STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	04/02/2026

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 a State Residential Licensure Survey. This visit included the Investigation of Intake 468563. Intake 468563 - No deficiencies related to the allegations are cited. Survey dates: March 31 and April 1, 2026 Facility number: 012161 Residential Census: 46 These State Residential Findings are cited in accordance with 410 IAC (Indiana Administrative Code) 16.2-5. Quality review completed on April 2, 2026.	R 0000		
R 0147	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(d)	R 0147		04/10/2026

	(d) The facility shall comply with fire and safety standards, including the applicable rules of the state fire prevention and building safety commission (675 IAC) where applicable to health facilities. Based on record review and interview, the facility failed to ensure fire drills were completed quarterly per shift for for 2 of 3 quarters reviewed from June 2025 through March 2026. This had the potential to affect 46 of 46 residents residing in the facility. Findings include: During a record review on 3/31/26 at 10:35 a.m., the Fire Drills had not been completed monthly or during different shifts. The current new Maintenance Director indicated they had a fire drill recently to restart the drills. During the review of the Fire Drill Observation Sheets on 4/1/26 at 1:36 p.m., the following drills between June 2025 and March 2026 were completed: On June 9, 2025 at 1:00 a.m., a fire drill was completed. The fire department was not in attendance. Only one shift was completed for the quarter. On October 2, 2025 at 9:30 p.m., a fire drill was completed.			

	The fire department was not in attendance. Only one shift was completed for the quarter. On March 13, 2026 at 1:31 p.m., a fire drill was completed. The fire department was not in attendance. On March 31, 2026 at 7:10 p.m., a fire drill was completed after the start of the survey. The fire department was not in attendance. The record lacked documentation of fire drills being completed per shift quraterly from June 2025 through March 2026. During an interview, on 3/31/26 at 10:43 a.m.,the Maintenance Director indicated he had started working at the facility five weeks ago and started conducting fire drills, but the previous two Maintenance Directors may not have completed the fire drills. During an interview, on 4/1/26 at 8:50 a.m., the Director of Nursing (DON) indicated she could not locate any more documentation in the facility related to the past fire drills. During an interview, on 4/1/26 at 10:30 a.m., the Executive Director (ED) indicated she conducted a fire drill yesterday evening. She knew it wouldn't			

	make up for the missing fire drills, but she wanted to start them. During an interview, on 4/1/26 at 12:37 p.m., the Maintenance Director, indicated that when he started working at the facility, he was looking for the maintenance binders and noticed the fire drills had not been conducted per policy at that time. The Fire Disaster Plan, revised April 2013, included, but was not limited to, " ... 2. Fire drills will be held monthly on alternating shifts so that each shift will experience a fire drill each quarter ..."			
R 0297	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(c)(1) (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on observation, record review and interview, the facility failed to ensure proper use of the insulin kwikpens for 1 of 5	R 0297		04/10/2026

	residents observed for medication administration. (Resident 8) Findings include: During an observation on 3/31/26 at 11:33 a.m. Qualified Medication Aide (QMA) 3 entered Resident 8's room to obtain her blood sugar and administer insulin. The glucometer and insulin pens were stored in the resident's room. The resident's blood sugar reading was 172 milligrams per deciliter (mg/dL). QMA 3 indicated the resident had an order for 7 units of routine Humalog (rapid acting man-made insulin) before lunch. There was no open date on the Humalog kwikpen. The QMA indicated she opened it 2 weeks ago and at this time wrote the date for 2 weeks ago on the pen, which was 3/21/26. QMA 3 dialed the Humalog kwikpen to 7 units and was about to administer the insulin. She was stopped before administering at that time.			

During an interview and observation, on 3/31/26 at 11:36 a.m., QMA 3 indicated she was supposed to prime the kwikpen needle. She dialed up 2 units of insulin and presented the drips at the end of the needle. She then dialed up the 7 units and administered the correct dose to the resdient.

The physician's order, dated 12/19/25, indicated the nursing staff were to administer 7 units of Humalog subcutaneously, to the resident every day at noon before lunch.

The record for Resident 8 was reviewed on 4/1/26 at 9:02 a.m. The diagnosis included, but was not limited to, type 2 diabetes mellitus (high blood sugars).

The record lacked documentation of a service care plan for the administration of insulin.

During an interview, on 4/1/26 at 10:35 a.m., the Director of Nursing (DON) indicated the kwikpen or flexpen needles should be primed before drawing up the insulin.

The [Corporation Name] Insulin Administration Policy, last revised on 5/2/25, included, but was not limited to, " ... This policy aims to reduce the risk of insulin errors, ensure correct dosages, and maintain safe

	glucose levels for residents ... 5.3 Insulin Pen Administration Prime Insulin Pen 1. Dial the priming dose. 2. Turn the dial to 2 units (some brands recommend 1-2 units-check your specific pen). 3. Hold pen upright. 4. Point the needle straight up. 5. Tap the pen gently so air bubbles rise to the top. 6. Push the injection button. 7. Press the button all the way in. 8. Watch for a drop of insulin at the needle tip ..."			

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