STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/30/2025

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 a State Residential Licensure Survey. This visit included the Investigation of Intake IN00463191. Intake IN00463191 - No deficiencies related to the allegations are cited. Survey dates: October 29 and 30, 2025 Facility number: 005729 Residential Census: 28 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on November 3, 2025.	R 0000	Submission of this plan of correction does not constitute an admission of guilt. All residents were found to have been at risk for potential harm of said issue, however no residents were found to have been harmed.	
R 0155	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(l) (l) The facility shall have an effective garbage and waste	R 0155	. The area around the dumpster was cleaned, the lids were closed and the fence	11/06/2025

	disposal program in accordance with 410 IAC 7-24. Provision shall be made for the safe and sanitary disposal of solid waste, including dressings, needles, syringes, and similar items. Based on observation, interview, and record review, the facility failed to ensure trash was contained in the dumpster for the potential to affect 28 of 28 residents in the facility. Findings include: An environmental tour of the facility was conducted with the Administrator on 10/30/25 at 11:45 a.m. An interview was conducted with the Administrator at that time. During the tour, the outside dumpster area was observed. There was an empty, extra-large sized, Styrofoam fountain cup, empty 20 oz. pop bottle, small plastic cup, Styrofoam take out container, lottery ticket, beer can, air freshener top, three empty medication cups, a plastic bag, cookie wrapper, empty pop can, and latex glove on the ground on either side and in front of the dumpster. There were leaves mixed in with all the trash. The Administrator indicated she was unsure why the trash was on the ground. The Sanitation and Safety Standards was provided by the Administrator on 10/30/25 at		around the dumpster was closed, immediately. . All residents have the potential to be affected. . The Executive Director will in-service all staff on the Sanitation and Safety Policy. The Executive Director or designee will monitor the dumpster twice daily to ensure that trash is contained in the dumpster and the area around the dumpster is free of trash and debris, the lid on dumpster as well as the fence is shut. . This will be reviewed in the Quality Assurance meeting and any recommendations will be followed to ensure ongoing compliance. . Date completed 11/21/2025	

	12:30 p.m. It indicated, "Purpose: To ensure facility is clean, orderly, and in a state of good repair, both inside and out, to provide reasonable comfort for all residents....This facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free from hazards that may affect the health and welfare of the residents or public..." Based on observation, interview, and record review, the facility failed to ensure trash was contained in the dumpster for the potential to affect 28 of 28 residents in the facility. Findings include: An environmental tour of the facility was conducted with the Administrator on 10/30/25 at 11:45 a.m. An interview was conducted with the Administrator at that time. During the tour, the outside dumpster area was observed. There was an empty, extra-large sized, Styrofoam fountain cup, empty 20 oz. pop bottle, small plastic cup, Styrofoam take out container, lottery ticket, beer can, air freshener top, three empty medication cups, a plastic bag, cookie wrapper, empty pop can, and latex glove on the ground on either side and in front of the dumpster. There were leaves mixed in with all the trash. The Administrator			

	indicated she was unsure why the trash was on the ground. The Sanitation and Safety Standards was provided by the Administrator on 10/30/25 at 12:30 p.m. It indicated, "Purpose: To ensure facility is clean, orderly, and in a state of good repair, both inside and out, to provide reasonable comfort for all residents....This facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free from hazards that may affect the health and welfare of the residents or public..."			
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. 3. The clinical record for Resident F was reviewed on 10/30/25 at 10:00 a.m. Her diagnoses included, but were not limited to, chronic pain and restless leg syndrome. She was currently receiving hospice services. The 9/16/25 Evaluation of Needs/Service Plan indicated she was alert, oriented, and made sound independent decisions. She was unable to	R 0240	R 240: . Parameters have been put in place for the residents in question. All residents currently using oxygen now have orders in place. . All residents have the potential to be affected. . The Director of Health Services or Nurse	11/06/2025

	take medications unless administered by someone else. An observation and interview were conducted with Resident F in her apartment on 10/30/25 at 10:33 a.m. She was sitting on her couch, wearing her oxygen via nasal cannula. She indicated she didn't get her morphine the other day, and she was in pain at the time. The physician's orders indicated to administer one 15 mg tablet of morphine sulfate extended release twice daily for pain, effective 10/27/25; two 500 mg caplets of acetaminophen every six hours as needed for pain, effective 8/15/24; and two 325 mg tablets of acetaminophen PRN (as needed) for headache/fever over 100/pain, effective 3/18/25. The October 2025 MAR indicated she was not administered the, 10/28/25, p.m. dose of morphine due to awaiting the medication from pharmacy or the, 10/29/25, a.m. dose with a note that indicated, "did not administer." An interview was conducted with the DON (Director of Nursing) on 10/30/25 at 11:30 a.m. She indicated the morphine was unavailable to administer. It wasn't in their emergency drug kit, and it hadn't come in yet from the pharmacy. The hospice		Consultant will observe medication pass on 3 residents receiving medications with parameters, as available, and/or controlled substances, as available, weekly x4 weeks, then bi-weekly x 8 weeks, then monthly x3 months to ensure ongoing compliance is maintained. . The Director of Health Services or Nurse Consultant will round on 3 residents with oxygen, as available, and ensure orders are in place weekly x4 weeks, then bi-weekly x 8 weeks, then monthly x3 months to ensure ongoing compliance is maintained. This will be reviewed in the Quality Assurance meeting and any recommendations will be followed to ensure ongoing compliance. . Date Completed 11/21/2025	

company did not process the order timely. Resident F received as needed administrations of acetaminophen, on 10/28/25 and 10/29/25, to address her pain. They were administered by QMA (Qualified Medication Aide) 2 and QMA 3, as the DON "saw staff give her" the acetaminophen. Both administrations should have been documented as given and follow-up assessment for effectiveness.

The October 2025 MAR did not indicate she was administered any as needed acetaminophen, on 10/28/25 or 10/29/25, or follow-up for effectiveness of those administrations.

The DON provided the PRN Medication Binder on 10/30/25 at 1:57 p.m. An interview was conducted with her at this time. There was no documentation of PRN acetaminophen administrations for Resident F on 10/28/25 or 10/29/25. The DON indicated they just started using this binder, so Resident F's acetaminophen administrations on 10/28/25 and 10/29/25 were not in there.

The PRN Procedure policy was provided by the DON on 10/30/25 at 12:25 p.m. It indicated, "When a resident requests a PRN medication: ...2. Once you verify that there is an

order on the MAR, contact the nurse on call to approve it via text or call. 3. Document in this book the date, time, resident, medication given, and the name of the nurse on call that gave you approval. The effectiveness of a PRN medication can only be signed off by a nurse."

Based on observation, interview, and record review, the facility failed to administer a resident's pain medication as ordered, document administration of as needed pain medication, and monitor for the effectiveness of as needed pain medication (Resident F); ensure a physician's order was present for a resident receiving oxygen services; and physician's orders were timely clarified prior to not administering medications as ordered for 3 of 5 residents reviewed. (Resident B, Resident F and Resident 24)

Findings include:

1. The clinical record for Resident B was reviewed on 10/29/25 at 10:30 a.m. The diagnoses included, but were not limited to, heart failure and hypertension.

A service plan, dated 8/20/25, indicated that staff were to administer medications to Resident B.

A physician's order, dated

2/20/24, indicated Resident B was to receive 50 milligrams (mg) of metoprolol twice a day. The order did not include blood pressure parameters for when to hold the metoprolol.

The October 2025 Medication Administration Record (MAR) indicated the following day(s) and time(s) the resident did not receive the 50 milligrams of metoprolol:

10/6/25 at 6:00 a.m. - no blood pressure or pulse reading recorded, - documented "blood pressure to low",

10/20/25 at 6:00 a.m. - blood pressure reading 142/80 no pulse reading recorded - documented "blood pressure to low",

10/26/25 at 6:00 a.m. - blood pressure reading 141/81 no pulse reading recorded - documented "blood pressure to low", and

10/27/25 at 6:00 a.m. - blood pressure reading 111/74 no pulse reading recorded - documented "blood pressure to low"

An interview was conducted with the Nurse Consultant on 10/30/25 at 1:57 p.m. She indicated Resident B did not have blood pressure parameters ordered for staff to hold his 50 milligrams of metoprolol due to

blood pressure reading. She had notified the medical provider to receive blood pressure reading parameters.

2a. The clinical record for Resident 24 was reviewed on 10/30/25 at 9:30 a.m. The diagnoses included, but were not limited to, congestive heart failure and chronic respiratory failure with hypoxia (not enough oxygen supply).

During an entrance tour, dated 10/29/25, Resident 24's room was observed. Resident 24 had oxygen usage signage on her door. The Director of Nursing (DON) indicated the resident used oxygen.

A service plan, dated 8/20/25, indicated necessary equipment Resident 24 needed included, but was not limited to, oxygen.

The resident's clinical record did not include physician's orders for oxygen services.

2b. A physician's order, dated 11/1/23, indicated Resident 24 was to receive 40 milligrams of propranolol twice a day. The order did not include blood pressure parameters on when to hold the medication.

The October 2025 MAR for Resident 24 indicated the following days and shifts the resident did not receive 40 milligrams of propranolol twice a

	day as ordered: 10/1/25 at 6:00 a.m. - no recorded blood pressure or pulse reading - documented "blood pressure to low", 6:00 p.m. - no recorded blood pressure or pulse reading - no documented reason, 10/2/25 at 6:00 a.m. - blood pressure reading 100/45 and 60 pulse reading - documented "blood sugar (sic) to low," 10/6/25 at 6:00 a.m. - no recorded blood pressure reading or pulse reading - documented "blood pressure to low," 10/8/25 at 6:00 a.m. - blood pressure reading 97/61 and 65 pulse reading - documented "blood pressure to low," 10/9/25 at 6:00 a.m. - blood pressure reading 996/65 (sic) and 73 pulse reading - documented "blood pressure to low," 10/12/25 at 6:00 a.m. - blood pressure reading 108/65 and 66 pulse reading - documented "blood pressure to low," 10/14/25 at 6:00 a.m. - blood pressure reading 85/62 and 61 pulse reading - documented "blood pressure to low," 10/21/25 at 6:00 a.m. - blood pressure reading 998/63 (sic)			

	and 73 pulse reading - documented "blood pressure to low," 10/22/25 at 6:00 a.m. - no recorded blood pressure reading or pulse reading - documented "blood pressure to low," 10/23/25 at 6:00 a.m. - blood pressure 104 (sic) and 56 pulse reading - documented "blood pressure to low," and 10/27/25 at 6:00 a.m. - blood pressure reading 103/60 and no recorded pulse reading - documented as "blood pressure to low". An interview was conducted with the Nurse Consultant (NC) on 10/30/25 at 12:01 p.m. She indicated Resident 24 did not have blood pressure parameters in place to hold the 40 milligrams of propranolol. The resident does use three liters of oxygen. She was unable to find physician's orders for oxygen usage. The NC notified the medical provider to receive blood pressure parameter orders for the 40 milligrams of propranolol medication and receive an order for oxygen usage. 3. The clinical record for Resident F was reviewed on 10/30/25 at 10:00 a.m. Her diagnoses included, but were not limited to, chronic pain and			

restless leg syndrome. She was currently receiving hospice services.

The 9/16/25 Evaluation of Needs/Service Plan indicated she was alert, oriented, and made sound independent decisions. She was unable to take medications unless administered by someone else.

An observation and interview were conducted with Resident F in her apartment on 10/30/25 at 10:33 a.m. She was sitting on her couch, wearing her oxygen via nasal cannula. She indicated she didn't get her morphine the other day, and she was in pain at the time.

The physician's orders indicated to administer one 15 mg tablet of morphine sulfate extended release twice daily for pain, effective 10/27/25; two 500 mg caplets of acetaminophen every six hours as needed for pain, effective 8/15/24; and two 325 mg tablets of acetaminophen PRN (as needed) for headache/fever over 100/pain, effective 3/18/25.

The October 2025 MAR indicated she was not administered the, 10/28/25, p.m. dose of morphine due to awaiting the medication from pharmacy or the, 10/29/25, a.m. dose with a note that indicated, "did not administer."

	An interview was conducted with the DON (Director of Nursing) on 10/30/25 at 11:30 a.m. She indicated the morphine was unavailable to administer. It wasn't in their emergency drug kit, and it hadn't come in yet from the pharmacy. The hospice company did not process the order timely. Resident F received as needed administrations of acetaminophen, on 10/28/25 and 10/29/25, to address her pain. They were administered by QMA (Qualified Medication Aide) 2 and QMA 3, as the DON "saw staff give her" the acetaminophen. Both administrations should have been documented as given and follow-up assessment for effectiveness. The October 2025 MAR did not indicate she was administered any as needed acetaminophen, on 10/28/25 or 10/29/25, or follow-up for effectiveness of those administrations. The DON provided the PRN Medication Binder on 10/30/25 at 1:57 p.m. An interview was conducted with her at this time. There was no documentation of PRN acetaminophen administrations for Resident F on 10/28/25 or 10/29/25. The DON indicated they just started using this binder, so Resident F's acetaminophen administrations on 10/28/25 and			

	10/29/25 were not in there. The PRN Procedure policy was provided by the DON on 10/30/25 at 12:25 p.m. It indicated, "When a resident requests a PRN medication: ...2. Once you verify that there is an order on the MAR, contact the nurse on call to approve it via text or call. 3. Document in this book the date, time, resident, medication given, and the name of the nurse on call that gave you approval. The effectiveness of a PRN medication can only be signed off by a nurse." Based on observation, interview, and record review, the facility failed to administer a resident's pain medication as ordered, document administration of as needed pain medication, and monitor for the effectiveness of as needed pain medication (Resident F); ensure a physician's order was present for a resident receiving oxygen services; and physician's orders were timely clarified prior to not administering medications as ordered for 3 of 5 residents reviewed. (Resident B, Resident F and Resident 24) Findings include: 1. The clinical record for Resident B was reviewed on 10/29/25 at 10:30 a.m. The diagnoses included, but were			

not limited to, heart failure and hypertension.

A service plan, dated 8/20/25, indicated that staff were to administer medications to Resident B.

A physician's order, dated 2/20/24, indicated Resident B was to receive 50 milligrams (mg) of metoprolol twice a day. The order did not include blood pressure parameters for when to hold the metoprolol.

The October 2025 Medication Administration Record (MAR) indicated the following day(s) and time(s) the resident did not receive the 50 milligrams of metoprolol:

10/6/25 at 6:00 a.m. - no blood pressure or pulse reading recorded, - documented "blood pressure to low",

10/20/25 at 6:00 a.m. - blood pressure reading 142/80 no pulse reading recorded - documented "blood pressure to low",

10/26/25 at 6:00 a.m. - blood pressure reading 141/81 no pulse reading recorded - documented "blood pressure to low", and

10/27/25 at 6:00 a.m. - blood pressure reading 111/74 no pulse reading recorded - documented "blood pressure to

low"

An interview was conducted with the Nurse Consultant on 10/30/25 at 1:57 p.m. She indicated Resident B did not have blood pressure parameters ordered for staff to hold his 50 milligrams of metoprolol due to blood pressure reading. She had notified the medical provider to receive blood pressure reading parameters.

2a. The clinical record for Resident 24 was reviewed on 10/30/25 at 9:30 a.m. The diagnoses included, but were not limited to, congestive heart failure and chronic respiratory failure with hypoxia (not enough oxygen supply).

During an entrance tour, dated 10/29/25, Resident 24's room was observed. Resident 24 had oxygen usage signage on her door. The Director of Nursing (DON) indicated the resident used oxygen.

A service plan, dated 8/20/25, indicated necessary equipment Resident 24 needed included, but was not limited to, oxygen.

The resident's clinical record did not include physician's orders for oxygen services.

2b. A physician's order, dated 11/1/23, indicated Resident 24 was to receive 40 milligrams of propranolol twice a day. The

order did not include blood pressure parameters on when to hold the medication.

The October 2025 MAR for Resident 24 indicated the following days and shifts the resident did not receive 40 milligrams of propranolol twice a day as ordered:

10/1/25 at 6:00 a.m. - no recorded blood pressure or pulse reading - documented "blood pressure to low", 6:00 p.m. - no recorded blood pressure or pulse reading - no documented reason,

10/2/25 at 6:00 a.m. - blood pressure reading 100/45 and 60 pulse reading - documented "blood sugar (sic) to low,"

10/6/25 at 6:00 a.m. - no recorded blood pressure reading or pulse reading - documented "blood pressure to low,"

10/8/25 at 6:00 a.m. - blood pressure reading 97/61 and 65 pulse reading - documented "blood pressure to low,"

10/9/25 at 6:00 a.m. - blood pressure reading 996/65 (sic) and 73 pulse reading - documented "blood pressure to low,"

10/12/25 at 6:00 a.m. - blood pressure reading 108/65 and 66 pulse reading - documented

"blood pressure to low,"

10/14/25 at 6:00 a.m. - blood pressure reading 85/62 and 61 pulse reading - documented "blood pressure to low,"

10/21/25 at 6:00 a.m. - blood pressure reading 998/63 (sic) and 73 pulse reading - documented "blood pressure to low,"

10/22/25 at 6:00 a.m. - no recorded blood pressure reading or pulse reading - documented "blood pressure to low,"

10/23/25 at 6:00 a.m. - blood pressure 104 (sic) and 56 pulse reading - documented "blood pressure to low," and

10/27/25 at 6:00 a.m. - blood pressure reading 103/60 and no recorded pulse reading - documented as "blood pressure to low".

An interview was conducted with the Nurse Consultant (NC) on 10/30/25 at 12:01 p.m. She indicated Resident 24 did not have blood pressure parameters in place to hold the 40 milligrams of propranolol. The resident does use three liters of oxygen. She was unable to find physician's orders for oxygen usage. The NC notified the medical provider to receive blood pressure parameter orders for the 40 milligrams of

propranolol medication and receive an order for oxygen usage.

3. The clinical record for Resident F was reviewed on 10/30/25 at 10:00 a.m. Her diagnoses included, but were not limited to, chronic pain and restless leg syndrome. She was currently receiving hospice services.

The 9/16/25 Evaluation of Needs/Service Plan indicated she was alert, oriented, and made sound independent decisions. She was unable to take medications unless administered by someone else.

An observation and interview were conducted with Resident F in her apartment on 10/30/25 at 10:33 a.m. She was sitting on her couch, wearing her oxygen via nasal cannula. She indicated she didn't get her morphine the other day, and she was in pain at the time.

The physician's orders indicated to administer one 15 mg tablet of morphine sulfate extended release twice daily for pain, effective 10/27/25; two 500 mg caplets of acetaminophen every six hours as needed for pain, effective 8/15/24; and two 325 mg tablets of acetaminophen PRN (as needed) for headache/fever over 100/pain, effective 3/18/25.

	The October 2025 MAR indicated she was not administered the, 10/28/25, p.m. dose of morphine due to awaiting the medication from pharmacy or the, 10/29/25, a.m. dose with a note that indicated, "did not administer." An interview was conducted with the DON (Director of Nursing) on 10/30/25 at 11:30 a.m. She indicated the morphine was unavailable to administer. It wasn't in their emergency drug kit, and it hadn't come in yet from the pharmacy. The hospice company did not process the order timely. Resident F received as needed administrations of acetaminophen, on 10/28/25 and 10/29/25, to address her pain. They were administered by QMA (Qualified Medication Aide) 2 and QMA 3, as the DON "saw staff give her" the acetaminophen. Both administrations should have been documented as given and follow-up assessment for effectiveness. The October 2025 MAR did not indicate she was administered any as needed acetaminophen, on 10/28/25 or 10/29/25, or follow-up for effectiveness of those administrations. The DON provided the PRN Medication Binder on 10/30/25 at 1:57 p.m. An interview was			

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reviewed. (Resident B, Resident F and Resident 24)

Findings include:

1. The clinical record for Resident B was reviewed on 10/29/25 at 10:30 a.m. The diagnoses included, but were not limited to, heart failure and hypertension.

A service plan, dated 8/20/25, indicated that staff were to administer medications to Resident B.

A physician's order, dated 2/20/24, indicated Resident B was to receive 50 milligrams (mg) of metoprolol twice a day. The order did not include blood pressure parameters for when to hold the metoprolol.

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A service plan, dated 8/20/25, indicated necessary equipment Resident 24 needed included, but was not limited to, oxygen.

The resident's clinical record did not include physician's orders for oxygen services.

2b. A physician's order, dated 11/1/23, indicated Resident 24 was to receive 40 milligrams of propranolol twice a day. The order did not include blood pressure parameters on when to hold the medication.

The October 2025 MAR for Resident 24 indicated the following days and shifts the resident did not receive 40 milligrams of propranolol twice a day as ordered:

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	administrations of acetaminophen, on 10/28/25 and 10/29/25, to address her pain. They were administered by QMA (Qualified Medication Aide) 2 and QMA 3, as the DON "saw staff give her" the acetaminophen. Both administrations should have been documented as given and follow-up assessment for effectiveness. The October 2025 MAR did not indicate she was administered any as needed acetaminophen, on 10/28/25 or 10/29/25, or follow-up for effectiveness of those administrations. The DON provided the PRN Medication Binder on 10/30/25 at 1:57 p.m. An interview was conducted with her at this time. There was no documentation of PRN acetaminophen administrations for Resident F on 10/28/25 or 10/29/25. The DON indicated they just started using this binder, so Resident F's acetaminophen administrations on 10/28/25 and 10/29/25 were not in there. The PRN Procedure policy was provided by the DON on 10/30/25 at 12:25 p.m. It indicated, "When a resident requests a PRN medication: ...2. Once you verify that there is an order on the MAR, contact the nurse on call to approve it via text or call. 3. Document in this			

book the date, time, resident, medication given, and the name of the nurse on call that gave you approval. The effectiveness of a PRN medication can only be signed off by a nurse."

Based on observation, interview, and record review, the facility failed to administer a resident's pain medication as ordered, document administration of as needed pain medication, and monitor for the effectiveness of as needed pain medication (Resident F); ensure a physician's order was present for a resident receiving oxygen services; and physician's orders were timely clarified prior to not administering medications as ordered for 3 of 5 residents reviewed. (Resident B, Resident F and Resident 24)

Findings include:

1. The clinical record for Resident B was reviewed on 10/29/25 at 10:30 a.m. The diagnoses included, but were not limited to, heart failure and hypertension.

A service plan, dated 8/20/25, indicated that staff were to administer medications to Resident B.

A physician's order, dated 2/20/24, indicated Resident B was to receive 50 milligrams (mg) of metoprolol twice a day.

	The order did not include blood pressure parameters for when to hold the metoprolol. The October 2025 Medication Administration Record (MAR) indicated the following day(s) and time(s) the resident did not receive the 50 milligrams of metoprolol: 10/6/25 at 6:00 a.m. - no blood pressure or pulse reading recorded, - documented "blood pressure to low", 10/20/25 at 6:00 a.m. - blood pressure reading 142/80 no pulse reading recorded - documented "blood pressure to low", 10/26/25 at 6:00 a.m. - blood pressure reading 141/81 no pulse reading recorded - documented "blood pressure to low", and 10/27/25 at 6:00 a.m. - blood pressure reading 111/74 no pulse reading recorded - documented "blood pressure to low" An interview was conducted with the Nurse Consultant on 10/30/25 at 1:57 p.m. She indicated Resident B did not have blood pressure parameters ordered for staff to hold his 50 milligrams of metoprolol due to blood pressure reading. She had notified the medical provider to receive blood			

pressure reading parameters.

2a. The clinical record for Resident 24 was reviewed on 10/30/25 at 9:30 a.m. The diagnoses included, but were not limited to, congestive heart failure and chronic respiratory failure with hypoxia (not enough oxygen supply).

During an entrance tour, dated 10/29/25, Resident 24's room was observed. Resident 24 had oxygen usage signage on her door. The Director of Nursing (DON) indicated the resident used oxygen.

A service plan, dated 8/20/25, indicated necessary equipment Resident 24 needed included, but was not limited to, oxygen.

The resident's clinical record did not include physician's orders for oxygen services.

2b. A physician's order, dated 11/1/23, indicated Resident 24 was to receive 40 milligrams of propranolol twice a day. The order did not include blood pressure parameters on when to hold the medication.

The October 2025 MAR for Resident 24 indicated the following days and shifts the resident did not receive 40 milligrams of propranolol twice a day as ordered:

10/1/25 at 6:00 a.m. - no

	recorded blood pressure or pulse reading - documented "blood pressure to low", 6:00 p.m. - no recorded blood pressure or pulse reading - no documented reason, 10/2/25 at 6:00 a.m. - blood pressure reading 100/45 and 60 pulse reading - documented "blood sugar (sic) to low," 10/6/25 at 6:00 a.m. - no recorded blood pressure reading or pulse reading - documented "blood pressure to low," 10/8/25 at 6:00 a.m. - blood pressure reading 97/61 and 65 pulse reading - documented "blood pressure to low," 10/9/25 at 6:00 a.m. - blood pressure reading 996/65 (sic) and 73 pulse reading - documented "blood pressure to low," 10/12/25 at 6:00 a.m. - blood pressure reading 108/65 and 66 pulse reading - documented "blood pressure to low," 10/14/25 at 6:00 a.m. - blood pressure reading 85/62 and 61 pulse reading - documented "blood pressure to low,"			

	10/21/25 at 6:00 a.m. - blood pressure reading 998/63 (sic) and 73 pulse reading - documented "blood pressure to low," 10/22/25 at 6:00 a.m. - no recorded blood pressure reading or pulse reading - documented "blood pressure to low," 10/23/25 at 6:00 a.m. - blood pressure 104 (sic) and 56 pulse reading - documented "blood pressure to low," and 10/27/25 at 6:00 a.m. - blood pressure reading 103/60 and no recorded pulse reading - documented as "blood pressure to low". An interview was conducted with the Nurse Consultant (NC) on 10/30/25 at 12:01 p.m. She indicated Resident 24 did not have blood pressure parameters in place to hold the 40 milligrams of propranolol. The resident does use three liters of oxygen. She was unable to find physician's orders for oxygen usage. The NC notified the medical provider to receive blood pressure parameter orders for the 40 milligrams of propranolol medication and receive an order for oxygen usage.			
R 0299	Pharmaceutical Services -	R 0299		11/06/2025

	Noncompliance 410 IAC 16.2-5-6(c)(3) (3) The medication review, recommendations, and notification of the physician, if necessary, shall be documented in accordance with the facility ' s policy. Based on interview and record review, the facility failed to timely follow-up on a pharmacy recommendation for 1 of 5 residents reviewed for pharmacy recommendations. (Resident 10) Findings include: The clinical record for Resident 10 was reviewed on 10/29/25 at 1:38 p.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease and hypertension. A physician's order, dated 5/13/25, indicated she was to receive fluticasone nasal spray; one spray in each nostril twice daily for 14 days. A July 2025 Consultant Pharmacy Report indicated Resident 10 had an order for fluticasone nasal spray; one spray in each nostril for 14 days. The order needed to be clarified or discontinued. The clinical record did not contain documentation that the pharmacy recommendation was		. The pharmacy recommendation in question has been addressed and the medication has been discontinued. . All residents have the potential to be affected. . Pharmacy recommendations will be audited by the DHS and/or Nurse Consultant . The Director of Health Services or Nurse Consultant will review all pharmacy recommendations for completion weekly x4 weeks, then bi- weekly x8 weeks, then monthly x3 to ensure ongoing compliance is maintained. This will be reviewed in the Quality Assurance meeting and any recommendations will be followed to ensure ongoing compliance. . Date completed 11/21/2025	

addressed until 9/24/25, when it was discontinued.

During an interview on 10/30/25 at 2:11 p.m., the Nurse Consultant indicated the pharmacy recommendation should have been followed up with.

On 10/30/25 at 2:12 p.m., the Nurse Consultant provided the Pharmacy Review and Recommendations policy, dated 1/2025, that indicated "...The facility shall have a contracted, licensed pharmacist. The pharmacist shall perform medication reviews on all residents every 60 days and provide the Director of Health Services a full report, including orders needing clarification and any recommendations that pharmacist has..."

Based on interview and record review, the facility failed to timely follow-up on a pharmacy recommendation for 1 of 5 residents reviewed for pharmacy recommendations. (Resident 10)

Findings include:

The clinical record for Resident 10 was reviewed on 10/29/25 at 1:38 p.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease and hypertension.

A physician's order, dated

5/13/25, indicated she was to receive fluticasone nasal spray; one spray in each nostril twice daily for 14 days.

A July 2025 Consultant Pharmacy Report indicated Resident 10 had an order for fluticasone nasal spray; one spray in each nostril for 14 days. The order needed to be clarified or discontinued.

The clinical record did not contain documentation that the pharmacy recommendation was addressed until 9/24/25, when it was discontinued.

During an interview on 10/30/25 at 2:11 p.m., the Nurse Consultant indicated the pharmacy recommendation should have been followed up with.

On 10/30/25 at 2:12 p.m., the Nurse Consultant provided the Pharmacy Review and Recommendations policy, dated 1/2025, that indicated "...The facility shall have a contracted, licensed pharmacist. The pharmacist shall perform medication reviews on all residents every 60 days and provide the Director of Health Services a full report, including orders needing clarification and any recommendations that pharmacist has..."

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 SIGNATUREAndrea Wilson	TITLERCA	(X6) DATE11/11/2025