STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELVEDERE SENIOR HOUSING	343 E 90TH DRIVE, MERRILLVILLE, , 46410

(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 Intakes 466192 and 468229. Intake 466192 - State deficiencies related to the allegations are cited at R0349. Intake 468229 - No deficiencies related to the allegations are cited. Survey dates: March 10 and 11, 2026 Facility number: 14178 Residential Census: 120 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality reiew completed on 3/20/26.	R 0000		

R 0216	Evaluation - Noncompliance 410 IAC 16.2-5-2(c)(1-4)(d) (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on record review and interview, the facility failed to ensure residents had physician's orders for medications and an assessment to self-administer their own medications for 1 of 8 sampled residents. (Resident 6) Finding includes: The record for Resident 6 was reviewed on 3/11/26 at 9:00 a.m. Diagnoses included, but were not limited to, diabetes mellitus and chronic obstructive	R 0216	1. Resident 6 had no adverse effects from alleged deficient practices. 2. All residents that have medications administered have the potential to be affected by alleged deficient practice. No other residents were negatively affected by alleged deficiencies. 3. DON and ADON, on 04/29/26, will complete education and training on physician orders for medications and assessments to self-administer their own medications. DON to complete an audit of all residents currently self-administering inhalers and creams and will ensure physician orders and self-administer assessments are completed. DON and/or designee will audit EMAR and documentation weekly for 4 weeks, bi-weekly for 1 month and monthly for 4 months. 4. Review audits will be completed during QAPI for 6 months.	04/01/2026

pulmonary disease (COPD).

The Level of Service Assessment/Evaluation, dated 1/19/26, indicated the resident was cognitively intact and required staff to assist with medication administration including insulin injections and/or fingerstick glucose monitoring.

The March 2026 Physician's Order Summary (POS), indicated the resident was to receive the following:

- ammonium lactate 12% cream to both lower extremities twice daily

- Breo Ellipta (inhaler used to treat COPD) 100-25 micrograms (mcg) inhalation, inhale one puff by mouth once daily

- triamcinolone 0.1% cream (30 grams), apply to buttocks at 4:00 p.m. and 8:00 p.m.

The February and March 2026 Medication Administration Records (MARs) indicated the resident self-administered the ammonium lactate cream on 2/3, 2/4, 2/8, 2/9, 2/12, 2/15, 2/17, 2/20, 2/21, 2/23, 2/26, 2/27, 2/28, 3/5, 3/8, and 3/9/26. The Breo Ellipta was self-administered on 2/4, 2/8, 2/21, 2/23, 2/26, and 3/8/26. The triamcinolone cream was self-administered on 2/3, 2/9,

	2/14, 2/15, 2/17, 2/18, 2/19, 2/20, 2/23, 2/24, 2/26, 2/28, 3/5, and 3/9/26. There was no physician's order for the resident to self-administer the ammonium lactate cream, Breo Ellipta, and triamcinolone cream. During an interview on 3/11/26 at 3:35 p.m., the Director of Nursing indicated there were no orders for self-administration or a self-administration assessment completed indicating the resident was able to self-administer any medications.			
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: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on record review and interview, the facility failed to ensure physician's orders were followed related to insulin administration for 1 of 8	R 0241	1. Resident 6 had no adverse effects from alleged deficient practices. 2. All residents that have medications administered have the potential to be affected by alleged deficient practice. No other residents were negatively affected by alleged deficiencies. 3. DON and ADON, on 04/29/26, to complete education and training on following physician orders related to insulin administration. DON and/or designee will audit insulin administration weekly for 4 weeks,	04/01/2026

	residents reviewed. (Resident 6) Finding includes: The record for Resident 6 was reviewed on 3/11/26 at 9:00 a.m. Diagnoses included, but were not limited to, diabetes mellitus and chronic obstructive pulmonary disease (COPD). The Level of Service Assessment/Evaluation, dated 1/19/26, indicated the resident was cognitively intact and required staff to assist with medication administration including insulin injections and/or fingerstick glucose monitoring. The March 2026 Physician's Order Summary (POS) indicated the resident received Novolog (insulin aspart, fast acting insulin) 100 unit/milliliter (u/mL) Flexpen, inject subcutaneously four times daily per sliding scale: <69 call physician; 70-150=0 units (U), 151-200=2U, 201-250=4U, 251-300=6U, 301-350=8U, 351-400=10U; >400= call physician. The February and March 2026 Medication Administration Records (MARs) indicated the Novolog insulin was not marked as administered on 2/4/26 at 8:00 p.m., 3/1/26 at 8:00 p.m., and 3/2/26 at 4:00 p.m. On 3/2/26 at 8:00 a.m., the		bi-weekly for 1 month and monthly for 4 months. 4. Review audits will be completed during QAPI for 6 months.	

	resident's blood sugar was documented as 225 and 6 units were documented as administered. During an interview on 3/11/26 at 3:35 p.m., the Director of Nursing indicated on the electronic MAR, it was marked that the residents blood sugar was 252 so the nurse had possibly documented incorrectly. She had no further information to provide.			
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	R 0301	1. Resident 10 had no adverse effects from alleged deficient practices. 2. All residents that have medications administered have the potential to be affected by alleged deficient practice. No other residents were negatively affected by alleged deficiencies. 3. DON and ADON, 04/29/26, to complete education and training on proper medication labeling for prescription and OTC medication. DON and/or designee will audit medication boxes weekly for 4 weeks, bi-weekly for 1 month, and monthly for 4 months. 4. Review audits will be completed during QAPI	04/01/2026

	permitted. Based on observation and interview, the facility failed to ensure prescription medications were labeled for 1 of 5 residents reviewed during a medication pass observation. (Resident 10) Finding includes: During an observation of medication pass on 3/11/26 at 11:20 a.m., QMA 1 was observed preparing medications for Resident 10. She put two tablets of Tylenol 325 milligrams and one tablet of alprazolam 1 milligram in a medication cup and then administered the pills with water. She then administered two drops of atropine sulfate 1% from a plastic squeeze bottle under the residents tongue. The bottle of atropine had no label that included the resident's name and directions for use. During an interview on 3/11/26 at 11:40 a.m., QMA 1 indicated the pharmacy had labeled the medication box, but that the box had been thrown out. She knew how to administer the medication by reading the eMAR order and the medication was supposed to stay in the locked box in the resident's room. During an interview on 3/11/26		for 6 months.	

	at 3:35 p.m., the Director of Nursing indicated the bottle should have had a label on it.			
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 record review and interview, the facility failed to ensure clinical records were complete and accurately documented related to a transfer to the hospital for 1 of 8 records reviewed. (Resident C) Finding includes: The record for Resident C was reviewed on 3/11/26 at 9:18 a.m. Diagnoses included, but were not limited to, bipolar disorder and diabetes mellitus. A Progress Note, dated 3/9/26 at 10:00 a.m., indicated the resident had been sent to the	R 0349	1. Resident C had no adverse effects from alleged deficient practices. 2. All residents that are transferred or discharged have the potential to be affected by alleged deficient practice. No other residents were negatively affected by alleged deficiencies. 3. DON and ADON, on 04/29/26, to complete education and training on accurately documenting transfer/discharges. DON and/or designee will audit Caremerge documentation weekly for 4 weeks, bi-weekly for 1 month, and monthly for 4 months. 4. Review audits will be completed during QAPI for 6 months.	04/01/2026

	hospital. There was no further documentation to indicate why the resident was sent to the hospital, if the Physician had been notified, or if the resident's family had been made aware. A Progress Note, dated 3/10/26 at 1:00 p.m., indicated the resident had been admitted to the hospital with pneumonia. There was lack of documentation to indicate if the resident's family had been made aware. During an interview on 3/11/26 at 11:02 a.m., the Director of Nursing indicated the resident had been sent out to the hospital for shortness of breath. The nurse had forgotten to write a progress note. The resident's family should have been made aware of the transfer to the hospital. This citation relates to Intake 466192.			

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 SIGNATUREStephanie Westphal	TITLEExecutive Director	(X6) DATE04/08/2026