STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAPTERS LIVING OF FLOYDS KNOBS	3700 LAFAYETTE PKWY, FLOYDS KNOBS, , 47119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Intakes 467197 and 467322. Intake 467197 - State deficiencies related to the allegations are cited at R0029 and R0349. Intake 467322 - State deficiencies related to the allegations are cited at R0029 and R0349. Survey dates: February 11 and 12, 2026 Facility number: 012161 Residential Census: 46 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on February 17, 2026.	R 0000		

R 0029	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(d) (d) Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality. Based on interview and record review, the facility failed to ensure consent was granted from a resident (Resident B) prior to entering the resident's apartment and removing medications for 1 of 3 residents reviewed for resident rights. Findings include: The clinical record for Resident B was reviewed on 2/11/26 at 1:25 p.m. The resident's diagnoses included, but were not limited to, chronic back pain and insomnia.	R 0029		02/23/2026

	During an interview on 2/11/26 at 1:48 p.m., Resident B indicated he had a fall on the evening of 12/29/25 and was sent to the hospital. Upon his return from the hospital, all of his over-the-counter medications and his pain medication had been taken out of his room. Resident B did not give permission for any staff member to remove anything from his room. The pain medication was the only medication he administered to himself. The December 2025 medication administration record indicated the resident was to receive Hydrocodone-Aetaminophen (pain medication) 7.5 - 325 mg (milligrams), one tablet every 6 hours for pain. The October 2025 self-administration assessment indicated the resident could safely administer and keep the Hycdrocodon-Acetaminophen in his room. The nurses' note, dated 12/29/25 at 5:30 p.m., indicated the resident was sent to the emergency room for evaluation and did not return to the facility until 12/31/25. The nurse's note, dated 12/29/25 at 8:00 p.m., indicated staff entered the resident's room and confiscated narcotic			

	medications and placed in the medication room lockbox for storage. Review of Resident B's lease agreement lacked documentation for staff to enter the resident's room and remove personal items. The clinical record lacked documentation of Resident B granting permission for any staff member to enter his apartment and remove personal items. During an interview on 2/12/26 at 2:25 p.m., Licensed Practical Nurse 4 indicated permission must be granted from the resident prior to removing items from a resident's apartment. On 2/12/26 at 2:32 p.m., LPN 2 provided a current copy of the document titled "Resident Rights Policy" dated 5/15/24. It included, but was not limited to, "Purpose...To ensure that all residents of this community are treated with dignity, respect and consideration, and that their rights are protected...This community is committed to protecting the...personal rights of all residents...Resident Rights...Each resident has the right to...Be treated with dignity, respect, and courtesy in all interactions...."			

	This Citation relates to Intakes 467197 and 467322			
R 0349	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(a)(1-4) (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on interview and record review, facility failed to ensure medication administration records (MAR) accurately reflected medications that were administered for 2 of 3 residents reviewed for Clinical Records. (Resident B and Resident C) Findings include: 1. The clinical record for Resident B was reviewed on 2/11/26 at 1:25 p.m. The resident's diagnoses included, but were not limited to, hypothyroidism (underactive thyroid), reflux disease (a chronic condition where stomach contents back flow),	R 0349		02/23/2026

pain, hypertension (high blood pressure), atrial fibrillation (irregular heart beat), diabetes and benign prostatic hyperplasia (enlargement of the prostate gland that compresses the urethra).

Review of the December 2025 MAR indicated the resident was to receive the following medications:

-Levothyroxine (thyroid medication) 112 mcg (micrograms) daily at 8:00 a.m.

-Protonix (reflux medication) 40 gm (milligrams) daily at 8:00 a.m.

-Torsemide (diuretic) 20 mg daily at 8:00 a.m.

-Brelinta (heart disease medication) 90 mg every 12 hours at 8:00 a.m. and 8:00 p.m.

-Eliquis (blood thinner) 5 mg every 12 hours at 8:00 a.m. and 8:00 p.m.

-Gabepentin (neuropathy pain) 800 mg every 12 hours at 8:00 a.m. and 8:00 p.m.

-Metformin (diabetes medication) 1,000 mg twice daily at 8:00 a.m. and 4:00 p.m.

-Tamsulosin (enlarged prostate medication) 0.4 mg every 12

hours at 8:00 a.m. and 8:00 p.m.

-Jardiance (diabetes medication) 25 mg daily at 8:00 a.m.

-Losartan (high blood pressure medication) 25 mg daily at 8:00 a.m.

-Potassium Chloride (supplement) 20 mg daily at 8:00 a.m.

The December 2025 MAR lacked documentation of the administration of the resident's medication or if medications were sent out of the facility on the following dates and times:

-Levothyroxine - 12/25/25 and 12/29/25

-Protonix - 12/25/25 and 12/29/25

-Torsamide - 12/25/25

-Brelinta - 12/25/25 and 12/29/25, 8:00 a.m. dose for both

-Eliquis - 12/25/25 and 12/29/25, 8:00 a.m. dose for both

-Metformin - 12/25/25 and 12/29/25 at 8:00 a.m. and 12/2/25 and 12/11/25 at 8:00 a.m.

-Tamsulosin - 12/25/25 and 12/29/25 at 8:00 a.m. and 12/10/25 at 8:00 p.m.

-Jardiance - 12/25/25 and 12/29/25

-Losartan - 12/25/25 and 12/29/25

-Potassium Chloride - 12/25/25 and 12/29/25

During an interview, on 2/12/26 at 2:25 p.m., Licensed Practical Nurse (LPN) 4 indicated when a resident was administered medication, the medication administration record should be signed by the nurse who administered the medication.

2. The clinical record for Resident C was reviewed on 2/11/26 at 2:29 p.m. The resident's diagnoses included, but were not limited to, atrial fibrillation, hypertension, edema (swelling caused by excess fluid trapped in body tissues), depression, mood disorder, and urinary tract infection (UTI).

Review of the December 2025 MAR indicated the resident was to receive the following medications:

-Digoxin (atrial fibrillation) 0.25 mg daily at 8:00 a.m.

-Diltiazem, extended release (hypertension), 240 mg at 8:00

a.m.

-Furosemide (edema) 20 mg daily at 8:00 a.m.

-Lamotrigine (mood stabilizer) 25 mg daily at 8:00 a.m.

-Sertraline (depression) 50 mg daily at 8:00 a.m.

-Marcrobid (antibiotic for UTI) 100 mg twice daily at 8:00 a.m. and 8:00 p.m.

The December 2025 MAR lacked documentation of the administration of the medication or if medications were sent out of the facility on the following dates and times:

-Digoxin - 12/28/25 and 12/29/25

-Diltiazem - 12/25/25 and 12/29/25

-Furosemide - 12/25/25 and 12/29/25

-Lamotrigine - 12/25/25 and 12/29/25

-Sertraline - 12/25/25, 12/28/25 and 12/29/25

-Macrobid - 12/25/25 and 12/29/25 at 8:00 a.m.

On 2/12/26 at 1:10 p.m., LPN 3 provided a current copy of the document titled "Resident Records Policy" dated 5/15/24.

	It included, but was not limited to, "Policy Statement...The facility shall establish and maintain a comprehensive clinical record for each resident that accurately documents the resident's care...." This Citation relates to Intakes 467197 and 467322			

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 SIGNATURE	TITLE	(X6) DATE