STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATEAU OF BATESVILLE	44 CHATEAU BLVD, BATESVILLE, , 47006

(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 IN00461828. Complaint IN00461828 - State Residential Findings related to the allegations are cited at R090 and R0241. Survey date: June 25, 2025. Facility number: 006489 Residential Census: 41 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Qualtiy review completed on June 26, 2025.	R 0000	This Plan of Correction is submitted as required under State law. The submission of this Plan of Correction does not constitute an admission on the part of Chateau of Batesville as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. The submission of this Plan of Correction does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures, as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any judicial and/or administrative	

			proceeding on that basis. The Community also submits this Plan of Correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.	
R 0090	Administration and Management - Deficiency 410 IAC 16.2-5-1.3(g)(1-6) (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or	R 0090	This citation did not meet reporting guidelines. Since this incident didn't qualify as a reportable, we should not be cited. The Community will ensure that all investigations and their outcomes are reported to the Indiana Department of Health (IDOH) within five working days of the incident. The Community reviewed each resident’s record to determine which residents, if any, could be affected by the alleged deficient practice. The Executive Director and Wellness Director reviewed the state incident reporting requirements,	06/25/2025

	(D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request		including the requirement to submit a 5-day follow-up report to IDOH. The Executive Director, the Wellness Director, or designee will review all new incidents at the weekday daily morning meeting to determine if the incident meets state reporting guidelines. This will be ongoing.	

R 0241	Health Services - Offense 410 IAC 16.2-5-4(e)(1) (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on observation, interview, and record review, the facility failed to prevent a medication error that required hospital intervention for 1 of 3 residents reviewed. (Resident B) Findings include: During an observation and interview, on 6/25/25 at 2:14 P.M., Resident B was sitting in her recliner in her room. She had gotten up and walked towards the door without any problems. During interview, on 06/25/25 at 10:25 A.M., Licensed Practical Nurse (LPN) 2 indicated she gave Resident B Resident C's medications, on the morning of 05/28/25, in the facility dining room. A short time after giving Resident B the medications, LPN 2 received a phone call from Resident B's family	R 0241	1 Resident B is free from medication errors. The Community reviewed each resident’s record to determine which residents, if any, could be affected by the alleged deficient practice. The Wellness Director completed medication administrations alongside Licensed Practical Nurse 2 (LPN#2) during the remainder of the shift on 5/25/2028 following the incident. The Wellness Director provided an in-service training to LPN#2 on medication administration, including resident identification. LPN#2 received one-on-one supervision for her next two shifts (5/31/25 & 6/1/25) in order to ensure competency and no further concerns were identified. The Wellness Director confirmed the Community’s electronic medication administration system displayed a current photo of each resident for each administration. A miniature binder with updated photos has also been placed securely in each medicine cart for easy reference.	06/25/2025

member saying that someone had given his family member someone else's medication in the dining room. His family member should have not received any medications from nursing staff because she self-administered her own medication. LPN 2 immediately reported it to the Director of Nursing (DON), obtained Resident B's vitals, and notified the physician. The on-call physician recommended the resident be sent to the local hospital emergency room for evaluation. The resident's family member came at that time and took her to the emergency room. The resident was kept overnight at the hospital and came back the next evening.

A Progress Note, dated 05/28/25 at 9:01 A.M., indicated LPN 2 had gone to the writer around 8:00 A.M., and stated that she had made a medication error. LPN 2 had given Resident B another resident's medications. The resident's Power of Attorney (POA) was coming in to check on the resident. The resident's vital signs were stable. The physician's office was notified of the resident being given the wrong medications and what the medications were. The resident had received duloxetine (an antidepressant medication) 40 milligrams (mg), famotidine (an antacid medication) 20 mg,

The Wellness Director or designee
will observe mealtime and or non-mealtime medication passes 5 times weekly for 2 weeks, then weekly
for an additional 6 months and the quarterly ongoing. The Wellness Director or designee will review the
medication exception report 5 times weekly for 2 weeks, then weekly for an
additional 6 months then quarterly on an ongoing basis. Any concerns will be brought to the attention of the Community's Quality Assurance Committee (consisting of the Executive Director,
Wellness Director, Regional Operations Director, and Regional Clinical Manager)
to consider further monitoring, training, or other appropriate action.

The Executive Director along with the Wellness Director will ensure that as an ongoing practice, each new incoming nursing staff member is trained for no less than 40 hours with a minimum of 8 hours of resident identification during a medication pass.

A Binder with record of audits performed as well as updated photos will be kept for a minimum of one year and will be stored in the front business

	gabapentin (a nerve pain medication) 900 mg, glipizide (a blood glucose medication) 5 mg, Losartan (a blood pressure medication) 100 mg, Ocuvite (a vitamin and mineral supplement), Tylenol 500 mg, pantoprazole (an antacid medication) 40 mg, Senna (a stool softener) 8.6 mg, and solifenacin succinate (an overactive bladder medication) 5 mg. The physician's office recommended that the resident be sent to the local emergency room for evaluation and treatment due to the large amount of gabapentin the resident had received. The POA agreed to take the resident to the emergency room. The resident left with the POA at 8:50 A.M. and report was called to the local hospital. A Progress Note, dated 05/28/25 at 4:41 P.M., indicated a call was placed to the local hospital to check on the resident and she was going to be admitted for accidental ingestion of medications. A Facility Fax to the physician, dated 05/28/25, indicated Resident B had received the following medications that were not hers at 7:30 A.M.: - duloxetine 40 mg, - famotidine 20 mg,		office.	

- gabapentin 900 mg,

- glipizide 5 mg,

- losartan 100 mg,

- Ocuvite,

- Tylenol 500 mg,

- pantoprazole 40 mg,

- senna 8.6 mg, and

- solifenacin succinate 5 mg.

The Hospital Record, with an admission date of 05/28/25, indicated Resident B's Assessment and Plan was for hypoglycemia, medication error, hypertensive urgency, and diabetes. She had an initial glucose serum of 48. Poison control was contacted who recommended continued observation for hypoglycemia. The resident was started on D5 half NS (an intravenous solution containing 5% dextrose and 0.45% sodium chloride, a glucose supplement). The resident discharged back to the facility on 05/29/25.

During an interview, on 06/25/25 at 11:45 A.M., the Administrator indicated Resident B was given Resident C's medication on the morning of 05/28/25. The resident went to the hospital with the family member and was kept overnight.

The current facility policy titled, "Health Related Services Manual", dated 8/17, was provided by the DON on 06/25/25 at 2:15 P.M. The policy indicated, "...Community Team Members Procedures for Medication Assistance...Rights of Medication Administration...Right Resident...Routine Medications...Checking the residents name...Read the MAR [Medication Administration Record]-AGAIN!...Medication Errors...If a medication is given to the wrong Resident: Record the details of the medication error on the back of the MAR sheet and follow the procedures..."

The current, undated, facility policy titled, "Resident Rights", was provided by the DON on 06/25/25 at 2:15 P.M. The policy indicated, "...When a person moves into a long-term care facility, they retain all their rights as a private citizen, plus, under federal and state law, they gain numerous other rights as a resident of the facility..."

This citation relates to Complaint IN00461828.

Based on observation, interview, and record review, the facility failed to prevent a medication error that required hospital intervention for 1 of 3 residents reviewed. (Resident

B)

Findings include:

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATUREAnnie	TITLEAdams	(X6) DATE08/04/2025