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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAPTERS LIVING OF GREENSBURG	1034 CROWN POINTE BLVD, GREENSBURG, , 47240

(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. Survey dates: October 9 and 10, 2025. Facility number: 011914 Residential Census: 35 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on October 15, 2025.	R 0000		
R 0154	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(k) (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24.	R 0154	R0154 POC Dietary staff will be re-educated on cleanliness of kitchen. Cleaning sheets have been made for each shift and must be checked off when task is completed for DM to review. This was completed on 10/12/2025. White stickers for labeling the date will no	10/31/2025

	Based on observation and interview, the facility failed to maintain the kitchen area in a sanitary manner for 1 of 2 observations. This deficient practice had the potential to affect 35 of 35 residents residing in the facility. Findings include: During the initial kitchen tour with the Dietary Manager (DM), on 10/09/2025 at 10:30 A.M., the following was observed: - A black three-shelf cart with a coffee pot on the top shelf, and a cardboard case labeled as applesauce on the bottom shelf, was littered with black, white, and brown debris/crumbs on every shelf, - A silver two-shelf cart with two five-gallon buckets containing flour and sugar on the bottom shelf, was littered with black, white, and brown debris/crumbs on every shelf, - A silver metal food preparation cabinet, with sliding doors on the bottom, had brown splatter marks, black, white, and brown debris/crumbs on the doors and in the door tracks, - Freezer 1 had nine loose, scattered stickers randomly stuck on the bottom shelf and around the edges of the door seal, not attached to any food items. The DM indicated they		longer be used, staff will go back to using black markers for dating effective immediately. This will prevent stickers from being stuck to bottom of freezer. Freezer cleaning was added to cleaning list. Kitchen floor will be cleaned thoroughly and focus on areas around equipment and under sinks to remove black debris stuck to floor. Five-gallon buckets are being replaced with new and equipment they are setting on cleaned. This will be completed by 10/28/25 Staff will be educated on the importance of leaving the lid on trash can when not in use. All carts will be cleaned and sanitized after use on each shift and before any clean dishes are put on them. This has already been completed. Kitchen staff will also be re-educated on safe practices for food preparation and handling. This education will be completed on 10/30/25	

	were labels with dates printed on them for when food items had been delivered. The DM ripped a few of the stickers off the freezer and threw them in the trash, - Freezer 2 had 18 loose, scattered stickers randomly stuck on the bottom shelf and around the edges of the door seal, not attached to any food items, one was dated for March of 2025, - A low four-wheeled tray containing an open trash can, had black debris caked between the edges of the tray and where the trash can was placed, one to two inches wide. The trash can contained garbage and was not currently in use, - A gray three-shelf cart in the dishwasher area, the DM identified was for clean dishes, had a baseball size area on the bottom shelf that was pink and sticky; the shelves were littered with black, white, and brown debris/crumbs; and the wheels were caked with debris. - The floor around a blue tank located under a sink had two hand-size areas with black debris. - Areas under the kitchen equipment were scattered with black, white, and brown debris/crumbs.			

	The DM indicated they did not have a cleaning schedule for the staff to follow. The refrigerator and freezers should have been wiped out weekly before the new shipments arrived. She had no answer as to when the equipment had been wiped down and indicated she was having trouble getting the staff to complete cleaning tasks. She had no current lists of tasks completed or that needed completed Items in the freezer were dated with the white stickers as to when they were received. The current undated kitchen policies were provided by the Administrator on 10/09/2025 at 12:58 P.M., and included, but were not limited to, the following: - A "Cleaning Frequency" policy indicated, " ...food-contact surfaces of equipment used in the storage, preparation, service, transportation [sic] or distribution of food shall be maintained in a clean and sanitary manner ...Non-food-contact surfaces of all equipment shall be cleaned at such a frequency as is necessary to be free of accumulations of dust, dirt, food particles [sic] and other debris ...", and - A "Manual Cleaning and Sanitation" policy indicated,			

	"...Purpose...To ensure the surfaces, utensils, equipment [sic] and items used in serving food are clean and free of debris, bacteria and virus [sic] that may cause health concerns..." Based on observation and interview, the facility failed to maintain the kitchen area in a sanitary manner for 1 of 2 observations. This deficient practice had the potential to affect 35 of 35 residents residing in the facility. Findings include: During the initial kitchen tour with the Dietary Manager (DM), on 10/09/2025 at 10:30 A.M., the following was observed: - A black three-shelf cart with a coffee pot on the top shelf, and a cardboard case labeled as applesauce on the bottom shelf, was littered with black, white, and brown debris/crumbs on every shelf, - A silver two-shelf cart with two five-gallon buckets containing flour and sugar on the bottom shelf, was littered with black, white, and brown debris/crumbs on every shelf, - A silver metal food preparation cabinet, with sliding doors on the bottom, had brown splatter marks, black, white, and brown debris/crumbs on the doors and			

in the door tracks,

- Freezer 1 had nine loose, scattered stickers randomly stuck on the bottom shelf and around the edges of the door seal, not attached to any food items. The DM indicated they were labels with dates printed on them for when food items had been delivered. The DM ripped a few of the stickers off the freezer and threw them in the trash,

- Freezer 2 had 18 loose, scattered stickers randomly stuck on the bottom shelf and around the edges of the door seal, not attached to any food items, one was dated for March of 2025,

- A low four-wheeled tray containing an open trash can, had black debris caked between the edges of the tray and where the trash can was placed, one to two inches wide. The trash can contained garbage and was not currently in use,

- A gray three-shelf cart in the dishwasher area, the DM identified was for clean dishes, had a baseball size area on the bottom shelf that was pink and sticky; the shelves were littered with black, white, and brown debris/crumbs; and the wheels were caked with debris.

- The floor around a blue tank located under a sink had two

	hand-size areas with black debris. - Areas under the kitchen equipment were scattered with black, white, and brown debris/crumbs. The DM indicated they did not have a cleaning schedule for the staff to follow. The refrigerator and freezers should have been wiped out weekly before the new shipments arrived. She had no answer as to when the equipment had been wiped down and indicated she was having trouble getting the staff to complete cleaning tasks. She had no current lists of tasks completed or that needed completed Items in the freezer were dated with the white stickers as to when they were received. The current undated kitchen policies were provided by the Administrator on 10/09/2025 at 12:58 P.M., and included, but were not limited to, the following: - A "Cleaning Frequency" policy indicated, " ...food-contact surfaces of equipment used in the storage, preparation, service, transportation [sic] or distribution of food shall be maintained in a clean and sanitary manner ...Non-food-contact surfaces of all equipment shall be cleaned			

	at such a frequency as is necessary to be free of accumulations of dust, dirt, food particles [sic] and other debris ...", and - A "Manual Cleaning and Sanitation" policy indicated, "...Purpose...To ensure the surfaces, utensils, equipment [sic] and items used in serving food are clean and free of debris, bacteria and virus [sic] that may cause health concerns..."			
R 0243	Health Services - Deficiency 410 IAC 16.2-5-4(e)(3) (3) The individual administering the medication shall document the administration in the individual ' s medication and treatment records that indicate the: (A) time; (B) name of medication or treatment; (C) dosage (if applicable); and (D) name or initials of the person administering the drug or treatment.	R 0243	**R0243 POC** **Nurses and QMA's will be educated on policy for following doctor's orders to prevent future errors. This education will be completed by 11/07/2025**	11/07/2025

	Based on record review and interview, the facility failed to follow the physician's orders related to obtaining the resident's daily weights for 1 of 7 residents reviewed. (Resident 301) Findings include: Resident 301's clinical record was reviewed on 10/09/2025 at 1:30 P.M. The resident's diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease (COPD) and hypertension. The resident was hospitalized in June 2025 related to cardiac and respiratory issues. The hospital discharge orders included, but were not limited to, the following: - An open-ended physician's order, with a start date of 06/13/2025, to obtain the resident's daily weights. A Facility Nurse's Note, dated 06/15/2025, indicated the resident returned from the local hospital. The resident was to resume all previous physician's orders. In addition, the resident had new orders for an antibiotic and for daily weights. The resident's record lacked documentation the resident was weighed daily. During an interview, on			

10/10/2025 at 10:37 A.M., the Facility Concierge (FC) indicated when the resident returned from the hospital, the nurse made a note about the order for daily weights, but she didn't write an actual physician's order for daily weights, so the order was not followed. There were no documented weights for the resident in the Weight Book.

The current facility policy, titled "Chapters Living Telephone Orders Policy", dated 09/17/2025, was provided by the FC on 10/10/2025 at 11:45 A.M. The policy indicated, "...All orders must be documented in the resident's clinical record...Licensed Nurse...ensure accurate transcription, documentation, and prompt follow up..."

Based on record review and interview, the facility failed to follow the physician's orders related to obtaining the resident's daily weights for 1 of 7 residents reviewed. (Resident 301)

Findings include:

Resident 301's clinical record was reviewed on 10/09/2025 at 1:30 P.M. The resident's diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease (COPD) and hypertension.

	The resident was hospitalized in June 2025 related to cardiac and respiratory issues. The hospital discharge orders included, but were not limited to, the following: - An open-ended physician's order, with a start date of 06/13/2025, to obtain the resident's daily weights. A Facility Nurse's Note, dated 06/15/2025, indicated the resident returned from the local hospital. The resident was to resume all previous physician's orders. In addition, the resident had new orders for an antibiotic and for daily weights. The resident's record lacked documentation the resident was weighed daily. During an interview, on 10/10/2025 at 10:37 A.M., the Facility Concierge (FC) indicated when the resident returned from the hospital, the nurse made a note about the order for daily weights, but she didn't write an actual physician's order for daily weights, so the order was not followed. There were no documented weights for the resident in the Weight Book. The current facility policy, titled "Chapters Living Telephone Orders Policy", dated 09/17/2025, was provided by the FC on 10/10/2025 at 11:45			

	A.M. The policy indicated, "...All orders must be documented in the resident's clinical record...Licensed Nurse...ensure accurate transcription, documentation, and prompt follow up..."			
R 0295	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(a) (a) Residents who self-medicate may keep and use prescription and nonprescription medications in their unit as long as they keep them secured from other residents. Based on observation and interview, the facility failed to store medications appropriately related to unsecured insulin medications for 2 of 2 medication cart observations. (Floor 1 Medication Cart and Floor 2 Medication Cart) Findings include: During a medication administration observation, on 10/09/2025 from 11:10 A.M. through 11:20 A.M., the Floor 1 Medication Cart was reviewed. Three clear, square, plastic containers were sitting out on the top of the cart. The containers belonged to Residents 111, 112, and 106. Each container held the resident's insulin supplies that	R 0295	**Nurses and QMA's will be re-educated on proper storage of insulin pens, and they are no longer being stored on top of med carts in storage containers. They will also be re-educated on proper labeling and dating insulin pens. This education will be completed by 11/07/2025**	11/07/2025

	included, but were not limited to, the resident's insulin pens. There were 2 Novolog pens, a Humalog pen, and a Lantus Pen. The plastic containers did not lock. The medication cart was unattended in the hallway while Qualified Medication Aide (QMA) 2 administered insulin to Residents 111 and 112. During a medication administration observation, on 10/09/2025 from 11:32 A.M. through 11:40 A.M., the Floor 2 Medication Cart was reviewed. Three clear, square, plastic containers were sitting out on the top of the cart. The containers belonged to Residents 216, 221, and 206. Each container held the resident's insulin supplies that included but were not limited to the resident's insulin pens. There were 2 Humalog pens and 2 Lantus pens. The plastic containers did not lock. The cart was taken upstairs where it stayed in the hallway unattended while QMA 2 went into a resident's room and then was downstairs in the common area unattended while the QMA administered insulin to Resident 216. There were two residents sitting in the common area while the cart was unattended. During an interview, on 10/09/2025 at 11:45 A.M., QMA 2 indicated all unattended medications should be stored in			

	the locked medication cart. The current facility policy titled, "Medication Policy", with a revision date of 05/02/2025, was provided by the Administrator on 10/09/2025 at 12:26 P.M. The policy indicated, "...Medications must be stored in locked cabinets or medication carts..." Based on observation and interview, the facility failed to store medications appropriately related to unsecured insulin medications for 2 of 2 medication cart observations. (Floor 1 Medication Cart and Floor 2 Medication Cart) Findings include: During a medication administration observation, on 10/09/2025 from 11:10 A.M. through 11:20 A.M., the Floor 1 Medication Cart was reviewed. Three clear, square, plastic containers were sitting out on the top of the cart. The containers belonged to Residents 111, 112, and 106. Each container held the resident's insulin supplies that included, but were not limited to, the resident's insulin pens. There were 2 Novolog pens, a Humalog pen, and a Lantus Pen. The plastic containers did not lock. The medication cart was unattended in the hallway while Qualified Medication Aide			

	(QMA) 2 administered insulin to Residents 111 and 112. During a medication administration observation, on 10/09/2025 from 11:32 A.M. through 11:40 A.M., the Floor 2 Medication Cart was reviewed. Three clear, square, plastic containers were sitting out on the top of the cart. The containers belonged to Residents 216, 221, and 206. Each container held the resident's insulin supplies that included but were not limited to the resident's insulin pens. There were 2 Humalog pens and 2 Lantus pens. The plastic containers did not lock. The cart was taken upstairs where it stayed in the hallway unattended while QMA 2 went into a resident's room and then was downstairs in the common area unattended while the QMA administered insulin to Resident 216. There were two residents sitting in the common area while the cart was unattended. During an interview, on 10/09/2025 at 11:45 A.M., QMA 2 indicated all unattended medications should be stored in the locked medication cart. The current facility policy titled, "Medication Policy", with a revision date of 05/02/2025, was provided by the Administrator on 10/09/2025 at 12:26 P.M. The policy indicated,			

	"...Medications must be stored in locked cabinets or medication carts..."			
R 0301	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(5) (5) Labeling of prescription drugs shall include the following: (A) Resident ' s full name. (B) Physician ' s name. (C) Prescription number. (D) Name and strength of the drug. (E) Directions for use. (F) Date of issue and expiration date (when applicable). (G) Name and address of the pharmacy that filled the prescription. If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted. Based on observation and interview, the facility failed to label medications appropriately 2 of 2 medication carts (Floor 1 Medication Cart and Floor 2 Medication Cart) and 1 of 1 medication refrigerator reviewed.	R 0301	**Nurses and QMA’s will be re-educated on policy for administering medications and ensuring the medication given belongs to the resident receiving it by 11/07/2025. (Insulin Pens)** **All insulin pens have been checked and have been labeled and dated correctly . This was completed on 10/11/2025**	11/07/2025

Findings include:

During an observation, on 10/09/2025 at 11:16 A.M., Qualified Medication Aide (QMA) 2 prepared to administer 8 units of Novolog insulin to Resident 112. The resident's Novolog insulin pen was not labeled with the date it was opened and was full of insulin. The QMA proceeded to administer the insulin.

During an observation, on 10/09/2025 at 11:20 A.M., QMA 2 prepared to administer 15 units of Humalog insulin to Resident 106. The resident's Humalog insulin pen was not labeled with the date it was opened and had 80 units of insulin left in the pen. The QMA proceeded to administer the insulin.

During an observation, on 10/09/2025 at 11:35 A.M., QMA 2 prepared to administer 8 units of Humalog insulin to Resident 216. The resident's Humalog insulin pen was not labeled with the date it was opened and had 160 units of insulin left in the pen. The QMA proceeded to administer the insulin.

The Floor 1 Medication Cart, Floor 2 Medication Cart, and the medication refrigerator were observed with QMA 2 on 10/09/2025 at 11:45 A.M., and contained the following:

-A Lantus insulin pen for Resident 221 that was not labeled with the date it was opened and contained 100 units of insulin,

-A Lantus insulin pen for Resident 206 that was not labeled with the date it was opened and contained 140 units of insulin,

-A Humalog insulin pen for Resident 206 that was not labeled with the date it was opened and was full, and

-A vial of Tuberculin (TB) serum, with an opened date of 06/18/2025 that was half full.

During an interview, on 10/09/2025 at 11:45 A.M., QMA 2 indicated the insulin pens were good for 30 days after being opened.

A "Humalog Insert" was provided by the Administrator on 10/09/2025 at 12:27 P.M. The insert indicated, "...Discard unused portion of the pen 28 days after opening..."

A "Lantus Insert" was provided by the Administrator on 10/09/2025 at 12:27 P.M. The insert indicated, "...Use within 28 days..."

A "Novolog Insert" was provided by the Administrator on 10/09/2025 at 12:27 P.M. The insert indicated, "...Discard

unused portion of the pen after 28 days after first opening the pen..."

The "TB Serum insert", the directions for storage indicated, "...vials in use more than 30 days should be discarded..."

Based on observation and interview, the facility failed to label medications appropriately 2 of 2 medication carts (Floor 1 Medication Cart and Floor 2 Medication Cart) and 1 of 1 medication refrigerator reviewed.

Findings include:

During an observation, on 10/09/2025 at 11:16 A.M., Qualified Medication Aide (QMA) 2 prepared to administer 8 units of Novolog insulin to Resident 112. The resident's Novolog insulin pen was not labeled with the date it was opened and was full of insulin. The QMA proceeded to administer the insulin.

During an observation, on 10/09/2025 at 11:20 A.M., QMA 2 prepared to administer 15 units of Humalog insulin to Resident 106. The resident's Humalog insulin pen was not labeled with the date it was opened and had 80 units of insulin left in the pen. The QMA proceeded to administer the insulin.

During an observation, on 10/09/2025 at 11:35 A.M., QMA 2 prepared to administer 8 units of Humalog insulin to Resident 216. The resident's Humalog insulin pen was not labeled with the date it was opened and had 160 units of insulin left in the pen. The QMA proceeded to administer the insulin.

The Floor 1 Medication Cart, Floor 2 Medication Cart, and the medication refrigerator were observed with QMA 2 on 10/09/2025 at 11:45 A.M., and contained the following:

-A Lantus insulin pen for Resident 221 that was not labeled with the date it was opened and contained 100 units of insulin,

-A Lantus insulin pen for Resident 206 that was not labeled with the date it was opened and contained 140 units of insulin,

-A Humalog insulin pen for Resident 206 that was not labeled with the date it was opened and was full, and

-A vial of Tuberculin (TB) serum, with an opened date of 06/18/2025 that was half full.

	During an interview, on 10/09/2025 at 11:45 A.M., QMA 2 indicated the insulin pens were good for 30 days after being opened. A "Humalog Insert" was provided by the Administrator on 10/09/2025 at 12:27 P.M. The insert indicated, "...Discard unused portion of the pen 28 days after opening..." A "Lantus Insert" was provided by the Administrator on 10/09/2025 at 12:27 P.M. The insert indicated, "...Use within 28 days..." A "Novolog Insert" was provided by the Administrator on 10/09/2025 at 12:27 P.M. The insert indicated, "...Discard unused portion of the pen after 28 days after first opening the pen..." The "TB Serum insert", the directions for storage indicated, "...vials in use more than 30 days should be discarded..."			

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 SIGNATUREJamie Smith	TITLEAdministrator	(X6) DATE12/16/2025