STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERWALK COMMUNITIES	401 S.E. 6TH STREET, EVANSVILLE, , 47713

(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 IN00464915 and IN00464372 Intake IN00464915-No deficiencies related to the allegations are cited. Intake IN00464372-No deficiencies related to the allegations are cited. Survey dates: October 7, 8, & 9, 2025 Facility number: 011274 Residential Census: 82 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on October 16, 2025.	R 0000		

R 0178	Physical Plant Standards - Deficiency 410 IAC 16.2-5-1.6(b) (b) The facility shall have adequate plumbing, heating, and ventilating systems as governed by applicable rules of the fire prevention and building safety commission (675 IAC). Plumbing, heating, and ventilating systems shall be maintained in normal operating condition and utilized as necessary to provide comfortable temperatures in all areas. Based on observation and interview, the facility failed to provide a safe and sanitary environment for residents, staff, and the public for 5 random observation on 3 of 3 survey dates. Smell of mouse excrement, feces, and smoke in facility entrance, conference room, and fourth floor resident hallway. (Facility Entrance, Conference Room, Fourth Floor Resident Hallway) Findings include: 1. On 10/7/25 at 8:45 A.M., upon entering the facility a strong smell of cigarette was observed in the facility entrance and hallway. On 10/8/25 at 8:00 A.M., upon entering the facility a strong smell of cigarette was observed in the facility entrance and hallway.	R 0178	R178 By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective 11/30/25. The facility requests that this Plan of Correction and items submitted be considered for desk review and paper compliance. Observation of odor in facility entrance, conference room, and fourth floor resident hallway: On 10/7, 10/8, and 10/9/25, upon entering the facility, a strong smell of cigarette was observed in the facility entrance and hallway. On 10/8 and 10/9, upon observation of the conference room, there	11/30/2025

	On 10/9/25 at 8:00 A.M., upon entering the facility, a strong smell of cigarettes was observed in the facility entrance and hallway. 2. On 10/8/25 at 8:05 A.M., during a random observation of the conference room there was strong smell of mouse excrement, feces, and smoke observed inside the conference room. On 10/9/25 at 8:00 A.M., upon entering the facility, a strong smell of cigarettes was observed in the facility entrance and hallway. On 10/9/25 at 8:05 A.M., during a random observation of the conference room there was strong smell of mouse excrement, feces, and smoke observed inside the conference room. 3. On 10/9/25 at 9:56 A.M., during a random observation there was a strong smell of cigarette smoke in a fourth-floor hallway. During an interview on 10/9/25 at 10:15 A.M., the Administrator indicated the facility should be free of offensive odors and there is no smoking inside the building. During an interview on 10/9/25 at 11:15 A.M., Licensed Practical Nurse (LPN) 5		was strong smell of mouse excrement, feces, and smoke observed inside the conference room. On 10/9/25, upon observation, there was a strong smell of cigarette smoke in a fourth-floor hallway. The corrective action taken immediately: The facility does ensure that all odors are addressed as soon as staff are made aware of offensive odor. Riverwalk residents smoke outside the building underneath the awning. The awning creates a wind tunnel when doors open and close causing outside air to be sucked inside. In August of 2025, Riverwalk purchased 4 automatic air fresheners and placed them in front entrance and hallway. The air freshener cans last 30 days, but are routinely checked every other week and replaced when empty. In September 2025, Riverwalk purchased a new product from ChemSearch Fe called Cast Out Total Release Lemon Aerosol deodorizer for smoke odor. Riverwalk also purchased Dr. Zyme, an enzyme odor control and eliminator to control the smell of urine. As soon as State	

	indicated once the staff has been alerted about resident smoking the facility has a process that is implemented utilizing several behavior modification interventions. On 10/9/25 at 1:10 P.M., the Director of Nursing (DON) provided a current, non-dated policy "Policy Environmental." The policy indicated "...the facility shall be clean, orderly...both inside and out...housekeeping will keep air deodorizers on carts to address odors..." On 10/9/25 at 1:10 P.M., the DON provided a current, non-dated policy "Smoking Policy and Procedure." The policy indicated "...it is the policy of the this facility that smoking inside the facility is strictly prohibited..." Based on observation and interview, the facility failed to provide a safe and sanitary environment for residents, staff, and the public for 5 random observation on 3 of 3 survey dates. Smell of mouse excrement, feces, and smoke in facility entrance, conference room, and fourth floor resident hallway. (Facility Entrance, Conference Room, Fourth Floor Resident Hallway) Findings include: 1. On 10/7/25 at 8:45 A.M.,		Surveyors exited the conference room after Annual Survey was complete, the conference room was cleaned, swept, mopped, and everything was removed from refrigerator. The counters and tables were wiped down. Alpha-Dog was contacted to check the room and found no evidence of a mouse or of mice excrement or feces. Action taken to prevent same deficiency: Riverwalk purchased four new automatic air fresheners on October 11, 2025 and installed three in the conference room and one in the lobby entrance area. The conference room was scheduled to be cleaned every week: swept, mopped, and replacement of air freshener spray cans as needed. Tables will be wiped down and refrigerator cleaned out weekly. Riverwalk purchased Essential Oil Aroma Diffuser’s on October 28, 2025 to be placed on the elevator landings on each floor. Riverwalk also contacted ChemSearchFE and purchased a new industrial grade automatic Mystic Air freshener that sprays as often as 30 seconds and is designed	

	upon entering the facility a strong smell of cigarette was observed in the facility entrance and hallway. On 10/8/25 at 8:00 A.M., upon entering the facility a strong smell of cigarette was observed in the facility entrance and hallway. On 10/9/25 at 8:00 A.M., upon entering the facility, a strong smell of cigarettes was observed in the facility entrance and hallway. 2. On 10/8/25 at 8:05 A.M., during a random observation of the conference room there was strong smell of mouse excrement, feces, and smoke observed inside the conference room. On 10/9/25 at 8:00 A.M., upon entering the facility, a strong smell of cigarettes was observed in the facility entrance and hallway. On 10/9/25 at 8:05 A.M., during a random observation of the conference room there was strong smell of mouse excrement, feces, and smoke observed inside the conference room.		to spray 6,000 cubic feet and will be placed in the first-floor entrance hallway. The corrective action put in place to ensure deficient practice does not recur is that audits will be completed weekly for four weeks to ensure there are no offensive odors and to ensure air fresheners and diffusers are working properly. Air fresheners and diffusers will then be checked semi-weekly during routine checks to ensure effectiveness of odor reduction and continuing compliance. Audit results will be reviewed and monitored.	

	3. On 10/9/25 at 9:56 A.M., during a random observation there was a strong smell of cigarette smoke in a fourth-floor hallway. During an interview on 10/9/25 at 10:15 A.M., the Administrator indicated the facility should be free of offensive odors and there is no smoking inside the building. During an interview on 10/9/25 at 11:15 A.M., Licensed Practical Nurse (LPN) 5 indicated once the staff has been alerted about resident smoking the facility has a process that is implemented utilizing several behavior modification interventions. On 10/9/25 at 1:10 P.M., the Director of Nursing (DON) provided a current, non-dated policy "Policy Environmental." The policy indicated "...the facility shall be clean, orderly...both inside and out...housekeeping will keep air deodorizers on carts to address odors..." On 10/9/25 at 1:10 P.M., the DON provided a current, non-dated policy "Smoking Policy and Procedure." The policy indicated "...it is the policy of the this facility that smoking inside the facility is strictly prohibited..."			

R 0193	Physical Plant Standards - Deficiency 410 IAC 16.2-5-1.6(q)(1-2) (q) The facility shall have laundry services either in-house or with a commercial laundry by contract as follows: (1) If a facility operates its own laundry, the laundry shall be designed and operated to promote a flow of laundry from the soiled utility area toward the clean utility area to prevent contamination. (2) Written procedures for handling, storage, transportation, and processing of linens shall be posted in the laundry and shall be implemented. Based on observation and interview, the facility failed to ensure the proper processing of infectious linen and not following the facility's own policy on bed bug protocol during 2 random observations of laundry room. (Six Floor Laundry Room) Findings include: On 10/7/25 at 10:18 A.M., during a random observation of the Sixth Floor Laundry Room, designated bed bug laundry, 2 unlabeled, gray trash bags of linen were observed lying on the floor. During an interview on 10/7/25 at 10:20 A.M, the Environmental	R 0193	R193 By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective 11/30/25. The facility requests that this Plan of Correction and items submitted be considered for desk review and paper compliance. Observation of Sixth Floor Laundry Room: On 10/7/25 during a random observation of the Sixth Floor Laundry Room, designated bed bug laundry, 2 unlabeled, gray trash bags of linen were observed lying on the floor. On 10/9/25 during a random	11/30/2025

	Supervisor indicated if resident's have bed bugs, the linen and clothes are removed from the infected room, placed in trash bags, and laundered in the designated bed bug washing machine and dryer. She did not know which resident's belongings were in the trash bags because they were not labeled and how long the bags had been there. On 10/9/25 at 10:20 A.M., during a random observation of the Sixth Floor Laundry Room, designated bed bug laundry, 1 unlabeled gray trash bag of linen was observed lying on the floor and dried, unlabeled linen in the dryer. During an interview on 10/7/25 at 10:20 A.M., the Environmental Supervisor indicated if resident's have bed bugs, the linen and clothes are removed from the infected room, placed in trash bags, and laundered in the designated bed bug washing machine and dryer. She did not know which resident's belongings were in the trash bags because they were not labeled and how long the bags had been there. During an interview on 10/9/25 at 11:18 A.M., the Administrator indicated that infectious linen should be labeled. On 10/9/25 at 8:20 A.M., the		observation of Sixth Floor Laundry Room, designated bed bug laundry, 1 unlabeled gray trash bag of linen was observed lying on the floor and dried, unlabeled linen in the dryer. The corrective action taken immediately: The facility does ensure the proper processing of infectious linen. On 10/6/25, Pest Control was onsite for monthly inspection and K9 alerted to bed bug odor in a resident room. Linen and clothes were placed in trash bags and transported to designated bed bug laundry room on sixth floor for processing. On 10/7/25, Environmental Supervisor indicated to Surveyor which resident/room was being treated. When showing Surveyor the sixth- floor designated laundry room, Environmental Supervisor informed Surveyor that the clothes in the trash bag came from the resident/room being treated. On 10/10/25, previously identified bed bug laundry was fully processed and removed from sixth floor laundry room by end of day.	

	Director of Nursing (DON) provided a current, non-dated policy "Bed Bug Protocol in Healthcare Facility." The policy indicated "...anything ...retrieved from the room, will need to be double bagged (outside bag is to be a biohazard bug)..." On 10/9/25 at 8:52 A.M., DON provided a current, non-dated policy "Linens." The policy indicated "...the facility shall handle, store, process, and transport clean and soiled lined in a safe and sanitary manner that will prevent the spread of infection..." Based on observation and interview, the facility failed to ensure the proper processing of infectious linen and not following the facility's own policy on bed bug protocol during 2 random observations of laundry room. (Six Floor Laundry Room) Findings include: On 10/7/25 at 10:18 A.M., during a random observation of the Sixth Floor Laundry Room, designated bed bug laundry, 2 unlabeled, gray trash bags of linen were observed lying on the floor. During an interview on 10/7/25 at 10:20 A.M, the Environmental Supervisor indicated if resident's have bed bugs, the linen and clothes are removed from the infected room, placed in trash		Action taken to prevent same deficiency: Riverwalk staff members in the following departments: Maintenance, Laundry, Housekeeping, and Nursing will be in-serviced on Facility Bed Bug Protocol including educating staff on the requirement to double bag all infectious laundry with biohazard bag on outside. Facility staff to be in-serviced on Facility Linen Policy to ensure linen is handled, stored, processed, and transported in a safe and sanitary manner to prevent the spread of infection. The corrective action put in place to ensure deficient practice does not recur is that Environmental Services Supervisor will monitor and ensure Facility Bed Bug Protocol and Linen Policy is followed in the event that there are future alerts from Pest Control of the presence of bed bugs in order to ensure continuing compliance with facility policies and protocols.	

bags, and laundered in the designated bed bug washing machine and dryer. She did not know which resident's belongings were in the trash bags because they were not labeled and how long the bags had been there.

On 10/9/25 at 10:20 A.M., during a random observation of the Sixth Floor Laundry Room, designated bed bug laundry, 1 unlabeled gray trash bag of linen was observed lying on the floor and dried, unlabeled linen in the dryer.

During an interview on 10/7/25 at 10:20 A.M., the Environmental Supervisor indicated if resident's have bed bugs, the linen and clothes are removed from the infected room, placed in trash bags, and laundered in the designated bed bug washing machine and dryer. She did not know which resident's belongings were in the trash bags because they were not labeled and how long the bags had been there.

During an interview on 10/9/25 at 11:18 A.M., the Administrator indicated that infectious linen should be labeled.

On 10/9/25 at 8:20 A.M., the Director of Nursing (DON) provided a current, non-dated policy "Bed Bug Protocol in Healthcare Facility." The policy

	indicated "...anything ...retrieved from the room, will need to be double bagged (outside bag is to be a biohazard bug)..." On 10/9/25 at 8:52 A.M., DON provided a current, non-dated policy "Linens." The policy indicated "...the facility shall handle, store, process, and transport clean and soiled lined in a safe and sanitary manner that will prevent the spread of infection..."			
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility	R 0217	By submitting the enclosed materials, we are not admitting to the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective 11/30/2025. The facility requests that this Plan of Correction and items submitted be considered for desk review and paper compliance.	11/30/2025

	or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on interview and record review, the facility failed to ensure resident service plans were signed or dated after a change was made to services provided for 1 of 2 discharged residents reviewed for service plans. (Resident 8) Finding includes: On 10/7/25 at 11:10 A.M., Resident 8's clinical record was reviewed. Resident 8 was admitted to the facility on 2/15/16. Diagnoses included, but were not limited to, end stage renal disease. The most current service plan was updated and revised on		R 217 Observation: After review, R *B's* service plan was not signed or dated by the resident. R 8 has been discharged, no longer resides at the facility. All residents have the potential to be affected. Corrective Action: Facility Service plan coordinator or licensed nurse designee will complete audit of all resident service plans to ensure that all service plans have been reviewed to include service plans have been signed/dated by licensed nurse and resident. All resident service plans will be reviewed every 6 months, updated and revised if indicated by the facility Service plan coordinator or licensed nurse designee. Facility Service plan coordinator or licensed nurse designee will meet and review service plan	

	6/1/25. It was not signed by the resident. A service plan, revised and upated on 9/7/24, was not signed by the resident. On 10/9/25 at 9:02 A.M., the Director of Nursing (DON) indicated that Resident 8 had not signed a service plan since 1/14/24. On 10/9/25 at 11:40 A.M., the Director of Nursing provided an undated policy titled Service Plans that indicated "Service plans shall be reviewed and updated every 6 months and as needed. Service plans shall be reviewed with resident by Service Plan Coordinator or designee." Based on interview and record review, the facility failed to ensure resident service plans were signed or dated after a change was made to services provided for 1 of 2 discharged residents reviewed for service plans. (Resident 8) Finding includes: On 10/7/25 at 11:10 A.M., Resident 8's clinical record was reviewed. Resident 8 was admitted to the facility on 2/15/16. Diagnoses included, but were not limited to, end stage renal disease. The most current service plan		with residents within five days of service plan being completed or revised. Upon completing service plan review both the resident and licensed nurse will sign/date service plan. Monitoring: Facility service plans will be audited by Service plan coordinator or licensed nurse designee weekly x 4 weeks, bi-monthly x 2 months, then monthly x 2 months to ensure continuing compliance. Completion Date: 11/30/25	

	was updated and revised on 6/1/25. It was not signed by the resident. A service plan, revised and upated on 9/7/24, was not signed by the resident. On 10/9/25 at 9:02 A.M., the Director of Nursing (DON) indicated that Resident 8 had not signed a service plan since 1/14/24. On 10/9/25 at 11:40 A.M., the Director of Nursing provided an undated policy titled Service Plans that indicated "Service plans shall be reviewed and updated every 6 months and as needed. Service plans shall be reviewed with resident by Service Plan Coordinator or designee." Based on interview and record review, the facility failed to ensure resident service plans were signed or dated after a change was made to services provided for 1 of 2 discharged residents reviewed for service plans. (Resident 8) Finding includes: On 10/7/25 at 11:10 A.M., Resident 8's clinical record was reviewed. Resident 8 was admitted to the facility on 2/15/16. Diagnoses included, but were not limited to, end stage renal disease.			

	The most current service plan was updated and revised on 6/1/25. It was not signed by the resident. A service plan, revised and upated on 9/7/24, was not signed by the resident. On 10/9/25 at 9:02 A.M., the Director of Nursing (DON) indicated that Resident 8 had not signed a service plan since 1/14/24. On 10/9/25 at 11:40 A.M., the Director of Nursing provided an undated policy titled Service Plans that indicated "Service plans shall be reviewed and updated every 6 months and as needed. Service plans shall be reviewed with resident by Service Plan Coordinator or designee." Based on interview and record review, the facility failed to ensure resident service plans were signed or dated after a change was made to services provided for 1 of 2 discharged residents reviewed for service plans. (Resident 8) Finding includes:			

	On 10/7/25 at 11:10 A.M., Resident 8's clinical record was reviewed. Resident 8 was admitted to the facility on 2/15/16. Diagnoses included, but were not limited to, end stage renal disease. The most current service plan was updated and revised on 6/1/25. It was not signed by the resident. A service plan, revised and upated on 9/7/24, was not signed by the resident. On 10/9/25 at 9:02 A.M., the Director of Nursing (DON) indicated that Resident 8 had not signed a service plan since 1/14/24. On 10/9/25 at 11:40 A.M., the Director of Nursing provided an undated policy titled Service Plans that indicated "Service plans shall be reviewed and updated every 6 months and as needed. Service plans shall be reviewed with resident by Service Plan Coordinator or designee."			
R 0246	Health Services - Deficiency 410 IAC 16.2-5-4(e)(6) (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must	R 0246	By submitting the enclosed materials, we are not admitting to the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and	11/30/2025

	receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on interview and record review, the facility failed to ensure as needed (PRN) medications administered by a Qualified Medication Aide (QMA) were preauthorized by a licensed nurse for 4 of 5 residents reviewed for medication administered by the facility. (Resident 6, Resident 8, Resident 2, and Resident 7) Findings include: 1. On 10/8/25 at 10:36 A.M., Resident 6's clinical record was reviewed. Diagnoses included, but were not limited to, insomnia. Physician orders included, but were not limited to: zolpidem (a sedative) 10 milligrams (mg) - Take one tablet (10 mg) by mouth at bedtime as needed for insomnia, dated 10/1/25. Resident 6's Medication Administration Record (MAR) from 10/1/25 through 10/8/25 included, but was not limited to, the following dates that		submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective 11/30/2025. The facility requests that this Plan of Correction and items submitted be considered for desk review and paper compliance. R246 Observation: PRN medication administration by QMA without authorization from a licensed nurse. All residents have the potential to be affected. Corrective Action: All current PRN medications will be audited and reviewed by licensed nurses for frequency of administration. Licensed Nurses and QMA's will be provided in-service training and re education on PRN medication	

	zolpidem 10 mg PRN was administered by a QMA without authorization from a licensed nurse: 10/3/25 at 5:35 P.M. (given by QMA 27) 10/4/25 at 6:10 P.M. (given by QMA 27) 10/5/25 at 5:47 P.M. (given by QMA 27) 2. On 10/7/25 at 11:10 A.M., Resident 8's clinical record was reviewed. Diagnoses included, but were not limited to, end stage renal disease and anxiety. Physician orders included, but were not limited to: Xanax (an antianxiety medication) 0.25 milligrams (mg) tablet - Give 0.25 mg by mouth every eight hours as needed for anxiety, dated 3/22/25 Promethazine (an antiemetic medication) 25 mg tablet - Give one tablet by mouth every six hours as needed for nausea, dated 3/31/25 oxycodone-acetaminophen (a narcotic pain reliever) 10 mg - 325 mg tablet - Give one tablet orally every six hours as needed for pain, dated 4/22/25 hydroxyzine (an antianxiety medication) 50 mg tablet - Take		administration inclusive of requirement that QMA must receive appropriate authorization from a licensed nurse prior to administering any/all PRN medications. Additionally, all QMA contacts with licensed nurses not on facility premises for authorization to administer PRN medications shall be documented in nursing notes indicating the date and time of QMA/Licensed nurse contact. Monitoring: PRN medication administrations and documentation will be audited Licensed nurse weekly x 4 weeks, bi-monthly x 2 months, then monthly x 2 months to ensure continuing compliance. Completion Date: 11/30/25	

	one tablet by mouth every eight hours as needed for anxiety, dated 11/20/23 Resident 6's Medication Administration Record (MAR) from 5/1/25 through 6/30/25 included, but was not limited to, the following dates that Xanax 0.25 mg PRN was administered by a QMA without authorization from a licensed nurse: 5/5/25 at 3:35 P.M. (given by QMA 11) 5/10/25 at 5:10 P.M. (given by QMA 15) 5/12/25 at 3:59 A.M. (given by QMA 7) 5/26/25 at 6:05 A.M. (given by QMA 19) 5/27/25 at 5:01 A.M. (given by QMA 7) 6/2/25 at 3:05 A.M. (given by QMA 25) Resident 6's Medication Administration Record (MAR) from 5/1/25 through 6/30/25 included, but was not limited to, the following dates that promethazine 25 mg PRN was administered by a QMA without authorization from a licensed nurse: 5/2/25 at 9:56 P.M. (given by QMA 7)			

	5/3/25 at 4:22 P.M. (given by QMA 21) 5/5/25 at 9:02 A.M. (given by QMA 11) 5/5/25 at 3:35 P.M. (given by QMA 11) 5/6/25 at 3:38 P.M. (given by QMA 15) 5/10/25 at 5:05 P.M. (given by QMA 15) 5/11/25 at 11:08 A.M. (given by QMA 15) 5/12/25 at 3:59 A.M. (given by QMA 7) 5/12/25 at 5:02 P.M. (given by QMA 11) 5/15/25 at 1:03 A.M. (given by QMA 7) 5/17/25 at 1:18 A.M. (given by QMA 7) 5/19/25 at 11:05 A.M. (given by QMA 17) 5/20/25 at 1:26 P.M. (given by QMA 17) 5/20/25 at 8:07 P.M. (given by QMA 7) 5/21/25 at 2:55 A.M. (given by QMA 7) 5/25/25 at 11:19 P.M. (given by QMA 19)			

	5/26/25 at 10:58 P.M. (given by QMA 7) 5/27/25 at 5:00 A.M. (given by QMA 7) 5/30/25 at 4:14 P.M. (given by QMA 23) 5/31/25 at 4:29 A.M. (given by QMA 19) 6/12/25 at 5:57 A.M. (given by QMA 7) Resident 6's Medication Administration Record (MAR) from 5/1/25 through 6/30/25 included, but was not limited to, the following dates that oxycodone-acetaminophen 10mg PRN was administered by a QMA without authorization from a licensed nurse: 5/1/25 at 4:00 A.M. (given by QMA 9) 5/2/25 at 9:55 P.M. (given by QMA 7) 5/5/25 at 9:04 A.M. (given by QMA 11) 5/6/25 at 3:40 P.M. (given by QMA 15) 5/10/25 at 5:07 P.M. (given by QMA 15) 5/11/25 at 11:11 A.M. (given by QMA 15) 5/11/25 at 8:16 P.M. (given by			

	QMA 7) 5/12/25 at 11:05 A.M. (given by QMA 11) 5/12/25 at 5:02 P.M. (given by QMA 11) 5/15/25 at 1:03 A.M. (given by QMA 7) 5/17/25 at 1:17 A.M. (given by QMA 7) 5/19/25 at 11:00 A.M. (given by QMA 17) 5/20/25 at 8:06 P.M. (given by QMA 7) 5/21/25 at 2:54 A.M. (given by QMA 7) 5/25/25 at 11:18 P.M. (given by QMA 19) 5/26/25 at 10:58 P.M. (given by QMA 7) 5/27/25 at 5:00 A.M. (given by QMA 7) Resident 6's Medication Administration Record (MAR) from 5/1/25 through 6/30/25 included, but was not limited to, the following dates that hydroxyzine 50 mg PRN was administered by a QMA without authorization from a licensed nurse:			

	5/17/25 at 1:18 A.M. (given by QMA 7) 3. On 10/7/25 at 10:56 A.M., Resident 2's clinical record was reviewed. Resident 2 was admitted on 8/2/22. Diagnosis included, but was not limited to, hypertension. Physician orders included, but were not limited to: Hydrocodone-acetaminophen 7.5-325 MG (milligrams) Give one tablet orally every 12 hours as needed for pain; Start date 8/29/25 Naproxen 500 MG tablet Give one tablet by mouth twice a day as needed for pain; Start date 8/21/23 The electronic medication administration record and progress notes during September 2025 indicated a QMA administered as needed medication without a nurse approval: 9/8/25 4:21 P.M. Naproxen 500 MG 9/11/25 11:17 A.M. Hydrocodone-acetaminophen 7.5-325 4. On 10/8/25 at 11:02 A.M., Resident 7's clinical record was reviewed. Resident 7 was admitted on 4/15/24. Diagnosis included, but was not limited to,			

paranoid schizophrenia.

Physician orders included, but were not limited to:

Hydrocodone-acetaminophen oral tablet 5-325 MG Give one tablet by mouth every eight hours as needed for pain; Start date 8/1/25

The electronic medication administration record and progress notes during September and October 2025 indicated a QMA administered as needed Hydrocodone-acetaminophen without a nurse approval:

9/3/25 3:15 A.M.

9/10/25 11:15 P.M.

9/12/25 3:22 A.M.

9/12/25 12:04 P.M.

9/16/25 1:15 A.M.

9/19/25 10:00 A.M.

9/21/25 2:11 P.M.

9/26/25 2:21 P.M.

9/27/25 3:27 P.M.

10/3/25 5:30 A.M.

On 10/9/25 at 9:35 A.M., Registered Nurse (RN) 3 indicated that when a QMA gave a PRN medication they first asked the nurse for

permission and then the nurse assessed the resident prior to the medication being administered by the QMA.

On 10/9/25 at 11:20 A.M., the Director of Nursing (DON) provided a current undated QMA - Outside the Scope policy that indicated "Duties that are outside the scope of QMA practice: ... May not give P.R.N. medications without the permission of a nurse. The nurse must initial after the QMA to indicate they gave authorization...".

Based on interview and record review, the facility failed to ensure as needed (PRN) medications administered by a Qualified Medication Aide (QMA) were preauthorized by a licensed nurse for 4 of 5 residents reviewed for medication administered by the facility. (Resident 6, Resident 8, Resident 2, and Resident 7)

Findings include:

1. On 10/8/25 at 10:36 A.M., Resident 6's clinical record was reviewed. Diagnoses included, but were not limited to, insomnia.

Physician orders included, but were not limited to:

zolpidem (a sedative) 10 milligrams (mg) - Take one tablet (10 mg) by mouth at

bedtime as needed for insomnia, dated 10/1/25.

Resident 6's Medication Administration Record (MAR) from 10/1/25 through 10/8/25 included, but was not limited to, the following dates that zolpidem 10 mg PRN was administered by a QMA without authorization from a licensed nurse:

10/3/25 at 5:35 P.M. (given by QMA 27)

10/4/25 at 6:10 P.M. (given by QMA 27)

10/5/25 at 5:47 P.M. (given by QMA 27)

2. On 10/7/25 at 11:10 A.M., Resident 8's clinical record was reviewed. Diagnoses included, but were not limited to, end stage renal disease and anxiety.

Physician orders included, but were not limited to:

Xanax (an antianxiety medication) 0.25 milligrams (mg) tablet - Give 0.25 mg by mouth every eight hours as needed for anxiety, dated 3/22/25

Promethazine (an antiemetic medication) 25 mg tablet - Give one tablet by mouth every six hours as needed for nausea, dated 3/31/25

	oxycodone-acetaminophen (a narcotic pain reliever) 10 mg - 325 mg tablet - Give one tablet orally every six hours as needed for pain, dated 4/22/25 hydroxyzine (an antianxiety medication) 50 mg tablet - Take one tablet by mouth every eight hours as needed for anxiety, dated 11/20/23 Resident 6's Medication Administration Record (MAR) from 5/1/25 through 6/30/25 included, but was not limited to, the following dates that Xanax 0.25 mg PRN was administered by a QMA without authorization from a licensed nurse: 5/5/25 at 3:35 P.M. (given by QMA 11) 5/10/25 at 5:10 P.M. (given by QMA 15) 5/12/25 at 3:59 A.M. (given by QMA 7) 5/26/25 at 6:05 A.M. (given by QMA 19) 5/27/25 at 5:01 A.M. (given by QMA 7) 6/2/25 at 3:05 A.M. (given by QMA 25) Resident 6's Medication Administration Record (MAR) from 5/1/25 through 6/30/25 included, but was not limited to, the following dates that			

	promethazine 25 mg PRN was administered by a QMA without authorization from a licensed nurse: 5/2/25 at 9:56 P.M. (given by QMA 7) 5/3/25 at 4:22 P.M. (given by QMA 21) 5/5/25 at 9:02 A.M. (given by QMA 11) 5/5/25 at 3:35 P.M. (given by QMA 11) 5/6/25 at 3:38 P.M. (given by QMA 15) 5/10/25 at 5:05 P.M. (given by QMA 15) 5/11/25 at 11:08 A.M. (given by QMA 15) 5/12/25 at 3:59 A.M. (given by QMA 7) 5/12/25 at 5:02 P.M. (given by QMA 11) 5/15/25 at 1:03 A.M. (given by QMA 7) 5/17/25 at 1:18 A.M. (given by QMA 7) 5/19/25 at 11:05 A.M. (given by QMA 17) 5/20/25 at 1:26 P.M. (given by QMA 17) 5/20/25 at 8:07 P.M. (given by			

	QMA 7) 5/21/25 at 2:55 A.M. (given by QMA 7) 5/25/25 at 11:19 P.M. (given by QMA 19) 5/26/25 at 10:58 P.M. (given by QMA 7) 5/27/25 at 5:00 A.M. (given by QMA 7) 5/30/25 at 4:14 P.M. (given by QMA 23) 5/31/25 at 4:29 A.M. (given by QMA 19) 6/12/25 at 5:57 A.M. (given by QMA 7) Resident 6's Medication Administration Record (MAR) from 5/1/25 through 6/30/25 included, but was not limited to, the following dates that oxycodone-acetaminophen 10mg PRN was administered by a QMA without authorization from a licensed nurse: 5/1/25 at 4:00 A.M. (given by QMA 9) 5/2/25 at 9:55 P.M. (given by QMA 7) 5/5/25 at 9:04 A.M. (given by QMA 11)			

	5/6/25 at 3:40 P.M. (given by QMA 15) 5/10/25 at 5:07 P.M. (given by QMA 15) 5/11/25 at 11:11 A.M. (given by QMA 15) 5/11/25 at 8:16 P.M. (given by QMA 7) 5/12/25 at 11:05 A.M. (given by QMA 11) 5/12/25 at 5:02 P.M. (given by QMA 11) 5/15/25 at 1:03 A.M. (given by QMA 7) 5/17/25 at 1:17 A.M. (given by QMA 7) 5/19/25 at 11:00 A.M. (given by QMA 17) 5/20/25 at 8:06 P.M. (given by QMA 7) 5/21/25 at 2:54 A.M. (given by QMA 7) 5/25/25 at 11:18 P.M. (given by QMA 19) 5/26/25 at 10:58 P.M. (given by QMA 7) 5/27/25 at 5:00 A.M. (given by QMA 7) Resident 6's Medication Administration Record (MAR) from 5/1/25 through 6/30/25			

	included, but was not limited to, the following dates that hydroxyzine 50 mg PRN was administered by a QMA without authorization from a licensed nurse: 5/17/25 at 1:18 A.M. (given by QMA 7) 3. On 10/7/25 at 10:56 A.M., Resident 2's clinical record was reviewed. Resident 2 was admitted on 8/2/22. Diagnosis included, but was not limited to, hypertension. Physician orders included, but were not limited to: Hydrocodone-acetaminophen 7.5-325 MG (milligrams) Give one tablet orally every 12 hours as needed for pain; Start date 8/29/25 Naproxen 500 MG tablet Give one tablet by mouth twice a day as needed for pain; Start date 8/21/23 The electronic medication administration record and progress notes during September 2025 indicated a QMA administered as needed medication without a nurse approval: 9/8/25 4:21 P.M. Naproxen 500 MG 9/11/25 11:17 A.M. Hydrocodone-acetaminophen			

7.5-325

4. On 10/8/25 at 11:02 A.M., Resident 7's clinical record was reviewed. Resident 7 was admitted on 4/15/24. Diagnosis included, but was not limited to, paranoid schizophrenia.

Physician orders included, but were not limited to:

Hydrocodone-acetaminophen oral tablet 5-325 MG Give one tablet by mouth every eight hours as needed for pain; Start date 8/1/25

The electronic medication administration record and progress notes during September and October 2025 indicated a QMA administered as needed Hydrocodone-acetaminophen without a nurse approval:

9/3/25 3:15 A.M.

9/10/25 11:15 P.M.

9/12/25 3:22 A.M.

9/12/25 12:04 P.M.

9/16/25 1:15 A.M.

9/19/25 10:00 A.M.

9/21/25 2:11 P.M.

9/26/25 2:21 P.M.

9/27/25 3:27 P.M.

	10/3/25 5:30 A.M. On 10/9/25 at 9:35 A.M., Registered Nurse (RN) 3 indicated that when a QMA gave a PRN medication they first asked the nurse for permission and then the nurse assessed the resident prior to the medication being administered by the QMA. On 10/9/25 at 11:20 A.M., the Director of Nursing (DON) provided a current undated QMA - Outside the Scope policy that indicated "Duties that are outside the scope of QMA practice: ... May not give P.R.N. medications without the permission of a nurse. The nurse must initial after the QMA to indicate they gave authorization...". Based on interview and record review, the facility failed to ensure as needed (PRN) medications administered by a Qualified Medication Aide (QMA) were preauthorized by a licensed nurse for 4 of 5 residents reviewed for medication administered by the facility. (Resident 6, Resident 8, Resident 2, and Resident 7) Findings include:			

	1. On 10/8/25 at 10:36 A.M., Resident 6's clinical record was reviewed. Diagnoses included, but were not limited to, insomnia. Physician orders included, but were not limited to: zolpidem (a sedative) 10 milligrams (mg) - Take one tablet (10 mg) by mouth at bedtime as needed for insomnia, dated 10/1/25. Resident 6's Medication Administration Record (MAR) from 10/1/25 through 10/8/25 included, but was not limited to, the following dates that zolpidem 10 mg PRN was administered by a QMA without authorization from a licensed nurse: 10/3/25 at 5:35 P.M. (given by QMA 27) 10/4/25 at 6:10 P.M. (given by QMA 27) 10/5/25 at 5:47 P.M. (given by QMA 27) 2. On 10/7/25 at 11:10 A.M., Resident 8's clinical record was reviewed. Diagnoses included, but were not limited to, end stage renal disease and anxiety. Physician orders included, but were not limited to: Xanax (an antianxiety			

	medication) 0.25 milligrams (mg) tablet - Give 0.25 mg by mouth every eight hours as needed for anxiety, dated 3/22/25 Promethazine (an antiemetic medication) 25 mg tablet - Give one tablet by mouth every six hours as needed for nausea, dated 3/31/25 oxycodone-acetaminophen (a narcotic pain reliever) 10 mg - 325 mg tablet - Give one tablet orally every six hours as needed for pain, dated 4/22/25 hydroxyzine (an antianxiety medication) 50 mg tablet - Take one tablet by mouth every eight hours as needed for anxiety, dated 11/20/23 Resident 6's Medication Administration Record (MAR) from 5/1/25 through 6/30/25 included, but was not limited to, the following dates that Xanax 0.25 mg PRN was administered by a QMA without authorization from a licensed nurse: 5/5/25 at 3:35 P.M. (given by QMA 11) 5/10/25 at 5:10 P.M. (given by QMA 15) 5/12/25 at 3:59 A.M. (given by QMA 7)			

	5/26/25 at 6:05 A.M. (given by QMA 19) 5/27/25 at 5:01 A.M. (given by QMA 7) 6/2/25 at 3:05 A.M. (given by QMA 25) Resident 6's Medication Administration Record (MAR) from 5/1/25 through 6/30/25 included, but was not limited to, the following dates that promethazine 25 mg PRN was administered by a QMA without authorization from a licensed nurse: 5/2/25 at 9:56 P.M. (given by QMA 7) 5/3/25 at 4:22 P.M. (given by QMA 21) 5/5/25 at 9:02 A.M. (given by QMA 11) 5/5/25 at 3:35 P.M. (given by QMA 11) 5/6/25 at 3:38 P.M. (given by QMA 15) 5/10/25 at 5:05 P.M. (given by QMA 15) 5/11/25 at 11:08 A.M. (given by QMA 15) 5/12/25 at 3:59 A.M. (given by QMA 7) 5/12/25 at 5:02 P.M. (given by			

	QMA 11) 5/15/25 at 1:03 A.M. (given by QMA 7) 5/17/25 at 1:18 A.M. (given by QMA 7) 5/19/25 at 11:05 A.M. (given by QMA 17) 5/20/25 at 1:26 P.M. (given by QMA 17) 5/20/25 at 8:07 P.M. (given by QMA 7) 5/21/25 at 2:55 A.M. (given by QMA 7) 5/25/25 at 11:19 P.M. (given by QMA 19) 5/26/25 at 10:58 P.M. (given by QMA 7) 5/27/25 at 5:00 A.M. (given by QMA 7) 5/30/25 at 4:14 P.M. (given by QMA 23) 5/31/25 at 4:29 A.M. (given by QMA 19) 6/12/25 at 5:57 A.M. (given by QMA 7) Resident 6's Medication Administration Record (MAR) from 5/1/25 through 6/30/25 included, but was not limited to, the following dates that oxycodone-acetaminophen			

	10mg PRN was administered by a QMA without authorization from a licensed nurse: 5/1/25 at 4:00 A.M. (given by QMA 9) 5/2/25 at 9:55 P.M. (given by QMA 7) 5/5/25 at 9:04 A.M. (given by QMA 11) 5/6/25 at 3:40 P.M. (given by QMA 15) 5/10/25 at 5:07 P.M. (given by QMA 15) 5/11/25 at 11:11 A.M. (given by QMA 15) 5/11/25 at 8:16 P.M. (given by QMA 7) 5/12/25 at 11:05 A.M. (given by QMA 11) 5/12/25 at 5:02 P.M. (given by QMA 11) 5/15/25 at 1:03 A.M. (given by QMA 7) 5/17/25 at 1:17 A.M. (given by QMA 7) 5/19/25 at 11:00 A.M. (given by QMA 17) 5/20/25 at 8:06 P.M. (given by QMA 7)			

	5/21/25 at 2:54 A.M. (given by QMA 7) 5/25/25 at 11:18 P.M. (given by QMA 19) 5/26/25 at 10:58 P.M. (given by QMA 7) 5/27/25 at 5:00 A.M. (given by QMA 7) Resident 6's Medication Administration Record (MAR) from 5/1/25 through 6/30/25 included, but was not limited to, the following dates that hydroxyzine 50 mg PRN was administered by a QMA without authorization from a licensed nurse: 5/17/25 at 1:18 A.M. (given by QMA 7) 3. On 10/7/25 at 10:56 A.M., Resident 2's clinical record was reviewed. Resident 2 was admitted on 8/2/22. Diagnosis included, but was not limited to, hypertension. Physician orders included, but were not limited to: Hydrocodone-acetaminophen 7.5-325 MG (milligrams) Give one tablet orally every 12 hours as needed for pain; Start date 8/29/25 Naproxen 500 MG tablet Give one tablet by mouth twice a day as needed for pain; Start date			

	8/21/23 The electronic medication administration record and progress notes during September 2025 indicated a QMA administered as needed medication without a nurse approval: 9/8/25 4:21 P.M. Naproxen 500 MG 9/11/25 11:17 A.M. Hydrocodone-acetaminophen 7.5-325 4. On 10/8/25 at 11:02 A.M., Resident 7's clinical record was reviewed. Resident 7 was admitted on 4/15/24. Diagnosis included, but was not limited to, paranoid schizophrenia. Physician orders included, but were not limited to: Hydrocodone-acetaminophen oral tablet 5-325 MG Give one tablet by mouth every eight hours as needed for pain; Start date 8/1/25 The electronic medication administration record and progress notes during September and October 2025 indicated a QMA administered as needed Hydrocodone-acetaminophen without a nurse approval: 9/3/25 3:15 A.M.			

	9/10/25 11:15 P.M. 9/12/25 3:22 A.M. 9/12/25 12:04 P.M. 9/16/25 1:15 A.M. 9/19/25 10:00 A.M. 9/21/25 2:11 P.M. 9/26/25 2:21 P.M. 9/27/25 3:27 P.M. 10/3/25 5:30 A.M. On 10/9/25 at 9:35 A.M., Registered Nurse (RN) 3 indicated that when a QMA gave a PRN medication they first asked the nurse for permission and then the nurse assessed the resident prior to the medication being administered by the QMA. On 10/9/25 at 11:20 A.M., the Director of Nursing (DON) provided a current undated QMA - Outside the Scope policy that indicated "Duties that are outside the scope of QMA practice: ... May not give P.R.N. medications without the permission of a nurse. The nurse must initial after the QMA to indicate they gave authorization...". Based on interview and record review, the facility failed to ensure as needed (PRN)			

	medications administered by a Qualified Medication Aide (QMA) were preauthorized by a licensed nurse for 4 of 5 residents reviewed for medication administered by the facility. (Resident 6, Resident 8, Resident 2, and Resident 7) Findings include: 1. On 10/8/25 at 10:36 A.M., Resident 6's clinical record was reviewed. Diagnoses included, but were not limited to, insomnia. Physician orders included, but were not limited to: zolpidem (a sedative) 10 milligrams (mg) - Take one tablet (10 mg) by mouth at bedtime as needed for insomnia, dated 10/1/25. Resident 6's Medication Administration Record (MAR) from 10/1/25 through 10/8/25 included, but was not limited to, the following dates that zolpidem 10 mg PRN was administered by a QMA without authorization from a licensed nurse: 10/3/25 at 5:35 P.M. (given by QMA 27) 10/4/25 at 6:10 P.M. (given by QMA 27)			

	10/5/25 at 5:47 P.M. (given by QMA 27) 2. On 10/7/25 at 11:10 A.M., Resident 8's clinical record was reviewed. Diagnoses included, but were not limited to, end stage renal disease and anxiety. Physician orders included, but were not limited to: Xanax (an antianxiety medication) 0.25 milligrams (mg) tablet - Give 0.25 mg by mouth every eight hours as needed for anxiety, dated 3/22/25 Promethazine (an antiemetic medication) 25 mg tablet - Give one tablet by mouth every six hours as needed for nausea, dated 3/31/25 oxycodone-acetaminophen (a narcotic pain reliever) 10 mg - 325 mg tablet - Give one tablet orally every six hours as needed for pain, dated 4/22/25 hydroxyzine (an antianxiety medication) 50 mg tablet - Take one tablet by mouth every eight hours as needed for anxiety, dated 11/20/23 Resident 6's Medication Administration Record (MAR) from 5/1/25 through 6/30/25 included, but was not limited to, the following dates that Xanax 0.25 mg PRN was administered by a QMA without authorization			

	from a licensed nurse: 5/5/25 at 3:35 P.M. (given by QMA 11) 5/10/25 at 5:10 P.M. (given by QMA 15) 5/12/25 at 3:59 A.M. (given by QMA 7) 5/26/25 at 6:05 A.M. (given by QMA 19) 5/27/25 at 5:01 A.M. (given by QMA 7) 6/2/25 at 3:05 A.M. (given by QMA 25) Resident 6's Medication Administration Record (MAR) from 5/1/25 through 6/30/25 included, but was not limited to, the following dates that promethazine 25 mg PRN was administered by a QMA without authorization from a licensed nurse: 5/2/25 at 9:56 P.M. (given by QMA 7) 5/3/25 at 4:22 P.M. (given by QMA 21) 5/5/25 at 9:02 A.M. (given by QMA 11) 5/5/25 at 3:35 P.M. (given by QMA 11)			

	5/6/25 at 3:38 P.M. (given by QMA 15) 5/10/25 at 5:05 P.M. (given by QMA 15) 5/11/25 at 11:08 A.M. (given by QMA 15) 5/12/25 at 3:59 A.M. (given by QMA 7) 5/12/25 at 5:02 P.M. (given by QMA 11) 5/15/25 at 1:03 A.M. (given by QMA 7) 5/17/25 at 1:18 A.M. (given by QMA 7) 5/19/25 at 11:05 A.M. (given by QMA 17) 5/20/25 at 1:26 P.M. (given by QMA 17) 5/20/25 at 8:07 P.M. (given by QMA 7) 5/21/25 at 2:55 A.M. (given by QMA 7) 5/25/25 at 11:19 P.M. (given by QMA 19) 5/26/25 at 10:58 P.M. (given by QMA 7) 5/27/25 at 5:00 A.M. (given by QMA 7) 5/30/25 at 4:14 P.M. (given by QMA 23)			

	5/31/25 at 4:29 A.M. (given by QMA 19) 6/12/25 at 5:57 A.M. (given by QMA 7) Resident 6's Medication Administration Record (MAR) from 5/1/25 through 6/30/25 included, but was not limited to, the following dates that oxycodone-acetaminophen 10mg PRN was administered by a QMA without authorization from a licensed nurse: 5/1/25 at 4:00 A.M. (given by QMA 9) 5/2/25 at 9:55 P.M. (given by QMA 7) 5/5/25 at 9:04 A.M. (given by QMA 11) 5/6/25 at 3:40 P.M. (given by QMA 15) 5/10/25 at 5:07 P.M. (given by QMA 15) 5/11/25 at 11:11 A.M. (given by QMA 15) 5/11/25 at 8:16 P.M. (given by QMA 7) 5/12/25 at 11:05 A.M. (given by QMA 11) 5/12/25 at 5:02 P.M. (given by QMA 11) 5/15/25 at 1:03 A.M. (given by			

	QMA 7) 5/17/25 at 1:17 A.M. (given by QMA 7) 5/19/25 at 11:00 A.M. (given by QMA 17) 5/20/25 at 8:06 P.M. (given by QMA 7) 5/21/25 at 2:54 A.M. (given by QMA 7) 5/25/25 at 11:18 P.M. (given by QMA 19) 5/26/25 at 10:58 P.M. (given by QMA 7) 5/27/25 at 5:00 A.M. (given by QMA 7) Resident 6's Medication Administration Record (MAR) from 5/1/25 through 6/30/25 included, but was not limited to, the following dates that hydroxyzine 50 mg PRN was administered by a QMA without authorization from a licensed nurse: 5/17/25 at 1:18 A.M. (given by QMA 7) 3. On 10/7/25 at 10:56 A.M., Resident 2's clinical record was reviewed. Resident 2 was admitted on 8/2/22. Diagnosis included, but was not limited to, hypertension. Physician orders included, but			

	were not limited to: Hydrocodone-acetaminophen 7.5-325 MG (milligrams) Give one tablet orally every 12 hours as needed for pain; Start date 8/29/25 Naproxen 500 MG tablet Give one tablet by mouth twice a day as needed for pain; Start date 8/21/23 The electronic medication administration record and progress notes during September 2025 indicated a QMA administered as needed medication without a nurse approval: 9/8/25 4:21 P.M. Naproxen 500 MG 9/11/25 11:17 A.M. Hydrocodone-acetaminophen 7.5-325 4. On 10/8/25 at 11:02 A.M., Resident 7's clinical record was reviewed. Resident 7 was admitted on 4/15/24. Diagnosis included, but was not limited to, paranoid schizophrenia. Physician orders included, but were not limited to: Hydrocodone-acetaminophen oral tablet 5-325 MG Give one tablet by mouth every eight hours as needed for pain; Start date 8/1/25			

	The electronic medication administration record and progress notes during September and October 2025 indicated a QMA administered as needed Hydrocodone-acetaminophen without a nurse approval: 9/3/25 3:15 A.M. 9/10/25 11:15 P.M. 9/12/25 3:22 A.M. 9/12/25 12:04 P.M. 9/16/25 1:15 A.M. 9/19/25 10:00 A.M. 9/21/25 2:11 P.M. 9/26/25 2:21 P.M. 9/27/25 3:27 P.M. 10/3/25 5:30 A.M. On 10/9/25 at 9:35 A.M., Registered Nurse (RN) 3 indicated that when a QMA gave a PRN medication they first asked the nurse for permission and then the nurse assessed the resident prior to the medication being administered by the QMA. On 10/9/25 at 11:20 A.M., the Director of Nursing (DON) provided a current undated QMA - Outside the Scope policy that indicated "Duties that are			

	outside the scope of QMA practice: ... May not give P.R.N. medications without the permission of a nurse. The nurse must initial after the QMA to indicate they gave authorization...".			
R 0247	Health Services - Deficiency 410 IAC 16.2-5-4(e)(7) (7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident. Based on observation, interview, and record review, the facility failed to ensure insulin was properly administered for 1 of 1 residents observed for insulin administration. (Resident 9) Finding includes: On 10/7/25 12 P.M., RN 3 was observed administering insulin to Resident 9. RN 3 attached the needle to the Novolin insulin pen and dialed the pen to 9 units and administered the insulin. RN 3 did not prime the pen prior to administered in the insulin to Resident 9. During an interview on 10/9/25 at 11:26 A.M., LPN 5 indicated insulin pens should be primed	R 0247	By submitting the enclosed materials, we are not admitting to the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective 11/30/2025. The facility requests that this Plan of Correction and items submitted be considered for desk review and paper compliance. R247 Observation:	11/30/2025

	with at least two units before administered insulin to a resident. The Novolin insulin pen product insert indicated "Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to make sure you take the right dose of insulin: turn the dose selector to two (2) units. Hold your Novolin FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. Keep the needle pointing upwards, press the push button all the way in. The dose selector returns to zero (0). A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than six (6) times." On 10/9/25 at 1:10 P.M., the Director of Nursing provided a policy titled Specific Medication Administration Procedures, dated 01/18, that indicated "Perform a safety test before each dose. Select a dose of two units by turning the dosage selector. Take off outer needle cap. Hold the pen with the needle facing upwards. Tape the insulin reservoir so that any air bubbles rise towards the needle. Press the injection button all the way in. Check if		Licensed nurse failed to ensure insulin was properly administered to R 9 All insulin dependent residents have the potential to be affected. Corrective Action: Licensed Nurses and insulin certified QMA's will be provided in-service training and re education on insulin and insulin pen medication administration inclusive of performing safety tests and priming insulin pen prior to each medication administration. Monitoring: Random insulin administration skills check for Licensed Nurses and insulin certified QMA's will be completed by DNS or licensed nurse designee weekly x 4 weeks, bi-monthly x 2 months, then monthly x 2 months to ensure continuing compliance. Completion Date: 11/30/25	

insulin comes out of the needle tip. If no insulin comes out, check for air bubbles and repeat the safety test up to two more times. If still no insulin comes out, the needle may be blocked. Change the needle and try again. If no insulin comes out after changing the needle, the pen may be damaged. Do not use this pen."

Based on observation, interview, and record review, the facility failed to ensure insulin was properly administered for 1 of 1 residents observed for insulin administration. (Resident 9)

Finding includes:

On 10/7/25 12 P.M., RN 3 was observed administering insulin to Resident 9. RN 3 attached the needle to the Novolin insulin pen and dialed the pen to 9 units and administered the insulin. RN 3 did not prime the pen prior to administered in the insulin to Resident 9.

During an interview on 10/9/25 at 11:26 A.M., LPN 5 indicated insulin pens should be primed with at least two units before administered insulin to a resident.

The Novolin insulin pen product insert indicated "Before each injection small amounts of air may collect in the cartridge during normal use. To avoid

	injecting air and to make sure you take the right dose of insulin: turn the dose selector to two (2) units. Hold your Novolin FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. Keep the needle pointing upwards, press the push button all the way in. The dose selector returns to zero (0). A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than six (6) times." On 10/9/25 at 1:10 P.M., the Director of Nursing provided a policy titled Specific Medication Administration Procedures, dated 01/18, that indicated "Perform a safety test before each dose. Select a dose of two units by turning the dosage selector. Take off outer needle cap. Hold the pen with the needle facing upwards. Tape the insulin reservoir so that any air bubbles rise towards the needle. Press the injection button all the way in. Check if insulin comes out of the needle tip. If no insulin comes out, check for air bubbles and repeat the safety test up to two more times. If still no insulin comes out, the needle may be blocked. Change the needle and try again. If no insulin comes out after changing the needle, the			

	pen may be damaged. Do not use this pen."			
R 0379	Mental Health Screening - Deficiency 410 IAC 16.2-5-11.1(c) (c) If a person is a recipient of Medicaid or federal SSI and has a major mental illness as defined by the individual needs assessment, the person will be referred to the mental health service provider for a consultation on needed treatment services. All residents who participate in Medicaid or SSI admitted after April 1, 1997, shall have a completed individual needs assessment in their clinical record. All persons admitted after April 1, 1997, shall have the assessment completed prior to the admission, and, if a mental health center consultation is needed, the consultation shall be completed prior to the admission and a copy maintained in the clinical record. Based on interview and record review, the facility failed to ensure a resident with major mental illness was assessed and offered consultation or treatment services, prior to or on admission for 1 of 3 residents reviewed for Medicaid recipients with major mental illness. (Resident 4) Finding includes: On 10/7/25 at 1:23 P.M., Resident 4's clinical record was	R 0379	By submitting the enclosed materials, we are not admitting to the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective 11/30/2025. The facility requests that this Plan of Correction and items submitted be considered for desk review and paper compliance. R379 Observation: After review, R 4's clinical record lacked documentation of mental health assessment. All residents	11/30/2025

	reviewed. Resident 4 was admitted on 8/30/22. Diagnosis included, but was not limited to, major depressive disorder. Resident 4's clinical record lacked documentation of a mental health assessment. During an interview on 10/9/25 at 11:45 A.M. the Director of Nursing indicated the facility did not have a mental health screening for Resident 4. On 10/9/25 at 11:40 A.M., the Director of Nursing provided an undated policy titled Mental Health Screening that indicated "If a person is a recipient of Medicaid of Federal SSI and has a major mental illness as defined by the individual needs assessment, the person will be referred to the mental health service provider for a consultation on needed treatment services." Based on interview and record review, the facility failed to ensure a resident with major mental illness was assessed and offered consultation or treatment services, prior to or on admission for 1 of 3 residents reviewed for Medicaid recipients with major mental illness. (Resident 4) Finding includes: On 10/7/25 at 1:23 P.M., Resident 4's clinical record was		with Major Mental Illness diagnosis have the potential to be affected. Corrective Action: The facility does provide Mental Health service providers inclusive of Mental Health NP and LCSW with routine scheduled visits weekly and PRN for facility residents with Major Mental Illness diagnosis. R 4 has been provided and received psychosocial consultation from LCSW on 10/13/25 & 10/27/25 and mental health consultation from NP on10/15/25. Continuing consultation will be made available to R 4 weekly and/or PRN by facility based on LCSW/NP recommendations. Facility Service Plan Coordinator will complete audit to identify all residents with Major Mental Illness diagnosis. All residents identified will be offered and provided scheduled initial	

	reviewed. Resident 4 was admitted on 8/30/22. Diagnosis included, but was not limited to, major depressive disorder. Resident 4's clinical record lacked documentation of a mental health assessment. During an interview on 10/9/25 at 11:45 A.M. the Director of Nursing indicated the facility did not have a mental health screening for Resident 4. On 10/9/25 at 11:40 A.M., the Director of Nursing provided an undated policy titled Mental Health Screening that indicated "If a person is a recipient of Medicaid of Federal SSI and has a major mental illness as defined by the individual needs assessment, the person will be referred to the mental health service provider for a consultation on needed treatment services."		consultation for mental health services with LCSW & NP for psychosocial/mental health needs. Mental health consultations will continue to be offered for any/all residents indicated based on LCSW/NP recommendations. Monitoring: Initial Mental health consultations for residents with Major Mental Illness diagnosis will be audited weekly x 4 weeks, bi-monthly x 2 months, then monthly x 2 months. Completion Date: 11/30/25	
R 0383	Mental Health Screening - Deficiency 410 IAC 16.2-5-11.1(g)(1-2) (g) The residential care facility, in cooperation with the mental health service providers, shall develop the comprehensive careplan for the resident that includes the following: (1) Psychosocial rehabilitation services that are to be provided within the community.	R 0383	By submitting the enclosed materials, we are not admitting to the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests	11/30/2025

(2) A comprehensive range of activities to meet multiple levels of need, including the following:

(A) Recreational and socialization activities.

(B) Social skills.

(C) Training, occupational, and work programs.

(D) Opportunities for progression into less restrictive and more independent living arrangements.

Based on interview and record review, the facility failed to ensure residents with major mental illness had a comprehensive care plan that addressed the needs related to major mental illnesses for 2 of 5 residents in the facility reviewed. (Resident 3 and Resident 4)

Findings include:

1. On 10/8/25 at 10:24 A.M., Resident 3's clinical record was reviewed. Resident 3 was admitted on 2/17/23. Diagnosis included, but was not limited to, major depressive disorder.

Resident 3's most recent plan of care, dated 8/17/25, did not address major depressive disorder or a comprehensive range of activities to meet multiple levels of the resident's needs.

2. On 10/7/25 at 1:23 P.M., Resident 4's clinical record was

the plan of
correction be considered our allegation of compliance effective 11/30/2025.

The facility requests
that this Plan of Correction and items submitted
be considered for desk review and paper compliance.

R383

Observation:

After review, R 3's and R 4's care plan failed
to address diagnosis major depressive disorder
or a comprehensive range of activities to meet multiple levels of the resident's needs.

All residents with Major Mental Illness diagnosis have the potential
to be affected. Corrective Action:

	reviewed. Resident 4 was admitted on 8/30/22. Diagnosis included, but was not limited to, major depressive disorder. Resident 4's most recent plan of care, dated 9/6/25, did not address major depressive disorder or a comprehensive range of activities to meet multiple levels of the resident's needs. During an interview on 10/9/25 at 11:45 A.M., the Director of Nursing indicated the service plan did not address major mental illness. On 10/9/25 at 11:40 A.M., the Director of Nursing provided an undated policy titled Service Plans Mental Health Diagnosis that indicated "Residents with major mental illness diagnosis shall be assessed with care plans and updated every six months and as needed. Psychosocial health services with mental health providers will be offered and provided to residents" Based on interview and record review, the facility failed to ensure residents with major mental illness had a comprehensive care plan that addressed the needs related to major mental illnesses for 2 of 5 residents in the facility reviewed. (Resident 3 and Resident 4)		Facility Service plan coordinator has revised and updated service plans for R 3 & R 4 to address major depressive disorder diagnosis. Additionally, the facility does provide Mental Health service providers inclusive of Mental Health NP and LCSW with routine scheduled visits weekly and PRN for facility residents with Major Mental Illness diagnosis to meet mental health/psychosocial needs. R 3 & R 4 have both received psychosocial/mental health consultations from LCSW & Mental Health NP weekly or PRN based on mental health providers' recommendations. Facility Service Plan Coordinator will complete audit to identify all facility residents with Major Mental Illness diagnosis. All residents service plans will be updated and revised to address any Major Mental Illness diagnosis identified. Monitoring:	

Findings include:

1. On 10/8/25 at 10:24 A.M., Resident 3's clinical record was reviewed. Resident 3 was admitted on 2/17/23. Diagnosis included, but was not limited to, major depressive disorder.

Resident 3's most recent plan of care, dated 8/17/25, did not address major depressive disorder or a comprehensive range of activities to meet multiple levels of the resident's needs.

2. On 10/7/25 at 1:23 P.M., Resident 4's clinical record was reviewed. Resident 4 was admitted on 8/30/22. Diagnosis included, but was not limited to, major depressive disorder.

Resident 4's most recent plan of care, dated 9/6/25, did not address major depressive disorder or a comprehensive range of activities to meet multiple levels of the resident's needs.

During an interview on 10/9/25 at 11:45 A.M., the Director of Nursing indicated the service plan did not address major mental illness.

On 10/9/25 at 11:40 A.M., the Director of Nursing provided an undated policy titled Service Plans Mental Health Diagnosis that indicated "Residents with major mental illness diagnosis

Facility Service plan coordinator will audit residents service plans involving
Major Mental Illness diagnosis weekly
x 4 weeks, bi-monthly x 2 months,
then monthly x 2 months.

Completion Date: 11/30/25

	shall be assessed with care plans and updated every six months and as needed. Psychosocial health services with mental health providers will be offered and provided to residents"			

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 SIGNATUREKatie Goldsberry	TITLEResidential Care Administrator	(X6) DATE10/31/2025