

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/24/2026
NAME OF PROVIDER OR SUPPLIER PRIMROSE MEMORY CARE OF ANDERSON		STREET ADDRESS, CITY, STATE, ZIP CODE 2101 N MADISON AVENUE, ANDERSON, , 46011			
(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: July 22, 23, and 24, 2026 Facility number: 013811 Residential Census: 20 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed July 31, 2026.	R 0000			
R 0086	Administration and Management - Deficiency 410 IAC 16.2-5-1.3(a)(1-2) The licensee: (1) is responsible for compliance with all applicable laws; and (2) has full authority and responsibility for the:	R 0086	We respectfully request an IDR on this tag due to the fact that under our current organizational structure we do meet the requirements of this standard. We have been approved during all past annual ISDH surveys under the existing structure where both AL and MC have separate and distinct RCA	08/03/2026	

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- (A) organization;
(B) management;
(C) operation; and
(D) control;

of the licensed facility.

The delegation of any authority by the licensee does not diminish the responsibilities of the licensee.

Based on observation, interview, and record review, the facility failed to follow state regulatory requirements regarding an Administrator having a history of leadership and administrative oversight over two separately licensed facility, a Director of Nursing having nursing administrative oversight over two separately licensed facilities. This deficient practice has the potential to impact 20 of 20 residents.

Findings include:

During an observation on 7/22/26 at 4:00 p.m., it was observed that Primrose Memory Care of Anderson was a free standing assisted living facility. The facility had a parking lot on its south side. The parking lot had a sidewalk running off the west side leading to the parking lot of a separate assisted living and independent living facility owned by the same corporation

Executive Directors and Directors of Nursing dedicated to their respective program. The dual licensure was originally pursued, to my understanding, because the ISDH directed us to adopt this structure because two different investor groups hold ownership in the buildings, one group for each (One for MC, one for AL). This year I queried Standards to determine the "why" of this structure and was advised that nothing in the current ISDH regulations for Residential Care required our current "separate but equal" structure.

What corrective actions will be accomplished for those residents found to have been affected by the deficient practice.

Leadership assignments were reviewed with regional leadership. A licensed administrator has been designated for Primrose Memory Care of Anderson with authority for the facility's day-to-day operations. Documentation of administrator licensure, designation, and authority will be maintained on-site.

How the facility will identify other residents having the

"Facility 2". Primrose Memory Care of Anderson was on Madison Avenue. "Facility 2" was located on Cross Street. Madison and Cross street intersected. Primrose Memory Care of Anderson and "Facility 2" were two separate facilities which abutted one another. The sidewalk which allowed access from one facility to the other was approximately one city block in length. On all days of the survey 7/22/26, 7/23/26, and 7/24/26 staff members were observed walking on said sidewalk.

During an interview on 7/22/26 at 10:40 a.m., Administrator 1 indicated he was the Executive Director over "Primrose Retirement Communities of Anderson" which was the combination of Primrose Memory Care of Anderson and "Facility 2". He was the Administrator/Executive Director of "Facility 2" and was to offer Administrative oversight to Primrose Memory Care of Anderson until a Memory Care Director was hired. After a Memory Care Director was hired, he would have Administrative oversight over said director.

During an interview, on 7/22/26 at 2:58 p.m., LPN 5 indicated she was the DON of the Primrose Anderson campus. The Primrose Anderson

potential to be affected by the same deficient practice and what corrective action will be taken.

All residents had the potential to be affected. No resident-specific adverse outcome was identified. The facility reviewed administrator coverage and operational oversight to ensure a designated licensed administrator is assigned to the Memory Care facility.

What measure will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur.

The organizational structure, key personnel list, and administrator job description/assignment documentation will be reviewed and revised as needed to reflect a licensed administrator responsible for the Memory Care facility. Required notifications to the State will be completed when administrator changes occur.

How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put in place.

Leadership will audit administrator designation, licensure, and State notification

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Campus included Primrose Memory Care and "Facility 2", two separately licensed facilities. A DON could not have their license over two licensed facilities. It was difficult since both buildings were having regulatory visits at the same time.

During an interview on 7/23/26 at 10:12 a.m., LPN 5 indicated she has been the DON for the Primrose Anderson Campus for 2.5 years. This included DON duties over two separately licensed facilities.

An email statement by Administrator 1 on 7/22/26 at 3:53 p.m. indicated:

" [LPN 5] is the full-time director of nursing that administratively is responsible for both programs, just as I am. As we drill down into more specific mechanics, [LPN 5] is primary for nursing in AL and [LPN 6] is primary for nursing in MC (Memory Care), thought [LPN 6] works directly for [LPN 5]...."

During confidential interviews the following statements were made regarding leadership for Primrose Memory Care of Anderson:

a For over 10 years, the Administrator over the building next door "Facility 2" has been the Administrator over both

documentation monthly for three months, then quarterly for two additional quarters. Findings will be reviewed through the quality assurance process and corrective action will be taken for any identified noncompliance.

By what date the systemic changes will be completed.

August 31, 2026

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	buildings. b The company runs the two buildings as one campus with one leadership team. c In the past few years, Administrator 2, Administrator 3, Administrator 4 have had an office in "Facility 2" next door and have been the Executive Director/Administrator for both buildings. d LPN 5 was the DON over both buildings (Primrose Memory Care of Anderson and "Facility 2"). e LPN 6 was the ADON and stationed primarily in Memory Care. f Although there have been Memory Care Directors, the Executive Director/Administrator was always the Administrator from next door, "Facility 2". 1. Resident 19's clinical record was reviewed on 7/23/26 at 2:44 p.m. Current diagnoses included dementia, bipolar disorder and hypothyroidism. The resident's records contained documents signed by individuals who were employed at "Facility 2" and signed as leadership in Memory Care as follows: a. A 6/3/26, "Service Plan",			
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	signed by LPN 5, who signed as DON (Director of Nursing). b. A 5/20/26, "DON Move in Checklist", signed by LPN 5, who signed as DON. 2. Resident 18's clinical record was reviewed on 7/22/26 at 3:09 p.m. Current diagnoses included dementia and depression. The resident's records contained documents signed by individuals who were employed at "Facility 2" and signed as leadership in Memory Care as follows: a. An 8/18/25 "DON Move in Checklist" signed by LPN 5, who signed as DON. b. A 2/26/26 "Service Plan" signed by LPN 5, who signed as DON and signed by Administrator 4, who signed as Executive Director. 3. Resident 17's clinical record was reviewed on 7/22/26 at 2:35 p.m. Current diagnoses included dementia, depression. The resident's records contained documents signed by individuals who were employed at "Facility 2" and signed as leadership in Memory Care as follows: a. A 1/13/26, "ED Move in			
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Checklist" signed by Administrator 4, who signed as Executive Director.

b. A 3/3/26, "Service Plan", signed by LPN 5, who signed as DON, and signed by Administrator 4, who signed as Executive Director.

4. Resident 4's clinical record was reviewed on 7/23/26 at 1:11 p.m. Current diagnoses included dementia.

The resident's records contained documents signed by individuals who were employed at "Facility 2" and signed as leadership in Memory Care as follows:

a. A 9/15/25, "ED Move In Checklist", signed by Administrator 4, who signed as Executive Director.

b. A 9/24/25, "Memory Care Occupancy Agreement" signed by Administrator 2, who signed as Executive Director.

c. A 6/25/26, "Service Plan" signed by LPN 5, who signed as DON.

5. Resident 3's clinical record was reviewed on 7/23/26 at 1:22 p.m. Current diagnoses included dementia, hypertension, and type II diabetes mellitus.

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	The resident's records contained documents signed by individuals who were employed at "Facility 2" and signed as leadership in Memory Care as follows: a. An 11/18/25, "ED Move In Checklist", signed by Administrator 4, who signed as Executive Director. b. A 6/9/26, "Memory Care Occupancy Agreement", signed by Administrator 3, who signed as Executive Director. c. A 6/20/26, "Service Plan", signed by LPN5, who signed as DON. A 7/22/26, facility document provided on 7/22/26 at 3:14 p.m. via email, titled "List of Key Personnel" indicated the following: "Primrose Retirement Communities of Anderson July 22, 2026 [Administrator 1's name]- Executive Director (RCA) ... [LPN 5's name]- Director of Nursing ... [LPN 6's name]-Assistant			
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	Director of Nursing, Memory Care ..." A current 10/31/2024, facility policy titled, "Director of Memory Care JOB DESCRIPTION", which was provided by Administrator 1 via email on 7/24/26 at 11:17 a.m., indicated the following: "JOB SUMMARY: The Director of Memory Care is responsible for leading the day-to-day operations of the Memory Care neighborhood under the supervision of the Executive Director. As part of the community leadership team, this role involves various responsibilities related to operations, life enrichment, and community leadership. QUALIFICATIONS AND EXPERIENCE: High School Diploma or equivalent is required. College degree in Nursing, Social Services, Health Care Administration, Psychology, Recreation Therapy, Occupational Therapy, or Human Services preferred.			
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	Strong knowledge of memory impairments, including Alzheimer's disease and dementia. Excellent communication and interpersonal skills, with the ability to build rapport with residents, families, and staff. Excellent written and verbal communication skills. Excellent organizational skills and attention to detail. Proficient in Microsoft Office Suite or similar software. Proficient or ability to quickly learn various software, including EHR and human resource information system (HRIS). Ability to multi-task with frequent interruptions. Ability to maintain confidentiality and handle sensitive information with integrity. Must be able to read, write, and speak the English language." The job description did not list a requirement as having a current Administrator License or Residential Administrator's Licenses.			
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	A current facility document revised January 2026, titled "DIRECTOR OF NURSING JOB DESCRIPTION", which was provided by Administrator 1 via email on 7/24/26 at 11:48 a.m. indicated: " DEPARTMENT: NURSING SUPERVISOR: EXECUTIVE DIRECTOR JOB SUMMARY: The Director of Nursing is responsible for leading the direct care staff in the delivery of nursing services, to enable each resident to attain or maintain the highest practical physical, mental, and psychosocial well-being. The Director of Nursing establishes the overall quality, adequacy of services provided, and the supervision of the nursing staff, adhering to the Primrose Mission of providing a quality "person-centered" care approach to our growing senior population. JOB DUTIES: ..Ensures timely completion of resident assessments and service plans at pre-admission, admission, 30 days, semi-annually, and with change of condition or at intervals specified by State regulations...			
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	Evaluates whether the community can meet each resident ' s clinical needs, which includes a potential new admission to the facility, a current resident, or the transfer of a resident from the community..."			
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R 0088	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(c)(1-2)(d)(1-2) c) The licensee shall: (1) appoint an administrator with either a: (A) comprehensive care facility administrator license as required by IC 25-19-1-5(c); or (B) residential care facility administrator license as required by IC 25-19-1-5(d); and (2) delegate to that administrator the authority to organize and implement the day-to-day operations of the facility. (d) The licensee shall notify the director: (1) within three (3) working days of a vacancy in the administrator's position; and (2) of the name and license number of the replacement administrator	R 0088	We respectfully request an IDR on this tag due to the fact that under our current organizational structure we do meet the requirements of this standard. We have been approved during all past annual ISDH surveys under the existing structure where both AL and MC have separate and distinct RCA Executive Directors and Directors of Nursing dedicated to their respective program. The dual licensure was originally pursued, to my understanding, because the ISDH directed us to adopt this structure because two different investor groups hold ownership in the buildings, one group for each (One for MC, one for AL). This year I queried Standards to determine the "why" of this structure and was advised that nothing in the current ISDH regulations for Residential Care required our current "separate but equal" structure. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. Leadership assignments were reviewed with regional leadership. A licensed administrator has been	08/03/2026
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Based on observation, interview, and record review, the facility failed to ensure the employment of a licensed administrator in a full-time capacity dedicated to the specific facility's day to day operations. This deficient practice had the potential to affect 20 of 20 residents residing in the facility.

Findings include:

On 7/22/26 at 4:00 p.m., it was observed that Primrose Memory Care of Anderson was a free standing assisted living facility. Primrose Memory Care of Anderson was on Madison Avenue. "Facility 2" was located on Cross Street. The sidewalk allowing access from one facility to the other was approximately one city block in length.

Review of Indiana Department of Health facility licensure information indicated Primrose Memory Care of Anderson's operating license number was 25138111 and Facility 2's operating license number was 26118061.

During an interview on 7/22/26 at 10:40 a.m., Administrator 1 indicated he was the Executive Director over "Primrose Retirement Communities of Anderson" which was the combination of Primrose Memory Care of Anderson and

designated for Primrose Memory Care of Anderson with authority for the facility's day-to-day operations. Documentation of administrator licensure, designation, and authority will be maintained on-site.

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.

All residents had the potential to be affected. No resident-specific adverse outcome was identified. The facility reviewed administrator coverage and operational oversight to ensure a designated licensed administrator is assigned to the Memory Care facility.

What measure will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur.

The organizational structure, key personnel list, and administrator job description/assignment documentation will be reviewed and revised as needed to reflect a licensed administrator responsible for the Memory Care facility. Required notifications to the State will be completed when administrator

"Facility 2". He was the Administrator/Executive Director of "Facility 2" and was to offer Administrative oversight to Primrose Memory Care of Anderson until a Memory Care Director was hired. After a Memory Care Director was hired, he would have Administrative oversight over that individual. An email statement by Administrator 1 on 7/22/26 at 3:53 p.m. indicated Administrator 1 was responsible for the oversight of operations at both Primrose Memory Care of Anderson and Facility 2. Confidential interviews were conducted during the survey. The confidential interviews indicated the following regarding leadership for Primrose Memory Care of Anderson: a. For over 10 years, the Administrator over the building next door, "Facility 2," had been the Administrator over both buildings. b. The company ran the two facilities as one campus with one leadership team. c. In the past few years, (former) Administrator 2, (former) Administrator 3, and (former) Administrator 4 had an office in "Facility 2" next door and had	changes occur. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put int place. Leadership will audit administrator designation, licensure, and State notification documentation monthly for three months, then quarterly for two additional quarters. Findings will be reviewed through the quality assurance process and corrective action will be taken for any identified noncompliance. By what date the systemic changes will be completed. August 31, 2026	
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been the Executive Director/Administrator for both buildings.

d. Although there have been Memory Care Directors, the Executive Director/Administrator was always the Administrator from next door, "Facility 2".

A 7/22/26, facility document, provided on 7/22/26 at 3:14 p.m. via email, titled "List of Key Personnel" indicated the following:

"Primrose Retirement Communities of Anderson July 22, 2026 [Administrator 1's name]- Executive Director (Residential Care Administrator)...."

A current 10/31/24, facility policy titled, "Director of Memory Care JOB DESCRIPTION", provided by Administrator 1 via email on 7/24/26 at 11:17 a.m., indicated the following:

"JOB SUMMARY: The Director of Memory Care is responsible for leading the day-to-day operations of the Memory Care neighborhood under the supervision of the Executive Director. As part of the community leadership team, this role involves various responsibilities related to operations, life enrichment, and community leadership.

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	QUALIFICATIONS AND EXPERIENCE: High School Diploma or equivalent is required. College degree in Nursing, Social Services, Health Care Administration, Psychology, Recreation Therapy, Occupational Therapy, or Human Services preferred...." The job description did not list a current Administrator License or Residential Administrator's License as a requirement.			
R 0092	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(i)(1-2) (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between	R 0092	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. The ED will monitor compliance with the fire drill requirement monthly and personally sign off each fire drill immediately after it is completed, in accordance with the company Fire Drill policy. The ED will ensure that all fire drills occur timely relative to the company-provided calendar to ensure no drills are inadvertently missed.	08/03/2026

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	9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on record review and interview, the facility failed to ensure a fire drill was completed on each shift quarterly to ensure resident safety in the event of a fire emergency. This deficiency had the potential to affect 20 of 20 residents who resided in the facility. Findings include: Fire drills, provided by Administrator 1 shortly after entrance conference, were reviewed on 7/22/26 at 2:00 p.m., and the following monthly fire drills were missing: third shift for Quarter 3 (August 2025) and second shift for Quarter 4 (December 2025).		How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. - The ED or designee will coordinate and schedule fire drills on a monthly basis, with support from the PMT, in accordance with facility policy and applicable regulatory requirements. 100% of residents could be affected by the same deficient practice, so the above plan of correction will apply to all residents. What measure will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur. - The facility completed a review of its "Fire Drills" policy with no changes. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put in place. - The ED, or designee, will conduct audits of fire drills monthly for 2 months, then every other	
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	During an interview, on 7/23/26 at 1:24 p.m., the Maintenance Director indicated the fire drills were performed every month and on every shift. He started in this position on 4/7/26 and provided all the fire drills he had access to. A facility policy, titled, "Fire Drills", provided by Administrator 1 on 7/24/26 at 11:14 a.m., indicated the following: "... The Executive Director or designee will ensure drills are scheduled monthly (or as required by State regulations) at designated times on each shift and under various circumstances which simulate actual fire conditions...The Executive Director or designee should document all fire drills on the Fire Drill Form..."		month for two months, and quarterly for the following six months. Audit findings will be reviewed during the monthly QA meetings. By what date the systemic changes will be completed. September 1, 2026.	
R 0095	Administration and Management -Noncompliance 410 IAC 16.2-5-1.3(l)(1-2) (l) In facilities that are required under IC 12-10-5.5 to submit an Alzheimer's and dementia special care unit disclosure form, the facility must designate a director for the Alzheimer's and dementia special care unit. The director shall have an earned degree from an educational institution in a health care, mental health, or social service profession or be a licensed health facility administrator. The director shall have a minimum of	R 0095	R 095 – Dementia Special Care Unit Disclosure Form Filing What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. Dementia Special Care Unit Disclosure Form filled on 8/13/2026 sent to the state.	08/03/2026

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one (1) year work experience with dementia or Alzheimer's residents, or both, within the past five (5) years. Persons serving as a director for an existing Alzheimer's and dementia special care unit at the time of adoption of this rule are exempt from the degree and experience requirements. The director shall have a minimum of twelve (12) hours of dementia-specific training within three (3) months of initial employment as the director of the Alzheimer's and dementia special care unit and six (6) hours annually thereafter to: (1) meet the needs or preferences, or both, of cognitively impaired residents; and (2) gain understanding of the current standards of care for residents with dementia. Based on record review and interview, the facility failed to ensure submission of the Family and Social Services Administration (FSSA) Dementia Special Care Unit Disclosure form in a timely manner. This deficient practice had the potential to impact 20 of 20 residents who resided in the secured facility. Findings include: The Dementia Special Care Unit Disclosure form, provided by Administrator 1 on 7/23/26 at 12:02 p.m., was reviewed on	How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. - The facility has identified that 100% of residents could be affected by the same deficient practice so the above and below plan of correction will apply to all residents. What measure will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur. - The Memory Care Director or designee will ensure that the Dementia Special Care Unit Disclosure Form is filed timely with ISDH at the end of each calendar year. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put in place. - The Dementia Special Care Unit Disclosure Form will be reviewed at the next monthly QA meeting to ensure it was	
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	7/23/26 12:02 p.m. The form was completed and signed by Administrator 2 on 12/1/24. Review of an electronic mail (e-mail) on 7/23/26 at 12:02 p.m., Administrator 1 indicated this was the last filing of the Dementia Special Care Unit Disclosure form completed for this location. The form was expired and needed to be re-filed immediately.		timely filed with the state. ED will annually check to ensure timely and accurate filing of the form with ISDH at the end of each calendar year. By what date the systemic changes will be completed. This systemic change takes effect immediately. September 1, 2026	
R 0299	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(c)(3) (3) The medication review, recommendations, and notification of the physician, if necessary, shall be documented in accordance with the facility ' s policy. Based on record review and interview, the facility failed to follow-up on pharmacy recommendations for 2 of 5 residents reviewed for pharmacy reviews and recommendations. (Residents 18 & 4) Findings include: 1. Resident 18's clinical record was reviewed on 7/22/26 at 3:09 p.m. Diagnoses included dementia and depression. Current physician's orders	R 0299	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. For the two residents identified without documented provider responses to the consultant pharmacist's recommendations, the ADON re-faxed to the respective providers, and an observation note was entered in each resident's clinical record. The ADON will follow up with each provider weekly until a response is received and documented in the resident's record. How the facility will identify other residents having the potential to	08/03/2026

included the following: a. Acetaminophen (a pain reliever) 500 mg, take two (2) tablets every 8 hours. b. Acetaminophen 500 mg, take one (1) tablet every 6 hours PRN (as needed). A review of the pharmacy recommendation, dated 10/23/25, indicated Resident 18 had the following orders containing acetaminophen as well as documentation to not exceed 3 grams (gm) of acetaminophen from all sources. Acetaminophen 1000 milligrams (mg) every 8 hours, dated 10/2025, acetaminophen 600 mg every 4 hours as needed (PRN) dated 8/2025, and hydrocodone-acetaminophen 5-325 mg every 6 hours PRN. The resident is getting 3 gm on a scheduled basis. Please clarify if the max dose needs to be adjusted, PRN orders discontinued, or the scheduled doses be reduced. The clinical record lacked a physicians response regarding the pharmacist's recommendation. 2. Resident 4's clinical record was reviewed on 7/23/26 at 1:11 p.m. Diagnoses included dementia and hypothyroidism.	be affected by the same deficient practice and what corrective action will be taken The DON and ADON will review all consultant pharmacist recommendations from the most recent pharmacy visit to verify that each provider response is documented in the corresponding resident's clinical record. For any recommendation lacking a documented provider response, the ADON will re-fax the recommendation to the appropriate provider and enter an observation note in the resident's clinical record. The ADON will follow up with each provider weekly until a response is received and documented. The facility has identified that 100% of the residents have the potential to be affected by the same deficient practice so the above and below plan of correction will apply to all residents. What measure will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur.	
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Current physician's orders included the following:
risperidone (an antipsychotic medication) 0.25 mg, take one tablet by mouth once daily at bedtime.

A review of the pharmacy recommendation, dated 2/24/26, indicated Resident 4 continued on risperidone 0.25 mg once daily at bedtime and has a diagnosis of dementia. Risperidone carries a black box warning for a dose related increased risk of death in geriatric patients with dementia. Would this be an appropriate time to attempt a dose reduction to risperidone 0.125 mg once daily at bedtime?

The clinical record lacked a physicians response regarding the pharmacist's recommendation.

During an interview, on 7/24/26 at 10:58 a.m., LPN 6/ADON indicated she was unable to provided any additional documentation to show the pharmacy reviews had been sent to the appropriate physicians.

During a follow-up interview, on 7/24/26 at 1:07 p.m., LPN 6/ADON indicated the pharmacy recommendations were able to be sent the appropriate physician by any charge nurse. When she completed this task,

- The facility reviewed its policies "Pharmacy Policies and Procedures" and "Consultant Pharmacy Services" with no changes.

How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put int place.

- DON or designee will audit pharmacy recommendations to verify that each recommendation was submitted to the provider and that a provider response was received. The audit will include 100% of recommendations at the next pharmacy review, 75% at the second pharmacy review, and 25% for the third pharmacy review. Audit findings will be reviewed during the monthly QA meeting.

By what date the systemic changes will be completed.

- 9/1/2026 or effective as of the next pharmacy review.

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	she ensured the clinical record contained a progress note and a copy of the recommendation sent to the doctor. This task should be completed as soon as possible once the recommendation was received from the pharmacy. A facility policy, effective 1/1/15, titled, "Pharmacy Policies and Procedures", provided by Administrator 1 on 7/24/26 at 11:09 a.m., indicated the following: "The purpose of this policy is to ensure the availability of regular and reliable pharmacy services to provide residents with prescription and non-prescription medications, as well as related services, equipment, and supplies. This policy aims to support the safe and effective use of medications within the organization or facility...: A facility policy, revised 8/19/24, titled, "Consultant Pharmacist Services", provided by Administrator 1 on 7/24/26 at 11:09 a.m., indicated the following: "The purpose of consultant pharmacist services is to provide expert pharmaceutical guidance and support. Consultant pharmacists offer their specialized knowledge and skills to optimize medication therapy, improve patient outcomes, ensure			
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	regulatory compliance, and enhance overall medication safety and quality of care...Review the medication regimen of each resident at least quarterly or as defined by applicable state regulation/Pharmacy Contract to identify any potential or actual medication-related problems...Communicate with the resident's physician and appropriate community staff regarding any recommendations on drug interactions, medication adverse effects, dosing, monitoring parameters, laboratory tests needed, or any other aspects of the resident ' s drug therapy; establish procedures for monitoring the outcome of recommendations..."			
R 0350	Clinical Records - Noncomformance 410 IAC 16.2-5-8.1(b)(1-2) (b) Clinical records must be retained after discharge: (1) for a minimum period of one (1) year in the facility and five (5) years total; or (2) for a minor, until twenty-one (21) years of age. Based on record review and interview, the facility failed to retain and store complete and accurate clinical records for	R 0350	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. The ED, Memory Care Director, Director of Nursing, and Assistant Director of Nursing will be fully trained on the process to retrieve closed resident records locally and on site. How the facility will identify other residents having the potential to	08/03/2026

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discharged resident for 1 of 1 residents reviewed for discharge. Findings include: A discharge records list, provided by Administrator 1 on 7/22/26 at 12:09 p.m., were reviewed on 7/23/26 at 11:10 a.m., indicated Resident 100 was the only resident to discharge during the last ninety (90) days An electronic mail (e-mail) request for the closed record was sent to Administrator 1 on 7/23/26 at 11:12 a.m., on 7/24/26 at 9:36 a.m., and on 7/24/26 at 11:33 a.m. Contained in an e-mail correspondence on 7/24/26 at 1:01 p.m., Administrator 1 indicated he had sent the closed record for Resident 100 by e-mail to the survey team. The closed clinical record was not received/provided by the end of the survey period and was not accessible on-site by surveyors. A facility policy, revised on 5/18/26, titled, "Record Retention", provided by Administrator 1 on 7/24/26 at 1:01 p.m., indicated the following: "...Primrose will retain, secure, and dispose of records in accordance with the retention	be affected by the same deficient practice and what corrective action will be taken. - The facility has identified that 100% of residents could potentially be affected by the same deficient practice and corrective action will be taken as specified above and below for all residents. What measure will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur. - The facility reviewed its policy "Record Retention" and the "ALIS Guide to Records Requests" job aid with no changes. The ED and Memory Care Director will establish skills checkoffs for the DON and ADON to ensure each has the requisite skills to promptly obtain closed records when needed. The check-off will be documented and included in each person's employee file. How the corrective action will be monitored to ensure the deficient practice will not recur,	
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	timeframes in this policy and all applicable federal, state, and local requirements. Records must be stored in a manner that protects confidentiality and allows timely retrieval...1. Discharged Resident Record Retention and Destruction Resident medical records for discharged residents must be retained for the period required by the state in which the community is located (see table below)... Indiana... 5 years..."		i.e. what quality assurance program will be put int place. - The ED and Memory Care Director will sign and date the documented skills checkoff forms for each person that will then be filed in each person's employee file. By what date the systemic changes will be completed. - September 1, 2026	
R 0410	Infection Control - Noncompliance 410 IAC 16.2-5-12(e)(f)(g) (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis.	R 0410	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. - The ADON will administer the two-step TB test to the residents identified during the survey. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. - The DON and ADON or designee will review 100% of existing resident charts to verify a TB test	08/03/2026

(g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.

Based on record review and interview, the facility failed to ensure an admission 2-step tuberculin (TB) skin tests were completed for 2 of 5 residents reviewed for admission TB testing. (Residents 18 & 4)

Findings include:

1. Resident 18's clinical record was reviewed on 7/22/26 at 3:09 p.m. Diagnoses included dementia and depression. Their admission date was 8/26/25.

The clinical record lack documentation of the 2-step TB skin tests upon admission.

2. Resident 4's clinical record was reviewed on 7/23/26 at 1:22 p.m. Diagnosis included dementia and hypothyroidism. The admission date was 9/15/25.

The clinical record lack documentation of the 2-step TB skin tests upon admission.

During an interview, on 7/24/26 at 10:58 a.m., LPN6/ADON indicated she was unable to locate any documentation that

was conducted and read at admission. Residents identified without the test will be promptly administered the test. The result will be placed in the resident chart.

What measure will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur.

- The facility reviewed the policy titled "Tuberculin Skin Test" with no changes.

How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put in place.

- DON or designee will audit every new admission weekly x 1 month, Bi-weekly for 2 months, and monthly for 3 months to ensure that the Tuberculin Skin Test policy is being followed. The results of the audit will be reviewed at QA meetings monthly.

By what date the systemic changes will be completed.

Resident 18 or Resident 4 received the 2-step TB testing when they admitted to the facility. All residents should receive the 2-step TB skin tests upon admission and the testing information should be documented in the clinical record.

A facility policy, revised 12/31/18, titled, "Tuberculin Skin Test", provided by Administrator 1 on 7/24/26 at 11:08 a.m., indicated the following: "All assisted living residents and health care workers shall receive the 2-step method of the Tuberculin Skin Testing within 14 days of admission or employment to the facility... Document results of both 1st step Mantoux and 2nd step Mantoux for both residents and employees utilizing "TB Screening and Immunization Record" form... Residents results shall be filed in resident 's record behind the Immunization tab..."

- September 1, 2026

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 Dan Fink

TITLE Executive Director

(X6) DATE 08/17/2026