STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/07/2026

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 the Investigation of Intakes 470456 and 470513. Intake 470456 - State deficiencies related to the allegations are cited at R0036 and R0241. Intake 470513 - State deficiency related to the allegations is cited at R0036. Survey date: July 6 and 7, 2026 Facility number: 014178 Residential Census: 123 These State Residential Findings are cited in accordance with 410 IAC (Indiana Administrative Code) 16.2-5. Quality review completed on 7/9/26.	R 0000		
R 0036	Residents' Rights- Deficiency	R 0036	1. Residents’ B and E had	07/13/2026

	410 IAC 16.2-5-1.2(k)(1-2) (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on record review and interview, the facility failed to ensure the resident's physician was notified of weight loss, blood pressure that was outside of parameters, and medication refusals for 2 of 3 residents reviewed for blood pressure monitoring and weight loss. (Residents B and E) Findings include: 1. Resident B's record was reviewed on 7/6/26 at 10:03 a.m. Diagnoses included, but were not limited to, abnormal weight loss, dementia, and major depressive disorder. The Service Plan, dated 1/26/26, indicated the resident was cognitively intact. The resident weighed 144 pounds (lbs) and had no unintended		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 ED, on 07/10/26, completed education and training on physician orders for medications, parameters, physician notification, and notification of weight loss or gain by 5 pounds or more. 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.	

	weight loss (5 lbs or more in the last 30 days). A Note, dated 6/2/26 at 6:32 p.m., indicated assist with weekly weights. The resident weighed 146.6 lbs. A Note, dated 6/9/26 at 9:36 a.m., indicated assist with weekly weights. The resident weighed 140.8 lbs. A Note, dated 6/16/26 at 1:23 p.m., indicated assist with weekly weights. The resident weighed 128.4 lbs. The resident had a 12.4 percent weight loss from 6/2/26 to 6/16/26. The record lacked documentation of notification to the physician regarding the weight loss. During an interview on 7/7/26 at 3:26 p.m., the Director of Nursing indicated the staff were supposed to notify the physician if a resident had a five pound gain or loss. The staff had put the note in for the weights and had not notified her or the physician. 2. Resident E's record was reviewed on 7/6/26 at 3:06 p.m. Diagnoses included, but were not limited to, hypertension. The Service Plan, dated			

	1/26/26, indicated the resident was cognitively intact. The resident required staff to prepare and administer medications. A Physician's Order, dated 5/6/22, indicated to check the blood pressure twice daily at 6:00 a.m. and 4:00 p.m., call provider for a systolic blood pressure (top number) less than 100 or diastolic blood pressure (bottom number) less than 60. The June and July 2026 Medication Administration Record indicated the resident's blood pressure (BP) was below the parameters and notification to the provider was required but not documented as completed on the following dates and times: - 6/22/26 at 6:12 a.m., BP 98/70 - 6/26/26 at 6:15 a.m., BP 98/61 - 6/29/26 at 6:08 a.m., BP 90/52 - 7/1/26 at 6:57 a.m., BP 98/69 - 7/2/26 at 6:25 a.m., BP 84/58 A Physician's Order, dated 2/18/26, indicated metoprolol tartrate (blood pressure medication) 25 milligrams, one half tablet twice daily, hold for systolic blood pressure below 100 or heart rate below 50.			

	The "Notes" section below the June 2026 Medication Administration Record for metoprolol indicated the medication was refused at 8:00 a.m. on 6/8/26, 6/13/26, 6/15/26, and 6/16/26. The medication was refused at 4:00 p.m. on 6/3/26, 6/6/26, 6/7/26, 6/9/26, 6/10/26, 6/15/26, 6/20/26, 6/26/26, and 6/29/26. There was no documentation in the record to indicate the resident's physician was notified of the refusals for medication administration. During an interview on 7/7/26 at 2:04 p.m., the Executive Director indicated she was unable to find any documentation of the staff notifying the physician related to the blood pressure reading outside of the parameters or notification related to the medication refusals. The resident's physician group had access to the charts so they should have been aware if they reviewed the resident's chart. This citation relates to Intake 470456 and 470513.			
R 0241	Health Services - Offense 410 IAC 16.2-5-4(e)(1) (e) The administration of medications and the provision of	R 0241	1. Resident H had no adverse effects from alleged deficient practices. 2. All residents that have	07/13/2026

	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 blood pressure medications not administered as ordered for 1 of 3 residents reviewed for blood pressure monitoring. (Resident H) Finding includes: Resident H's record was reviewed on 7/7/26 at 10:11 a.m. Diagnoses included, but were not limited to, hypotension. The Physician's Order Summary, dated 7/2026, indicated an order for midodrine (a medication used to treat low blood pressure) 10 milligrams (mg) three times a day, hold for blood pressure greater than 120/70. The Medication Administration Records, dated 6/2026 and 7/2026, indicated the midodrine medication was administered when the blood pressure was greater than 120/70 on the		medications administered have the potential to be affected by alleged deficient practice. No other residents were negatively affected by alleged deficiencies. 1. DON and ED, on 07/10/26, completed education and training on physician orders for medications, parameters, physician notification, and notification of weight loss or gain by 5 pounds or more. DON and/or designee will audit EMAR and documentation weekly for 4 weeks, bi-weekly for 1 month and monthly for 4 months. 2. DON audited residents with orders for parameters and requested pharmacy to change verbiage in Caremerge to read “greater than” or “less than”, instead of “<” or “>”. This change was effective as of 07/13/26. 1. Review audits will be completed during QAPI for 6 months.	

following dates and times:

- Noon: 6/4/26 blood pressure 138/78

- Evening: 6/5/26 blood pressure 131/83 and 7/4/26 blood pressure 124/86

The midodrine medication had not been signed out as given and there were no recorded blood pressure readings for the following dates and times:

- Morning: 6/5/26

- Noon: 6/3/26, 6/5/26, 6/8/26, and 6/17/26

- Evening: 6/17/26

The morning dose of the midodrine medication was held on 6/8/26 and the blood pressure was 105/53.

During an interview on 7/7/26 at 12:18 p.m., the Director of Nursing and the Administrator were made aware the medication had not been signed out and had been given/held outside of the parameters. They indicated they would have to provide more education on blood pressure parameters for the staff.

During an interview on 7/7/26 at 2:04 p.m., the Administrator indicated she was unable to provide any further

	documentation. This citation relates to Intake 470456.			

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 R Westphal	TITLEExecutive Director	(X6) DATE07/16/2026