STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	11/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALNUT CREEK MEMORY CARE	525 BENTEE WES COURT, EVANSVILLE, , 47715

(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: November 6 and 7, 2025. Facility number: 013642 Residential Census: 43 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on November 18, 2025.	R 0000	**This plan of Correction is not to be interpreted as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies dated 11/7/25. It is a submission of our ongoing efforts to comply with regulatory requirements. We have outlined specific actions in response to identified issues. We remain committed to the delivery of quality health care services and will continue to make changes and improvements in line with that objective**.	
R 0241	Health Services - Offense 410 IAC 16.2-5-4(e)(1) (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows:	R 0241	As residents identified and all residents have potential to be affected by the deficient practice, corrective action included in-service by Health Services Director/Designee to all medication staff on proper administration of insulin injections to include	11/24/2025

	(1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on observation, record review, and interview, the facility failed to ensure that medications were administered according to standard practices of care. Insulin pen was not primed (expelling air) prior to the administration of insulin in 1 random observation of a resident receiving insulin. (Resident 13) Findings include: On 11/7/25 at 8:10 A.M., Licensed Practical Nurse (LPN) 5, performed a random blood sugar on Resident 13; the blood sugar was 248. LPN 5 did not prime the pen needle prior to the administration of ordered dose on insulin. On 11/7/25 at 8:30 A.M., Resident 13's clinical record was reviewed. Diagnosis included, but was not limited to, diabetes mellitus. Current physician order included, but was not limited to: Lantus Solostar 100 U/ML (Units/Milliliter) give 10 Units daily at routine time dated 3/14/25 During an interview on 11/7/25		priming of the insulin pen completed by 11/24/25. The Administration of Injectable medications policy will be reviewed upon hire and annual evaluation skills check for all relevant nursing staff. Health Services Director/Designee will complete med pass audits in community weekly x4weeks, monthly x3 months and monthly thereafter. The results of this audit will be discussed monthly during our CQI/CQM meetings.	

	at 8:20 A.M., the LPN 5 indicated that she should have primed the pen needle prior to administration. On 11/7/25 at 12:15 P.M., the Director of Nursing (DON) provided a current policy "Insulin Administration" dated 6/21/2017. The policy indicated "...if the staff is unsure how to operate the device, they should seek additional advice and support...and follow manufacturer's instructions..." Based on observation, record review, and interview, the facility failed to ensure that medications were administered according to standard practices of care. Insulin pen was not primed (expelling air) prior to the administration of insulin in 1 random observation of a resident receiving insulin. (Resident 13) Findings include: On 11/7/25 at 8:10 A.M., Licensed Practical Nurse (LPN) 5, performed a random blood sugar on Resident 13; the blood sugar was 248. LPN 5 did not prime the pen needle prior to the administration of ordered dose on insulin.			

	On 11/7/25 at 8:30 A.M., Resident 13's clinical record was reviewed. Diagnosis included, but was not limited to, diabetes mellitus. Current physician order included, but was not limited to: Lantus Solostar 100 U/ML (Units/Milliliter) give 10 Units daily at routine time dated 3/14/25 During an interview on 11/7/25 at 8:20 A.M., the LPN 5 indicated that she should have primed the pen needle prior to administration. On 11/7/25 at 12:15 P.M., the Director of Nursing (DON) provided a current policy "Insulin Administration" dated 6/21/2017. The policy indicated "...if the staff is unsure how to operate the device, they should seek additional advice and support...and follow manufacturer's instructions..."			
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 receive appropriate authorization for each administration of a PRN medication. All contacts with a	R 0246	As residents identified and all residents have potential to be affected by the deficient practice, corrective action included in-service by Health Services Director/Designee to all medication staff on receiving prior authorization from a licensed nurse or physician prior	11/24/2025

	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. 3. On 11/6/25 at 10:28 A.M., Resident 5's clinical record was reviewed. Diagnoses included, but were not limited to, dementia. The October 2025 MAR was reviewed from 10/1/25 through 10/31/25 and indicated the as needed (PRN) does of Tylenol 500 mg given on 10/19/25 at 11:54 P.M., was administered by and documented as effective by QMA 12. The clinical record lacked documentation of authorization from a nurse prior to administering the medication. During an interview on 11/7/25 at 11:25 A.M., the Administrator indicated there was no additional documentation that the nurse authorized the medication. On 11/7/25 at 11:30 A.M., the Director of Nursing (DON) indicated the QMAs working for the facility were aware they needed to get authorization from a nurse prior to administering PRN medications. She indicated they could call her at any time for authorization and if the authorization was not		to administration of prn medications and proper documentation of those medications by 11/24/25. Facility has updated the Medication administration module within the Medical Record to include the documentation of the individual that approved the medication prior to administration. Health Services Director/Designee will audit residents' medication administration records weekly x4 weeks, then weekly ongoing for prior authorization and documentation of prn meds. The results of this audit will be discussed monthly during our CQI/CQM meetings.	

documented in the Electronic Health Record (EHR) under the comments of the MAR at the time of administration, then it wasn't documented. On the paper copies of the narcotic sheets, she would document "DON" behind the QMA the next time she returned to work. She indicated the facility did not have a policy about QMAs administering PRN medications, but it would be the policy to follow the regulation.

On 11/10/25 at 6:37 A.M., the QMA Scope of Practice in Indiana was reviewed and indicated, " ... (11) Administer previously ordered pro re nata (PRN) medication only if authorization is obtained from the facility ' s licensed nurse on duty or on call. If authorization is obtained, the QMA must do the following: (A) Document in the resident record symptoms indicating the need for the medication and time the symptoms occurred. (B) Document in the resident record that the facility ' s licensed nurse was contacted, symptoms

were described, and permission was granted to administer the medication, including the time of contact. (C) Obtain permission to administer the medication each time the symptoms occur in the resident. (D) Ensure that the resident ' s record is cosigned by the licensed nurse

who gave permission by the end of the nurse ' s shift, or if the nurse was on call, by the end of the nurse ' s next tour of

duty ... "

2. On 11/6/25 at 2:15 P.M., Resident 8's clinical record was reviewed. Diagnoses included, but were limited to, dementia, history of falls, and arthritis.

Current physicians' orders included, but were not limited to:

ABH (Ativan, Benadryl, Haldol) (Lorazepam (Ativan), diphenhydramine (Benadryl), haloperidol (Haldol)

2-25-2 MG/ML (Milligrams/Milliter), Apply 1 ml lotion topically 3 times a day dated 9/19/25.

ABH 2-25-2 MG/ML, apply 1 ml lotion topically every 4 hours as needed for behaviors dated 9/19/25.

September 2025 Medication Administration record reviewed and the following dates the ABH gel for PRN was administered without permission by a Qualified Medication Aide (QMA):

9/25/2025 2:27 P.M. by QMA 3

Based on interview and record review, the facility failed to obtain authorization from a

licensed nurse prior to a Qualified Medication Aide (QMA) administering as needed (PRN) medications for 3 of 8 resident records reviewed. (Resident 5, Resident 6, and Resident 8)

Findings include:

1. On 11/6/25 at 10:57 A.M., Resident 6's clinical record was reviewed. Resident 6 was admitted on 9/1/25. Diagnoses included, but were not limited to, Alzheimer's Disease.

Physician orders included, but were not limited to:

Lorazepam (antianxiety medication) 0.5 MG (milligrams) Give by mouth every six hours as needed for anxiety; start date 9/1/25.

The Medication Administration Record (MAR) was reviewed and indicated a Qualified Medication Aide (QMA) administered controlled narcotic Lorazepam to Resident 6, without documenting approval from a nurse, on the following dates during October 2025:

10/11/25 11:23 A.M. by QMA 12

10/12/25 3:41 P.M. by QMA 12

The clinical record lacked documentation of authorization from a nurse prior to administering the medication.

3. On 11/6/25 at 10:28 A.M., Resident 5's clinical record was reviewed. Diagnoses included, but were not limited to, dementia.

The October 2025 MAR was reviewed from 10/1/25 through 10/31/25 and indicated the as needed (PRN) does of Tylenol 500 mg given on 10/19/25 at 11:54 P.M., was administered by and documented as effective by QMA 12.

The clinical record lacked documentation of authorization from a nurse prior to administering the medication.

During an interview on 11/7/25 at 11:25 A.M., the Administrator indicated there was no additional documentation that the nurse authorized the medication.

On 11/7/25 at 11:30 A.M., the Director of Nursing (DON) indicated the QMAs working for the facility were aware they needed to get authorization from a nurse prior to administering PRN medications. She indicated they could call her at any time for authorization and if the authorization was not documented in the Electronic Health Record (EHR) under the

comments of the MAR at the time of administration, then it wasn't documented. On the paper copies of the narcotic sheets, she would document "DON" behind the QMA the next time she returned to work. She indicated the facility did not have a policy about QMAs administering PRN medications, but it would be the policy to follow the regulation.

On 11/10/25 at 6:37 A.M., the QMA Scope of Practice in Indiana was reviewed and indicated, " ... (11) Administer previously ordered pro re nata (PRN) medication only if authorization is obtained from the facility ' s licensed nurse on duty or on call. If authorization is obtained, the QMA must do the following: (A) Document in the resident record symptoms indicating the need for the medication and time the symptoms occurred. (B) Document in the resident record that the facility ' s licensed nurse was contacted, symptoms

were described, and permission was granted to administer the medication, including the time of contact. (C) Obtain permission to administer the medication each time the symptoms occur in the resident. (D) Ensure that the resident ' s record is cosigned by the licensed nurse who gave permission by the end of the nurse ' s shift, or if the

nurse was on call, by the end of the nurse ' s next tour of

duty ... "

2. On 11/6/25 at 2:15 P.M., Resident 8's clinical record was reviewed. Diagnoses included, but were limited to, dementia, history of falls, and arthritis.

Current physicians' orders included, but were not limited to:

ABH (Ativan, Benadryl, Haldol) (Lorazepam (Ativan), diphenhydramine (Benadryl), haloperidol (Haldol)

2-25-2 MG/ML (Milligrams/Milliter), Apply 1 ml lotion topically 3 times a day dated 9/19/25.

ABH 2-25-2 MG/ML, apply 1 ml lotion topically every 4 hours as needed for behaviors dated 9/19/25.

September 2025 Medication Administration record reviewed and the following dates the ABH gel for PRN was administered without permission by a Qualified Medication Aide (QMA):

9/25/2025 2:27 P.M. by QMA 3

Based on interview and record review, the facility failed to obtain authorization from a licensed nurse prior to a Qualified Medication Aide

(QMA) administering as needed (PRN) medications for 3 of 8 resident records reviewed. (Resident 5, Resident 6, and Resident 8)

Findings include:

1. On 11/6/25 at 10:57 A.M., Resident 6's clinical record was reviewed. Resident 6 was admitted on 9/1/25. Diagnoses included, but were not limited to, Alzheimer's Disease.

Physician orders included, but were not limited to:

Lorazepam (antianxiety medication) 0.5 MG (milligrams) Give by mouth every six hours as needed for anxiety; start date 9/1/25.

The Medication Administration Record (MAR) was reviewed and indicated a Qualified Medication Aide (QMA) administered controlled narcotic Lorazepam to Resident 6, without documenting approval from a nurse, on the following dates during October 2025:

10/11/25 11:23 A.M. by QMA 12

10/12/25 3:41 P.M. by QMA 12

The clinical record lacked documentation of authorization from a nurse prior to administering the medication.

3. On 11/6/25 at 10:28 A.M.,

Resident 5's clinical record was reviewed. Diagnoses included, but were not limited to, dementia.

The October 2025 MAR was reviewed from 10/1/25 through 10/31/25 and indicated the as needed (PRN) does of Tylenol 500 mg given on 10/19/25 at 11:54 P.M., was administered by and documented as effective by QMA 12.

The clinical record lacked documentation of authorization from a nurse prior to administering the medication.

During an interview on 11/7/25 at 11:25 A.M., the Administrator indicated there was no additional documentation that the nurse authorized the medication.

On 11/7/25 at 11:30 A.M., the Director of Nursing (DON) indicated the QMAs working for the facility were aware they needed to get authorization from a nurse prior to administering PRN medications. She indicated they could call her at any time for authorization and if the authorization was not documented in the Electronic Health Record (EHR) under the comments of the MAR at the time of administration, then it wasn't documented. On the paper copies of the narcotic sheets, she would document

"DON" behind the QMA the next time she returned to work. She indicated the facility did not have a policy about QMAs administering PRN medications, but it would be the policy to follow the regulation.

On 11/10/25 at 6:37 A.M., the QMA Scope of Practice in Indiana was reviewed and indicated, " ... (11) Administer previously ordered pro re nata (PRN) medication only if authorization is obtained from the facility ' s licensed nurse on duty or on call. If authorization is obtained, the QMA must do the following: (A) Document in the resident record symptoms indicating the need for the medication and time the symptoms occurred. (B) Document in the resident record that the facility ' s licensed nurse was contacted, symptoms

were described, and permission was granted to administer the medication, including the time of contact. (C) Obtain permission to administer the medication each time the symptoms occur in the resident. (D) Ensure that the resident ' s record is cosigned by the licensed nurse who gave permission by the end of the nurse ' s shift, or if the nurse was on call, by the end of the nurse ' s next tour of

duty ... "

	2. On 11/6/25 at 2:15 P.M., Resident 8's clinical record was reviewed. Diagnoses included, but were limited to, dementia, history of falls, and arthritis. Current physicians' orders included, but were not limited to: ABH (Ativan, Benadryl, Haldol) (Lorazepam (Ativan), diphenhydramine (Benadryl), haloperidol (Haldol) 2-25-2 MG/ML (Milligrams/Milliter), Apply 1 ml lotion topically 3 times a day dated 9/19/25. ABH 2-25-2 MG/ML, apply 1 ml lotion topically every 4 hours as needed for behaviors dated 9/19/25. September 2025 Medication Administration record reviewed and the following dates the ABH gel for PRN was administered without permission by a Qualified Medication Aide (QMA): 9/25/2025 2:27 P.M. by QMA 3			

Based on interview and record review, the facility failed to obtain authorization from a licensed nurse prior to a Qualified Medication Aide (QMA) administering as needed (PRN) medications for 3 of 8 resident records reviewed. (Resident 5, Resident 6, and Resident 8)

Findings include:

1. On 11/6/25 at 10:57 A.M., Resident 6's clinical record was reviewed. Resident 6 was admitted on 9/1/25. Diagnoses included, but were not limited to, Alzheimer's Disease.

Physician orders included, but were not limited to:

Lorazepam (antianxiety medication) 0.5 MG (milligrams) Give by mouth every six hours as needed for anxiety; start date 9/1/25.

The Medication Administration Record (MAR) was reviewed and indicated a Qualified Medication Aide (QMA) administered controlled narcotic Lorazepam to Resident 6, without documenting approval from a nurse, on the following dates during October 2025:

10/11/25 11:23 A.M. by QMA 12

10/12/25 3:41 P.M. by QMA 12

The clinical record lacked

documentation of authorization from a nurse prior to administering the medication.

3. On 11/6/25 at 10:28 A.M., Resident 5's clinical record was reviewed. Diagnoses included, but were not limited to, dementia.

The October 2025 MAR was reviewed from 10/1/25 through 10/31/25 and indicated the as needed (PRN) does of Tylenol 500 mg given on 10/19/25 at 11:54 P.M., was administered by and documented as effective by QMA 12.

The clinical record lacked documentation of authorization from a nurse prior to administering the medication.

During an interview on 11/7/25 at 11:25 A.M., the Administrator indicated there was no additional documentation that the nurse authorized the medication.

On 11/7/25 at 11:30 A.M., the Director of Nursing (DON) indicated the QMAs working for the facility were aware they needed to get authorization from a nurse prior to administering PRN medications. She indicated they could call her at any time for authorization and if the authorization was not documented in the Electronic Health Record (EHR) under the comments of the MAR at the

time of administration, then it wasn't documented. On the paper copies of the narcotic sheets, she would document "DON" behind the QMA the next time she returned to work. She indicated the facility did not have a policy about QMAs administering PRN medications, but it would be the policy to follow the regulation.

On 11/10/25 at 6:37 A.M., the QMA Scope of Practice in Indiana was reviewed and indicated, " ... (11) Administer previously ordered pro re nata (PRN) medication only if authorization is obtained from the facility ' s licensed nurse on duty or on call. If authorization is obtained, the QMA must do the following: (A) Document in the resident record symptoms indicating the need for the medication and time the symptoms occurred. (B) Document in the resident record that the facility ' s licensed nurse was contacted, symptoms

were described, and permission was granted to administer the medication, including the time of contact. (C) Obtain permission to administer the medication each time the symptoms occur in the resident. (D) Ensure that the resident ' s record is cosigned by the licensed nurse who gave permission by the end of the nurse ' s shift, or if the nurse was on call, by the end of

the nurse ' s next tour of

duty ... "

2. On 11/6/25 at 2:15 P.M., Resident 8's clinical record was reviewed. Diagnoses included, but were limited to, dementia, history of falls, and arthritis.

Current physicians' orders included, but were not limited to:

ABH (Ativan, Benadryl, Haldol) (Lorazepam (Ativan), diphenhydramine (Benadryl), haloperidol (Haldol)

2-25-2 MG/ML (Milligrams/Milliter), Apply 1 ml lotion topically 3 times a day dated 9/19/25.

ABH 2-25-2 MG/ML, apply 1 ml lotion topically every 4 hours as needed for behaviors dated 9/19/25.

September 2025 Medication Administration record reviewed and the following dates the ABH gel for PRN was administered without permission by a Qualified Medication Aide (QMA):

9/25/2025 2:27 P.M. by QMA 3

Based on interview and record review, the facility failed to obtain authorization from a licensed nurse prior to a Qualified Medication Aide (QMA) administering as needed

(PRN) medications for 3 of 8 resident records reviewed. (Resident 5, Resident 6, and Resident 8)

Findings include:

1. On 11/6/25 at 10:57 A.M., Resident 6's clinical record was reviewed. Resident 6 was admitted on 9/1/25. Diagnoses included, but were not limited to, Alzheimer's Disease.

Physician orders included, but were not limited to:

Lorazepam (antianxiety medication) 0.5 MG (milligrams) Give by mouth every six hours as needed for anxiety; start date 9/1/25.

The Medication Administration Record (MAR) was reviewed and indicated a Qualified Medication Aide (QMA) administered controlled narcotic Lorazepam to Resident 6, without documenting approval from a nurse, on the following dates during October 2025:

10/11/25 11:23 A.M. by QMA 12

10/12/25 3:41 P.M. by QMA 12

The clinical record lacked documentation of authorization from a nurse prior to administering the medication.

3. On 11/6/25 at 10:28 A.M., Resident 5's clinical record was

reviewed. Diagnoses included, but were not limited to, dementia.

The October 2025 MAR was reviewed from 10/1/25 through 10/31/25 and indicated the as needed (PRN) does of Tylenol 500 mg given on 10/19/25 at 11:54 P.M., was administered by and documented as effective by QMA 12.

The clinical record lacked documentation of authorization from a nurse prior to administering the medication.

During an interview on 11/7/25 at 11:25 A.M., the Administrator indicated there was no additional documentation that the nurse authorized the medication.

On 11/7/25 at 11:30 A.M., the Director of Nursing (DON) indicated the QMAs working for the facility were aware they needed to get authorization from a nurse prior to administering PRN medications. She indicated they could call her at any time for authorization and if the authorization was not documented in the Electronic Health Record (EHR) under the comments of the MAR at the time of administration, then it wasn't documented. On the paper copies of the narcotic sheets, she would document "DON" behind the QMA the next

time she returned to work. She indicated the facility did not have a policy about QMAs administering PRN medications, but it would be the policy to follow the regulation.

On 11/10/25 at 6:37 A.M., the QMA Scope of Practice in Indiana was reviewed and indicated, " ... (11) Administer previously ordered pro re nata (PRN) medication only if authorization is obtained from the facility ' s licensed nurse on duty or on call. If authorization is obtained, the QMA must do the following: (A) Document in the resident record symptoms indicating the need for the medication and time the symptoms occurred. (B) Document in the resident record that the facility ' s licensed nurse was contacted, symptoms

were described, and permission was granted to administer the medication, including the time of contact. (C) Obtain permission to administer the medication each time the symptoms occur in the resident. (D) Ensure that the resident ' s record is cosigned by the licensed nurse who gave permission by the end of the nurse ' s shift, or if the nurse was on call, by the end of the nurse ' s next tour of

duty ... "

2. On 11/6/25 at 2:15 P.M.,

Resident 8's clinical record was reviewed. Diagnoses included, but were limited to, dementia, history of falls, and arthritis.

Current physicians' orders included, but were not limited to:

ABH (Ativan, Benadryl, Haldol) (Lorazepam (Ativan), diphenhydramine (Benadryl), haloperidol (Haldol)

2-25-2 MG/ML (Milligrams/Milliter), Apply 1 ml lotion topically 3 times a day dated 9/19/25.

ABH 2-25-2 MG/ML, apply 1 ml lotion topically every 4 hours as needed for behaviors dated 9/19/25.

September 2025 Medication Administration record reviewed and the following dates the ABH gel for PRN was administered without permission by a Qualified Medication Aide (QMA):

9/25/2025 2:27 P.M. by QMA 3

Based on interview and record review, the facility failed to obtain authorization from a licensed nurse prior to a Qualified Medication Aide (QMA) administering as needed (PRN) medications for 3 of 8 resident records reviewed. (Resident 5, Resident 6, and Resident 8)

Findings include:

1. On 11/6/25 at 10:57 A.M., Resident 6's clinical record was reviewed. Resident 6 was admitted on 9/1/25. Diagnoses included, but were not limited to, Alzheimer's Disease.

Physician orders included, but were not limited to:

Lorazepam (antianxiety medication) 0.5 MG (milligrams) Give by mouth every six hours as needed for anxiety; start date 9/1/25.

The Medication Administration Record (MAR) was reviewed and indicated a Qualified Medication Aide (QMA) administered controlled narcotic Lorazepam to Resident 6, without documenting approval from a nurse, on the following dates during October 2025:

10/11/25 11:23 A.M. by QMA 12

10/12/25 3:41 P.M. by QMA 12

The clinical record lacked documentation of authorization from a nurse prior to administering the medication.

3. On 11/6/25 at 10:28 A.M., Resident 5's clinical record was reviewed. Diagnoses included, but were not limited to, dementia.

The October 2025 MAR was

reviewed from 10/1/25 through 10/31/25 and indicated the as needed (PRN) does of Tylenol 500 mg given on 10/19/25 at 11:54 P.M., was administered by and documented as effective by QMA 12.

The clinical record lacked documentation of authorization from a nurse prior to administering the medication.

During an interview on 11/7/25 at 11:25 A.M., the Administrator indicated there was no additional documentation that the nurse authorized the medication.

On 11/7/25 at 11:30 A.M., the Director of Nursing (DON) indicated the QMAs working for the facility were aware they needed to get authorization from a nurse prior to administering PRN medications. She indicated they could call her at any time for authorization and if the authorization was not documented in the Electronic Health Record (EHR) under the comments of the MAR at the time of administration, then it wasn't documented. On the paper copies of the narcotic sheets, she would document "DON" behind the QMA the next time she returned to work. She indicated the facility did not have a policy about QMAs administering PRN medications, but it would be the policy to

follow the regulation.

On 11/10/25 at 6:37 A.M., the QMA Scope of Practice in Indiana was reviewed and indicated, " ... (11) Administer previously ordered pro re nata (PRN) medication only if authorization is obtained from the facility ' s licensed nurse on duty or on call. If authorization is obtained, the QMA must do the following: (A) Document in the resident record symptoms indicating the need for the medication and time the symptoms occurred. (B) Document in the resident record that the facility ' s licensed nurse was contacted, symptoms

were described, and permission was granted to administer the medication, including the time of contact. (C) Obtain permission to administer the medication each time the symptoms occur in the resident. (D) Ensure that the resident ' s record is cosigned by the licensed nurse who gave permission by the end of the nurse ' s shift, or if the nurse was on call, by the end of the nurse ' s next tour of

duty ... "

2. On 11/6/25 at 2:15 P.M., Resident 8's clinical record was reviewed. Diagnoses included, but were limited to, dementia, history of falls, and arthritis.

Current physicians' orders

included, but were not limited to:

ABH (Ativan, Benadryl, Haldol) (Lorazepam (Ativan), diphenhydramine (Benadryl), haloperidol (Haldol)

2-25-2 MG/ML (Milligrams/Milliter), Apply 1 ml lotion topically 3 times a day dated 9/19/25.

ABH 2-25-2 MG/ML, apply 1 ml lotion topically every 4 hours as needed for behaviors dated 9/19/25.

September 2025 Medication Administration record reviewed and the following dates the ABH gel for PRN was administered without permission by a Qualified Medication Aide (QMA):

9/25/2025 2:27 P.M. by QMA 3

Based on interview and record review, the facility failed to obtain authorization from a licensed nurse prior to a Qualified Medication Aide (QMA) administering as needed (PRN) medications for 3 of 8 resident records reviewed. (Resident 5, Resident 6, and Resident 8)

Findings include:

1. On 11/6/25 at 10:57 A.M., Resident 6's clinical record was reviewed. Resident 6 was admitted on 9/1/25. Diagnoses

included, but were not limited to, Alzheimer's Disease.

Physician orders included, but were not limited to:

Lorazepam (antianxiety medication) 0.5 MG (milligrams) Give by mouth every six hours as needed for anxiety; start date 9/1/25.

The Medication Administration Record (MAR) was reviewed and indicated a Qualified Medication Aide (QMA) administered controlled narcotic Lorazepam to Resident 6, without documenting approval from a nurse, on the following dates during October 2025:

10/11/25 11:23 A.M. by QMA 12

10/12/25 3:41 P.M. by QMA 12

The clinical record lacked documentation of authorization from a nurse prior to administering the medication.

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 SIGNATUREPhilip Travis	TITLEExecutive Director	(X6) DATE12/01/2025