STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELLENIC SENIOR LIVING OF ELKHART	2528 BYPASS ROAD, ELKHART, , 46514

(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 Intake IN00463746. Intake IN00463746 - State deficiencies related to the allegations are cited at R0117, R0245, R0246 and R0247. Survey date: October 8 & 9, 2025 Facility number: 014241 Residential Census: 117 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review completed on 10/15/2025	R 0000		
R 0117	Personnel - Deficiency 410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the	R 0117	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient	11/01/2025

	twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure nursing staff worked within their scope of practice during medication administrations of nebulizer treatments for 1 of 3 residents reviewed for pharmaceutical medications. (Resident B) See citations R0245 and R0246 for additional information regarding administration of intramuscular injections and administration of as needed		practice;	

	(PRN) medication without prior authorization from a licensed nurse. (Resident B and C) Finding include: A record review for Resident B was completed on 10/8/2025 at 9:52 A.M. Diagnoses included, but were not limited to: congestive heart failure, bradycardia and atrial fibrillation. A Service Plan, dated 7/30/2025, indicated Resident B was cognitively intact and required assistance for all aspects of medication administration. A Physician's Order, dated 7/22/2025, indicated ipratropium/albuterol solution (ipratropium blocks different signals that cause the airways to tighten/albuterol quickly relaxes the muscles in the lungs) use the contents of one vial per nebulizer three times a day for wheezing due to congestive heart failure and chronic obstructive pulmonary disease. The July 2025 Medication Administration Record indicated a QMA administered the ipratropium/albuterol solution on the following dates: -7/26/2025 morning dose by QMA 3 -7/26/2025 midday dose by		**1** **In-service and training was conducted on 10/23/2025 for all QMAs and Insulin Certified QMAs reviewing the following: Qualifed Medication Aide Scope of Practice; Indiana State Department of Health Residential Regulations regarding medication administration, injectable and PRN medications: 410 IAC 16.2-5-4(e)(1), 410 IAC 16.2-5-4(e)(5), 410 IAC 16.2-5-4(e)(6); Hellenic Senior Living Policy and Procedure MED 06-Medication Administration; Hellenic Policy and Procedure MED-08 Insulin Administration QMA; QMA Duties (including Insulin Certified QMA) with signature of QMA and Insulin Certified QMA acknowledging they understand job expectations; Hellenic Senior Living Training -QMA with all items listed above with signature of QMA and Insulin Certified QMA acknowledging they received training and understand all training given during in-service. (copy of in-service attached)** **2**	

	QMA 3 -7/27/2025 morning dose by QMA 3 -7/27/2025 bedtime dose by QMA 3 -7/28/2025 morning dose by QMA 3 -7/28/2025 bedtime dose by QMA 4 -7/29/2025 morning dose by QMA 5 -7/29/2025 midday dose by QMA 6 -7/29/2025 bedtime dose by QMA 4 -7/30/2025 morning dose by QMA 6 -7/30/2025 midday dose by QMA 6 -7/30/2025 bedtime dose by QMA 3 The August 2025 Medication Administration Record indicated a QMA administered the ipratropium/albuterol solution for 85 of 93 administrations.		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; 1 **Community Nurse will compile a list of all residents receiving: nebulizer treatments and injections other than insulin.** 2 **Community Executive Director and designated community nurse will keep both list undated as new orders are received.** 3 **Licensed Nurse will be present in building for all scheduled Nebulizer treatments and injectables will be scheduled at time nurse is present in community.** 4 **If PRN Nebulizer treatment is needed and nurse is not physically present in the community nurse will be contacted by QMA to come in**	

	The September 2025 Medication Administration Record indicated a QMA administered the ipratropium/albuterol solution for 88 of 90 administrations. During an interview on 10/9/25 at 11:14 AM QMA 7 indicated she checked the MAR and administered nebulizer treatments if a resident had an order for one. She indicated she followed up with the resident about 30 minutes after she had administered the medication and asked the resident if they were able to breathe better and she also checked the residents oxygen with the pulse ox machine. During an interview, on 10/9/2025 at 11:15 A.M., the Interim Director of Nursing indicated QMA's could not administer nebulizer treatments because they were not qualified to complete the required lung assessment. He indicated the facility tried to get residents to administer the nebulizers for themselves and the physician would need to provide orders for the residents to self-administer nebulizer treatments. A document was provided by the Interim Director of Nursing, on 10/9/2025 at 11:59 A.M. entitled, "Qualified Medication Aide Scope of Practice". The document indicated, " ...(3) The		**to administer.** What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; 1 **All injectable medications other than Insulins will be scheduled to be administered when Licensed Nurse is present in community.** 2 **All scheduled Nebulizer treatments will be scheduled when nurse is present in the community.** How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; 1 **Community Nurse will refer to list of all residents receiving: nebulizer treatments and**	

	QMA shall not document in a resident's clinical record any medication that was administered by another person or not administered at all ...(11) Administer previously ordered pro re nata [PRN] medications 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:..(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. (D) Ensure 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 ...The following tasks shall NOT be included in the QMA scope of practice: (1) Administer medications by the injection route, including the following: (A) Intramuscular route ...(2) Administer medication used for intermittent positive pressure breathing [IPPD] treatments or any form of medication inhalation treatments, such as nebulizers ...." This citation relates to Intake IN00463746 Based on record review and interview, the facility failed to		**injections other than insulin ensuring any new orders are added to the list and nurse is scheduled to present in community for administration every day for 30 days, then once weekly for 4 weeks, then reviewed monthly for 6 months.** By what date the systemic changes will be completed. **11/01/2025**	

ensure nursing staff worked within their scope of practice during medication administrations of nebulizer treatments for 1 of 3 residents reviewed for pharmaceutical medications. (Resident B)

See citations R0245 and R0246 for additional information regarding administration of intramuscular injections and administration of as needed (PRN) medication without prior authorization from a licensed nurse. (Resident B and C)

Finding include:

A record review for Resident B was completed on 10/8/2025 at 9:52 A.M. Diagnoses included, but were not limited to: congestive heart failure, bradycardia and atrial fibrillation.

A Service Plan, dated 7/30/2025, indicated Resident B was cognitively intact and required assistance for all aspects of medication administration.

A Physician's Order, dated 7/22/2025, indicated ipratropium/albuterol solution (ipratropium blocks different signals that cause the airways to tighten/albuterol quickly relaxes the muscles in the lungs) use the contents of one vial per nebulizer three times a day for wheezing due to congestive heart failure and

chronic obstructive pulmonary disease.

The July 2025 Medication Administration Record indicated a QMA administered the ipratropium/albuterol solution on the following dates:

-7/26/2025 morning dose by QMA 3

-7/26/2025 midday dose by QMA 3

-7/27/2025 morning dose by QMA 3

-7/27/2025 bedtime dose by QMA 3

-7/28/2025 morning dose by QMA 3

-7/28/2025 bedtime dose by QMA 4

-7/29/2025 morning dose by QMA 5

-7/29/2025 midday dose by QMA 6

-7/29/2025 bedtime dose by QMA 4

-7/30/2025 morning dose by QMA 6

-7/30/2025 midday dose by QMA 6

-7/30/2025 bedtime dose by QMA 3

	The August 2025 Medication Administration Record indicated a QMA administered the ipratropium/albuterol solution for 85 of 93 administrations. The September 2025 Medication Administration Record indicated a QMA administered the ipratropium/albuterol solution for 88 of 90 administrations. During an interview on 10/9/25 at 11:14 AM QMA 7 indicated she checked the MAR and administered nebulizer treatments if a resident had an order for one. She indicated she followed up with the resident about 30 minutes after she had administered the medication and asked the resident if they were able to breathe better and she also checked the residents oxygen with the pulse ox machine. During an interview, on 10/9/2025 at 11:15 A.M., the Interim Director of Nursing indicated QMA's could not administer nebulizer treatments because they were not qualified to complete the required lung assessment. He indicated the facility tried to get residents to administer the nebulizers for themselves and the physician would need to provide orders for the residents to self-administer nebulizer treatments.			

	A document was provided by the Interim Director of Nursing, on 10/9/2025 at 11:59 A.M. entitled, "Qualified Medication Aide Scope of Practice". The document indicated, " ...(3) The QMA shall not document in a resident's clinical record any medication that was administered by another person or not administered at all ...(11) Administer previously ordered pro re nata [PRN] medications 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:..(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. (D) Ensure 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 ...The following tasks shall NOT be included in the QMA scope of practice: (1) Administer medications by the injection route, including the following: (A) Intramuscular route ...(2) Administer medication used for intermittent positive pressure breathing [IPPD] treatments or any form of medication inhalation treatments, such as nebulizers ...."			

R 0245	Health Services - Offense 410 IAC 16.2-5-4(e)(5) (5) Injectable medications shall be given only by licensed personnel. Based on record review and interview, the facility failed to ensure an injectable medication was administered by a licensed nurse for 1 of 3 residents reviewed for pharmaceutical services. (Resident C) Finding includes: A record review for Resident C was completed on 10/9/2025 at 9:03 A.M. Diagnoses included, but were not limited to: schizoaffective disorder, mixed obsessional thoughts, personality disorder, anxiety disorder and obsessive-compulsive disorder. A Service Plan, dated 5/27/2025, indicated Resident C was cognitively intact and required assistance for all aspects of medication administration. A Physician's Order, dated 5/27/2025, indicated Resident C was to receive Invega Sustenna Injection (an atypical antipsychotic medication) 234 milligrams per 1.5 milliliters, inject 1.5 milliliters intramuscularly every 28 days. The 2025 July Medication	R 0245	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **1** **In-service and training was conducted on 10/23/2025 for all QMAs and** **Insulin Certified QMAs reviewing the following: Qualified Medication Aide Scope** **of Practice; Indiana State Department of Health Residential Regulations regarding** **medication administration, injectable and PRN medications: 410 IAC 16.2-5-4(e)(1), 410 IAC 16.2-5-4(e)(5), 410 IAC 16.2-5-4(e)(6); Hellenic Senior Living Policy and Procedure MED 06-Medication Administration; Hellenic Policy and Procedure MED-08 Insulin Administration QMA; QMA Duties (including Insulin Certified QMA** **) with signature of QMA and Insulin Certified QMA acknowledging they understand** **job expectations; Hellenic Senior Living Training -QMA with all items listed**	11/01/2025

	Administration Record (MAR) indicated the Invega Sustenna Injection was administered on 7/27/2025 by Qualified Medication Assistant (QMA) 2. The 2025 August MAR indicated the Invega Sustenna Injection was administered on 8/27/2025 by QMA 3. During an interview on 10/9/25 at 11:14 AM with QMA 7, she indicated only nurses were allowed to give IM injections. During an interview, on 10/9/2025 at 10:54 A.M., the Interim Director of Nursing indicated QMA's could not provide intramuscular injections under the QMA's scope of practice. He indicated if an intramuscular injection would have been needed to be administered, the QMA should have alerted the nurse in the building or have called the on-call nurse for the administration of the medication. A document was provided by the Interim Director of Nursing, on 10/9/2025 at 11:59 A.M. entitled, "Qualified Medication Aide Scope of Practice". The document indicated, " ...(3) The QMA shall not document in a resident's clinical record any medication that was administered by another person or not administered at all ...The following tasks shall NOT be		**above with signature of QMA and Insulin Certified QMA acknowledging they received training and understand all training given during in-service. (copy of in-service attached)** **2** 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; 1 **Community Nurse will compile a list of all residents receiving: nebulizer treatments and injections other than insulin.** 2 **Community Executive Director and designated community nurse will keep both list undated as new orders are received.** 3 **Licensed Nurse will be present in building for all scheduled Nebulizer treatments and injectables will be scheduled**	

	included in the QMA scope of practice: (1) Administer medications by the injection route, including the following: (A) Intramuscular route ...." This citation relates to Intake IN00463746 Based on record review and interview, the facility failed to ensure an injectable medication was administered by a licensed nurse for 1 of 3 residents reviewed for pharmaceutical services. (Resident C) Finding includes: A record review for Resident C was completed on 10/9/2025 at 9:03 A.M. Diagnoses included, but were not limited to: schizoaffective disorder, mixed obsessional thoughts, personality disorder, anxiety disorder and obsessive-compulsive disorder. A Service Plan, dated 5/27/2025, indicated Resident C was cognitively intact and required assistance for all aspects of medication administration.		**at time nurse is present in community.** 4 **If** **PRN Nebulizer treatment is needed and nurse is not physically present in the community nurse will be contacted by QMA to come in to administer.** What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; 1 **All** **injectable medications other than Insulins will be scheduled to be administered when Licensed Nurse is present in community.** 2 **All** **scheduled Nebulizer treatments will be scheduled when nurse is present in the community.** How the corrective action(s) will be monitored to ensure the deficient practice will not	

	A Physician's Order, dated 5/27/2025, indicated Resident C was to receive Invega Sustenna Injection (an atypical antipsychotic medication) 234 milligrams per 1.5 milliliters, inject 1.5 milliliters intramuscularly every 28 days. The 2025 July Medication Administration Record (MAR) indicated the Invega Sustenna Injection was administered on 7/27/2025 by Qualified Medication Assistant (QMA) 2. The 2025 August MAR indicated the Invega Sustenna Injection was administered on 8/27/2025 by QMA 3. During an interview on 10/9/25 at 11:14 AM with QMA 7, she indicated only nurses were allowed to give IM injections. During an interview, on 10/9/2025 at 10:54 A.M., the Interim Director of Nursing indicated QMA's could not provide intramuscular injections under the QMA's scope of practice. He indicated if an intramuscular injection would have been needed to be administered, the QMA should have alerted the nurse in the building or have called the on-call nurse for the administration of the medication. A document was provided by the Interim Director of Nursing, on 10/9/2025 at 11:59 A.M.		recur, i.e., what quality assurance program will be put into place; 1 **Community Nurse will refer to list of all residents receiving: nebulizer treatments and injections other than insulin ensuring any new orders are added to the list and nurse is scheduled to present in community for administration every day for 30 days, then once weekly for 4 weeks, then reviewed monthly for 6 months.** By what date the systemic changes will be completed. **11/01/2025**	

	entitled, "Qualified Medication Aide Scope of Practice". The document indicated, " ...(3) The QMA shall not document in a resident's clinical record any medication that was administered by another person or not administered at all ...The following tasks shall NOT be included in the QMA scope of practice: (1) Administer medications by the injection route, including the following: (A) Intramuscular route ...." This citation relates to Intake IN00463746			
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 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. Based on record review and interview, the facility failed to ensure Qualified Medication Assistants (QMA) obtained authorization from a licensed nurse prior to administering as	R 0246	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **1** **In-service and training was conducted on 10/23/2025 for all QMAs and** **Insulin Certified QMAs reviewing the following: Qualified Medication Aide Scope** **of Practice; Indiana State Department of Health Residential Regulations regarding** **medication administration, injectable and PRN medications: 410 IAC**	11/01/2025

	needed (PRN) medications to 1 of 3 residents reviewed for pharmaceutical services. (Resident C) Finding includes: A record review for Resident C was completed on 10/9/2025 at 9:03 A.M. Diagnoses included, but were not limited to: schizoaffective disorder, mixed obsessional thoughts, personality disorder, anxiety disorder and obsessive-compulsive disorder. A Service Plan, dated 5/27/2025, indicated Resident C was cognitively intact and required assistance for all aspects of medication administration. A Physician's Order, dated 5/27/2025, indicated an order for tramadol (pain medication) 50 milligrams every six hours as needed for pain. The July 2025 Medication Administration Record (MAR) indicated tramadol 50 milligrams had been given to Resident C without prior authorization from a licensed nursing professional on the following dates by QMAs: -7/3/2025 at 9:03 P.M. -7/8/2025 at 10:14 P.M. -7/31/2025 at 4:18 P.M.		**16.2-5-4(e)(1), 410 IAC 16.2-5-4(e)(5), 410 IAC 16.2-5-4(e)(6); Hellenic Senior Living Policy and Procedure MED 06-Medication Administration; Hellenic Policy and Procedure MED-08 Insulin Administration QMA; QMA Duties (including Insulin Certified QMA) with signature of QMA and Insulin Certified QMA acknowledging they understand job expectations; Hellenic Senior Living Training -QMA with all items listed above with signature of QMA and Insulin Certified QMA acknowledging they received training and understand all training given during in-service. (copy of in-service attached)** 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; 1 **Community nurse will review medication administration record for all PRN medications administered and confirm**	

	The August 2025 MAR indicated tramadol 50 milligrams had been given to Resident C without prior authorization from a licensed nursing professional on the following dates by QMAs: -8/1/2025 at 8:35 P.M. -8/9/2025 at 5:10 P.M. -8/19/2025 at 5:23 P.M. -8/20/2025 at 4:43 P.M. -8/26/2025 at 7:47 P.M. -8/31/2025 7:25 A.M. The September 2025 MAR indicated tramadol 50 milligrams had been given to Resident C without prior authorization from a licensed nursing professional on the following dates by QMAs: -9/1/2025 at 12:25 P.M. -9/3/2025 at 6:47 P.M. -9/9/2025 at 8:55 P.M. -9/15/2025 at 10:41 P.M. -9/17/2025 at 5:14 P.M. -9/21/2025 at 1:05 P.M. -9/23/2025 at 9:14 P.M. -9/24/2025 at 8:35 P.M. -9/25/2025 at 5:36 P.M.		**documented confirmation from QMA that nurse was contacted and permission to administer was given, including the time of contact** What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; 1 **Current Staff: QMA Duties (including Insulin Certified QMA) with signature of QMA and Insulin Certified QMA acknowledging they understand job expectations; Hellenic Senior Living Training -QMA with all items listed above with signature of QMA and Insulin Certified QMA acknowledging they received training and understand all training given during in-service.** 2 **All new hire QMA and insulin Certified QMA will receive training and sign QMA Duties (including Insulin Certified QMA) with signature of QMA and**	

	-9/29/2025 at 8:34 P.M. The October 2025 MAR indicated tramadol 50 milligrams had been given to Resident C without prior authorization from a licensed nursing professional on the following dates by QMAs: -10/7/2025 at 9:15 P.M. -10/8/2025 at 8:36 P.M. A Physician's Order, dated 5/27/2025, included an order for acetaminophen extended release (Tylenol) 650 milligrams every six hours as needed for pain. The August 2025 MAR indicated acetaminophen extended release 650 milligrams had been given to Resident C by a QMA without prior authorization from a licensed nursing professional on 8/14/2025 at 4:51 P.M. The September 2025 MAR indicated acetaminophen extended release 650 milligrams had been given to Resident C without prior authorization from a licensed nursing professional on 9/27/2025 at 11:57 A.M by a QMA. The October 2025 MAR indicated acetaminophen extended release 650 milligrams had been given to Resident C without prior authorization from a licensed nursing professional		**Insulin Certified QMA acknowledging they understand job expectations; Hellenic Senior Living Training -QMA with all items listed above with signature of QMA and Insulin Certified QMA acknowledging they received training and understand all training** 3 **Community nurse will review medication administration record for all PRN medications administered and confirm documented confirmation from QMA that nurse was contacted and permission to administer was given, including the time of contact** How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; **1** **Community nurse will review medication administration record for all PRN medications administered and confirm documented**	

	on 10/8/2025 at 6:02 P.M. by a QMA. During an interview on 10/9/25 at 11:14 AM QMA 7 indicated if she was giving PRN medications, she checked the MAR, verified the prescription and gave the medication. She then made sure she charted it and asked the resident if their pain level, if it was a pain pill, and then she charted the resident's pain level. She indicated she did follow up afterwards, and if the resident was on tramadol and norco due to nerve pain, she generally asked the reisdent if the medication was effective an hour after she had administeered the medication. During an interview, on 10/9/2025 at 10:54 A.M., the Interim Director of Nursing indicated QMA's should have alerted the licensed nurse about the symptoms the resident had experienced and obtained permission to administer an as needed medication. He indicated the QMA should not have given as needed medications without the licensed nurse's permission. A form provided by the Executive Director titled, "QMA Duties", indicated, " ...Notify nurse when administering PRN [as needed] medications ...."		**confirmation from QMA that nurse was contacted and permission to administer was given, including the time of contact every day for 30 days, then once weekly for 4 weeks, then reviewed monthly for 6 months.** By what date the systemic changes will be completed. **11/01/2025**	

	A document was provided by the Interim Director of Nursing, on 10/9/2025 at 11:59 A.M. entitled, "Qualified Medication Aide Scope of Practice". The document indicated, " ...(3) The QMA shall not document in a resident's clinical record any medication that was administered by another person or not administered at all ...(11) Administer previously ordered pro re nata [PRN] medications 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:..(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. (D) Ensure 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 ...." This citation relates to Intake IN00463746 Based on record review and interview, the facility failed to ensure Qualified Medication Assistants (QMA) obtained authorization from a licensed nurse prior to administering as needed (PRN) medications to 1 of 3 residents reviewed for			

	pharmaceutical services. (Resident C) Finding includes: A record review for Resident C was completed on 10/9/2025 at 9:03 A.M. Diagnoses included, but were not limited to: schizoaffective disorder, mixed obsessional thoughts, personality disorder, anxiety disorder and obsessive-compulsive disorder. A Service Plan, dated 5/27/2025, indicated Resident C was cognitively intact and required assistance for all aspects of medication administration. A Physician's Order, dated 5/27/2025, indicated an order for tramadol (pain medication) 50 milligrams every six hours as needed for pain. The July 2025 Medication Administration Record (MAR) indicated tramadol 50 milligrams had been given to Resident C without prior authorization from a licensed nursing professional on the following dates by QMAs: -7/3/2025 at 9:03 P.M. -7/8/2025 at 10:14 P.M. -7/31/2025 at 4:18 P.M. The August 2025 MAR indicated tramadol 50 milligrams had			

	been given to Resident C without prior authorization from a licensed nursing professional on the following dates by QMAs: -8/1/2025 at 8:35 P.M. -8/9/2025 at 5:10 P.M. -8/19/2025 at 5:23 P.M. -8/20/2025 at 4:43 P.M. -8/26/2025 at 7:47 P.M. -8/31/2025 7:25 A.M. The September 2025 MAR indicated tramadol 50 milligrams had been given to Resident C without prior authorization from a licensed nursing professional on the following dates by QMAs: -9/1/2025 at 12:25 P.M. -9/3/2025 at 6:47 P.M. -9/9/2025 at 8:55 P.M. -9/15/2025 at 10:41 P.M. -9/17/2025 at 5:14 P.M. -9/21/2025 at 1:05 P.M. -9/23/2025 at 9:14 P.M. -9/24/2025 at 8:35 P.M. -9/25/2025 at 5:36 P.M. -9/29/2025 at 8:34 P.M. The October 2025 MAR			

	indicated tramadol 50 milligrams had been given to Resident C without prior authorization from a licensed nursing professional on the following dates by QMAs: -10/7/2025 at 9:15 P.M. -10/8/2025 at 8:36 P.M. A Physician's Order, dated 5/27/2025, included an order for acetaminophen extended release (Tylenol) 650 milligrams every six hours as needed for pain. The August 2025 MAR indicated acetaminophen extended release 650 milligrams had been given to Resident C by a QMA without prior authorization from a licensed nursing professional on 8/14/2025 at 4:51 P.M. The September 2025 MAR indicated acetaminophen extended release 650 milligrams had been given to Resident C without prior authorization from a licensed nursing professional on 9/27/2025 at 11:57 A.M by a QMA. The October 2025 MAR indicated acetaminophen extended release 650 milligrams had been given to Resident C without prior authorization from a licensed nursing professional on 10/8/2025 at 6:02 P.M. by a QMA.			

	During an interview on 10/9/25 at 11:14 AM QMA 7 indicated if she was giving PRN medications, she checked the MAR, verified the prescription and gave the medication. She then made sure she charted it and asked the resident if their pain level, if it was a pain pill, and then she charted the resident's pain level. She indicated she did follow up afterwards, and if the resident was on tramadol and norco due to nerve pain, she generally asked the reisdent if the medication was effective an hour after she had administeered the medication. During an interview, on 10/9/2025 at 10:54 A.M., the Interim Director of Nursing indicated QMA's should have alerted the licensed nurse about the symptoms the resident had experienced and obtained permission to administer an as needed medication. He indicated the QMA should not have given as needed medications without the licensed nurse's permission. A form provided by the Executive Director titled, "QMA Duties", indicated, " ...Notify nurse when administering PRN [as needed] medications ...." A document was provided by the Interim Director of Nursing, on 10/9/2025 at 11:59 A.M.			

	entitled, "Qualified Medication Aide Scope of Practice". The document indicated, " ...(3) The QMA shall not document in a resident's clinical record any medication that was administered by another person or not administered at all ...(11) Administer previously ordered pro re nata [PRN] medications 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:..(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. (D) Ensure 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 ...." This citation relates to Intake IN00463746			
R 0247	Health Services - Deficiency 410 IAC 16.2-5-4(e)(7) (7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident.	R 0247	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **1)Medication orders received on admission along with all new orders will be double checked by nurse entering orders for**	11/01/2025

	Based on record review and interview, the facility failed to properly administer a hypotensive (low blood pressure) medication for 1 of 3 residents reviewed for pharmaceutical services. (Resident B) Finding includes: A record review for Resident B was completed on 10/8/2025 at 9:52 A.M. Diagnoses included, but were not limited to: congestive heart failure, bradycardia and atrial fibrillation. A Service Plan, dated 7/30/2025, indicated Resident B was cognitively intact and required assistance for all aspects of medication administration. A Physician's Order, dated 7/22/2025 and discontinued on 7/26/2025, indicated midodrine tablet 2.5 milligram three times daily, hold for a systolic blood pressure less than 120 mmHg (millimeters of mercury) for hypotension. However, the order was incorrectly transcribed, on 7/23/2025, for midodrine tablet 2.5 milligrams three times daily, hold for a systolic blood pressure greater than 120 mmHg for hypertension. The August 2025 Medication		**accuracy** **2)All orders entered into the eMAR will be checked for accuracy by a second nurse comparing written order to order entered in eMAR** 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; **1)Medication orders received on admission along with all new orders will be double checked by nurse entering orders for accuracy** **2)All orders entered into the eMAR will be checked for accuracy by a second nurse comparing written order to order entered in eMAR** What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; **1)Medication orders received on admission along with all new orders will be double checked by nurse entering orders for accuracy** **2)All orders entered into the eMAR will be checked for accuracy by a second nurse comparing written order to order entered in eMAR**	

	Administration Record (MAR) indicated the midodrine medication was given even though the blood pressure parameters ordered were beyond the use of the medication on the following dates: -8/6/2025 A.M. dose given for blood pressure 152/95 mmHg -8/10/2025 A.M. dose given for blood pressure142/80 mmHg -8/12/2025 bedtime dose given for blood pressure 140/74 mmHg -8/15/2025 A.M. dose given for blood pressure 138/72 mmHg -8/22/2025 bedtime dose held for blood pressure 91/88 mmHg -8/24/2025 bedtime dose given for blood pressure 134/78 mmHg -8/25/2025 afternoon dose given for blood pressure 132/70 mmHg The September 2025 Medication Administration Record (MAR) indicated the midodrine medication was given even though the blood pressure parameters ordered were beyond the use of the medication on the following dates: -9/2/2025 afternoon dose for		How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; **1)Nurse number one entering the order in the eMAR will initial and date the hard copy of the order showing it has been double checked and acknowledging the order has been checked for accuracy. Nurse number two will initial and date the hard copy of the order acknowledging that order was double checked for accuracy. This practice will be in place indefinitely.** **2)Medication rewrites will be sent to primary care provider for signature verifying orders are correct upon admission and monthly indefinitely.**	

blood pressure 148/90 mmHg

-9/3/2025 afternoon dose for blood pressure 132/80 mmHg

-9/5/2025 A.M. dose for blood pressure 158/80 mmHg

-9/8/2025 A.M. dose for blood pressure 149/110 mmHg

-9/14/2025 A.M. dose for blood pressure 145/82 mmHg

-9/18/2025 A.M. dose for blood pressure 151/96 mmHg

During an interview, on 10/9/2025 at 10:54 A.M., the Interim Director of Nursing indicated midodrine was a blood pressure medication to increase a resident's blood pressure. He indicated if a resident was having a low blood pressure, the midodrine would be given but held if a blood pressure was high. He indicated a high blood pressure reading would have been a systolic blood pressure greater than 140 mmHg or a diastolic blood pressure greater than 90 mmHg. He indicated the midodrine medication should not have been given for a systolic blood pressure over 120 mmHg as the order stated the opposite of the parameters needed to give the midodrine.

A current policy was provided by the Interim Director of Nursing, on 10/9/2025 ay 11:59 A.M. The policy titled, "Medication

Administration", indicated, " ...The administration of medications shall be as ordered by the resident's physician and shall be supervised by a licensed nurse on the premise ...29. Any medication discrepancy will be reported to the licensed nurse and the Director of Nursing ...."

This citation relates to Intake IN00463746

Based on record review and interview, the facility failed to properly administer a hypotensive (low blood pressure) medication for 1 of 3 residents reviewed for pharmaceutical services. (Resident B)

Finding includes:

A record review for Resident B was completed on 10/8/2025 at 9:52 A.M. Diagnoses included, but were not limited to: congestive heart failure, bradycardia and atrial fibrillation.

A Service Plan, dated 7/30/2025, indicated Resident B was cognitively intact and required assistance for all aspects of medication administration.

A Physician's Order, dated 7/22/2025 and discontinued on 7/26/2025, indicated midodrine tablet 2.5 milligram three times daily, hold for a systolic blood

pressure less than 120 mmHg (millimeters of mercury) for hypotension. However, the order was incorrectly transcribed, on 7/23/2025, for midodrine tablet 2.5 milligrams three times daily, hold for a systolic blood pressure greater than 120 mmHg for hypertension.

The August 2025 Medication Administration Record (MAR) indicated the midodrine medication was given even though the blood pressure parameters ordered were beyond the use of the medication on the following dates:

-8/6/2025 A.M. dose given for blood pressure 152/95 mmHg

-8/10/2025 A.M. dose given for blood pressure142/80 mmHg

-8/12/2025 bedtime dose given for blood pressure 140/74 mmHg

-8/15/2025 A.M. dose given for blood pressure 138/72 mmHg

-8/22/2025 bedtime dose held for blood pressure 91/88 mmHg

-8/24/2025 bedtime dose given for blood pressure 134/78 mmHg

-8/25/2025 afternoon dose given for blood pressure 132/70 mmHg

The September 2025 Medication Administration Record (MAR) indicated the midodrine medication was given even though the blood pressure parameters ordered were beyond the use of the medication on the following dates:

-9/2/2025 afternoon dose for blood pressure 148/90 mmHg

-9/3/2025 afternoon dose for blood pressure 132/80 mmHg

-9/5/2025 A.M. dose for blood pressure 158/80 mmHg

-9/8/2025 A.M. dose for blood pressure 149/110 mmHg

-9/14/2025 A.M. dose for blood pressure 145/82 mmHg

-9/18/2025 A.M. dose for blood pressure 151/96 mmHg

During an interview, on 10/9/2025 at 10:54 A.M., the Interim Director of Nursing indicated midodrine was a blood pressure medication to increase a resident's blood pressure. He indicated if a resident was having a low blood pressure, the midodrine would be given but held if a blood pressure was high. He indicated a high blood pressure reading would have

	been a systolic blood pressure greater than 140 mmHg or a diastolic blood pressure greater than 90 mmHg. He indicated the midodrine medication should not have been given for a systolic blood pressure over 120 mmHg as the order stated the opposite of the parameters needed to give the midodrine. A current policy was provided by the Interim Director of Nursing, on 10/9/2025 ay 11:59 A.M. The policy titled, "Medication Administration", indicated, " ...The administration of medications shall be as ordered by the resident's physician and shall be supervised by a licensed nurse on the premise ...29. Any medication discrepancy will be reported to the licensed nurse and the Director of Nursing ...." This citation relates to Intake IN00463746			

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 SIGNATURELinsey Fitterling	TITLEExecutive Director	(X6) DATE10/29/2025