| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | | A. BUILDING<br>B. WING | 10/28/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| BLOOM AT WILLOW | 2725 LAKE CIRCLE DR, INDIANAPOLIS, , 46268 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES... | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION... | (X5) COMPLETION DATE |
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| R 0000 | INITIAL COMMENTS<br><br>This visit was for the Investigation of Intakes IN00465061 and IN00464333.<br><br>Intake IN00465061-State deficiencies related to the allegations are cited at R0036, R0297 and R0298.<br><br>Intake IN00464333-State deficiencies related to the allegations are cited at R0036, R0297 and R0298.<br><br>Survey dates: October 27 and 28, 2025.<br><br>Facility number: 010234<br><br>Residential Census: 59<br><br>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.<br><br>Quality review was completed on November 3, 2025. | R 0000 | | |
| R 0036 | Residents' Rights- Deficiency | R 0036 | Submission of this | 11/15/2025 |

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| | 410 IAC 16.2-5-1.2(k)(1-2)<br><br>(k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed:<br><br>(1) a significant decline in the resident ' s physical, mental, or psychosocial status; or<br><br>(2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment.<br><br>Based on interview and record review, the facility failed to ensure the physician was notified when medications were not available for administration and when a resident refused to take medications for 2 of 3 residents reviewed for notification of change. (Resident E and F)<br><br>Findings include:<br><br>1. The clinical record for Resident E was reviewed on 10/27/25 at 9:50 a.m. The diagnoses included, but were not limited to, diabetes, low thyroid, and pain.<br><br>a. A physician's order, dated 6/22/25, indicated to administer Lasix (a diuretic medication) 20 milligrams by mouth every day. | | Plan of Correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. The Plan of Correction is prepared and submitted because of requirements under state law. Please accept this Plan of Correction as our credible allegation of compliance.<br><br>R-036<br><br>1<br>Residents E and F have exhibited no adverse effects from the lack of physician notification.<br><br>2<br>All residents have the potential to be affected.<br><br>3<br>In an effort to ensure the deficient practice will not recur, all staff that administer medication will be given an in-service for review of best practice | |

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| | The medication administration record indicated the medication was not available on 6/30/25 and 7/7/25.<br><br>A facility emergency drug kit (EDK) list indicated Lasix 20 milligrams were available in the emergency drug kit.<br><br>There was no documentation in the clinical record to indicate the physician had been notified the resident did not receive the medication.<br><br>b. A physician's order, dated 7/3/25, indicated to administer Lasix 20 milligrams by mouth for three days.<br><br>The medication administration record indicated the resident refused the medication on 7/2/25 and 7/3/25.<br><br>There was no documentation in the clinical record to indicate the physician had been notified the resident refused the medication.<br><br>c. A physician's order, dated 5/30/25, indicated to give levothyroxine (a medication used to treat an underactive thyroid gland) 125 micrograms by mouth once a day.<br><br>The medication administration record indicated the resident refused the medication on 6/22/25 and 6/23/25.<br><br>There was no documentation in | | for residents rights regarding medication administration, notification of physician for any missed or refused medication doses, utilizing the Emergency Drug Kit (EDK) to reduce risk of missed doses.<br><br>4<br>In an effort to ensure continued monitoring to ensure the corrective actions are sustained, the Director of Nursing/designee shall conduct weekly audits of medication administrations including exception notes to ensure notification to physician is being made and documented, and monitor EDK for any refills as needed times four weeks, bi-weekly times 8 weeks, and monthly for a minimum of a cumulative six months. Should concerns or non-compliance be identified, additional education shall be provided. Continued monitoring may be increased or decreased on the basis of findings.<br><br>Date of Compliance: 11/15/2025 | |

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| | the clinical record to indicate the physician had been notified the resident refused the medication.<br><br>d. A physician's order, dated 5/30/25, indicated to give vitamin B12 (a vitamin supplement) 1,000 micrograms once a day.<br><br>The medication administration record indicated the medication was not available on 7/14/25, 7/15/25, and 7/16/25.<br><br>There was no documentation in the clinical record to indicate the physician had been notified that medication was not available.<br><br>2. The clinical record for Resident F was reviewed on 10/27/25 at 10:16 a.m. The diagnoses included, but were not limited to, diabetes and low thyroid.<br><br>a. A physician's order, dated 5/29/25, indicated to apply Gold Bond diabetic lotion liberally to the bilateral lower extremities.<br><br>The medication and treatment administration record indicated the medication was not available on 6/13/25, 6/14/25, 6/15/25, 6/17/25, 6/18/25, 6/20/25, 6/21/25, 6/22/25, 6/23/25, 6/24/25, 6/25/25, 6/27/25, 6/28/25, 6/29/25, 6/30/25, 7/1/25, 7/2/25, 7/4/25, and 7/6/25.<br><br>There was no documentation in | | | |

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| | the clinical record to indicate the physician had been notified the medication was unavailable and the resident had not received the treatment.<br><br>b. A physician's order, dated 5/24/25, indicated to give levothyroxine (a medication used to treat an underactive thyroid gland) 75 micrograms once a day.<br><br>The medication administration record indicated the medication was not available on 7/7/25 and 7/8/25.<br><br>A list of medications available in the facility emergency drug kit indicated levothyroxine 25 micrograms was available in the emergency drug kit.<br><br>There was no documentation in the clinical record to indicate the physician had been notified the resident had not received the medication.<br><br>During an interview, on 10/28/25 at 9:31a.m., the Director of Nursing indicated if a medication or treatment was not available, the pharmacy would be called for an estimated time of arrival, the physician or nurse practitioner would be notified, and the resident would be placed on alert charting.<br><br>During an interview, on 10/28/25 at 12:25 p.m., LPN 6 indicated if a medication or treatment was | | | |

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| | not available, the emergency drug kit and overflow stock would be checked and the physician, nurse practitioner, and pharmacy would be notified. The pharmacy would be asked about the medication, and the information would be documented.<br><br>During an interview, on 10/28/25 at 11:58 a.m., the ED indicated the facility did not have a policy related to physician notification and the facility followed all state regulations.<br><br>This citation relates to Intakes IN00464333 and IN00465061.<br><br>Based on interview and record review, the facility failed to ensure the physician was notified when medications were not available for administration and when a resident refused to take medications for 2 of 3 residents reviewed for notification of change. (Resident E and F)<br><br>Findings include:<br><br>1. The clinical record for Resident E was reviewed on 10/27/25 at 9:50 a.m. The diagnoses included, but were not limited to, diabetes, low thyroid, and pain. | | | |

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| | a. A physician's order, dated 6/22/25, indicated to administer Lasix (a diuretic medication) 20 milligrams by mouth every day.<br><br>The medication administration record indicated the medication was not available on 6/30/25 and 7/7/25.<br><br>A facility emergency drug kit (EDK) list indicated Lasix 20 milligrams were available in the emergency drug kit.<br><br>There was no documentation in the clinical record to indicate the physician had been notified the resident did not receive the medication.<br><br>b. A physician's order, dated 7/3/25, indicated to administer Lasix 20 milligrams by mouth for three days.<br><br>The medication administration record indicated the resident refused the medication on 7/2/25 and 7/3/25.<br><br>There was no documentation in the clinical record to indicate the physician had been notified the resident refused the medication.<br><br>c. A physician's order, dated 5/30/25, indicated to give levothyroxine (a medication used to treat an underactive thyroid gland) 125 micrograms by mouth once a day.<br><br>The medication administration | | | |

record indicated the resident refused the medication on 6/22/25 and 6/23/25.

There was no documentation in the clinical record to indicate the physician had been notified the resident refused the medication.

d. A physician's order, dated 5/30/25, indicated to give vitamin B12 (a vitamin supplement) 1,000 micrograms once a day.

The medication administration record indicated the medication was not available on 7/14/25, 7/15/25, and 7/16/25.

There was no documentation in the clinical record to indicate the physician had been notified that medication was not available.

2. The clinical record for Resident F was reviewed on 10/27/25 at 10:16 a.m. The diagnoses included, but were not limited to, diabetes and low thyroid.

a. A physician's order, dated 5/29/25, indicated to apply Gold Bond diabetic lotion liberally to the bilateral lower extremities.

The medication and treatment administration record indicated the medication was not available on 6/13/25, 6/14/25, 6/15/25, 6/17/25, 6/18/25, 6/20/25, 6/21/25, 6/22/25, 6/23/25, 6/24/25, 6/25/25,

6/27/25, 6/28/25, 6/29/25, 6/30/25, 7/1/25, 7/2/25, 7/4/25, and 7/6/25.

There was no documentation in the clinical record to indicate the physician had been notified the medication was unavailable and the resident had not received the treatment.

b. A physician's order, dated 5/24/25, indicated to give levothyroxine (a medication used to treat an underactive thyroid gland) 75 micrograms once a day.

The medication administration record indicated the medication was not available on 7/7/25 and 7/8/25.

A list of medications available in the facility emergency drug kit indicated levothyroxine 25 micrograms was available in the emergency drug kit.

There was no documentation in the clinical record to indicate the physician had been notified the resident had not received the medication.

During an interview, on 10/28/25 at 9:31a.m., the Director of Nursing indicated if a medication or treatment was not available, the pharmacy would be called for an estimated time of arrival, the physician or nurse practitioner would be notified, and the resident would be

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| | placed on alert charting.<br><br>During an interview, on 10/28/25 at 12:25 p.m., LPN 6 indicated if a medication or treatment was not available, the emergency drug kit and overflow stock would be checked and the physician, nurse practitioner, and pharmacy would be notified. The pharmacy would be asked about the medication, and the information would be documented.<br><br>During an interview, on 10/28/25 at 11:58 a.m., the ED indicated the facility did not have a policy related to physician notification and the facility followed all state regulations.<br><br>This citation relates to Intakes IN00464333 and IN00465061. | | | |
| R 0297 | Pharmaceutical Services - Noncompliance<br><br>410 IAC 16.2-5-6(c)(1)<br><br>(c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident:<br><br>(1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana.<br><br>3. The clinical record for | R 0297 | R-297<br><br>1 Residents B, C, D, and E have exhibited no<br>adverse effects from missed medication doses due to medication being unavailable. .<br><br>2 All residents have the potential to be<br>affected. | 11/15/2025 |

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| | Resident D was reviewed on 10/27/25 at 9:50 a.m. The diagnoses included, but were not limited to, diabetes, low thyroid, and pain.<br><br>A physician's order, dated 5/30/25, indicated to administer vitamin B12 (a vitamin supplement) 1,000 micrograms once a day.<br><br>The MAR indicated the medication was not available on 6/14/25, 6/15/25, and 6/16/25.<br><br>There was no documentation in the clinical record to indicate the pharmacy had been notified the medication was not available.<br><br>4. The clinical record for Resident E was reviewed on 10/27/25 at 10:16 a.m. The diagnoses included, but were not limited to, diabetes and low thyroid.<br><br>A physician's order, dated 5/29/25, indicated to apply Gold Bond diabetic lotion liberally to the bilateral lower extremities.<br><br>The medication and treatment administration record indicated the medication was not available on 6/13/25, 6/14/25, 6/15/25, 6/17/25, 6/18/25, 6/20/25, 6/21/25, 6/22/25, 6/23/25, 6/24/25, 6/25/25, 6/27/25, 6/28/25, 6/29/25, 6/30/25, 7/1/25, 7/2/25, 7/4/25, and 7/6/25. | | 3<br>In an effort to ensure the deficient practice will not recur, all staff that administer medication will be given an in-service for review of best practice for residents regarding medication administration, notification of pharmacy for any medications unavailable, utilizing the Emergency Drug Kit (EDK) to reduce risk of missed doses.<br><br>4<br>In an effort to ensure continued monitoring to ensure the corrective actions are sustained, the Director of Nursing/designee shall conduct weekly audits of medication administrations including exception notes to ensure notification to pharmacy is being made and documented, and monitor EDK for any refills as needed times four weeks, bi-weekly times 8 weeks, and monthly for a minimum of a cumulative six months. Should concerns or non-compliance be identified, additional education shall be provided. Continued monitoring may be increased or decreased on the basis of | |

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| | There was no documentation in the clinical record to indicate the pharmacy had been notified that the medication or treatment was not available.<br><br>During an interview, on 10/28/25 at 9:31a.m., the Director of Nursing indicated if a medication or treatment was not available, the pharmacy would be called for an estimated time of arrival, the physician or nurse practitioner would be notified, and the resident would be placed on alert charting.<br><br>During an interview, on 10/28/25 at 12:25 p.m., LPN 6 indicated if a medication or treatment was not available, the emergency drug kit and overflow stock would be checked and the physician, nurse practitioner, and pharmacy would be notified. The pharmacy would be asked about the medication, and the information would be documented.<br><br>During an interview, on 10/28/25 at 11:58 a.m., the ED indicated the facility did not have a policy related to pharmacy services and the facility followed all state regulations.<br><br>This citation relates to Intakes IN00464333 and IN00465061.<br><br>Based on interview and record review, the facility failed to ensure physician's ordered medications were available and | | findings.<br><br>Date of Compliance: 11/15/2025 | |

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| | administered for 4 of 4 residents reviewed for pharmacy services. (Resident B, C, D and E)<br><br>Findings include:<br><br>1. During an interview, on 10/27/25 at 9:55 a.m., Resident B's daughter indicated the facility had not given Resident B her medication the first 6 days after being admitted to the facility. Resident B was discharged from the hospital with a prescription for Aricept (a dementia medication).<br><br>During an interview, on 10/28/25 at 10:47 a.m., an outside company pharmacist indicated they did not send prescriptions to care facilities. It would be the responsibility of a family member to pick up the medication and take it to the patient. A prescription for Aricept was filled and picked up on 6/4/25 for Resident B.<br><br>During an interview, on 10/28/25 at 12:34 p.m., Resident B's daughter indicated she picked up the prescription for Aricept from the pharmacy and took Resident B and the medication to the facility on move in day (6/6/25). The medication was given to a staff member. | | | |

The clinical record for Resident B was reviewed on 10/27/25 at 9:47 a.m. The diagnoses included, but were not limited to, dementia and hydro cephalitis.

A physician's order, dated 6/6/25, indicated Resident B was to receive Aricept 5 mg (milligram) once a day at bedtime.

A physician's order, dated 6/6/25, indicated the facility nursing staff were to order, store, and administer all medications with exceptions of those noted as able to self-administer or kept at bedside.

A service plan, dated 7/8/25, indicated Resident B required medication management assistance for 1 medication pass per day.

The Medication Administration Record (MAR), for June 2025, indicated Resident B did not receive Aricept 5 mg, once a day, from 6/6/25 to 6/11/25, which resulted in 6 missed doses of the medication.

During an interview, on 10/28/25 at 11:58 a.m., the Executive Director (ED) indicated when a resident was admitted to the facility and arrived with medications, the nurse who performed the admission assessment would document all the medications which arrived

with the resident.

During an interview, on 10/28/25 at 12:17 p.m., Licensed Practical Nurse (LPN) 6 indicated medications would be verified and documented by the nurse when it was brought in with the resident on admission. The medications would be placed into the medication cart, a medication order with the next refill date would be sent to the pharmacy, and the pharmacist would place the orders into the resident's record. LPN 6 indicated he completed Resident B's admission assessment, but he could not recall if Resident B arrived at the facility with any medications. Resident B "either arrived with a partial prescription or no medication at all."

2. The clinical record for Resident C was reviewed on 10/27/25 at 10:34 a.m. The diagnoses included, but were not limited to, hypertension, hyponatremia (low sodium), transient cerebral ischemic attack (stroke), dementia, and convulsions.

The MAR, dated 7/1/25 to 8/31/25, indicated the following medications were unavailable and resulted in missed doses:

a. Clopidogrel (a medication used to prevent blood clots) 75 mg was not available for 6

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| | doses.<br><br>b. Valsartan (a medication used to treat high blood pressure) 320 mg was not available for 1 dose.<br><br>c. Sodium Chloride (a medication used to treat low sodium levels) 1 gm (gram) was not available for 5 doses.<br><br>d. Levetiracetam (a medication used to treat seizures) 1,000 mg was not available for 1 dose.<br><br>e. Quetiapine (an antipsychotic medication) 25 mg was not available for 1 dose.<br><br>f. Amlodipine (a medication used to treat high blood pressure) 5 mg was not available for 3 doses.<br><br>During an interview, on 10/28/25 at 12:17 p.m., LPN 6 indicated when a resident's medication stock was low, a refill order would be completed and the order sent to the pharmacy. If the medication was available in the emergency drug kit, the medication would be pulled from the kit and administered to the resident. | | | |

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| | The facility emergency drug kit was reviewed, and the following medications and doses were available in the emergency drug kit: clopidogrel 75 mg (4), amlodipine 5 mg (4), and levetiracetam 500 mg (6).<br><br>3. The clinical record for Resident D was reviewed on 10/27/25 at 9:50 a.m. The diagnoses included, but were not limited to, diabetes, low thyroid, and pain.<br><br>A physician's order, dated 5/30/25, indicated to administer vitamin B12 (a vitamin supplement) 1,000 micrograms once a day.<br><br>The MAR indicated the medication was not available on 6/14/25, 6/15/25, and 6/16/25.<br><br>There was no documentation in the clinical record to indicate the pharmacy had been notified the medication was not available.<br><br>4. The clinical record for Resident E was reviewed on 10/27/25 at 10:16 a.m. The diagnoses included, but were not limited to, diabetes and low thyroid.<br><br>A physician's order, dated 5/29/25, indicated to apply Gold Bond diabetic lotion liberally to the bilateral lower extremities.<br><br>The medication and treatment administration record indicated | | | |

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| | the medication was not available on 6/13/25, 6/14/25, 6/15/25, 6/17/25, 6/18/25, 6/20/25, 6/21/25, 6/22/25, 6/23/25, 6/24/25, 6/25/25, 6/27/25, 6/28/25, 6/29/25, 6/30/25, 7/1/25, 7/2/25, 7/4/25, and 7/6/25.<br><br>There was no documentation in the clinical record to indicate the pharmacy had been notified that the medication or treatment was not available.<br><br>During an interview, on 10/28/25 at 9:31a.m., the Director of Nursing indicated if a medication or treatment was not available, the pharmacy would be called for an estimated time of arrival, the physician or nurse practitioner would be notified, and the resident would be placed on alert charting.<br><br>During an interview, on 10/28/25 at 12:25 p.m., LPN 6 indicated if a medication or treatment was not available, the emergency drug kit and overflow stock would be checked and the physician, nurse practitioner, and pharmacy would be notified. The pharmacy would be asked about the medication, and the information would be documented.<br><br>During an interview, on 10/28/25 at 11:58 a.m., the ED indicated the facility did not have a policy related to pharmacy services | | | |

and the facility followed all state regulations.

This citation relates to Intakes IN00464333 and IN00465061.

Based on interview and record review, the facility failed to ensure physician's ordered medications were available and administered for 4 of 4 residents reviewed for pharmacy services. (Resident B, C, D and E)

Findings include:

1. During an interview, on 10/27/25 at 9:55 a.m., Resident B's daughter indicated the facility had not given Resident B her medication the first 6 days after being admitted to the facility. Resident B was discharged from the hospital with a prescription for Aricept (a dementia medication).

During an interview, on 10/28/25 at 10:47 a.m., an outside company pharmacist indicated they did not send prescriptions to care facilities. It would be the responsibility of a family member to pick up the medication and take it to the patient. A prescription for Aricept was filled and picked up on 6/4/25 for Resident B.

During an interview, on 10/28/25 at 12:34 p.m., Resident B's daughter indicated she picked up the prescription for Aricept from the pharmacy and took

Resident B and the medication to the facility on move in day (6/6/25). The medication was given to a staff member.

The clinical record for Resident B was reviewed on 10/27/25 at 9:47 a.m. The diagnoses included, but were not limited to, dementia and hydro cephalitis.

A physician's order, dated 6/6/25, indicated Resident B was to receive Aricept 5 mg (milligram) once a day at bedtime.

A physician's order, dated 6/6/25, indicated the facility nursing staff were to order, store, and administer all medications with exceptions of those noted as able to self-administer or kept at bedside.

A service plan, dated 7/8/25, indicated Resident B required medication management assistance for 1 medication pass per day.

The Medication Administration Record (MAR), for June 2025, indicated Resident B did not receive Aricept 5 mg, once a day, from 6/6/25 to 6/11/25, which resulted in 6 missed doses of the medication.

During an interview, on 10/28/25 at 11:58 a.m., the Executive Director (ED) indicated when a resident was admitted to the

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| | facility and arrived with medications, the nurse who performed the admission assessment would document all the medications which arrived with the resident.<br><br>During an interview, on 10/28/25 at 12:17 p.m., Licensed Practical Nurse (LPN) 6 indicated medications would be verified and documented by the nurse when it was brought in with the resident on admission. The medications would be placed into the medication cart, a medication order with the next refill date would be sent to the pharmacy, and the pharmacist would place the orders into the resident's record. LPN 6 indicated he completed Resident B's admission assessment, but he could not recall if Resident B arrived at the facility with any medications. Resident B "either arrived with a partial prescription or no medication at all."<br><br>2. The clinical record for Resident C was reviewed on 10/27/25 at 10:34 a.m. The diagnoses included, but were not limited to, hypertension, hyponatremia (low sodium), transient cerebral ischemic attack (stroke), dementia, and convulsions.<br><br>The MAR, dated 7/1/25 to 8/31/25, indicated the following medications were unavailable | | | |

and resulted in missed doses:

a. Clopidogrel (a medication used to prevent blood clots) 75 mg was not available for 6 doses.

b. Valsartan (a medication used to treat high blood pressure) 320 mg was not available for 1 dose.

c. Sodium Chloride (a medication used to treat low sodium levels) 1 gm (gram) was not available for 5 doses.

d. Levetiracetam (a medication used to treat seizures) 1,000 mg was not available for 1 dose.

e. Quetiapine (an antipsychotic medication) 25 mg was not available for 1 dose.

f. Amlodipine (a medication used to treat high blood pressure) 5 mg was not available for 3 doses.

During an interview, on 10/28/25 at 12:17 p.m., LPN 6 indicated when a resident's medication stock was low, a refill order would be completed and the order sent to the pharmacy. If the medication was available in the emergency drug kit, the medication would be pulled from the kit and administered to the resident.

The facility emergency drug kit was reviewed, and the following

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| | medications and doses were available in the emergency drug kit: clopidogrel 75 mg (4), amlodipine 5 mg (4), and levetiracetam 500 mg (6).<br><br>3. The clinical record for Resident D was reviewed on 10/27/25 at 9:50 a.m. The diagnoses included, but were not limited to, diabetes, low thyroid, and pain.<br><br>A physician's order, dated 5/30/25, indicated to administer vitamin B12 (a vitamin supplement) 1,000 micrograms once a day.<br><br>The MAR indicated the medication was not available on 6/14/25, 6/15/25, and 6/16/25.<br><br>There was no documentation in the clinical record to indicate the pharmacy had been notified the medication was not available.<br><br>4. The clinical record for Resident E was reviewed on 10/27/25 at 10:16 a.m. The diagnoses included, but were not limited to, diabetes and low thyroid.<br><br>A physician's order, dated 5/29/25, indicated to apply Gold Bond diabetic lotion liberally to the bilateral lower extremities.<br><br>The medication and treatment administration record indicated the medication was not available on 6/13/25, 6/14/25, | | | |

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| | 6/15/25, 6/17/25, 6/18/25, 6/20/25, 6/21/25, 6/22/25, 6/23/25, 6/24/25, 6/25/25, 6/27/25, 6/28/25, 6/29/25, 6/30/25, 7/1/25, 7/2/25, 7/4/25, and 7/6/25.<br><br>There was no documentation in the clinical record to indicate the pharmacy had been notified that the medication or treatment was not available.<br><br>During an interview, on 10/28/25 at 9:31a.m., the Director of Nursing indicated if a medication or treatment was not available, the pharmacy would be called for an estimated time of arrival, the physician or nurse practitioner would be notified, and the resident would be placed on alert charting.<br><br>During an interview, on 10/28/25 at 12:25 p.m., LPN 6 indicated if a medication or treatment was not available, the emergency drug kit and overflow stock would be checked and the physician, nurse practitioner, and pharmacy would be notified. The pharmacy would be asked about the medication, and the information would be documented.<br><br>During an interview, on 10/28/25 at 11:58 a.m., the ED indicated the facility did not have a policy related to pharmacy services and the facility followed all state regulations. | | | |

This citation relates to Intakes IN00464333 and IN00465061.

Based on interview and record review, the facility failed to ensure physician's ordered medications were available and administered for 4 of 4 residents reviewed for pharmacy services. (Resident B, C, D and E)

Findings include:

1. During an interview, on 10/27/25 at 9:55 a.m., Resident B's daughter indicated the facility had not given Resident B her medication the first 6 days after being admitted to the facility. Resident B was discharged from the hospital with a prescription for Aricept (a dementia medication).

During an interview, on 10/28/25 at 10:47 a.m., an outside company pharmacist indicated they did not send prescriptions to care facilities. It would be the responsibility of a family member to pick up the medication and take it to the patient. A prescription for Aricept was filled and picked up on 6/4/25 for Resident B.

During an interview, on 10/28/25 at 12:34 p.m., Resident B's daughter indicated she picked up the prescription for Aricept from the pharmacy and took Resident B and the medication to the facility on move in day (6/6/25). The medication was

given to a staff member.

The clinical record for Resident B was reviewed on 10/27/25 at 9:47 a.m. The diagnoses included, but were not limited to, dementia and hydro cephalitis.

A physician's order, dated 6/6/25, indicated Resident B was to receive Aricept 5 mg (milligram) once a day at bedtime.

A physician's order, dated 6/6/25, indicated the facility nursing staff were to order, store, and administer all medications with exceptions of those noted as able to self-administer or kept at bedside.

A service plan, dated 7/8/25, indicated Resident B required medication management assistance for 1 medication pass per day.

The Medication Administration Record (MAR), for June 2025, indicated Resident B did not receive Aricept 5 mg, once a day, from 6/6/25 to 6/11/25, which resulted in 6 missed doses of the medication.

During an interview, on 10/28/25 at 11:58 a.m., the Executive Director (ED) indicated when a resident was admitted to the facility and arrived with medications, the nurse who performed the admission

assessment would document all the medications which arrived with the resident.

During an interview, on 10/28/25 at 12:17 p.m., Licensed Practical Nurse (LPN) 6 indicated medications would be verified and documented by the nurse when it was brought in with the resident on admission. The medications would be placed into the medication cart, a medication order with the next refill date would be sent to the pharmacy, and the pharmacist would place the orders into the resident's record. LPN 6 indicated he completed Resident B's admission assessment, but he could not recall if Resident B arrived at the facility with any medications. Resident B "either arrived with a partial prescription or no medication at all."

2. The clinical record for Resident C was reviewed on 10/27/25 at 10:34 a.m. The diagnoses included, but were not limited to, hypertension, hyponatremia (low sodium), transient cerebral ischemic attack (stroke), dementia, and convulsions.

The MAR, dated 7/1/25 to 8/31/25, indicated the following medications were unavailable and resulted in missed doses:

a. Clopidogrel (a medication

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| | used to prevent blood clots) 75 mg was not available for 6 doses.<br><br>b. Valsartan (a medication used to treat high blood pressure) 320 mg was not available for 1 dose.<br><br>c. Sodium Chloride (a medication used to treat low sodium levels) 1 gm (gram) was not available for 5 doses.<br><br>d. Levetiracetam (a medication used to treat seizures) 1,000 mg was not available for 1 dose.<br><br>e. Quetiapine (an antipsychotic medication) 25 mg was not available for 1 dose.<br><br>f. Amlodipine (a medication used to treat high blood pressure) 5 mg was not available for 3 doses.<br><br>During an interview, on 10/28/25 at 12:17 p.m., LPN 6 indicated when a resident's medication stock was low, a refill order would be completed and the order sent to the pharmacy. If the medication was available in the emergency drug kit, the medication would be pulled from the kit and administered to the resident.<br><br>The facility emergency drug kit was reviewed, and the following medications and doses were available in the emergency drug kit: clopidogrel 75 mg (4), | | | |

amlodipine 5 mg (4), and levetiracetam 500 mg (6).

3. The clinical record for Resident D was reviewed on 10/27/25 at 9:50 a.m. The diagnoses included, but were not limited to, diabetes, low thyroid, and pain.

A physician's order, dated 5/30/25, indicated to administer vitamin B12 (a vitamin supplement) 1,000 micrograms once a day.

The MAR indicated the medication was not available on 6/14/25, 6/15/25, and 6/16/25.

There was no documentation in the clinical record to indicate the pharmacy had been notified the medication was not available.

4. The clinical record for Resident E was reviewed on 10/27/25 at 10:16 a.m. The diagnoses included, but were not limited to, diabetes and low thyroid.

A physician's order, dated 5/29/25, indicated to apply Gold Bond diabetic lotion liberally to the bilateral lower extremities.

The medication and treatment administration record indicated the medication was not available on 6/13/25, 6/14/25, 6/15/25, 6/17/25, 6/18/25, 6/20/25, 6/21/25, 6/22/25, 6/23/25, 6/24/25, 6/25/25,

6/27/25, 6/28/25, 6/29/25, 6/30/25, 7/1/25, 7/2/25, 7/4/25, and 7/6/25.

There was no documentation in the clinical record to indicate the pharmacy had been notified that the medication or treatment was not available.

During an interview, on 10/28/25 at 9:31a.m., the Director of Nursing indicated if a medication or treatment was not available, the pharmacy would be called for an estimated time of arrival, the physician or nurse practitioner would be notified, and the resident would be placed on alert charting.

During an interview, on 10/28/25 at 12:25 p.m., LPN 6 indicated if a medication or treatment was not available, the emergency drug kit and overflow stock would be checked and the physician, nurse practitioner, and pharmacy would be notified. The pharmacy would be asked about the medication, and the information would be documented.

During an interview, on 10/28/25 at 11:58 a.m., the ED indicated the facility did not have a policy related to pharmacy services and the facility followed all state regulations.

This citation relates to Intakes IN00464333 and IN00465061.

Based on interview and record review, the facility failed to ensure physician's ordered medications were available and administered for 4 of 4 residents reviewed for pharmacy services. (Resident B, C, D and E)

Findings include:

1. During an interview, on 10/27/25 at 9:55 a.m., Resident B's daughter indicated the facility had not given Resident B her medication the first 6 days after being admitted to the facility. Resident B was discharged from the hospital with a prescription for Aricept (a dementia medication).

During an interview, on 10/28/25 at 10:47 a.m., an outside company pharmacist indicated they did not send prescriptions to care facilities. It would be the responsibility of a family member to pick up the medication and take it to the patient. A prescription for Aricept was filled and picked up on 6/4/25 for Resident B.

During an interview, on 10/28/25 at 12:34 p.m., Resident B's daughter indicated she picked up the prescription for Aricept from the pharmacy and took Resident B and the medication to the facility on move in day (6/6/25). The medication was given to a staff member.

The clinical record for Resident

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| | B was reviewed on 10/27/25 at 9:47 a.m. The diagnoses included, but were not limited to, dementia and hydro cephalitis.<br><br>A physician's order, dated 6/6/25, indicated Resident B was to receive Aricept 5 mg (milligram) once a day at bedtime.<br><br>A physician's order, dated 6/6/25, indicated the facility nursing staff were to order, store, and administer all medications with exceptions of those noted as able to self-administer or kept at bedside.<br><br>A service plan, dated 7/8/25, indicated Resident B required medication management assistance for 1 medication pass per day.<br><br>The Medication Administration Record (MAR), for June 2025, indicated Resident B did not receive Aricept 5 mg, once a day, from 6/6/25 to 6/11/25, which resulted in 6 missed doses of the medication. | | | |

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| | During an interview, on 10/28/25 at 11:58 a.m., the Executive Director (ED) indicated when a resident was admitted to the facility and arrived with medications, the nurse who performed the admission assessment would document all the medications which arrived with the resident.<br><br>During an interview, on 10/28/25 at 12:17 p.m., Licensed Practical Nurse (LPN) 6 indicated medications would be verified and documented by the nurse when it was brought in with the resident on admission. The medications would be placed into the medication cart, a medication order with the next refill date would be sent to the pharmacy, and the pharmacist would place the orders into the resident's record. LPN 6 indicated he completed Resident B's admission assessment, but he could not recall if Resident B arrived at the facility with any medications. Resident B "either arrived with a partial prescription or no medication at all." | | | |

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| | 2. The clinical record for Resident C was reviewed on 10/27/25 at 10:34 a.m. The diagnoses included, but were not limited to, hypertension, hyponatremia (low sodium), transient cerebral ischemic attack (stroke), dementia, and convulsions.<br><br>The MAR, dated 7/1/25 to 8/31/25, indicated the following medications were unavailable and resulted in missed doses:<br><br>a. Clopidogrel (a medication used to prevent blood clots) 75 mg was not available for 6 doses.<br><br>b. Valsartan (a medication used to treat high blood pressure) 320 mg was not available for 1 dose.<br><br>c. Sodium Chloride (a medication used to treat low sodium levels) 1 gm (gram) was not available for 5 doses.<br><br>d. Levetiracetam (a medication used to treat seizures) 1,000 mg was not available for 1 dose.<br><br>e. Quetiapine (an antipsychotic medication) 25 mg was not available for 1 dose.<br><br>f. Amlodipine (a medication used to treat high blood pressure) 5 mg was not available for 3 doses.<br><br>During an interview, on 10/28/25 | | | |

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| | at 12:17 p.m., LPN 6 indicated when a resident's medication stock was low, a refill order would be completed and the order sent to the pharmacy. If the medication was available in the emergency drug kit, the medication would be pulled from the kit and administered to the resident.<br><br>The facility emergency drug kit was reviewed, and the following medications and doses were available in the emergency drug kit: clopidogrel 75 mg (4), amlodipine 5 mg (4), and levetiracetam 500 mg (6). | | | |
| R 0298 | Pharmaceutical Services - Deficiency<br><br>410 IAC 16.2-5-6(c)(2)<br><br>(2) A consultant pharmacist shall be employed, or under contract, and shall:<br><br>(A) be responsible for the duties as specified in 856 IAC 1-7;<br><br>(B) review the drug handling and storage practices in the facility;<br><br>(C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping;<br><br>(D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of | R 0298 | R-298<br><br>1 Resident C’s medication has since been<br>corrected to the correctly ordered time on the MAR no further actions can take place.<br><br>2 All residents had the potential to be<br>effected.<br><br>3 In an effort to ensure the deficient<br>practice will not recur, Director of Nursing, Memory Care Coordinator and | 11/15/2025 |

drugs; and

(E) review the drug regimen of each resident receiving these services at least once every sixty (60) days.

Based on interview and record review, the facility failed to ensure a physician's order was transcribed correctly and the resident received the medication at the physician's ordered time for 1 of 3 residents reviewed for pharmaceutical services. (Resident C)

Findings include:

During an interview, on 10/27/25 at 9:55 a.m., Resident C's daughter indicated the facility had been administering Resident C's quetiapine (an antipsychotic medication) at the wrong time of the day. Resident C took quetiapine before bed at the facility he transferred from and had always taken the medication at bedtime. The facility had administered Resident C the medication in the morning from the day he admitted into the facility (6/12/25) to August. The facility did not know they had been administering the medication at the wrong time and blamed the pharmacy when they became aware of the error.

The clinical record for Resident C was reviewed on 10/27/25 at 10:34 a.m. The diagnoses

Executive Director had a meeting with pharmacy consultant regarding medications
being entered into the resident MAR, best practice for double checking all
medications prior to placing on the MAR, the Director of nursing will monitor
all medication orders and changes prior to approving them for the MAR, and
having pharmacy send Re-Writes monthly to ensure correct orders are being maintained.

4 In an effort to ensure continued monitoring
to ensure corrective actions are sustained, Director of Nursing/Designee will review all new orders, changes, or discontinued medications prior to approving for the
MAR to ensure accuracy, conduct monthly audits of all MARs via Re-Writes to ensure accuracy times 6 months.

Date of Compliance: 11/15/2025

included, but were not limited to, dementia, mood disorder, and pain.

The discharge instructions from the facility Resident C transferred from included, but were not limited to, administer quetiapine 25 milligrams (mg) once a day at bedtime.

A current active physician's order, dated 6/11/25, indicated to administer quetiapine 25 mg once daily at 8:00 a.m.

A physician's visit note, dated 7/2/25, indicated Resident C was a new resident to the facility. During the visit, Resident C's current medications were reviewed. Resident C's current medications included, but were not limited to, quetiapine 25 mg, nightly.

The Medication Administration Record (MAR), dated 6/13/25 to 8/19/25, indicated Resident C was administered 66 doses of quetiapine 25 mg at 8:00 a.m.

During an interview, on 10/28/25 at 9:45 a.m., the Executive Director (ED) indicated when a resident was admitted to the facility the Director of Nursing (DON) would review the discharge paperwork sent with the resident and send the medication list to the pharmacy. The pharmacy would enter the orders into the resident's

electronic health record. The ED, DON, and the Memory Care Director would then review the orders for accuracy. At the time Resident C was admitted to the facility, the facility did not have a DON, and the on-call nurse would have reviewed the discharge instructions and medications. The pharmacy made an error when transcribing the order for Resident C's quetiapine and the error should have been caught during the review.

During an interview, on 10/28/25 at 10:25 a.m., the pharmacy technician indicated when the pharmacist entered an order, the order was triple checked for accuracy before the order was pushed through to the resident's record.

During an interview, on 10/28/25 at 10:27 a.m., the pharmacist indicated admission orders were sent to the pharmacy by the facility and the pharmacist entered the orders into the record. Sometimes the orders were handwritten by the facility and sometimes the orders were typed on a document. The pharmacy preferred the facility to fax the resident's updated medication list to the pharmacy after verifying the medications with the provider, resident, or resident representative. The medication order would be reviewed several times before

submitting it to the record.

During an interview, on 10/28/25 at 11:58 a.m., the ED indicated the facility did not have a policy related to pharmacy services and the facility followed all state regulations.

A current facility policy, titled "Bill of Rights (General)," dated 9/2011 and received from the ED on 10/28/25 at 11:15 a.m., indicated "...Every resident shall have the right to...Receive adequate and appropriate care and treatment...."

This citation relates to Intakes IN00464333 and IN00465061.

Based on interview and record review, the facility failed to ensure a physician's order was transcribed correctly and the resident received the medication at the physician's ordered time for 1 of 3 residents reviewed for pharmaceutical services. (Resident C)

Findings include:

During an interview, on 10/27/25 at 9:55 a.m., Resident C's daughter indicated the facility had been administering Resident C's quetiapine (an antipsychotic medication) at the wrong time of the day. Resident C took quetiapine before bed at the facility he transferred from and had always taken the medication at bedtime. The

facility had administered Resident C the medication in the morning from the day he admitted into the facility (6/12/25) to August. The facility did not know they had been administering the medication at the wrong time and blamed the pharmacy when they became aware of the error.

The clinical record for Resident C was reviewed on 10/27/25 at 10:34 a.m. The diagnoses included, but were not limited to, dementia, mood disorder, and pain.

The discharge instructions from the facility Resident C transferred from included, but were not limited to, administer quetiapine 25 milligrams (mg) once a day at bedtime.

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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.)

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATUREKourtney Harvey | TITLEExecutive Director | (X6) DATE11/14/2025 |