 151-200 blood sugar reading = 2 units of insulin, 201-250 blood sugar reading = 3 units of insulin, 251-300 blood sugar reading = 4 units of insulin, 301-350 blood sugar reading = 5 units of insulin, 351-400 blood sugar reading = 6 units of insulin, 401-450 blood sugar reading = 7 units of insulin, if the blood sugar reading were greater than

	450, the staff was to notify the medical provider. The July 2025 Medication Administration Record (MAR) indicated the resident was on a sliding scale of lispro insulin before meals. The following days and times; the blood sugar readings, injection site, and administration notes documentation were not consistent, complete or accurate: 7/1/25 at 7:00 a.m. - symbol used for not administered, blood sugar reading 157, site administration was abdomen - documented notes indicated - self-administered; 11:00 a.m. - symbol used for self-administered, symbol used for not recorded (NR) for injection site and blood sugar reading, 7/2/25 at 7:00 a.m. - symbol used for self-administered, symbol used for not recorded (NR) for injection site and blood sugar reading; 11:00 a.m. - symbol used for self-administered, symbol used for not recorded (NR) for injection site and blood sugar reading, 7/3/25 at 7:00 a.m. - symbol used for self-administered, symbol used for not recorded (NR) for injection site and blood sugar reading; 5:00 p.m. -			

	symbol used for self-administered, symbol used for not recorded (NR) for injection site and blood sugar reading, 7/4/25 at 7:00 a.m. - symbol used for not administered, blood sugar reading 145, injection site NR, documented as resident refused; 11:00 a.m. - symbol used for not administered, blood sugar reading 169, injection site abdomen, documented as self-administered; 5:00 p.m. - symbol used for not administered, symbol used for not recorded (NR) for injection site and blood sugar reading, documented as refused medication, and 7/8/25 at 11:00 a.m. - symbol used for not administered, blood sugar reading 315, and injection site abdomen, documented as self-administered. The July 2025 MAR did not include the amount of insulin administered by staff nor the resident utilizing the lispro insulin sliding scale. An observation was conducted of an insulin administration for Resident E with Qualified Medication Aide (QMA) 1 on 7/8/25 at 11:17 a.m. QMA 1 was observed preparing to obtain Resident E's blood sugar reading. QMA 1 obtained the resident's blood sugar utilizing a			

	glucometer. She indicated the blood sugar reading was 145. After, QMA 1 returned to her cart and pulled up the physician's order. She indicated at that time; the resident was to receive one unit of lispro insulin per the sliding scale. QMA 1 dialed up one unit of lispro insulin on the flex pen dial. QMA 1 returned to the resident's room; handed an alcohol wipe, and the lispro insulin flex pen to the resident. The resident administered one unit of lispro insulin into her abdomen. An interview was conducted with QMA 1 on 7/8/25 at 11:19 a.m. QMA 1 indicated she was unable to administer insulin to the residents, because she was not certified to administered insulin. She could set the insulin flex pens up by dialing up the insulin amount based on the blood sugar readings. The residents would then administer the insulin to themselves. The QMA staff that were certified in insulin administration do administer insulin to Resident E. An interview was conducted with the Nurse Consultant (NC) on 7/8/25 at 1:00 p.m. She indicated the staff's documentation was not consistent with Resident E's sliding scale of lispro insulin. Education needed to be provided to the staff.			

R 0414	Infection Control - Deficiency 410 IAC 16.2-5-12(k) (k) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Based on observation, interview, and record review, the facility failed to maintain infection control practices by utilizing hand hygiene for 2 of 3 residents observed during medication administrations. (Resident D and Resident E) Findings include: 1. The clinical record for Resident D was reviewed on 7/8/25 at 11:11 a.m. The diagnoses included, but were not limited to, diabetes mellitus type 2. An observation was conducted of obtaining Resident D's blood sugar reading with Qualified Medication Aide (QMA) 1 on 7/8/25 at 11:11 a.m. QMA 1 was observed gathering her insulin supplies and placing them on a black roll cart. She then rolled the cart to Resident D's room. She pulled out alcohol wipes and a black bag with the resident's glucometer. She then entered the resident's room and donned on a pair of gloves.	R 0414	. QMA will receive disciplinary action for failing to follow proper handwashing techniques when administering medications. . Nurse Manager will in service nursing staff on Handwashing/ Hand Hygiene . Nurse Manager will perform skills check off quarterly for all nursing staff quarterly for the next six months.	07/28/2025

After, she obtained the resident's blood sugar reading utilizing a glucometer and a lancet with a prick of her finger. The resident's blood sugar reading was 315. She then doffed her gloves and left the room. She walked down the hall; entered a nurse's station and grabbed a hand sanitizer bottle. She then discarded her gloves and utilized hand hygiene. There was no observation of hand hygiene prior to obtaining the supplies nor donning the gloves prior to obtaining the resident's blood sugar reading.

2. The clinical record for Resident E was reviewed on 7/8/25 at 11:30 a.m. The diagnoses included, but were not limited to, diabetes mellitus type 2.

An observation was conducted of an insulin administration with QMA 1 for Resident E on 7/8/25 at 11:17 a.m. QMA 1 was observed preparing to obtain Resident E's blood sugar reading. QMA 1 gathered her supplies and a pair of gloves. She then walked to a window and opened it. After, she requested Resident E to return inside to obtain her blood sugar. The resident returned to her room, and QMA 1 entered the resident's room. She then donned gloves and obtained the resident's blood sugar reading

utilizing a glucometer and a lancet with a prick of the resident's finger. There was no observation of hand hygiene prior to gathering the supplies; nor prior to donning or doffing the gloves. After, she returned to the cart and prepared the resident's insulin utilizing a flex pen. During that time, she was observed touching the mouse on her computer and a basket of insulin supplies. After, she entered the resident's room and handed the resident an alcohol wipe and the insulin flex pen to administer the insulin to herself. There was no observation of hand hygiene prior or after preparing the insulin flex pen.

An interview was conducted with QMA 1 on 7/8/25 at 11:19 a.m. QMA 1 indicated she should have utilized hand hygiene prior to donning gloves but had forgotten.

An interview was conducted with the Nurse Consultant (NC) on 7/8/25 at 1:00 p.m. She indicated QMA 1 should have utilized hand hygiene prior to donning gloves and after doffing gloves.

A handwashing policy was provided by the NC on 7/8/25 at 3:45 p.m. It indicated "...Purpose: Handwashing is the single most important measure for preventing the spread of infection. Policy: The employee

should was his/her hands routinely after each direct Resident contact...and after handling contaminated articles...Note: Remember, when a resident's body is weakened by illness of any kind, even his/her own germs can be a danger to him/her. It is your responsibility to minimize the spread of germs in the nursing facility by keeping the resident, his/her surroundings, and yourself as clean and free of germs as possible..."

This citation is related to Complaint IN00462735.

Based on observation, interview, and record review, the facility failed to maintain infection control practices by utilizing hand hygiene for 2 of 3 residents observed during medication administrations. (Resident D and Resident E)

Findings include:

1. The clinical record for Resident D was reviewed on 7/8/25 at 11:11 a.m. The diagnoses included, but were not limited to, diabetes mellitus type 2.

An observation was conducted of obtaining Resident D's blood sugar reading with Qualified Medication Aide (QMA) 1 on 7/8/25 at 11:11 a.m. QMA 1 was observed gathering her insulin supplies and placing them on a

black roll cart. She then rolled the cart to Resident D's room. She pulled out alcohol wipes and a black bag with the resident's glucometer. She then entered the resident's room and donned on a pair of gloves. After, she obtained the resident's blood sugar reading utilizing a glucometer and a lancet with a prick of her finger. The resident's blood sugar reading was 315. She then doffed her gloves and left the room. She walked down the hall; entered a nurse's station and grabbed a hand sanitizer bottle. She then discarded her gloves and utilized hand hygiene. There was no observation of hand hygiene prior to obtaining the supplies nor donning the gloves prior to obtaining the resident's blood sugar reading.

2. The clinical record for Resident E was reviewed on 7/8/25 at 11:30 a.m. The diagnoses included, but were not limited to, diabetes mellitus type 2.

An observation was conducted of an insulin administration with QMA 1 for Resident E on 7/8/25 at 11:17 a.m. QMA 1 was observed preparing to obtain Resident E's blood sugar reading. QMA 1 gathered her supplies and a pair of gloves. She then walked to a window and opened it. After, she

requested Resident E to return inside to obtain her blood sugar. The resident returned to her room, and QMA 1 entered the resident's room. She then donned gloves and obtained the resident's blood sugar reading utilizing a glucometer and a lancet with a prick of the resident's finger. There was no observation of hand hygiene prior to gathering the supplies; nor prior to donning or doffing the gloves. After, she returned to the cart and prepared the resident's insulin utilizing a flex pen. During that time, she was observed touching the mouse on her computer and a basket of insulin supplies. After, she entered the resident's room and handed the resident an alcohol wipe and the insulin flex pen to administer the insulin to herself. There was no observation of hand hygiene prior or after preparing the insulin flex pen.

An interview was conducted with QMA 1 on 7/8/25 at 11:19 a.m. QMA 1 indicated she should have utilized hand hygiene prior to donning gloves but had forgotten.

An interview was conducted with the Nurse Consultant (NC) on 7/8/25 at 1:00 p.m. She indicated QMA 1 should have utilized hand hygiene prior to donning gloves and after doffing gloves.

	A handwashing policy was provided by the NC on 7/8/25 at 3:45 p.m. It indicated "...Purpose: Handwashing is the single most important measure for preventing the spread of infection. Policy: The employee should was his/her hands routinely after each direct Resident contact...and after handling contaminated articles...Note: Remember, when a resident's body is weakened by illness of any kind, even his/her own germs can be a danger to him/her. It is your responsibility to minimize the spread of germs in the nursing facility by keeping the resident, his/her surroundings, and yourself as clean and free of germs as possible..." This citation is related to Complaint IN00462735.			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE