STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE WOODS OF NEWBURGH	4211 GRIMM ROAD, NEWBURGH, , 47630

(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 IN00465173 and IN00465438. Intake IN00465173 - State deficiencies related to the allegations are cited at R0241 and R0247. Intake IN00465438 - State deficiencies related to the allegations are cited at R0349. Unrelated deficiency is cited. Survey dates: October 22, 23, and 24, 2025 Facility number: 014377 Residential Census: 120 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed October 30, 2025.	R 0000	The creation of this plan of correction constitutes this provider’s written compliance for the alleged deficiencies cited. The submission of this plan of correction is not an admission of nor agreement with the deficiencies or conclusions contained in the Indiana Department of Health’s inspection report. Heritage Woods of Newburgh respectfully requests consideration for a desk review (paper compliance) of this plan of correction.	

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 observation, interview, and record review, the facility failed to ensure residents without a Self Administration of Medication Assessment did not self administer medications for 1 of 5 residents observed during the medication pass and 1 of 1 random observations. (Resident B, Resident D) Findings include: 1. On 10/24/25 at 8:25 A.M., Resident B was observed alone in her room sitting in a recliner. A medicine cup was observed	R 0216	Resident B and D were given a self-administration of medication assessment. All residents that self-administer medications have the potential to be affected by the alleged deficient practice. An audit of self-administration of medication assessments was completed. Any deficient practices were corrected. An in-service on medication management, administration and storage was completed by the DON. Random room auditrs will be completed to ensure that there are no residents self administering medications that have not been properly assessed. A self adminstration report will be ran and signed every shift and placed in the DON mailbox. The DON will monitor random rooms and the self administration of medication report daily for 4 weeks, 3x week for 4 weeks, 2x week for 4 weeks, weekly for 4 weeks and then monthly for 2 months. Results of the monitoring will be forwarded to QAPI for any further recommendations.	11/21/2025

	on a table next to the recliner with a black round tablet, a long white capsule, a small round blue tablet, a beige square tablet, and a pink oblong tablet inside. At that time, the resident indicated, "I don't even live here. Those may be my son's medicines but I don't know. I haven't been taking them. They could be from yesterday." On 10/22/25 at 10:23 A.M., Resident B's clinical record was reviewed. The diagnoses included, but were not limited to, dementia, hypertension, hypothyroidism, asthma, malignant neoplasm of part of the bronchus, and diabetes mellitus type II. The most recent service plan, dated 8/22/25, indicated Resident B's decisions were poor, and required cueing and supervision in planning and organizing daily routines. She also had a dementia diagnosis and/or significant memory loss combined with behaviors that included, but were not limited to, wandering, requiring directions or reminding, and continuous daily cuing. Current Physician's Orders included the following medications given daily at 8:00 A.M.: - N-acetylcysteine (NAC) 600 milligram (mg) capsule (used for			

	thinning mucus in airways), take one capsule by mouth, ordered 8/21/25 - Eliquis 5 mg tablet (anticoagulant), take one by mouth, ordered 9/9/25 - ferrous sulfate 325 mg tablet (iron supplement), take one by mouth, ordered 9/2/25 - levothyroxine 75 microgram (mcg) tablet (hypothyroid), take one by mouth, ordered 8/21/25 - montelukast 10 mg tablet (asthma), take one by mouth, ordered 8/21/25 The clinical record lacked a self administration of medication evaluation and an order for the resident to administer her own medications.			

	During an interview on 10/24/25 at 8:30 A.M., Qualified Medication Aide (QMA) 16 indicated Resident B did not self administer medications. At that time, she indicated, "She started to take the meds [medications]. I didn't notice that she had stopped. She takes five morning meds". QMA 16 went into the room and observed the medication cup with five pills inside on the table by the recliner. She indicated, "Those are the ones I got ready for her this morning. We are supposed to watch the resident take their the meds." 2. On 10/22/25 at 9:40 A.M., Licensed Practical Nurse (LPN) 25 was observed to administer medications to Resident D. At that time, LPN 25 asked Resident D if she wanted her to apply her treatment under her breasts or come back and do it later. Resident D indicated to do it later. All medications were observed to be in a locked cabinet in the resident's room. LPN 25 indicated Resident D did not self administer medications as they were supposed to be locked in the room for staff to administer.			

On 10/22/25 at 10:00 A.M., Resident D's clinical record was reviewed. The diagnoses included, but were not limited to, osteoarthritis and diabetes mellitus.

Current physician orders included, but were not limited to:

- Antifungal 2% powder, apply under bilateral breast folds daily, dated 6/30/25.

- Miralax powder, mix 17g (grams) with liquid and take by mouth every day, dated 6/30/25.

- Triad wound dressing paste, apply to bilateral buttocks daily, dated 10/14/24.

Resident D's October 2025 medication administration record (MAR) indicated the following medications and dates that were marked "self administered":

- Antifungal 2% powder on 10/1/25, 10/3/25, 10/6/25, 10/7/25, 10/12/25, 10/13/25, 10/14/25, and 10/17/25.

- Miralax on 10/7/25.

- Triad wound dressing paste on 10/1/25, 10/3/25, 10/6/25, 10/7/25, 10/12/25, 10/13/25, 10/14/25, and 10/17/25.

The most recent self administration of medications assessment, completed on

	9/25/23, indicated "Resident requires medications to be stored and locked". A Level of Service Assessment/Evaluation, dated 9/19/25, indicated a medication procedure for the caregiver to administer and/or observe medication administration. On 10/23/25 at 2:37 P.M., the Director of Nursing (DON) provided a current Medication Administration policy, last revised 1/2024, that indicated "The Director of Nursing, or licensed nurse designee, will assess the resident's ability to self-administer daily medications utilizing the Self-Medication Assessment. The assessment will determine what level of assistance, if any, is needed by the resident. Medication set-up and storage protocol will be implemented based on the assessment outcome. The medication assessment will be reviewed biannually as part of the review process, and episodically with any significant change in condition or as level of service indicate" Based on observation, interview, and record review, the facility failed to ensure residents without a Self Administration of Medication Assessment did not self administer medications for 1 of 5 residents observed during			

	the medication pass and 1 of 1 random observations. (Resident B, Resident D) Findings include: 1. On 10/24/25 at 8:25 A.M., Resident B was observed alone in her room sitting in a recliner. A medicine cup was observed on a table next to the recliner with a black round tablet, a long white capsule, a small round blue tablet, a beige square tablet, and a pink oblong tablet inside. At that time, the resident indicated, "I don't even live here. Those may be my son's medicines but I don't know. I haven't been taking them. They could be from yesterday." On 10/22/25 at 10:23 A.M., Resident B's clinical record was reviewed. The diagnoses included, but were not limited to, dementia, hypertension, hypothyroidism, asthma, malignant neoplasm of part of the bronchus, and diabetes mellitus type II. The most recent service plan, dated 8/22/25, indicated Resident B's decisions were poor, and required cueing and supervision in planning and organizing daily routines. She also had a dementia diagnosis and/or significant memory loss combined with behaviors that included, but were not limited to, wandering, requiring directions			

or reminding, and continuous daily cuing.

Current Physician's Orders included the following medications given daily at 8:00 A.M.:

- N-acetylcysteine (NAC) 600 milligram (mg) capsule (used for thinning mucus in airways), take one capsule by mouth, ordered 8/21/25

- Eliquis 5 mg tablet (anticoagulant), take one by mouth, ordered 9/9/25

- ferrous sulfate 325 mg tablet (iron supplement), take one by mouth, ordered 9/2/25

- levothyroxine 75 microgram (mcg) tablet (hypothyroid), take one by mouth, ordered 8/21/25

- montelukast 10 mg tablet (asthma), take one by mouth, ordered 8/21/25

The clinical record lacked a self administration of medication evaluation and an order for the resident to administer her own medications.

During an interview on 10/24/25 at 8:30 A.M., Qualified Medication Aide (QMA) 16 indicated Resident B did not self administer medications. At that time, she indicated, "She started to take the meds [medications]. I didn't notice that she had

stopped. She takes five morning meds". QMA 16 went into the room and observed the medication cup with five pills inside on the table by the recliner. She indicated, "Those are the ones I got ready for her this morning. We are supposed to watch the resident take their the meds."

2. On 10/22/25 at 9:40 A.M., Licensed Practical Nurse (LPN) 25 was observed to administer medications to Resident D. At that time, LPN 25 asked Resident D if she wanted her to apply her treatment under her breasts or come back and do it later. Resident D indicated to do it later. All medications were observed to be in a locked cabinet in the resident's room. LPN 25 indicated Resident D did not self administer medications as they were supposed to be locked in the room for staff to administer.

On 10/22/25 at 10:00 A.M., Resident D's clinical record was reviewed. The diagnoses included, but were not limited to, osteoarthritis and diabetes mellitus.

Current physician orders included, but were not limited to:

- Antifungal 2% powder, apply under bilateral breast folds daily, dated 6/30/25.

- Miralax powder, mix 17g

(grams) with liquid and take by mouth every day, dated 6/30/25.

- Triad wound dressing paste, apply to bilateral buttocks daily, dated 10/14/24.

Resident D's October 2025 medication administration record (MAR) indicated the following medications and dates that were marked "self administered":

- Antifungal 2% powder on 10/1/25, 10/3/25, 10/6/25, 10/7/25, 10/12/25, 10/13/25, 10/14/25, and 10/17/25.

- Miralax on 10/7/25.

- Triad wound dressing paste on 10/1/25, 10/3/25, 10/6/25, 10/7/25, 10/12/25, 10/13/25, 10/14/25, and 10/17/25.

The most recent self administration of medications assessment, completed on 9/25/23, indicated "Resident requires medications to be stored and locked".

A Level of Service Assessment/Evaluation, dated 9/19/25, indicated a medication procedure for the caregiver to administer and/or observe medication administration.

On 10/23/25 at 2:37 P.M., the Director of Nursing (DON) provided a current Medication Administration policy, last

	revised 1/2024, that indicated "The Director of Nursing, or licensed nurse designee, will assess the resident's ability to self-administer daily medications utilizing the Self-Medication Assessment. The assessment will determine what level of assistance, if any, is needed by the resident. Medication set-up and storage protocol will be implemented based on the assessment outcome. The medication assessment will be reviewed biannually as part of the review process, and episodically with any significant change in condition or as level of service indicate" Based on observation, interview, and record review, the facility failed to ensure residents without a Self Administration of Medication Assessment did not self administer medications for 1 of 5 residents observed during the medication pass and 1 of 1 random observations. (Resident B, Resident D) Findings include: 1. On 10/24/25 at 8:25 A.M., Resident B was observed alone in her room sitting in a recliner. A medicine cup was observed on a table next to the recliner with a black round tablet, a long white capsule, a small round blue tablet, a beige square tablet, and a pink oblong tablet			

inside. At that time, the resident indicated, "I don't even live here. Those may be my son's medicines but I don't know. I haven't been taking them. They could be from yesterday."

On 10/22/25 at 10:23 A.M., Resident B's clinical record was reviewed. The diagnoses included, but were not limited to, dementia, hypertension, hypothyroidism, asthma, malignant neoplasm of part of the bronchus, and diabetes mellitus type II.

The most recent service plan, dated 8/22/25, indicated Resident B's decisions were poor, and required cueing and supervision in planning and organizing daily routines. She also had a dementia diagnosis and/or significant memory loss combined with behaviors that included, but were not limited to, wandering, requiring directions or reminding, and continuous daily cuing.

Current Physician's Orders included the following medications given daily at 8:00 A.M.:

- N-acetylcysteine (NAC) 600 milligram (mg) capsule (used for thinning mucus in airways), take one capsule by mouth, ordered 8/21/25

- Eliquis 5 mg tablet (anticoagulant), take one by

mouth, ordered 9/9/25

- ferrous sulfate 325 mg tablet (iron supplement), take one by mouth, ordered 9/2/25

- levothyroxine 75 microgram (mcg) tablet (hypothyroid), take one by mouth, ordered 8/21/25

- montelukast 10 mg tablet (asthma), take one by mouth, ordered 8/21/25

The clinical record lacked a self administration of medication evaluation and an order for the resident to administer her own medications.

During an interview on 10/24/25 at 8:30 A.M., Qualified Medication Aide (QMA) 16 indicated Resident B did not self administer medications. At that time, she indicated, "She started to take the meds [medications]. I didn't notice that she had stopped. She takes five morning meds". QMA 16 went into the room and observed the medication cup with five pills inside on the table by the recliner. She indicated, "Those are the ones I got ready for her this morning. We are supposed to watch the resident take their the meds."

2. On 10/22/25 at 9:40 A.M., Licensed Practical Nurse (LPN) 25 was observed to administer medications to Resident D. At that time, LPN 25 asked

Resident D if she wanted her to apply her treatment under her breasts or come back and do it later. Resident D indicated to do it later. All medications were observed to be in a locked cabinet in the resident's room. LPN 25 indicated Resident D did not self administer medications as they were supposed to be locked in the room for staff to administer.

On 10/22/25 at 10:00 A.M., Resident D's clinical record was reviewed. The diagnoses included, but were not limited to, osteoarthritis and diabetes mellitus.

Current physician orders included, but were not limited to:

- Antifungal 2% powder, apply under bilateral breast folds daily, dated 6/30/25.

- Miralax powder, mix 17g (grams) with liquid and take by mouth every day, dated 6/30/25.

- Triad wound dressing paste, apply to bilateral buttocks daily, dated 10/14/24.

Resident D's October 2025 medication administration record (MAR) indicated the following medications and dates that were marked "self administered":

- Antifungal 2% powder on 10/1/25, 10/3/25, 10/6/25,

10/7/25, 10/12/25, 10/13/25, 10/14/25, and 10/17/25.

- Miralax on 10/7/25.

- Triad wound dressing paste on 10/1/25, 10/3/25, 10/6/25, 10/7/25, 10/12/25, 10/13/25, 10/14/25, and 10/17/25.

The most recent self administration of medications assessment, completed on 9/25/23, indicated "Resident requires medications to be stored and locked".

A Level of Service Assessment/Evaluation, dated 9/19/25, indicated a medication procedure for the caregiver to administer and/or observe medication administration.

On 10/23/25 at 2:37 P.M., the Director of Nursing (DON) provided a current Medication Administration policy, last revised 1/2024, that indicated "The Director of Nursing, or licensed nurse designee, will assess the resident's ability to self-administer daily medications utilizing the Self-Medication Assessment. The assessment will determine what level of assistance, if any, is needed by the resident. Medication set-up and storage protocol will be implemented based on the assessment outcome. The medication assessment will be reviewed biannually as part of the review

process, and episodically with any significant change in condition or as level of service indicate"

Based on observation, interview, and record review, the facility failed to ensure residents without a Self Administration of Medication Assessment did not self administer medications for 1 of 5 residents observed during the medication pass and 1 of 1 random observations. (Resident B, Resident D)

Findings include:

1. On 10/24/25 at 8:25 A.M., Resident B was observed alone in her room sitting in a recliner. A medicine cup was observed on a table next to the recliner with a black round tablet, a long white capsule, a small round blue tablet, a beige square tablet, and a pink oblong tablet inside. At that time, the resident indicated, "I don't even live here. Those may be my son's medicines but I don't know. I haven't been taking them. They could be from yesterday."

On 10/22/25 at 10:23 A.M., Resident B's clinical record was reviewed. The diagnoses included, but were not limited to, dementia, hypertension, hypothyroidism, asthma, malignant neoplasm of part of the bronchus, and diabetes mellitus type II.

The most recent service plan, dated 8/22/25, indicated Resident B's decisions were poor, and required cueing and supervision in planning and organizing daily routines. She also had a dementia diagnosis and/or significant memory loss combined with behaviors that included, but were not limited to, wandering, requiring directions or reminding, and continuous daily cuing.

Current Physician's Orders included the following medications given daily at 8:00 A.M.:

- N-acetylcysteine (NAC) 600 milligram (mg) capsule (used for thinning mucus in airways), take one capsule by mouth, ordered 8/21/25

- Eliquis 5 mg tablet (anticoagulant), take one by mouth, ordered 9/9/25

- ferrous sulfate 325 mg tablet (iron supplement), take one by mouth, ordered 9/2/25

- levothyroxine 75 microgram (mcg) tablet (hypothyroid), take one by mouth, ordered 8/21/25

- montelukast 10 mg tablet (asthma), take one by mouth, ordered 8/21/25

The clinical record lacked a self administration of medication evaluation and an order for the

resident to administer her own medications.

During an interview on 10/24/25 at 8:30 A.M., Qualified Medication Aide (QMA) 16 indicated Resident B did not self administer medications. At that time, she indicated, "She started to take the meds [medications]. I didn't notice that she had stopped. She takes five morning meds". QMA 16 went into the room and observed the medication cup with five pills inside on the table by the recliner. She indicated, "Those are the ones I got ready for her this morning. We are supposed to watch the resident take their the meds."

2. On 10/22/25 at 9:40 A.M., Licensed Practical Nurse (LPN) 25 was observed to administer medications to Resident D. At that time, LPN 25 asked Resident D if she wanted her to apply her treatment under her breasts or come back and do it later. Resident D indicated to do it later. All medications were observed to be in a locked cabinet in the resident's room. LPN 25 indicated Resident D did not self administer medications as they were supposed to be locked in the room for staff to administer.

On 10/22/25 at 10:00 A.M., Resident D's clinical record was reviewed. The diagnoses

	included, but were not limited to, osteoarthritis and diabetes mellitus. Current physician orders included, but were not limited to: - Antifungal 2% powder, apply under bilateral breast folds daily, dated 6/30/25. - Miralax powder, mix 17g (grams) with liquid and take by mouth every day, dated 6/30/25. - Triad wound dressing paste, apply to bilateral buttocks daily, dated 10/14/24. Resident D's October 2025 medication administration record (MAR) indicated the following medications and dates that were marked "self administered": - Antifungal 2% powder on 10/1/25, 10/3/25, 10/6/25, 10/7/25, 10/12/25, 10/13/25, 10/14/25, and 10/17/25. - Miralax on 10/7/25. - Triad wound dressing paste on 10/1/25, 10/3/25, 10/6/25, 10/7/25, 10/12/25, 10/13/25, 10/14/25, and 10/17/25.			

	The most recent self administration of medications assessment, completed on 9/25/23, indicated "Resident requires medications to be stored and locked". A Level of Service Assessment/Evaluation, dated 9/19/25, indicated a medication procedure for the caregiver to administer and/or observe medication administration. On 10/23/25 at 2:37 P.M., the Director of Nursing (DON) provided a current Medication Administration policy, last revised 1/2024, that indicated "The Director of Nursing, or licensed nurse designee, will assess the resident's ability to self-administer daily medications utilizing the Self-Medication Assessment. The assessment will determine what level of assistance, if any, is needed by the resident. Medication set-up and storage protocol will be implemented based on the assessment outcome. The medication assessment will be reviewed biannually as part of the review process, and episodically with any significant change in condition or as level of service indicate"			
R 0241	Health Services - Offense 410 IAC 16.2-5-4(e)(1)	R 0241	Resident E’s compression socks were placed on her lower extremities. Resident B’s	11/21/2025

	(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. 2. On 10/24/25 at 8:25 A.M., Resident B was alone in her room sitting in a recliner. A Dexcom G7 Sensor was observed on Resident B's upper right arm, not dated. On 10/22/25 at 10:23 A.M., Resident B's clinical record was reviewed. The diagnoses included, but were not limited to, dementia, hypertension, hypothyroidism, asthma, malignant neoplasm of part of the bronchus, and diabetes mellitus type II.		dexacom was dated. Resident B’s physician was notified of the abnormal blood sugars. All diabetics have the potential to be affected by the alleged deficient practice. An audit of all diabetic censors was completed, and any deficiencies were corrected. A vital signs audit was also completed for blood sugars of all diabetics to ensure physicians had been notified of all high blood sugars. An in-service by the DON was completed on insulin administration. A skills check was completed for all QMA and licensed nurses on insulin administration and physician notification as well as dating insulin sensors. An in-service was also completed on documentation of “tasks” to ensure compression garments are being documented correctly. An unavailable med pass report and “task” completion report will be printed signed and placed in the DON mailbox after every shift. An audit tool was	

	The most recent Service Plan, dated 8/22/25, indicated Resident B's decisions were poor, and required cueing and supervision in planning and organizing daily routines. She also had a dementia diagnosis and/or significant memory loss combined with behaviors that included, but were not limited to, wandering, requiring directions or reminding, and continuous daily cuing. Current Physician's Orders included, but were not limited to, the following: - Dexcom G7 Sensor, change sensor every 10 days, ordered 8/21/25 - Humalog 100 units (U)/milliliter (mL) KwikPen insulin, inject subcutaneously per sliding scale before meals and at bedtime (8:00 A.M., 12:00 P.M., 4:00 P.M., 8:00 P.M.), under 100=0 U; 101-150=2 U; 151-200=4 U; 201-300=5 U; 301-350=6 U; 351-400=7 U; above 400=8 U and call Medical Doctor (MD), ordered 9/4/25 and discontinued 10/15/25 - Humalog 100 U/ML KwikPen insulin, inject 6 units subcutaneously three times daily before meals (8:00 A.M., 12:00 P.M., 4:00 P.M.), ordered 9/8/25 and discontinued 10/15/25 - Lantus Solostar 100 U/ML		created for insulin pen administration. The Director of Nursing will monitor insulin administration, physician notification, dating of insulin censors, and task documentation daily for 4 weeks, 3x week for 4 weeks, 2x week for 4 weeks, weekly for 4 weeks and monthly for 2 months. Results of the monitoring will be forwarded to QAPI for any further recommendations.	

insulin, inject 10 units subcutaneously twice daily (8:00 A.M., 8:00 P.M.), give half dose under 140 and skip dose if under 80, ordered 9/8/25 and discontinued 10/15/25

- Humalog 100 U/ML KwikPen insulin, inject subcutaneously three times daily before meals (8:00 A.M., 12:00 P.M., 4:00 P.M.) per sliding scale, 150-199=1 U; 200-249=2U; 250-299=3 U; > (greater than) 300=4 U and repeat next scheduled time. For consecutive blood sugars >300 mg/dl call MD, ordered 10/16/25

- Humalog 100 U/ML KwikPen insulin, inject 5 units subcutaneously three times daily before meals (8:00 AM, 12:00 PM, 4:00 PM), ordered 10/16/25

- Lantus Solostar 100 U/ML insulin, inject 12 units subcutaneously twice daily (8:00 A.M., 8:00 P.M.), ordered 10/16/25

The September and October 2025 Medication Administration Record (MAR) indicated the resident's Dexcom G7 Sensor was last changed 9/30/25. On 10/10/25, the MAR indicated "Sensor doesn't need replaced". On 10/20/25, the MAR indicated "Sensor still good".

The following blood sugars were recorded as greater than 400

	milligram (mg)/deciliter (dl) in the October 2025 MAR: On 10/4/25 at 5:47 P.M., 425 On 10/6/25 at 8:10 A.M., 406 On 10/6/25 at 5:39 P.M., 493 On 10/9/25 at 8:07 A.M., 532 On 10/9/25 at 12:14 P.M. 522 On 10/9/25 at 1:02 P.M. 544 On 10/11/25 at 7:43 A.M., 408 On 10/12/25 at 11:31 P.M., 489 On 10/12/25 at 12:51 P.M., 465 On 10/23/25 at 11:08 A.M., 561 The clinical record lacked documentation of a physician being notified, new orders, and how many units of insulin were given to the resident at those times. During an interview on 10/24/25 at 8:25 A.M., the Director of Nursing (DON) indicated Resident B was under the care of an endocrinologist and that was who staff should have notified. The Qualified Medication Aide (QMA) would get the resident's blood sugars and if it was high, they would notify a nurse, and the nurse would be responsible for calling or faxing the MD. Most of the time, the staff should put in a			

	note . If the Dexcom G7 monitor indicated the sensor was still good, then the staff would wait until it showed expired, otherwise it was costly to the resident. At that time, the DON indicated there was no policy for using the blood sugar sensors, but the facility would use the manufacturer's guidelines as a policy. On 10/23/25 at 2:37 P.M., a current Medication Administration Policy, last revised January 2024, was provided by the Director of Nursing (DON) and indicated, " ... Medication administration will be administered as ordered by the resident's provider and will be administered by a licensed nurse or a QMA.1. Rights of Medication Administration: All medication will be administered by licensed nursing personnel or QMAs. The rights of medication administration will be adhered to at all times and includes: right resident, right medication, right dose, right route, right time, right response, and right documentation ..." At that time, the DON indicated there was no policy related to insulin administration, as the facility would just follow manufacturer's guidelines. On 10/23/25 at 3:00 P.M., the Humalog Kwikpen Manufacturer's Guidelines, last revised July 2023, indicated, " ...			

	Prime before each injection. Priming your pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin" On 10/24/25 at 10:00 A.M., the Dexcom G7 Manufacturer's Guidelines, last revised July 2025, indicated " ... a glucose monitoring system indicated for continuously measuring glucose in the interstitial fluid in persons with diabetes mellitus age 2 years and older, where self-monitoring of blood glucose is indicated. The Dexcom G7 System is designed to replace finger stick blood glucose testing for treatment decisions ... Each sensor session lasts up to 10 days with a 12-hour grace period at the end. At the end of the grace period, you'll get the Replace Sensor Now alert ... " This citation relates to Intake IN00465173. Based on observation, interview, and record review, the facility failed to ensure medications and nursing care were provided as ordered by the physician for 2 of 4 residents reviewed for pharmacological services. An insulin pen was not primed prior to administration of insulin, compression socks were			

not supplied to a resident, Dexcom G7 sensors were not changed as ordered, and high blood sugars were not reported to the physician. (Resident E, Resident B)

Findings include:

1. On 10/22/25 at 11:00 A.M., Licensed Practical Nurse (LPN) 25 was observed to administer insulin to Resident E. LPN 25 was observed to obtain a Humalog Kwik pen (insulin pen) from the resident's locked cabinet, and twist the bottom to 7 units. She then placed a needle on the pen, and administered it to the resident. The pen was not observed to be primed. At that time, LPN 25 indicated she was unaware that the insulin needed to be primed, and did not prime any needle when administering injections to residents.

On 10/22/25 at 1:00 P.M., Resident E's clinical record was reviewed. The diagnoses included, but were not limited to, diabetes mellitus and hypertension.

Current physician orders included, but were not limited to:

- Compression socks: put on every morning and remove at bedtime, dated 9/2/25.

- Humalog 100 U (units)/ml (milliliters) Kwik pen, inject 5

units subcutaneous three times a day with meals, dated 8/6/24.

- Humalog 100 U/ml Kwik pen, inject per sliding scale three times daily: 150-200=2U; 201-250=4U; 251-300=6U; 301-350=8U; 351-400=10U, dated 1/3/24.

Resident E's October 2025 Medication Administration Record (MAR) indicated the following related to the compression socks:

- 10/1/25 does not have

- 10/2/25 resident doesn't have any

- 10/2/25 resident not wearing

- 10/3/25 resident not wearing

- 10/5/25 resident not wearing compression socks

- 10/6/25 not wearing compression socks

- 10/6/25 resident doesn't have any

- 10/7/25 doesn't have

- 10/12/25 resident states she doesn't have these

- 10/13/25 resident doesn't have any

- 10/14/25 resident doesn't have any

	- 10/17/25 doesn't have any On 10/24/25 at 9:30 A.M., Qualified Medication Aide (QMA) 16 indicated insulin pens should be primed with 2 units every time used. On 10/25/25 at 10:02 A.M., Resident E indicated she did not have compression socks and did not know what they were. At that time, Resident E was observed to be barefoot. On 10/25/25 at 11:51 A.M., the Director of Nursing (DON) indicated Resident E would often refuse compression socks and hide them indicating she did not have them. She indicated staff would mark refuse on the MAR on those occasions. 2. On 10/24/25 at 8:25 A.M., Resident B was alone in her room sitting in a recliner. A Dexcom G7 Sensor was observed on Resident B's upper right arm, not dated. On 10/22/25 at 10:23 A.M., Resident B's clinical record was reviewed. The diagnoses included, but were not limited to, dementia, hypertension, hypothyroidism, asthma, malignant neoplasm of part of the bronchus, and diabetes mellitus type II. The most recent Service Plan, dated 8/22/25, indicated Resident B's decisions were			

poor, and required cueing and supervision in planning and organizing daily routines. She also had a dementia diagnosis and/or significant memory loss combined with behaviors that included, but were not limited to, wandering, requiring directions or reminding, and continuous daily cuing.

Current Physician's Orders included, but were not limited to, the following:

- Dexcom G7 Sensor, change sensor every 10 days, ordered 8/21/25

- Humalog 100 units (U)/milliliter (mL) KwikPen insulin, inject subcutaneously per sliding scale before meals and at bedtime (8:00 A.M., 12:00 P.M., 4:00 P.M., 8:00 P.M.), under 100=0 U; 101-150=2 U; 151-200=4 U; 201-300=5 U; 301-350=6 U; 351-400=7 U; above 400=8 U and call Medical Doctor (MD), ordered 9/4/25 and discontinued 10/15/25

- Humalog 100 U/ML KwikPen insulin, inject 6 units subcutaneously three times daily before meals (8:00 A.M., 12:00 P.M., 4:00 P.M.), ordered 9/8/25 and discontinued 10/15/25

- Lantus Solostar 100 U/ML insulin, inject 10 units subcutaneously twice daily (8:00 A.M., 8:00 P.M.), give half dose

under 140 and skip dose if under 80, ordered 9/8/25 and discontinued 10/15/25

- Humalog 100 U/ML KwikPen insulin, inject subcutaneously three times daily before meals (8:00 A.M., 12:00 P.M., 4:00 P.M.) per sliding scale, 150-199=1 U; 200-249=2U; 250-299=3 U; > (greater than) 300=4 U and repeat next scheduled time. For consecutive blood sugars >300 mg/dl call MD, ordered 10/16/25

- Humalog 100 U/ML KwikPen insulin, inject 5 units subcutaneously three times daily before meals (8:00 AM, 12:00 PM, 4:00 PM), ordered 10/16/25

- Lantus Solostar 100 U/ML insulin, inject 12 units subcutaneously twice daily (8:00 A.M., 8:00 P.M.), ordered 10/16/25

The September and October 2025 Medication Administration Record (MAR) indicated the resident's Dexcom G7 Sensor was last changed 9/30/25. On 10/10/25, the MAR indicated "Sensor doesn't need replaced". On 10/20/25, the MAR indicated "Sensor still good".

The following blood sugars were recorded as greater than 400 milligram (mg)/deciliter (dl) in the October 2025 MAR:

	On 10/4/25 at 5:47 P.M., 425 On 10/6/25 at 8:10 A.M., 406 On 10/6/25 at 5:39 P.M., 493 On 10/9/25 at 8:07 A.M., 532 On 10/9/25 at 12:14 P.M. 522 On 10/9/25 at 1:02 P.M. 544 On 10/11/25 at 7:43 A.M., 408 On 10/12/25 at 11:31 P.M., 489 On 10/12/25 at 12:51 P.M., 465 On 10/23/25 at 11:08 A.M., 561 The clinical record lacked documentation of a physician being notified, new orders, and how many units of insulin were given to the resident at those times. During an interview on 10/24/25 at 8:25 A.M., the Director of Nursing (DON) indicated Resident B was under the care of an endocrinologist and that was who staff should have notified. The Qualified Medication Aide (QMA) would get the resident's blood sugars and if it was high, they would notify a nurse, and the nurse would be responsible for calling or faxing the MD. Most of the time, the staff should put in a note . If the Dexcom G7 monitor indicated the sensor was still good, then the staff would wait			

	until it showed expired, otherwise it was costly to the resident. At that time, the DON indicated there was no policy for using the blood sugar sensors, but the facility would use the manufacturer's guidelines as a policy. On 10/23/25 at 2:37 P.M., a current Medication Administration Policy, last revised January 2024, was provided by the Director of Nursing (DON) and indicated, " ... Medication administration will be administered as ordered by the resident's provider and will be administered by a licensed nurse or a QMA.1. Rights of Medication Administration: All medication will be administered by licensed nursing personnel or QMAs. The rights of medication administration will be adhered to at all times and includes: right resident, right medication, right dose, right route, right time, right response, and right documentation ..." At that time, the DON indicated there was no policy related to insulin administration, as the facility would just follow manufacturer's guidelines. On 10/23/25 at 3:00 P.M., the Humalog Kwikpen Manufacturer's Guidelines, last revised July 2023, indicated, " ... Prime before each injection. Priming your pen means removing the air from the needle			

	and cartridge that may collect during normal use and ensures that the pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin" On 10/24/25 at 10:00 A.M., the Dexcom G7 Manufacturer's Guidelines, last revised July 2025, indicated " ... a glucose monitoring system indicated for continuously measuring glucose in the interstitial fluid in persons with diabetes mellitus age 2 years and older, where self-monitoring of blood glucose is indicated. The Dexcom G7 System is designed to replace finger stick blood glucose testing for treatment decisions ... Each sensor session lasts up to 10 days with a 12-hour grace period at the end. At the end of the grace period, you'll get the Replace Sensor Now alert ... " This citation relates to Intake IN00465173. Based on observation, interview, and record review, the facility failed to ensure medications and nursing care were provided as ordered by the physician for 2 of 4 residents reviewed for pharmacological services. An insulin pen was not primed prior to administration of insulin, compression socks were not supplied to a resident, Dexcom G7 sensors were not changed as ordered, and high			

blood sugars were not reported to the physician. (Resident E, Resident B)

Findings include:

1. On 10/22/25 at 11:00 A.M., Licensed Practical Nurse (LPN) 25 was observed to administer insulin to Resident E. LPN 25 was observed to obtain a Humalog Kwik pen (insulin pen) from the resident's locked cabinet, and twist the bottom to 7 units. She then placed a needle on the pen, and administered it to the resident. The pen was not observed to be primed. At that time, LPN 25 indicated she was unaware that the insulin needed to be primed, and did not prime any needle when administering injections to residents.

On 10/22/25 at 1:00 P.M., Resident E's clinical record was reviewed. The diagnoses included, but were not limited to, diabetes mellitus and hypertension.

Current physician orders included, but were not limited to:

- Compression socks: put on every morning and remove at bedtime, dated 9/2/25.

- Humalog 100 U (units)/ml (milliliters) Kwik pen, inject 5 units subcutaneous three times a day with meals, dated 8/6/24.

- Humalog 100 U/ml Kwik pen, inject per sliding scale three times daily: 150-200=2U; 201-250=4U; 251-300=6U; 301-350=8U; 351-400=10U, dated 1/3/24.

Resident E's October 2025 Medication Administration Record (MAR) indicated the following related to the compression socks:

- 10/1/25 does not have

- 10/2/25 resident doesn't have any

- 10/2/25 resident not wearing

- 10/3/25 resident not wearing

- 10/5/25 resident not wearing compression socks

- 10/6/25 not wearing compression socks

- 10/6/25 resident doesn't have any

- 10/7/25 doesn't have

- 10/12/25 resident states she doesn't have these

- 10/13/25 resident doesn't have any

- 10/14/25 resident doesn't have any

- 10/17/25 doesn't have any

On 10/24/25 at 9:30 A.M.,

Qualified Medication Aide (QMA) 16 indicated insulin pens should be primed with 2 units every time used.

On 10/25/25 at 10:02 A.M., Resident E indicated she did not have compression socks and did not know what they were. At that time, Resident E was observed to be barefoot.

On 10/25/25 at 11:51 A.M., the Director of Nursing (DON) indicated Resident E would often refuse compression socks and hide them indicating she did not have them. She indicated staff would mark refuse on the MAR on those occasions.

2. On 10/24/25 at 8:25 A.M., Resident B was alone in her room sitting in a recliner. A Dexcom G7 Sensor was observed on Resident B's upper right arm, not dated.

On 10/22/25 at 10:23 A.M., Resident B's clinical record was reviewed. The diagnoses included, but were not limited to, dementia, hypertension, hypothyroidism, asthma, malignant neoplasm of part of the bronchus, and diabetes mellitus type II.

The most recent Service Plan, dated 8/22/25, indicated Resident B's decisions were poor, and required cueing and supervision in planning and organizing daily routines. She

	also had a dementia diagnosis and/or significant memory loss combined with behaviors that included, but were not limited to, wandering, requiring directions or reminding, and continuous daily cuing. Current Physician's Orders included, but were not limited to, the following: - Dexcom G7 Sensor, change sensor every 10 days, ordered 8/21/25 - Humalog 100 units (U)/milliliter (mL) KwikPen insulin, inject subcutaneously per sliding scale before meals and at bedtime (8:00 A.M., 12:00 P.M., 4:00 P.M., 8:00 P.M.), under 100=0 U; 101-150=2 U; 151-200=4 U; 201-300=5 U; 301-350=6 U; 351-400=7 U; above 400=8 U and call Medical Doctor (MD), ordered 9/4/25 and discontinued 10/15/25 - Humalog 100 U/ML KwikPen insulin, inject 6 units subcutaneously three times daily before meals (8:00 A.M., 12:00 P.M., 4:00 P.M.), ordered 9/8/25 and discontinued 10/15/25			

	- Lantus Solostar 100 U/ML insulin, inject 10 units subcutaneously twice daily (8:00 A.M., 8:00 P.M.), give half dose under 140 and skip dose if under 80, ordered 9/8/25 and discontinued 10/15/25 - Humalog 100 U/ML KwikPen insulin, inject subcutaneously three times daily before meals (8:00 A.M., 12:00 P.M., 4:00 P.M.) per sliding scale, 150-199=1 U; 200-249=2U; 250-299=3 U; > (greater than) 300=4 U and repeat next scheduled time. For consecutive blood sugars >300 mg/dl call MD, ordered 10/16/25 - Humalog 100 U/ML KwikPen insulin, inject 5 units subcutaneously three times daily before meals (8:00 AM, 12:00 PM, 4:00 PM), ordered 10/16/25 - Lantus Solostar 100 U/ML insulin, inject 12 units subcutaneously twice daily (8:00 A.M., 8:00 P.M.), ordered 10/16/25 The September and October 2025 Medication Administration Record (MAR) indicated the resident's Dexcom G7 Sensor was last changed 9/30/25. On 10/10/25, the MAR indicated "Sensor doesn't need replaced". On 10/20/25, the MAR indicated "Sensor still good". The following blood sugars were			

	recorded as greater than 400 milligram (mg)/deciliter (dl) in the October 2025 MAR: On 10/4/25 at 5:47 P.M., 425 On 10/6/25 at 8:10 A.M., 406 On 10/6/25 at 5:39 P.M., 493 On 10/9/25 at 8:07 A.M., 532 On 10/9/25 at 12:14 P.M. 522 On 10/9/25 at 1:02 P.M. 544 On 10/11/25 at 7:43 A.M., 408 On 10/12/25 at 11:31 P.M., 489 On 10/12/25 at 12:51 P.M., 465 On 10/23/25 at 11:08 A.M., 561 The clinical record lacked documentation of a physician being notified, new orders, and how many units of insulin were given to the resident at those times. During an interview on 10/24/25 at 8:25 A.M., the Director of Nursing (DON) indicated Resident B was under the care of an endocrinologist and that was who staff should have notified. The Qualified Medication Aide (QMA) would get the resident's blood sugars and if it was high, they would notify a nurse, and the nurse would be responsible for calling or faxing the MD. Most of the			

	time, the staff should put in a note . If the Dexcom G7 monitor indicated the sensor was still good, then the staff would wait until it showed expired, otherwise it was costly to the resident. At that time, the DON indicated there was no policy for using the blood sugar sensors, but the facility would use the manufacturer's guidelines as a policy. On 10/23/25 at 2:37 P.M., a current Medication Administration Policy, last revised January 2024, was provided by the Director of Nursing (DON) and indicated, " ... Medication administration will be administered as ordered by the resident's provider and will be administered by a licensed nurse or a QMA.1. Rights of Medication Administration: All medication will be administered by licensed nursing personnel or QMAs. The rights of medication administration will be adhered to at all times and includes: right resident, right medication, right dose, right route, right time, right response, and right documentation ..." At that time, the DON indicated there was no policy related to insulin administration, as the facility would just follow manufacturer's guidelines. On 10/23/25 at 3:00 P.M., the Humalog Kwikpen Manufacturer's Guidelines, last			

	revised July 2023, indicated, " ... Prime before each injection. Priming your pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin" On 10/24/25 at 10:00 A.M., the Dexcom G7 Manufacturer's Guidelines, last revised July 2025, indicated " ... a glucose monitoring system indicated for continuously measuring glucose in the interstitial fluid in persons with diabetes mellitus age 2 years and older, where self-monitoring of blood glucose is indicated. The Dexcom G7 System is designed to replace finger stick blood glucose testing for treatment decisions ... Each sensor session lasts up to 10 days with a 12-hour grace period at the end. At the end of the grace period, you'll get the Replace Sensor Now alert ... " This citation relates to Intake IN00465173. Based on observation, interview, and record review, the facility failed to ensure medications and nursing care were provided as ordered by the physician for 2 of 4 residents reviewed for pharmacological services. An insulin pen was not primed prior to administration of			

insulin, compression socks were not supplied to a resident, Dexcom G7 sensors were not changed as ordered, and high blood sugars were not reported to the physician. (Resident E, Resident B)

Findings include:

1. On 10/22/25 at 11:00 A.M., Licensed Practical Nurse (LPN) 25 was observed to administer insulin to Resident E. LPN 25 was observed to obtain a Humalog Kwik pen (insulin pen) from the resident's locked cabinet, and twist the bottom to 7 units. She then placed a needle on the pen, and administered it to the resident. The pen was not observed to be primed. At that time, LPN 25 indicated she was unaware that the insulin needed to be primed, and did not prime any needle when administering injections to residents.

On 10/22/25 at 1:00 P.M., Resident E's clinical record was reviewed. The diagnoses included, but were not limited to, diabetes mellitus and hypertension.

Current physician orders included, but were not limited to:

- Compression socks: put on every morning and remove at bedtime, dated 9/2/25.

- Humalog 100 U (units)/ml

	(milliliters) Kwik pen, inject 5 units subcutaneous three times a day with meals, dated 8/6/24. - Humalog 100 U/ml Kwik pen, inject per sliding scale three times daily: 150-200=2U; 201-250=4U; 251-300=6U; 301-350=8U; 351-400=10U, dated 1/3/24. Resident E's October 2025 Medication Administration Record (MAR) indicated the following related to the compression socks: - 10/1/25 does not have - 10/2/25 resident doesn't have any - 10/2/25 resident not wearing - 10/3/25 resident not wearing - 10/5/25 resident not wearing compression socks - 10/6/25 not wearing compression socks - 10/6/25 resident doesn't have any - 10/7/25 doesn't have - 10/12/25 resident states she doesn't have these - 10/13/25 resident doesn't have any - 10/14/25 resident doesn't have			

any

- 10/17/25 doesn't have any

On 10/24/25 at 9:30 A.M., Qualified Medication Aide (QMA) 16 indicated insulin pens should be primed with 2 units every time used.

On 10/25/25 at 10:02 A.M., Resident E indicated she did not have compression socks and did not know what they were. At that time, Resident E was observed to be barefoot.

On 10/25/25 at 11:51 A.M., the Director of Nursing (DON) indicated Resident E would often refuse compression socks and hide them indicating she did not have them. She indicated staff would mark refuse on the MAR on those occasions.

2. On 10/24/25 at 8:25 A.M., Resident B was alone in her room sitting in a recliner. A Dexcom G7 Sensor was observed on Resident B's upper right arm, not dated.

On 10/22/25 at 10:23 A.M., Resident B's clinical record was reviewed. The diagnoses included, but were not limited to, dementia, hypertension, hypothyroidism, asthma, malignant neoplasm of part of the bronchus, and diabetes mellitus type II.

The most recent Service Plan,

dated 8/22/25, indicated Resident B's decisions were poor, and required cueing and supervision in planning and organizing daily routines. She also had a dementia diagnosis and/or significant memory loss combined with behaviors that included, but were not limited to, wandering, requiring directions or reminding, and continuous daily cuing.

Current Physician's Orders included, but were not limited to, the following:

- Dexcom G7 Sensor, change sensor every 10 days, ordered 8/21/25

- Humalog 100 units (U)/milliliter (mL) KwikPen insulin, inject subcutaneously per sliding scale before meals and at bedtime (8:00 A.M., 12:00 P.M., 4:00 P.M., 8:00 P.M.), under 100=0 U; 101-150=2 U; 151-200=4 U; 201-300=5 U; 301-350=6 U; 351-400=7 U; above 400=8 U and call Medical Doctor (MD), ordered 9/4/25 and discontinued 10/15/25

- Humalog 100 U/ML KwikPen insulin, inject 6 units subcutaneously three times daily before meals (8:00 A.M., 12:00 P.M., 4:00 P.M.), ordered 9/8/25 and discontinued 10/15/25

- Lantus Solostar 100 U/ML insulin, inject 10 units

	subcutaneously twice daily (8:00 A.M., 8:00 P.M.), give half dose under 140 and skip dose if under 80, ordered 9/8/25 and discontinued 10/15/25 - Humalog 100 U/ML KwikPen insulin, inject subcutaneously three times daily before meals (8:00 A.M., 12:00 P.M., 4:00 P.M.) per sliding scale, 150-199=1 U; 200-249=2U; 250-299=3 U; > (greater than) 300=4 U and repeat next scheduled time. For consecutive blood sugars >300 mg/dl call MD, ordered 10/16/25 - Humalog 100 U/ML KwikPen insulin, inject 5 units subcutaneously three times daily before meals (8:00 AM, 12:00 PM, 4:00 PM), ordered 10/16/25 - Lantus Solostar 100 U/ML insulin, inject 12 units subcutaneously twice daily (8:00 A.M., 8:00 P.M.), ordered 10/16/25 The September and October 2025 Medication Administration Record (MAR) indicated the resident's Dexcom G7 Sensor was last changed 9/30/25. On 10/10/25, the MAR indicated "Sensor doesn't need replaced". On 10/20/25, the MAR indicated "Sensor still good". The following blood sugars were recorded as greater than 400 milligram (mg)/deciliter (dl) in			

	the October 2025 MAR: On 10/4/25 at 5:47 P.M., 425 On 10/6/25 at 8:10 A.M., 406 On 10/6/25 at 5:39 P.M., 493 On 10/9/25 at 8:07 A.M., 532 On 10/9/25 at 12:14 P.M. 522 On 10/9/25 at 1:02 P.M. 544 On 10/11/25 at 7:43 A.M., 408 On 10/12/25 at 11:31 P.M., 489 On 10/12/25 at 12:51 P.M., 465 On 10/23/25 at 11:08 A.M., 561 The clinical record lacked documentation of a physician being notified, new orders, and how many units of insulin were given to the resident at those times. During an interview on 10/24/25 at 8:25 A.M., the Director of Nursing (DON) indicated Resident B was under the care of an endocrinologist and that was who staff should have notified. The Qualified Medication Aide (QMA) would get the resident's blood sugars and if it was high, they would notify a nurse, and the nurse would be responsible for calling or faxing the MD. Most of the time, the staff should put in a note . If the Dexcom G7 monitor			

	indicated the sensor was still good, then the staff would wait until it showed expired, otherwise it was costly to the resident. At that time, the DON indicated there was no policy for using the blood sugar sensors, but the facility would use the manufacturer's guidelines as a policy. On 10/23/25 at 2:37 P.M., a current Medication Administration Policy, last revised January 2024, was provided by the Director of Nursing (DON) and indicated, " ... Medication administration will be administered as ordered by the resident's provider and will be administered by a licensed nurse or a QMA.1. Rights of Medication Administration: All medication will be administered by licensed nursing personnel or QMAs. The rights of medication administration will be adhered to at all times and includes: right resident, right medication, right dose, right route, right time, right response, and right documentation ..." At that time, the DON indicated there was no policy related to insulin administration, as the facility would just follow manufacturer's guidelines. On 10/23/25 at 3:00 P.M., the Humalog Kwikpen Manufacturer's Guidelines, last revised July 2023, indicated, " ... Prime before each injection.			

	Priming your pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin" On 10/24/25 at 10:00 A.M., the Dexcom G7 Manufacturer's Guidelines, last revised July 2025, indicated " ... a glucose monitoring system indicated for continuously measuring glucose in the interstitial fluid in persons with diabetes mellitus age 2 years and older, where self-monitoring of blood glucose is indicated. The Dexcom G7 System is designed to replace finger stick blood glucose testing for treatment decisions ... Each sensor session lasts up to 10 days with a 12-hour grace period at the end. At the end of the grace period, you'll get the Replace Sensor Now alert ... " This citation relates to Intake IN00465173. Based on observation, interview, and record review, the facility failed to ensure medications and nursing care were provided as ordered by the physician for 2 of 4 residents reviewed for pharmacological services. An insulin pen was not primed prior to administration of insulin, compression socks were not supplied to a resident,			

Dexcom G7 sensors were not changed as ordered, and high blood sugars were not reported to the physician. (Resident E, Resident B)

Findings include:

1. On 10/22/25 at 11:00 A.M., Licensed Practical Nurse (LPN) 25 was observed to administer insulin to Resident E. LPN 25 was observed to obtain a Humalog Kwik pen (insulin pen) from the resident's locked cabinet, and twist the bottom to 7 units. She then placed a needle on the pen, and administered it to the resident. The pen was not observed to be primed. At that time, LPN 25 indicated she was unaware that the insulin needed to be primed, and did not prime any needle when administering injections to residents.

On 10/22/25 at 1:00 P.M., Resident E's clinical record was reviewed. The diagnoses included, but were not limited to, diabetes mellitus and hypertension.

Current physician orders included, but were not limited to:

- Compression socks: put on every morning and remove at bedtime, dated 9/2/25.

- Humalog 100 U (units)/ml (milliliters) Kwik pen, inject 5 units subcutaneous three times

	a day with meals, dated 8/6/24. - Humalog 100 U/ml Kwik pen, inject per sliding scale three times daily: 150-200=2U; 201-250=4U; 251-300=6U; 301-350=8U; 351-400=10U, dated 1/3/24. Resident E's October 2025 Medication Administration Record (MAR) indicated the following related to the compression socks: - 10/1/25 does not have - 10/2/25 resident doesn't have any - 10/2/25 resident not wearing - 10/3/25 resident not wearing - 10/5/25 resident not wearing compression socks - 10/6/25 not wearing compression socks - 10/6/25 resident doesn't have any - 10/7/25 doesn't have - 10/12/25 resident states she doesn't have these - 10/13/25 resident doesn't have any - 10/14/25 resident doesn't have any			

	- 10/17/25 doesn't have any On 10/24/25 at 9:30 A.M., Qualified Medication Aide (QMA) 16 indicated insulin pens should be primed with 2 units every time used. On 10/25/25 at 10:02 A.M., Resident E indicated she did not have compression socks and did not know what they were. At that time, Resident E was observed to be barefoot. On 10/25/25 at 11:51 A.M., the Director of Nursing (DON) indicated Resident E would often refuse compression socks and hide them indicating she did not have them. She indicated staff would mark refuse on the MAR on those occasions.			
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. On 10/23/25 at 2:37 P.M., a current Medication Administration Policy, last revised January 2024, was provided by the Director of Nursing (DON) and indicated, " ... Medication administration will	R 0247	Resident B was sent to the ER for high blood sugars. Resident C's order for vraylar was scanned into the medical record and physician was notified of missed doses. Resident C's BP was checked and reported to the physician. Resident D's BP was checked and reported to the physician. Resident E's blood sugar was documented and physician was notified. Resident E's BP was checked and physician notified.	11/21/2025

	be administered as ordered by the resident's provider and will be administered by a licensed nurse or a QMA.1. Rights of Medication Administration: All medication will be administered by licensed nursing personnel or QMAs. The rights of medication administration will be adhered to at all times and includes: right resident, right medication, right dose, right route, right time, right response, and right documentation....Documentation of any observed/reported undesirable effects will be included in the clinical record. The resident's primary care provider will be notified immediately if undesirable effects occur, and such notification will be documented in the clinical record ... The provider will be notified by a licensed nurse if: patterns in refusal are noted and/or as warranted per professional clinical judgment and/or as indicated per any provider parameters noted within the medication orders ... " This citation relates to Intake IN00465173. Based on interview and record review, the facility failed to ensure the resident's physician was notified following errors in medication administration for 4 of 4 residents reviewed for pharmacological services. The physician was not notified when		All residents have the potential for the alleged deficient practice to occur. All diabetic documentation and vital signs documentation was audited. Any deficient practice was corrected including physician notification of any undocumented BP’s and blood sugars. An in-service was given by the DON on physician notification, documentation, change of condition, abnormal vitals, special treatments. The implementation of “stop and watch” was completed to ensure that there is improved physician communication. A report on unattended medications will be run after every shift and placed in the DON mailbox. DON will run vital signs reports to ensure vital signs are getting completed and documented. The DON will monitor the stop and watch program, med pass report and vital signs report daily for 4 weeks, 3x week for 4 weeks, 2x week for 4 weeks, weekly for 4 weeks and monthly for 2 months. Results of the monitoring will be	

	blood pressure medication were not given, a newly prescribed antipsychotic was not given, blood sugars were not checked, and insulin was not given. This deficient practice resulted in a resident being admitted to the Intensive Care Unit with diabetic ketoacidosis (a life threatening condition when the body lacks insulin, breaks down fat for energy producing acidic ketones that build up in blood) and acute kidney injury. (Resident C, Resident D, Resident E, Resident B) Findings include: 1. On 10/22/25 at 8:45 A.M., an Indiana Department of Health (IDOH) incident report was reviewed and indicated on 10/13/25 at 8:01 P.M., Resident B was transferred to the Emergency Room (ER) due to an immeasurable, high blood sugar. Upon admission, the resident's blood glucose was 668 milligrams (mg)/deciliter (dl), the resident was diagnosed with diabetic ketoacidosis and an acute kidney injury, and admitted to the Intensive Care Unit (ICU). The resident was readmitted to the facility on 10/15/25. On 10/22/25 at 10:23 A.M., Resident B's clinical record was reviewed. The diagnoses included, but were not limited to, dementia, hypertension,		forwarded to QAOI for any further recommendations.	

hypothyroidism, asthma, malignant neoplasm of part of the bronchus, and diabetes mellitus type II.

The most recent Service Plan, dated 8/22/25, indicated Resident B was able to transfer independently, but her decisions were poor, and required cueing and supervision in planning, organizing, and daily routines.

Current Physician's Orders included, but were not limited to, the following:

- Humalog 100 units (U)/milliliter (ML) KwikPen insulin, inject subcutaneously per sliding scale before meals and at bedtime (8:00 A.M., 12:00 P.M., 4:00 P.M., 8:00 P.M.), under 100=0 U; 101-150=2 U; 151-200=4 U; 201-300=5 U; 301-350=6 U; 351-400=7 U; above 400=8 U and call Medical Doctor (MD), ordered 9/4/25 and discontinued 10/15/25

- Humalog 100 U/ML KwikPen insulin, inject 6 units subcutaneously three times daily before meals (8:00 A.M., 12:00 P.M., 4:00 P.M.), ordered 9/8/25 and discontinued 10/15/25

- Lantus Solostar 100 U/ML insulin, inject 10 units subcutaneously twice daily (8:00 A.M., 8:00 P.M.), give half dose under 140 and skip dose if under 80, ordered 9/8/25 and

discontinued 10/15/25

- Humalog 100 U/ML KwikPen insulin, inject subcutaneously three times daily before meals (8:00 A.M., 12:00 P.M., 4:00 P.M.) per sliding scale, 150-199=1 U; 200-249=2U; 250-299=3 U; > (greater than) 300=4 U and repeat next scheduled time. For consecutive blood sugars >300 mg/dl call MD, ordered 10/16/25

- Humalog 100 U/ML KwikPen insulin, inject 5 units subcutaneously three times daily before meals (8:00 AM, 12:00 PM, 4:00 PM), ordered 10/16/25

- Lantus Solostar 100 U/ML insulin, inject 12 units subcutaneously twice daily (8:00 A.M., 8:00 P.M.), ordered 10/16/25

The October 2025 Medication Administration Record (MAR) indicated Resident B's last blood sugar was checked on 10/12/25 at 7:35 P.M., and documented as 66 milligram (mg)/deciliter (dl). The clinical record indicated no blood sugars were checked and no insulin was given on 10/13/25 (missed 3 doses of routine Humalog 6 units, 1 dose of routine Lantus 10 units, and possible doses of sliding scale insulin during the day shift of 6:00 A.M. until 6:00 P.M.)

	The Progress Notes lacked documentation about the resident's vital signs, symptoms, missed medications, MD notification about the resident's condition, and what lead to the transfer of Resident B to the ER. During an interview on 10/24/25 at 8:25 A.M., Resident B was observed in her room sitting in the recliner with a Dexcom G7 sensor on her right upper arm, not dated. The resident was pleasantly confused and had no recollection of the recent blood sugar incident or hospital stay. She indicated she didn't live at the facility. During an interview on 10/24/25 at 8:25 A.M., the Director of Nursing (DON) indicated at approximately 7:00 P.M. on 10/13/25, Qualified Medication Aide (QMA) 20 called her at home because Resident B's Dexcom G7 monitor was reading "high". She indicated she told QMA 20 to give routine insulin and then get an accucheck machine, calibrate it, and recheck the resident's blood sugar. The QMA reported to her that the accucheck still read high. The DON called the MD and after 15 minutes, she had not heard back from him so the DON told them to send Resident B to the ER. Later that evening, upon reviewing the lack of documentation, the DON called QMA 8 who was responsible for			

	the resident from 6:00 A.M. until 6:00 P.M. that day. QMA 8 reported that the Resident's blood sugar was 326 at dinner, she gave her the insulin, and when she left, the resident was in her room eating dinner. The DON educated her about the lack of documentation, and at that time, QMA 8 was suspended pending an investigation. The DON indicated she was not sure why the MAR didn't include the actual unit of insulin given to the resident and insulin administration was monitored for being unavailable or refused, but not "missed" medications on a daily basis. During an interview on 10/24/25 at 11:58 A.M., the DON indicated she would expect the QMA/nurse to document notification and any change in the resident's condition. At that time, she indicated staff had gotten too relaxed with documentation and they needed to educate and develop a plan going forward for staff with documentation. At that time, the DON indicated she was instructed by the corporate office not to share her investigation notes for QMA 8 because it was still an ongoing investigation. She indicated QMA 8 was still suspended. The Administrator had been out all week so he has not done the required 5 day follow up on the			

incident to the IDOH.

2. On 10/22/25 at 10:15 A.M., Resident C's clinical record was reviewed. The diagnoses included, but were not limited to, depressive disorder and hypertension.

Physician orders included, but were not limited to:

- Vraylar (an antipsychotic) 1.5 mg (milligrams) daily, dated 9/9/25 through 10/10/25.

- Carvedilol 6.25 mg, take 1 tablet twice daily hold if systolic (top number of blood pressure) is 90 or less, and/or diastolic (bottom number of blood pressure) is 60 or less recheck blood pressure later in the day to make sure it has not increased, dated 6/20/23 through 10/10/25

- Carvedilol 3.125 mg, take 1 tablet twice daily, hold if blood pressure < (less than) 90/50 or heart rate <60, dated 10/10/25.

Resident C's September 2025 through October 2025 medication administration record (MAR) indicated the following related to the medication Vraylar:

9/9/25 blank

9/10/25 not available

	9/14/25 not available 9/15/25 blank 9/17/25 not available 9/18/25 waiting on prior authorization 9/22/25 not available 9/23/25 not available 9/24/25 blank 9/27/25 no medication 9/28/25 needs prior authorization 9/29/25 waiting on prior authorization 10/1/25 needs prior authorization 10/2/25 not available waiting on prior authorization 10/3/25 prior authorization required 10/4/25 need prior authorization 10/5/25 not available 10/6/25 prior authorization required 10/7/25 needs prior authorization 10/8/25 blank A pharmacy recommendation			

	form, dated 10/2/25, included a hand written note from Resident C's physician to continue Vraylar, signed 10/3/25. An order form, dated 10/10/25, indicated to discontinue Resident C's Vraylar as insurance would not pay. Resident C's clinical record lacked any type of notification to the physician related to the medication Vraylar, or that it had been administered sporadically. Resident C's October 2025 MAR indicated the following related to Carvedilol: 10/7/25 at 8:00 P.M., not given. The blood pressure at that time was 92/58 and was not rechecked. 10/9/25 at 8:00 A.M., not given. The blood pressure at that time was 102/48 and was not rechecked. 10/9/25 at 8:00 P.M., not given. The blood pressure at that time was 105/60 (within perimeters to give). 10/10/25 at 8:00 A.M., not given. The blood pressure at that time was 100/59 and was not rechecked. 10/19/25 8:00 A.M., not given. The blood pressure at that time was 116/57 and heart rate was 67 (both within perimeters to			

	give). Resident C's clinical record lacked documentation of notification to the physician following the blood pressure readings listed above. On 10/24/25 at 11:51 A.M., the DON indicated when Resident C had been prescribed Vraylar, they had acquired samples of the medication. She indicated staff must have seen the samples on the days the MAR had indicated it was given. She indicated they were waiting on a prior authorization for the medication and insurance had ultimately denied it, so the physician then discontinued it. She indicated at that time that staff should have been entering communication with the physician in the clinical records, but many times would verbally communicate with them if they were in the facility and did not document it. She indicated when a blood pressure is held even though it was in perimeters to give, it was often a judgement call on the nurse's part to not give the medication. 3. On 10/22/25 at 10:00 A.M., Resident D's clinical record was reviewed. The diagnoses included, but were not limited to, diabetes mellitus and hypertension. Current physician orders			

included, but were not limited to:

- Hydralizine 50 mg by mouth three times a day at 7:00 A.M., 3:00 P.M., 11:00 P.M., hold if blood pressure <100/60 and notify nurse if blood pressure is > (greater than) 180/110.

Resident D's October 2025 MAR indicated the following related to hydralizine:

10/1/25 at 3:00 P.M., not given. The blood pressure at that time was 108/64 (within perimeters to give).

10/13/25 at 3:00 P.M., not given. The blood pressure at that time was 108/78 (within perimeters to give).

Resident D's clinical record lacked documentation of notification to the physician following the blood pressure readings listed above or information as to why the medication was not given despite the blood pressure being within perimeters to be given.

4. On 10/22/25 at 1:00 P.M., Resident E's clinical record was reviewed. The diagnoses included, but were not limited to, diabetes mellitus and hypertension.

Current physician orders included, but were not limited to:

	- Humalog 100U (units)/ml (milliliters) Kwik pen, inject 5 units subcutaneous three times a day with meals, dated 8/6/24. - Humalog 100U/ml Kwik pen, inject per sliding scale three times daily: 150-200=2U; 201-250=4U; 251-300=6U; 301-350=8U; 351-400=10U, dated 1/3/24. - Lantus solostar 100U/ml, inject 25 units subcutaneous daily, dated 9/12/25. - lisinopril - hydrochlorothiazide (HCTZ) 20-25 tablet, take 1 daily, dated 9/2/25. Resident E's October MAR indicated the following related to the sliding scale Humalog: 10/5/25 at 12:00 P.M., not given. No blood sugar documented at that time. 10/5/25 at 4:00 P.M., given. The blood sugar at that time was 127 (insulin not indicated). 10/10/25 at 12:00 P.M., not given. No blood sugar documented at that time. 10/11/25 at 12:00 P.M., not given. The blood sugar at that time was 150 (within perimeters to give). Resident E's clinical record lacked documentation of notification to the physician			

related to the Humalog listed above.

Resident E's October MAR indicated the following related to Lantus:

10/21/25 not given - missed. The clinical record lacked notification to the physician about the missed dose.

Resident E's October MAR indicated the following related to lisinopril-hydrochlorothiazide:

10/12/25 not given - held, blood pressure 100/56. The clinical record lacked notification to the physician.

10/17/25 not given - held, blood pressure 102/50. The clinical record lacked notification to the physician.

10/22/25 not given - diastolic is low. The blood pressure at that time was 112/58. The clinical record lacked notification to the physician.

On 10/23/25 at 2:37 P.M., a current Medication Administration Policy, last revised January 2024, was provided by the Director of Nursing (DON) and indicated, " ... Medication administration will be administered as ordered by the resident's provider and will be administered by a licensed nurse or a QMA.1. Rights of Medication Administration: All

	medication will be administered by licensed nursing personnel or QMAs. The rights of medication administration will be adhered to at all times and includes: right resident, right medication, right dose, right route, right time, right response, and right documentation....Documentation of any observed/reported undesirable effects will be included in the clinical record. The resident's primary care provider will be notified immediately if undesirable effects occur, and such notification will be documented in the clinical record ... The provider will be notified by a licensed nurse if: patterns in refusal are noted and/or as warranted per professional clinical judgment and/or as indicated per any provider parameters noted within the medication orders ... " This citation relates to Intake IN00465173. Based on interview and record review, the facility failed to ensure the resident's physician was notified following errors in medication administration for 4 of 4 residents reviewed for pharmacological services. The physician was not notified when blood pressure medication were not given, a newly prescribed antipsychotic was not given, blood sugars were not checked, and insulin was not given. This			

deficient practice resulted in a resident being admitted to the Intensive Care Unit with diabetic ketoacidosis (a life threatening condition when the body lacks insulin, breaks down fat for energy producing acidic ketones that build up in blood) and acute kidney injury. (Resident C, Resident D, Resident E, Resident B)

Findings include:

1. On 10/22/25 at 8:45 A.M., an Indiana Department of Health (IDOH) incident report was reviewed and indicated on 10/13/25 at 8:01 P.M., Resident B was transferred to the Emergency Room (ER) due to an immeasurable, high blood sugar. Upon admission, the resident's blood glucose was 668 milligrams (mg)/deciliter (dl), the resident was diagnosed with diabetic ketoacidosis and an acute kidney injury, and admitted to the Intensive Care Unit (ICU). The resident was readmitted to the facility on 10/15/25.

On 10/22/25 at 10:23 A.M., Resident B's clinical record was reviewed. The diagnoses included, but were not limited to, dementia, hypertension, hypothyroidism, asthma, malignant neoplasm of part of the bronchus, and diabetes mellitus type II.

The most recent Service Plan, dated 8/22/25, indicated Resident B was able to transfer independently, but her decisions were poor, and required cueing and supervision in planning, organizing, and daily routines.

Current Physician's Orders included, but were not limited to, the following:

- Humalog 100 units (U)/milliliter (ML) KwikPen insulin, inject subcutaneously per sliding scale before meals and at bedtime (8:00 A.M., 12:00 P.M., 4:00 P.M., 8:00 P.M.), under 100=0 U; 101-150=2 U; 151-200=4 U; 201-300=5 U; 301-350=6 U; 351-400=7 U; above 400=8 U and call Medical Doctor (MD), ordered 9/4/25 and discontinued 10/15/25

- Humalog 100 U/ML KwikPen insulin, inject 6 units subcutaneously three times daily before meals (8:00 A.M., 12:00 P.M., 4:00 P.M.), ordered 9/8/25 and discontinued 10/15/25

- Lantus Solostar 100 U/ML insulin, inject 10 units subcutaneously twice daily (8:00 A.M., 8:00 P.M.), give half dose under 140 and skip dose if under 80, ordered 9/8/25 and discontinued 10/15/25

- Humalog 100 U/ML KwikPen insulin, inject subcutaneously three times daily before meals

	(8:00 A.M., 12:00 P.M., 4:00 P.M.) per sliding scale, 150-199=1 U; 200-249=2U; 250-299=3 U; > (greater than) 300=4 U and repeat next scheduled time. For consecutive blood sugars >300 mg/dl call MD, ordered 10/16/25 - Humalog 100 U/ML KwikPen insulin, inject 5 units subcutaneously three times daily before meals (8:00 AM, 12:00 PM, 4:00 PM), ordered 10/16/25 - Lantus Solostar 100 U/ML insulin, inject 12 units subcutaneously twice daily (8:00 A.M., 8:00 P.M.), ordered 10/16/25 The October 2025 Medication Administration Record (MAR) indicated Resident B's last blood sugar was checked on 10/12/25 at 7:35 P.M., and documented as 66 milligram (mg)/deciliter (dl). The clinical record indicated no blood sugars were checked and no insulin was given on 10/13/25 (missed 3 doses of routine Humalog 6 units, 1 dose of routine Lantus 10 units, and possible doses of sliding scale insulin during the day shift of 6:00 A.M. until 6:00 P.M.) The Progress Notes lacked documentation about the resident's vital signs, symptoms, missed medications, MD			

	notification about the resident's condition, and what lead to the transfer of Resident B to the ER. During an interview on 10/24/25 at 8:25 A.M., Resident B was observed in her room sitting in the recliner with a Dexcom G7 sensor on her right upper arm, not dated. The resident was pleasantly confused and had no recollection of the recent blood sugar incident or hospital stay. She indicated she didn't live at the facility. During an interview on 10/24/25 at 8:25 A.M., the Director of Nursing (DON) indicated at approximately 7:00 P.M. on 10/13/25, Qualified Medication Aide (QMA) 20 called her at home because Resident B's Dexcom G7 monitor was reading "high". She indicated she told QMA 20 to give routine insulin and then get an accucheck machine, calibrate it, and recheck the resident's blood sugar. The QMA reported to her that the accucheck still read high. The DON called the MD and after 15 minutes, she had not heard back from him so the DON told them to send Resident B to the ER. Later that evening, upon reviewing the lack of documentation, the DON called QMA 8 who was responsible for the resident from 6:00 A.M. until 6:00 P.M. that day. QMA 8 reported that the Resident's blood sugar was 326 at dinner,			

	she gave her the insulin, and when she left, the resident was in her room eating dinner. The DON educated her about the lack of documentation, and at that time, QMA 8 was suspended pending an investigation. The DON indicated she was not sure why the MAR didn't include the actual unit of insulin given to the resident and insulin administration was monitored for being unavailable or refused, but not "missed" medications on a daily basis. During an interview on 10/24/25 at 11:58 A.M., the DON indicated she would expect the QMA/nurse to document notification and any change in the resident's condition. At that time, she indicated staff had gotten too relaxed with documentation and they needed to educate and develop a plan going forward for staff with documentation. At that time, the DON indicated she was instructed by the corporate office not to share her investigation notes for QMA 8 because it was still an ongoing investigation. She indicated QMA 8 was still suspended. The Administrator had been out all week so he has not done the required 5 day follow up on the incident to the IDOH. 2. On 10/22/25 at 10:15 A.M., Resident C's clinical record was			

reviewed. The diagnoses included, but were not limited to, depressive disorder and hypertension.

Physician orders included, but were not limited to:

- Vraylar (an antipsychotic) 1.5 mg (milligrams) daily, dated 9/9/25 through 10/10/25.

- Carvedilol 6.25 mg, take 1 tablet twice daily hold if systolic (top number of blood pressure) is 90 or less, and/or diastolic (bottom number of blood pressure) is 60 or less recheck blood pressure later in the day to make sure it has not increased, dated 6/20/23 through 10/10/25

- Carvedilol 3.125 mg, take 1 tablet twice daily, hold if blood pressure < (less than) 90/50 or heart rate <60, dated 10/10/25.

Resident C's September 2025 through October 2025 medication administration record (MAR) indicated the following related to the medication Vraylar:

9/9/25 blank

9/10/25 not available

9/14/25 not available

9/15/25 blank

	9/17/25 not available 9/18/25 waiting on prior authorization 9/22/25 not available 9/23/25 not available 9/24/25 blank 9/27/25 no medication 9/28/25 needs prior authorization 9/29/25 waiting on prior authorization 10/1/25 needs prior authorization 10/2/25 not available waiting on prior authorization 10/3/25 prior authorization required 10/4/25 need prior authorization 10/5/25 not available 10/6/25 prior authorization required 10/7/25 needs prior authorization 10/8/25 blank			

	A pharmacy recommendation form, dated 10/2/25, included a hand written note from Resident C's physician to continue Vraylar, signed 10/3/25. An order form, dated 10/10/25, indicated to discontinue Resident C's Vraylar as insurance would not pay. Resident C's clinical record lacked any type of notification to the physician related to the medication Vraylar, or that it had been administered sporadically. Resident C's October 2025 MAR indicated the following related to Carvedilol: 10/7/25 at 8:00 P.M., not given. The blood pressure at that time was 92/58 and was not rechecked. 10/9/25 at 8:00 A.M., not given. The blood pressure at that time was 102/48 and was not rechecked. 10/9/25 at 8:00 P.M., not given. The blood pressure at that time was 105/60 (within perimeters to give). 10/10/25 at 8:00 A.M., not given. The blood pressure at that time was 100/59 and was not rechecked. 10/19/25 8:00 A.M., not given. The blood pressure at that time was 116/57 and heart rate was			

	67 (both within perimeters to give). Resident C's clinical record lacked documentation of notification to the physician following the blood pressure readings listed above. On 10/24/25 at 11:51 A.M., the DON indicated when Resident C had been prescribed Vraylar, they had acquired samples of the medication. She indicated staff must have seen the samples on the days the MAR had indicated it was given. She indicated they were waiting on a prior authorization for the medication and insurance had ultimately denied it, so the physician then discontinued it. She indicated at that time that staff should have been entering communication with the physician in the clinical records, but many times would verbally communicate with them if they were in the facility and did not document it. She indicated when a blood pressure is held even though it was in perimeters to give, it was often a judgement call on the nurse's part to not give the medication. 3. On 10/22/25 at 10:00 A.M., Resident D's clinical record was reviewed. The diagnoses included, but were not limited to, diabetes mellitus and hypertension.			

	Current physician orders included, but were not limited to: - Hydralizine 50 mg by mouth three times a day at 7:00 A.M., 3:00 P.M., 11:00 P.M., hold if blood pressure <100/60 and notify nurse if blood pressure is > (greater than) 180/110. Resident D's October 2025 MAR indicated the following related to hydralizine: 10/1/25 at 3:00 P.M., not given. The blood pressure at that time was 108/64 (within perimeters to give). 10/13/25 at 3:00 P.M., not given. The blood pressure at that time was 108/78 (within perimeters to give). Resident D's clinical record lacked documentation of notification to the physician following the blood pressure readings listed above or information as to why the medication was not given despite the blood pressure being within perimeters to be given. 4. On 10/22/25 at 1:00 P.M., Resident E's clinical record was reviewed. The diagnoses included, but were not limited to, diabetes mellitus and hypertension.			

Current physician orders included, but were not limited to:

- Humalog 100U (units)/ml (milliliters) Kwik pen, inject 5 units subcutaneous three times a day with meals, dated 8/6/24.

- Humalog 100U/ml Kwik pen, inject per sliding scale three times daily: 150-200=2U; 201-250=4U; 251-300=6U; 301-350=8U; 351-400=10U, dated 1/3/24.

- Lantus solostar 100U/ml, inject 25 units subcutaneous daily, dated 9/12/25.

- lisinopril - hydrochlorothiazide (HCTZ) 20-25 tablet, take 1 daily, dated 9/2/25.

Resident E's October MAR indicated the following related to the sliding scale Humalog:

10/5/25 at 12:00 P.M., not given. No blood sugar documented at that time.

10/5/25 at 4:00 P.M., given. The blood sugar at that time was 127 (insulin not indicated).

10/10/25 at 12:00 P.M., not given. No blood sugar documented at that time.

10/11/25 at 12:00 P.M., not given. The blood sugar at that time was 150 (within perimeters to give).

	Resident E's clinical record lacked documentation of notification to the physician related to the Humalog listed above. Resident E's October MAR indicated the following related to Lantus: 10/21/25 not given - missed. The clinical record lacked notification to the physician about the missed dose. Resident E's October MAR indicated the following related to lisinopril-hydrochlorothiazide: 10/12/25 not given - held, blood pressure 100/56. The clinical record lacked notification to the physician. 10/17/25 not given - held, blood pressure 102/50. The clinical record lacked notification to the physician. 10/22/25 not given - diastolic is low. The blood pressure at that time was 112/58. The clinical record lacked notification to the physician. On 10/23/25 at 2:37 P.M., a current Medication Administration Policy, last revised January 2024, was provided by the Director of Nursing (DON) and indicated, " ... Medication administration will be administered as ordered by the resident's provider and will			

	be administered by a licensed nurse or a QMA.1. Rights of Medication Administration: All medication will be administered by licensed nursing personnel or QMAs. The rights of medication administration will be adhered to at all times and includes: right resident, right medication, right dose, right route, right time, right response, and right documentation....Documentation of any observed/reported undesirable effects will be included in the clinical record. The resident's primary care provider will be notified immediately if undesirable effects occur, and such notification will be documented in the clinical record ... The provider will be notified by a licensed nurse if: patterns in refusal are noted and/or as warranted per professional clinical judgment and/or as indicated per any provider parameters noted within the medication orders ... " This citation relates to Intake IN00465173. Based on interview and record review, the facility failed to ensure the resident's physician was notified following errors in medication administration for 4 of 4 residents reviewed for pharmacological services. The physician was not notified when blood pressure medication were not given, a newly prescribed			

antipsychotic was not given, blood sugars were not checked, and insulin was not given. This deficient practice resulted in a resident being admitted to the Intensive Care Unit with diabetic ketoacidosis (a life threatening condition when the body lacks insulin, breaks down fat for energy producing acidic ketones that build up in blood) and acute kidney injury. (Resident C, Resident D, Resident E, Resident B)

Findings include:

1. On 10/22/25 at 8:45 A.M., an Indiana Department of Health (IDOH) incident report was reviewed and indicated on 10/13/25 at 8:01 P.M., Resident B was transferred to the Emergency Room (ER) due to an immeasurable, high blood sugar. Upon admission, the resident's blood glucose was 668 milligrams (mg)/deciliter (dl), the resident was diagnosed with diabetic ketoacidosis and an acute kidney injury, and admitted to the Intensive Care Unit (ICU). The resident was readmitted to the facility on 10/15/25.

On 10/22/25 at 10:23 A.M., Resident B's clinical record was reviewed. The diagnoses included, but were not limited to, dementia, hypertension, hypothyroidism, asthma, malignant neoplasm of part of

the bronchus, and diabetes mellitus type II.

The most recent Service Plan, dated 8/22/25, indicated Resident B was able to transfer independently, but her decisions were poor, and required cueing and supervision in planning, organizing, and daily routines.

Current Physician's Orders included, but were not limited to, the following:

- Humalog 100 units (U)/milliliter (ML) KwikPen insulin, inject subcutaneously per sliding scale before meals and at bedtime (8:00 A.M., 12:00 P.M., 4:00 P.M., 8:00 P.M.), under 100=0 U; 101-150=2 U; 151-200=4 U; 201-300=5 U; 301-350=6 U; 351-400=7 U; above 400=8 U and call Medical Doctor (MD), ordered 9/4/25 and discontinued 10/15/25

- Humalog 100 U/ML KwikPen insulin, inject 6 units subcutaneously three times daily before meals (8:00 A.M., 12:00 P.M., 4:00 P.M.), ordered 9/8/25 and discontinued 10/15/25

- Lantus Solostar 100 U/ML insulin, inject 10 units subcutaneously twice daily (8:00 A.M., 8:00 P.M.), give half dose under 140 and skip dose if under 80, ordered 9/8/25 and discontinued 10/15/25

	- Humalog 100 U/ML KwikPen insulin, inject subcutaneously three times daily before meals (8:00 A.M., 12:00 P.M., 4:00 P.M.) per sliding scale, 150-199=1 U; 200-249=2U; 250-299=3 U; > (greater than) 300=4 U and repeat next scheduled time. For consecutive blood sugars >300 mg/dl call MD, ordered 10/16/25 - Humalog 100 U/ML KwikPen insulin, inject 5 units subcutaneously three times daily before meals (8:00 AM, 12:00 PM, 4:00 PM), ordered 10/16/25 - Lantus Solostar 100 U/ML insulin, inject 12 units subcutaneously twice daily (8:00 A.M., 8:00 P.M.), ordered 10/16/25 The October 2025 Medication Administration Record (MAR) indicated Resident B's last blood sugar was checked on 10/12/25 at 7:35 P.M., and documented as 66 milligram (mg)/deciliter (dl). The clinical record indicated no blood sugars were checked and no insulin was given on 10/13/25 (missed 3 doses of routine Humalog 6 units, 1 dose of routine Lantus 10 units, and possible doses of sliding scale insulin during the day shift of 6:00 A.M. until 6:00 P.M.) The Progress Notes lacked			

	documentation about the resident's vital signs, symptoms, missed medications, MD notification about the resident's condition, and what lead to the transfer of Resident B to the ER. During an interview on 10/24/25 at 8:25 A.M., Resident B was observed in her room sitting in the recliner with a Dexcom G7 sensor on her right upper arm, not dated. The resident was pleasantly confused and had no recollection of the recent blood sugar incident or hospital stay. She indicated she didn't live at the facility. During an interview on 10/24/25 at 8:25 A.M., the Director of Nursing (DON) indicated at approximately 7:00 P.M. on 10/13/25, Qualified Medication Aide (QMA) 20 called her at home because Resident B's Dexcom G7 monitor was reading "high". She indicated she told QMA 20 to give routine insulin and then get an accucheck machine, calibrate it, and recheck the resident's blood sugar. The QMA reported to her that the accucheck still read high. The DON called the MD and after 15 minutes, she had not heard back from him so the DON told them to send Resident B to the ER. Later that evening, upon reviewing the lack of documentation, the DON called QMA 8 who was responsible for the resident from 6:00 A.M. until			

	6:00 P.M. that day. QMA 8 reported that the Resident's blood sugar was 326 at dinner, she gave her the insulin, and when she left, the resident was in her room eating dinner. The DON educated her about the lack of documentation, and at that time, QMA 8 was suspended pending an investigation. The DON indicated she was not sure why the MAR didn't include the actual unit of insulin given to the resident and insulin administration was monitored for being unavailable or refused, but not "missed" medications on a daily basis.			

	During an interview on 10/24/25 at 11:58 A.M., the DON indicated she would expect the QMA/nurse to document notification and any change in the resident's condition. At that time, she indicated staff had gotten too relaxed with documentation and they needed to educate and develop a plan going forward for staff with documentation. At that time, the DON indicated she was instructed by the corporate office not to share her investigation notes for QMA 8 because it was still an ongoing investigation. She indicated QMA 8 was still suspended. The Administrator had been out all week so he has not done the required 5 day follow up on the incident to the IDOH. 2. On 10/22/25 at 10:15 A.M., Resident C's clinical record was reviewed. The diagnoses included, but were not limited to, depressive disorder and hypertension. Physician orders included, but were not limited to: - Vraylar (an antipsychotic) 1.5 mg (milligrams) daily, dated 9/9/25 through 10/10/25. - Carvedilol 6.25 mg, take 1 tablet twice daily hold if systolic (top number of blood pressure) is 90 or less, and/or diastolic (bottom number of blood			

pressure) is 60 or less recheck blood pressure later in the day to make sure it has not increased, dated 6/20/23 through 10/10/25

- Carvedilol 3.125 mg, take 1 tablet twice daily, hold if blood pressure < (less than) 90/50 or heart rate <60, dated 10/10/25.

Resident C's September 2025 through October 2025 medication administration record (MAR) indicated the following related to the medication Vraylar:

9/9/25 blank

9/10/25 not available

9/14/25 not available

9/15/25 blank

9/17/25 not available

9/18/25 waiting on prior authorization

9/22/25 not available

9/23/25 not available

9/24/25 blank

9/27/25 no medication

9/28/25 needs prior authorization

9/29/25 waiting on prior authorization

	10/1/25 needs prior authorization 10/2/25 not available waiting on prior authorization 10/3/25 prior authorization required 10/4/25 need prior authorization 10/5/25 not available 10/6/25 prior authorization required 10/7/25 needs prior authorization 10/8/25 blank A pharmacy recommendation form, dated 10/2/25, included a hand written note from Resident C's physician to continue Vraylar, signed 10/3/25. An order form, dated 10/10/25, indicated to discontinue Resident C's Vraylar as insurance would not pay. Resident C's clinical record lacked any type of notification to the physician related to the medication Vraylar, or that it had been administered sporadically. Resident C's October 2025 MAR indicated the following related to Carvedilol: 10/7/25 at 8:00 P.M., not given. The blood pressure at that time			

was 92/58 and was not rechecked.

10/9/25 at 8:00 A.M., not given. The blood pressure at that time was 102/48 and was not rechecked.

10/9/25 at 8:00 P.M., not given. The blood pressure at that time was 105/60 (within perimeters to give).

10/10/25 at 8:00 A.M., not given. The blood pressure at that time was 100/59 and was not rechecked.

10/19/25 8:00 A.M., not given. The blood pressure at that time was 116/57 and heart rate was 67 (both within perimeters to give).

Resident C's clinical record lacked documentation of notification to the physician following the blood pressure readings listed above.

On 10/24/25 at 11:51 A.M., the DON indicated when Resident C had been prescribed Vraylar, they had acquired samples of the medication. She indicated staff must have seen the samples on the days the MAR had indicated it was given. She indicated they were waiting on a prior authorization for the medication and insurance had ultimately denied it, so the physician then discontinued it. She indicated at that time that

staff should have been entering communication with the physician in the clinical records, but many times would verbally communicate with them if they were in the facility and did not document it. She indicated when a blood pressure is held even though it was in perimeters to give, it was often a judgement call on the nurse's part to not give the medication.

3. On 10/22/25 at 10:00 A.M., Resident D's clinical record was reviewed. The diagnoses included, but were not limited to, diabetes mellitus and hypertension.

Current physician orders included, but were not limited to:

- Hydralizine 50 mg by mouth three times a day at 7:00 A.M., 3:00 P.M., 11:00 P.M., hold if blood pressure <100/60 and notify nurse if blood pressure is > (greater than) 180/110.

Resident D's October 2025 MAR indicated the following related to hydralizine:

10/1/25 at 3:00 P.M., not given. The blood pressure at that time was 108/64 (within perimeters to give).

10/13/25 at 3:00 P.M., not given. The blood pressure at that time was 108/78 (within perimeters to give).

	Resident D's clinical record lacked documentation of notification to the physician following the blood pressure readings listed above or information as to why the medication was not given despite the blood pressure being within perimeters to be given. 4. On 10/22/25 at 1:00 P.M., Resident E's clinical record was reviewed. The diagnoses included, but were not limited to, diabetes mellitus and hypertension. Current physician orders included, but were not limited to: - Humalog 100U (units)/ml (milliliters) Kwik pen, inject 5 units subcutaneous three times a day with meals, dated 8/6/24. - Humalog 100U/ml Kwik pen, inject per sliding scale three times daily: 150-200=2U; 201-250=4U; 251-300=6U; 301-350=8U; 351-400=10U, dated 1/3/24. - Lantus solostar 100U/ml, inject 25 units subcutaneous daily, dated 9/12/25. - lisinopril - hydrochlorothiazide (HCTZ) 20-25 tablet, take 1 daily, dated 9/2/25.			

	Resident E's October MAR indicated the following related to the sliding scale Humalog: 10/5/25 at 12:00 P.M., not given. No blood sugar documented at that time. 10/5/25 at 4:00 P.M., given. The blood sugar at that time was 127 (insulin not indicated). 10/10/25 at 12:00 P.M., not given. No blood sugar documented at that time. 10/11/25 at 12:00 P.M., not given. The blood sugar at that time was 150 (within perimeters to give). Resident E's clinical record lacked documentation of notification to the physician related to the Humalog listed above. Resident E's October MAR indicated the following related to Lantus: 10/21/25 not given - missed. The clinical record lacked notification to the physician about the missed dose. Resident E's October MAR indicated the following related to lisinopril-hydrochlorothiazide:			

	10/12/25 not given - held, blood pressure 100/56. The clinical record lacked notification to the physician. 10/17/25 not given - held, blood pressure 102/50. The clinical record lacked notification to the physician. 10/22/25 not given - diastolic is low. The blood pressure at that time was 112/58. The clinical record lacked notification to the physician. On 10/23/25 at 2:37 P.M., a current Medication Administration Policy, last revised January 2024, was provided by the Director of Nursing (DON) and indicated, " ... Medication administration will be administered as ordered by the resident's provider and will be administered by a licensed nurse or a QMA.1. Rights of Medication Administration: All medication will be administered by licensed nursing personnel or QMAs. The rights of medication administration will be adhered to at all times and includes: right resident, right medication, right dose, right route, right time, right response, and right documentation....Documentation of any observed/reported undesirable effects will be included in the clinical record. The resident's primary care provider will be notified immediately if undesirable			

	effects occur, and such notification will be documented in the clinical record ... The provider will be notified by a licensed nurse if: patterns in refusal are noted and/or as warranted per professional clinical judgment and/or as indicated per any provider parameters noted within the medication orders ... " This citation relates to Intake IN00465173. Based on interview and record review, the facility failed to ensure the resident's physician was notified following errors in medication administration for 4 of 4 residents reviewed for pharmacological services. The physician was not notified when blood pressure medication were not given, a newly prescribed antipsychotic was not given, blood sugars were not checked, and insulin was not given. This deficient practice resulted in a resident being admitted to the Intensive Care Unit with diabetic ketoacidosis (a life threatening condition when the body lacks insulin, breaks down fat for energy producing acidic ketones that build up in blood) and acute kidney injury. (Resident C, Resident D, Resident E, Resident B) Findings include: 1. On 10/22/25 at 8:45 A.M., an			

	Indiana Department of Health (IDOH) incident report was reviewed and indicated on 10/13/25 at 8:01 P.M., Resident B was transferred to the Emergency Room (ER) due to an immeasurable, high blood sugar. Upon admission, the resident's blood glucose was 668 milligrams (mg)/deciliter (dl), the resident was diagnosed with diabetic ketoacidosis and an acute kidney injury, and admitted to the Intensive Care Unit (ICU). The resident was readmitted to the facility on 10/15/25. On 10/22/25 at 10:23 A.M., Resident B's clinical record was reviewed. The diagnoses included, but were not limited to, dementia, hypertension, hypothyroidism, asthma, malignant neoplasm of part of the bronchus, and diabetes mellitus type II. The most recent Service Plan, dated 8/22/25, indicated Resident B was able to transfer independently, but her decisions were poor, and required cueing and supervision in planning, organizing, and daily routines. Current Physician's Orders included, but were not limited to, the following: - Humalog 100 units (U)/milliliter (ML) KwikPen insulin, inject subcutaneously per sliding scale			

	before meals and at bedtime (8:00 A.M., 12:00 P.M., 4:00 P.M., 8:00 P.M.), under 100=0 U; 101-150=2 U; 151-200=4 U; 201-300=5 U; 301-350=6 U; 351-400=7 U; above 400=8 U and call Medical Doctor (MD), ordered 9/4/25 and discontinued 10/15/25 - Humalog 100 U/ML KwikPen insulin, inject 6 units subcutaneously three times daily before meals (8:00 A.M., 12:00 P.M., 4:00 P.M.), ordered 9/8/25 and discontinued 10/15/25 - Lantus Solostar 100 U/ML insulin, inject 10 units subcutaneously twice daily (8:00 A.M., 8:00 P.M.), give half dose under 140 and skip dose if under 80, ordered 9/8/25 and discontinued 10/15/25 - Humalog 100 U/ML KwikPen insulin, inject subcutaneously three times daily before meals (8:00 A.M., 12:00 P.M., 4:00 P.M.) per sliding scale, 150-199=1 U; 200-249=2U; 250-299=3 U; > (greater than) 300=4 U and repeat next scheduled time. For consecutive blood sugars >300 mg/dl call MD, ordered 10/16/25 - Humalog 100 U/ML KwikPen insulin, inject 5 units subcutaneously three times daily before meals (8:00 AM, 12:00 PM, 4:00 PM), ordered			

10/16/25

- Lantus Solostar 100 U/ML insulin, inject 12 units subcutaneously twice daily (8:00 A.M., 8:00 P.M.), ordered 10/16/25

The October 2025 Medication Administration Record (MAR) indicated Resident B's last blood sugar was checked on 10/12/25 at 7:35 P.M., and documented as 66 milligram (mg)/deciliter (dl). The clinical record indicated no blood sugars were checked and no insulin was given on 10/13/25 (missed 3 doses of routine Humalog 6 units, 1 dose of routine Lantus 10 units, and possible doses of sliding scale insulin during the day shift of 6:00 A.M. until 6:00 P.M.)

The Progress Notes lacked documentation about the resident's vital signs, symptoms, missed medications, MD notification about the resident's condition, and what lead to the transfer of Resident B to the ER.

During an interview on 10/24/25 at 8:25 A.M., Resident B was observed in her room sitting in the recliner with a Dexcom G7 sensor on her right upper arm, not dated. The resident was pleasantly confused and had no recollection of the recent blood sugar incident or hospital stay. She indicated she didn't live at

	the facility. During an interview on 10/24/25 at 8:25 A.M., the Director of Nursing (DON) indicated at approximately 7:00 P.M. on 10/13/25, Qualified Medication Aide (QMA) 20 called her at home because Resident B's Dexcom G7 monitor was reading "high". She indicated she told QMA 20 to give routine insulin and then get an accucheck machine, calibrate it, and recheck the resident's blood sugar. The QMA reported to her that the accucheck still read high. The DON called the MD and after 15 minutes, she had not heard back from him so the DON told them to send Resident B to the ER. Later that evening, upon reviewing the lack of documentation, the DON called QMA 8 who was responsible for the resident from 6:00 A.M. until 6:00 P.M. that day. QMA 8 reported that the Resident's blood sugar was 326 at dinner, she gave her the insulin, and when she left, the resident was in her room eating dinner. The DON educated her about the lack of documentation, and at that time, QMA 8 was suspended pending an investigation. The DON indicated she was not sure why the MAR didn't include the actual unit of insulin given to the resident and insulin administration was monitored for being unavailable or refused,			

but not "missed" medications on a daily basis.

During an interview on 10/24/25 at 11:58 A.M., the DON indicated she would expect the QMA/nurse to document notification and any change in the resident's condition. At that time, she indicated staff had gotten too relaxed with documentation and they needed to educate and develop a plan going forward for staff with documentation. At that time, the DON indicated she was instructed by the corporate office not to share her investigation notes for QMA 8 because it was still an ongoing investigation. She indicated QMA 8 was still suspended. The Administrator had been out all week so he has not done the required 5 day follow up on the incident to the IDOH.

2. On 10/22/25 at 10:15 A.M., Resident C's clinical record was reviewed. The diagnoses included, but were not limited to, depressive disorder and hypertension.

Physician orders included, but were not limited to:

- Vraylar (an antipsychotic) 1.5 mg (milligrams) daily, dated 9/9/25 through 10/10/25.

- Carvedilol 6.25 mg, take 1 tablet twice daily hold if systolic (top number of blood pressure)

is 90 or less, and/or diastolic (bottom number of blood pressure) is 60 or less recheck blood pressure later in the day to make sure it has not increased, dated 6/20/23 through 10/10/25

- Carvedilol 3.125 mg, take 1 tablet twice daily, hold if blood pressure < (less than) 90/50 or heart rate <60, dated 10/10/25.

Resident C's September 2025 through October 2025 medication administration record (MAR) indicated the following related to the medication Vraylar:

9/9/25 blank

9/10/25 not available

9/14/25 not available

9/15/25 blank

9/17/25 not available

9/18/25 waiting on prior authorization

9/22/25 not available

9/23/25 not available

9/24/25 blank

9/27/25 no medication

9/28/25 needs prior authorization

9/29/25 waiting on prior

	authorization 10/1/25 needs prior authorization 10/2/25 not available waiting on prior authorization 10/3/25 prior authorization required 10/4/25 need prior authorization 10/5/25 not available 10/6/25 prior authorization required 10/7/25 needs prior authorization 10/8/25 blank A pharmacy recommendation form, dated 10/2/25, included a hand written note from Resident C's physician to continue Vraylar, signed 10/3/25. An order form, dated 10/10/25, indicated to discontinue Resident C's Vraylar as insurance would not pay. Resident C's clinical record lacked any type of notification to the physician related to the medication Vraylar, or that it had been administered sporadically. Resident C's October 2025 MAR indicated the following related to Carvedilol:			

	10/7/25 at 8:00 P.M., not given. The blood pressure at that time was 92/58 and was not rechecked. 10/9/25 at 8:00 A.M., not given. The blood pressure at that time was 102/48 and was not rechecked. 10/9/25 at 8:00 P.M., not given. The blood pressure at that time was 105/60 (within perimeters to give). 10/10/25 at 8:00 A.M., not given. The blood pressure at that time was 100/59 and was not rechecked. 10/19/25 8:00 A.M., not given. The blood pressure at that time was 116/57 and heart rate was 67 (both within perimeters to give). Resident C's clinical record lacked documentation of notification to the physician following the blood pressure readings listed above. On 10/24/25 at 11:51 A.M., the DON indicated when Resident C had been prescribed Vraylar, they had acquired samples of the medication. She indicated staff must have seen the samples on the days the MAR had indicated it was given. She indicated they were waiting on a prior authorization for the medication and insurance had ultimately denied it, so the			

physician then discontinued it. She indicated at that time that staff should have been entering communication with the physician in the clinical records, but many times would verbally communicate with them if they were in the facility and did not document it. She indicated when a blood pressure is held even though it was in perimeters to give, it was often a judgement call on the nurse's part to not give the medication.

3. On 10/22/25 at 10:00 A.M., Resident D's clinical record was reviewed. The diagnoses included, but were not limited to, diabetes mellitus and hypertension.

Current physician orders included, but were not limited to:

- Hydralizine 50 mg by mouth three times a day at 7:00 A.M., 3:00 P.M., 11:00 P.M., hold if blood pressure <100/60 and notify nurse if blood pressure is > (greater than) 180/110.

Resident D's October 2025 MAR indicated the following related to hydralizine:

10/1/25 at 3:00 P.M., not given. The blood pressure at that time was 108/64 (within perimeters to give).

10/13/25 at 3:00 P.M., not given. The blood pressure at that time was 108/78 (within

perimeters to give).

Resident D's clinical record lacked documentation of notification to the physician following the blood pressure readings listed above or information as to why the medication was not given despite the blood pressure being within perimeters to be given.

4. On 10/22/25 at 1:00 P.M., Resident E's clinical record was reviewed. The diagnoses included, but were not limited to, diabetes mellitus and hypertension.

Current physician orders included, but were not limited to:

- Humalog 100U (units)/ml (milliliters) Kwik pen, inject 5 units subcutaneous three times a day with meals, dated 8/6/24.

- Humalog 100U/ml Kwik pen, inject per sliding scale three times daily: 150-200=2U; 201-250=4U; 251-300=6U; 301-350=8U; 351-400=10U, dated 1/3/24.

- Lantus solostar 100U/ml, inject 25 units subcutaneous daily, dated 9/12/25.

- lisinopril - hydrochlorothiazide (HCTZ) 20-25 tablet, take 1 daily, dated 9/2/25.

Resident E's October MAR

	indicated the following related to the sliding scale Humalog: 10/5/25 at 12:00 P.M., not given. No blood sugar documented at that time. 10/5/25 at 4:00 P.M., given. The blood sugar at that time was 127 (insulin not indicated). 10/10/25 at 12:00 P.M., not given. No blood sugar documented at that time. 10/11/25 at 12:00 P.M., not given. The blood sugar at that time was 150 (within perimeters to give). Resident E's clinical record lacked documentation of notification to the physician related to the Humalog listed above. Resident E's October MAR indicated the following related to Lantus: 10/21/25 not given - missed. The clinical record lacked notification to the physician about the missed dose. Resident E's October MAR indicated the following related to lisinopril-hydrochlorothiazide: 10/12/25 not given - held, blood pressure 100/56. The clinical record lacked notification to the physician.			

	10/17/25 not given - held, blood pressure 102/50. The clinical record lacked notification to the physician. 10/22/25 not given - diastolic is low. The blood pressure at that time was 112/58. The clinical record lacked notification to the physician.			
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 interview and record review, the facility failed to maintain complete and accurate clinical records for each resident for 4 of 4 resident records reviewed. Medications and treatments were left blank in the clinical records. (Resident C, Resident D, Resident E, Resident B) Findings include:	R 0349	Resident C,D,B and E's clinical record was audited and completed. QMA 8 was terminated. All residents have the potential for the alleged documentation deficient practice to occur. An audit of all residents' clinical records was completed. Any deficient practices were corrected. An in-service was completed by the DON on clinical documentation. Med pass and vital signs reports will be ran and signed every shift and placed in the DON mailbox. The DON will monitor med pass and vital signs reports daily for 4 weeks, 3x week for 4	11/21/2025

	1. On 10/22/25 at 10:15 A.M., Resident C's clinical record was reviewed. The diagnoses included, but were not limited to, depressive disorder and hypertension. Physician orders included, but were not limited to: - Vraylar (an antipsychotic) 1.5 mg (milligrams) daily, dated 9/9/25 through 10/10/25. - Carvedilol (heart medication) 6.25 mg, take 1 tablet twice daily, dated 6/20/23 - 10/10/25. - Aspirin (non-steroidal anti-inflammatory medication) 81 mg, chew 1 tablet daily, dated 2/24/23. - atorvastatin (medication used to lower cholesterol) 80 mg once daily, dated 2/24/23. - Citracal+D (supplement) take 2 tablets daily, dated 7/15/25. - escitalopram (antidepressant) 20 mg once daily, dated 9/9/25. - ezetimibe (medication used to lower cholesterol) 10 mg once daily, dated 2/24/23. - ferrous sulfate (iron supplement) 325 mg, 1 tablet in the morning with breakfast, dated 12/6/23. - check blood pressure and heart rate twice daily, dated		weeks, 2x week for 4 weeks weekly for 4 weeks and monthly for 2 months.	

5/12/23.

- Lasix (diuretic medication) 40 mg once daily, dated 8/17/23.

- omeprazole (medication used to treat reflux) 20 mg once daily, dated 3/6/23.

- potassium chloride (potassium supplement) 10 meq (milliequivalent) once daily, dated 9/13/24.

- Xarelto (blood thinner) 20 mg once daily, dated 2/24/23.

The following were left blank on Resident C's October 2025 medication administration record (MAR):

On 10/8/25 at 8:00 am: Vraylar, Carvedilol, Aspirin, atorvastatin, Citracal+D, escitalopram, ezetimibe, ferrous sulfate, check blood pressure and heart rate twice daily, Lasix, omeprazole, potassium chloride, and Xarelto.

2. On 10/22/25 at 10:00 A.M., Resident D's clinical record was reviewed. The diagnoses included, but were not limited to, diabetes mellitus and hypertension.

Current physician orders included, but were not limited to:

- hydralizine (anti-hypertensive medication) 50 mg by mouth three times a day, dated 9/21/23.

- acidophilus capsule (probiotic medication) by mouth twice daily, dated 10/14/24.

- antifungal 2% powder, apply under bilateral breast folds daily, dated 10/14/24.

- Arthritis pain 650-I, 1 tablet four times daily, dated 11/19/24.

- Aspirin 81 mg once daily, dated 10/14/24.

- cetrizine (allergy medication) 10 mg once daily, dated 10/14/24.

- docusate (stool softner) 100 mg once daily, dated 9/21/23.

- doxycyline 100-I (antibiotic), take 1 tablet daily for 7 days, dated 10/2/25 through 10/9/25.

- folic acid (supplement) 1 mg once daily, dated 9/21/23.

- Lasix 20 mg once daily, dated 9/21/23.

- Incruse ellipta (inhaled medication used treat chronic obstructive pulmonary disease) 62.5 mcg (microgram), inhale 1 puff daily, dated 10/14/24.

- levothyroxine (thyroid medication) 325 mcg, 1 tablet in

the morning at 7:00 A.M., dated 9/21/23.

- metoprolol (heart medication) 25 mg once daily, dated 9/21/23.

- Miralax powder (stool softner), mix 17gm (gram) with liquid and take daily, dated 6/6/25.

- potassium chloride 20meq daily, dated 9/21/23.

- triad wound dressing paste, apply to bilateral buttocks daily, dated 10/14/24.

The following were left blank on Resident D's October 2025 MAR:

On 10/8/25 at 8:00 A.M.: hydralizine, acidophilus capsule, antifungal 2% powder, Arthritis pain, aspirin, cetrizine, docusate, doxycyline, folic acid, Lasix, Incruse ellipta, levothyroxine, metoprolol, Miralax, potassium chloride, and triad wound dressing paste.

Resident D's October MAR included the following that were left blank

On 10/8/25 at 12:00 P.M., arthritis pain

Hydralizine was blank on 10/3/25 at 11:00 P.M., 10/4/25 at 7:00 A.M., 10/8/25 at 3:00 P.M., 10/12/25 at 11:00 P.M., 10/17/25 at 11:00 P.M.,

10/18/25 at 11:00 P.M., and 10/20/25 at 11:00 P.M.

3. On 10/22/25 at 1:00 P.M., Resident E's clinical record was reviewed. The diagnoses included, but were not limited to, diabetes mellitus and hypertension.

Current physician orders included, but were not limited to:

- Humalog 100U (units)/ml (milliliters) Kwik pen, inject 5 units subcutaneous three times a day with meals, dated 8/6/24.

- Humalog 100U/ml Kwik pen, inject per sliding scale three times daily: 150-200=2U; 201-250=4U; 251-300=6U; 301-350=8U; 351-400=10U, dated 1/3/24.

- Lantus solostar 100U/ml, inject 25 units subcutaneous daily, dated 9/12/25.

- lisinopril - hydrochlorothiazide (anti hypertensive medication) 20-25 tablet, take one daily, dated 9/2/25.

- metformin extended release (oral anti-diabetic) 500-I, take two tablets twice daily, dated 9/17/25.

- pioglitazone (oral anti-diabetic) 15 mg, take one tablet once daily, dated 12/11/23.

- Trajenta (anti-diabetic) 5 mg

once daily, dated 10/17/23.

The following were left blank on Resident E's October 2025 MAR:

On 10/8/25 at 8:00 A.M.: Humalog 5 units, Humalog sliding scale, Lantus solostar, lisinopril - hydrochlorothiazide, metformin extended release, pioglitazone, and Trajenta

Resident E's October MAR also included the following that were left blank:

Humalog per sliding scale on 10/4/25 at 12:00 P.M., 10/8/25 at 12:00 P.M., 10/15/25 at 8:00 A.M., and 10/15/25 at 4:00 P.M.

Lantus solostar on 10/15/25 at 8:00 A.M.

4. On 10/22/25 at 10:23 A.M., Resident B's clinical record was reviewed. The diagnoses included, but were not limited to, dementia, hypertension, hypothyroidism, asthma, malignant neoplasm of part of the bronchus, and diabetes mellitus type II.

Current Physician's Orders included, but were not limited to, the following:

- Humalog 100 units (U)/milliliter (ML) KwikPen insulin, inject subcutaneously per sliding scale before meals and at bedtime (8:00 A.M., 12:00 P.M., 4:00

P.M., 8:00 P.M.), under 100=0 U; 101-150=2 U; 151-200=4 U; 201-300=5 U; 301-350=6 U; 351-400=7 U; above 400=8 U and call Medical Doctor (MD), ordered 9/4/25 and discontinued 10/15/25

- Humalog 100 U/ML KwikPen insulin, inject 6 units subcutaneously three times daily before meals (8:00 A.M., 12:00 P.M., 4:00 P.M.), ordered 9/8/25 and discontinued 10/15/25

- Lantus Solostar 100 U/ML insulin, inject 10 units subcutaneously twice daily (8:00 A.M., 8:00 P.M.), give half dose under 140 and skip dose if under 80, ordered 9/8/25 and discontinued 10/15/25

- Humalog 100 U/ML KwikPen insulin, inject subcutaneously three times daily before meals (8:00 A.M., 12:00 P.M., 4:00 P.M.) per sliding scale, 150-199=1 U; 200-249=2U; 250-299=3 U; > (greater than) 300=4 U and repeat next scheduled time. For consecutive blood sugars >300 mg/dl call MD, ordered 10/16/25

- Humalog 100 U/ML KwikPen insulin, inject 5 units subcutaneously three times daily before meals (8:00 AM, 12:00 PM, 4:00 PM), ordered 10/16/25

- Lantus Solostar 100 U/ML

insulin, inject 12 units subcutaneously twice daily (8:00 A.M., 8:00 P.M.), ordered 10/16/25

The October 2025 Medication Administration Record (MAR) indicated Resident B's last blood sugar was checked on 10/12/25 at 7:35 P.M., and documented as 66 milligram (mg)/deciliter (dl). The clinical record indicated no blood sugars were tested and no insulin was given on 10/13/25.

The Progress Notes lacked documentation about the resident's vital signs, symptoms, and physician notification about the resident's condition.

During an interview on 10/24/25 at 8:25 A.M., the Director of Nursing (DON) indicated at approximately 7:00 P.M. on 10/13/25, Qualified Medication Aide (QMA) 20 called her at home because Resident B's Dexcom G7 monitor was reading "high". She indicated she told QMA 20 to give routine insulin and then get an accucheck machine, calibrate it, and recheck the resident's blood sugar. The QMA reported to her that the accucheck still read high. The DON called the Medical Doctor (MD) and after 15 minutes, she had not heard back from him so the DON told them to send Resident B to the ER. Later that evening, upon

	reviewing the lack of documentation, the DON called QMA 8 who was responsible for the resident from 6:00 A.M. until 6:00 P.M. that day. QMA 8 reported that the Resident's blood sugar was 326 at dinner, she gave her the insulin, and when she left, the resident was in her room eating dinner. The DON educated her about the lack of documentation, and at that time, QMA 8 was suspended pending an investigation. The DON indicated she was not sure why the MAR didn't include the actual unit of insulin given to the resident and insulin administration was monitored for being unavailable or refused, but not "missed" medications on a daily basis. On 10/24/25 at 11:51 A.M., the DON indicated the blank spots in the resident's MARs indicated the staff member had forgotten to document that the medication had been administered.			

During an interview on 10/24/25 at 11:58 A.M., the DON indicated she would expect the QMA/nurse to document notification and any change in the resident's condition. At that time, she indicated staff had gotten too relaxed with documentation and they needed to educate and develop a plan going forward for staff with documentation.

On 10/23/25 at 2:37 P.M., a current Medication Administration Policy, last revised January 2024, was provided by the Director of Nursing (DON) and indicated, " ... Medication administration will be administered as ordered by the resident's provider and will be administered by a licensed nurse or a QMA.1. Rights of Medication Administration: All medication will be administered by licensed nursing personnel or QMAs. The rights of medication administration will be adhered to at all times and includes: right resident, right medication, right dose, right route, right time, right response, and right documentation ... At the time of administration, the licensed nurse or QMA administering the medication will document the administration in the medication (or treatment) administration record that includes the following: a. Resident Name b. Name of Medication or Treatment c. Date, Time d.

Route e. Dosage (if applicable) f. Name or initials of the person administering the drug or treatment ... "

This citation relates to Intake IN00465438.

Based on interview and record review, the facility failed to maintain complete and accurate clinical records for each resident for 4 of 4 resident records reviewed. Medications and treatments were left blank in the clinical records. (Resident C, Resident D, Resident E, Resident B)

Findings include:

1. On 10/22/25 at 10:15 A.M., Resident C's clinical record was reviewed. The diagnoses included, but were not limited to, depressive disorder and hypertension.

Physician orders included, but were not limited to:

- Vraylar (an antipsychotic) 1.5 mg (milligrams) daily, dated 9/9/25 through 10/10/25.

- Carvedilol (heart medication) 6.25 mg, take 1 tablet twice daily, dated 6/20/23 - 10/10/25.

- Aspirin (non-steroidal anti-inflammatory medication) 81 mg, chew 1 tablet daily, dated 2/24/23.

- atorvastatin (medication used to lower cholesterol) 80 mg once daily, dated 2/24/23.

- Citracal+D (supplement) take 2 tablets daily, dated 7/15/25.

- escitalopram (antidepressant) 20 mg once daily, dated 9/9/25.

- ezetimibe (medication used to lower cholesterol) 10 mg once daily, dated 2/24/23.

- ferrous sulfate (iron supplement) 325 mg, 1 tablet in the morning with breakfast, dated 12/6/23.

- check blood pressure and heart rate twice daily, dated 5/12/23.

- Lasix (diuretic medication) 40 mg once daily, dated 8/17/23.

- omeprazole (medication used to treat reflux) 20 mg once daily, dated 3/6/23.

- potassium chloride (potassium supplement) 10 meq (milliequivalent) once daily, dated 9/13/24.

- Xarelto (blood thinner) 20 mg once daily, dated 2/24/23.

The following were left blank on Resident C's October 2025 medication administration record (MAR):

On 10/8/25 at 8:00 am: Vraylar,

Carvedilol, Aspirin, atorvastatin, Citracal+D, escitalopram, ezetimibe, ferrous sulfate, check blood pressure and heart rate twice daily, Lasix, omeprazole, potassium chloride, and Xarelto.

2. On 10/22/25 at 10:00 A.M., Resident D's clinical record was reviewed. The diagnoses included, but were not limited to, diabetes mellitus and hypertension.

Current physician orders included, but were not limited to:

- hydralizine (anti-hypertensive medication) 50 mg by mouth three times a day, dated 9/21/23.

- acidophilus capsule (probiotic medication) by mouth twice daily, dated 10/14/24.

- antifungal 2% powder, apply under bilateral breast folds daily, dated 10/14/24.

- Arthritis pain 650-I, 1 tablet four times daily, dated 11/19/24.

- Aspirin 81 mg once daily, dated 10/14/24.

- cetrizine (allergy medication) 10 mg once daily, dated 10/14/24.

- docusate (stool softner) 100 mg once daily, dated 9/21/23.

- doxycyline 100-I (antibiotic),

take 1 tablet daily for 7 days, dated 10/2/25 through 10/9/25.

- folic acid (supplement) 1 mg once daily, dated 9/21/23.

- Lasix 20 mg once daily, dated 9/21/23.

- Incruse ellipta (inhaled medication used treat chronic obstructive pulmonary disease) 62.5 mcg (microgram), inhale 1 puff daily, dated 10/14/24.

- levothyroxine (thyroid medication) 325 mcg, 1 tablet in the morning at 7:00 A.M., dated 9/21/23.

- metoprolol (heart medication) 25 mg once daily, dated 9/21/23.

- Miralax powder (stool softner), mix 17gm (gram) with liquid and take daily, dated 6/6/25.

- potassium chloride 20meq daily, dated 9/21/23.

- triad wound dressing paste, apply to bilateral buttocks daily, dated 10/14/24.

The following were left blank on Resident D's October 2025 MAR:

On 10/8/25 at 8:00 A.M.: hydralizine, acidophilus capsule, antifungal 2% powder, Arthritis pain, aspirin, cetrizine, docusate, doxycyline, folic acid,

Lasix, Incruse ellipta, levothyroxine, metoprolol, Miralax, potassium chloride, and triad wound dressing paste.

Resident D's October MAR included the following that were left blank

On 10/8/25 at 12:00 P.M., arthritis pain

Hydralizine was blank on 10/3/25 at 11:00 P.M., 10/4/25 at 7:00 A.M., 10/8/25 at 3:00 P.M., 10/12/25 at 11:00 P.M., 10/17/25 at 11:00 P.M., 10/18/25 at 11:00 P.M., and 10/20/25 at 11:00 P.M.

3. On 10/22/25 at 1:00 P.M., Resident E's clinical record was reviewed. The diagnoses included, but were not limited to, diabetes mellitus and hypertension.

Current physician orders included, but were not limited to:

- Humalog 100U (units)/ml (milliliters) Kwik pen, inject 5 units subcutaneous three times a day with meals, dated 8/6/24.

- Humalog 100U/ml Kwik pen, inject per sliding scale three times daily: 150-200=2U; 201-250=4U; 251-300=6U; 301-350=8U; 351-400=10U, dated 1/3/24.

- Lantus solostar 100U/ml, inject 25 units subcutaneous daily,

dated 9/12/25.

- lisinopril - hydrochlorothiazide (anti hypertensive medication) 20-25 tablet, take one daily, dated 9/2/25.

- metformin extended release (oral anti-diabetic) 500-I, take two tablets twice daily, dated 9/17/25.

- pioglitazone (oral anti-diabetic) 15 mg, take one tablet once daily, dated 12/11/23.

- Trajenta (anti-diabetic) 5 mg once daily, dated 10/17/23.

The following were left blank on Resident E's October 2025 MAR:

On 10/8/25 at 8:00 A.M.: Humalog 5 units, Humalog sliding scale, Lantus solostar, lisinopril - hydrochlorothiazide, metformin extended release, pioglitazone, and Trajenta

Resident E's October MAR also included the following that were left blank:

Humalog per sliding scale on 10/4/25 at 12:00 P.M., 10/8/25 at 12:00 P.M., 10/15/25 at 8:00 A.M., and 10/15/25 at 4:00 P.M.

Lantus solostar on 10/15/25 at 8:00 A.M.

4. On 10/22/25 at 10:23 A.M., Resident B's clinical record was

reviewed. The diagnoses included, but were not limited to, dementia, hypertension, hypothyroidism, asthma, malignant neoplasm of part of the bronchus, and diabetes mellitus type II.

Current Physician's Orders included, but were not limited to, the following:

- Humalog 100 units (U)/milliliter (ML) KwikPen insulin, inject subcutaneously per sliding scale before meals and at bedtime (8:00 A.M., 12:00 P.M., 4:00 P.M., 8:00 P.M.), under 100=0 U; 101-150=2 U; 151-200=4 U; 201-300=5 U; 301-350=6 U; 351-400=7 U; above 400=8 U and call Medical Doctor (MD), ordered 9/4/25 and discontinued 10/15/25

- Humalog 100 U/ML KwikPen insulin, inject 6 units subcutaneously three times daily before meals (8:00 A.M., 12:00 P.M., 4:00 P.M.), ordered 9/8/25 and discontinued 10/15/25

- Lantus Solostar 100 U/ML insulin, inject 10 units subcutaneously twice daily (8:00 A.M., 8:00 P.M.), give half dose under 140 and skip dose if under 80, ordered 9/8/25 and discontinued 10/15/25

- Humalog 100 U/ML KwikPen insulin, inject subcutaneously three times daily before meals

(8:00 A.M., 12:00 P.M., 4:00 P.M.) per sliding scale, 150-199=1 U; 200-249=2U; 250-299=3 U; > (greater than) 300=4 U and repeat next scheduled time. For consecutive blood sugars >300 mg/dl call MD, ordered 10/16/25

- Humalog 100 U/ML KwikPen insulin, inject 5 units subcutaneously three times daily before meals (8:00 AM, 12:00 PM, 4:00 PM), ordered 10/16/25

- Lantus Solostar 100 U/ML insulin, inject 12 units subcutaneously twice daily (8:00 A.M., 8:00 P.M.), ordered 10/16/25

The October 2025 Medication Administration Record (MAR) indicated Resident B's last blood sugar was checked on 10/12/25 at 7:35 P.M., and documented as 66 milligram (mg)/deciliter (dl). The clinical record indicated no blood sugars were tested and no insulin was given on 10/13/25.

The Progress Notes lacked documentation about the resident's vital signs, symptoms, and physician notification about the resident's condition.

During an interview on 10/24/25 at 8:25 A.M., the Director of Nursing (DON) indicated at approximately 7:00 P.M. on 10/13/25, Qualified Medication

Aide (QMA) 20 called her at home because Resident B's Dexcom G7 monitor was reading "high". She indicated she told QMA 20 to give routine insulin and then get an accucheck machine, calibrate it, and recheck the resident's blood sugar. The QMA reported to her that the accucheck still read high. The DON called the Medical Doctor (MD) and after 15 minutes, she had not heard back from him so the DON told them to send Resident B to the ER. Later that evening, upon reviewing the lack of documentation, the DON called QMA 8 who was responsible for the resident from 6:00 A.M. until 6:00 P.M. that day. QMA 8 reported that the Resident's blood sugar was 326 at dinner, she gave her the insulin, and when she left, the resident was in her room eating dinner. The DON educated her about the lack of documentation, and at that time, QMA 8 was suspended pending an investigation. The DON indicated she was not sure why the MAR didn't include the actual unit of insulin given to the resident and insulin administration was monitored for being unavailable or refused, but not "missed" medications on a daily basis.

On 10/24/25 at 11:51 A.M., the DON indicated the blank spots in the resident's MARs indicated

the staff member had forgotten to document that the medication had been administered.

During an interview on 10/24/25 at 11:58 A.M., the DON indicated she would expect the QMA/nurse to document notification and any change in the resident's condition. At that time, she indicated staff had gotten too relaxed with documentation and they needed to educate and develop a plan going forward for staff with documentation.

On 10/23/25 at 2:37 P.M., a current Medication Administration Policy, last revised January 2024, was provided by the Director of Nursing (DON) and indicated, " ... Medication administration will be administered as ordered by the resident's provider and will be administered by a licensed nurse or a QMA.1. Rights of Medication Administration: All medication will be administered by licensed nursing personnel or QMAs. The rights of medication administration will be adhered to at all times and includes: right resident, right medication, right dose, right route, right time, right response, and right documentation ... At the time of administration, the licensed nurse or QMA administering the medication will document the administration in the medication (or treatment) administration

record that includes the following: a. Resident Name b. Name of Medication or Treatment c. Date, Time d. Route e. Dosage (if applicable) f. Name or initials of the person administering the drug or treatment ... "

This citation relates to Intake IN00465438.

Based on interview and record review, the facility failed to maintain complete and accurate clinical records for each resident for 4 of 4 resident records reviewed. Medications and treatments were left blank in the clinical records. (Resident C, Resident D, Resident E, Resident B)

Findings include:

1. On 10/22/25 at 10:15 A.M., Resident C's clinical record was reviewed. The diagnoses included, but were not limited to, depressive disorder and hypertension.

Physician orders included, but were not limited to:

- Vraylar (an antipsychotic) 1.5 mg (milligrams) daily, dated 9/9/25 through 10/10/25.

- Carvedilol (heart medication) 6.25 mg, take 1 tablet twice daily, dated 6/20/23 - 10/10/25.

- Aspirin (non-steroidal

anti-inflammatory medication) 81 mg, chew 1 tablet daily, dated 2/24/23.

- atorvastatin (medication used to lower cholesterol) 80 mg once daily, dated 2/24/23.

- Citracal+D (supplement) take 2 tablets daily, dated 7/15/25.

- escitalopram (antidepressant) 20 mg once daily, dated 9/9/25.

- ezetimibe (medication used to lower cholesterol) 10 mg once daily, dated 2/24/23.

- ferrous sulfate (iron supplement) 325 mg, 1 tablet in the morning with breakfast, dated 12/6/23.

- check blood pressure and heart rate twice daily, dated 5/12/23.

- Lasix (diuretic medication) 40 mg once daily, dated 8/17/23.

- omeprazole (medication used to treat reflux) 20 mg once daily, dated 3/6/23.

- potassium chloride (potassium supplement) 10 meq (milliequivalent) once daily, dated 9/13/24.

- Xarelto (blood thinner) 20 mg once daily, dated 2/24/23.

The following were left blank on Resident C's October 2025

medication administration record (MAR):

On 10/8/25 at 8:00 am: Vraylar, Carvedilol, Aspirin, atorvastatin, Citracal+D, escitalopram, ezetimibe, ferrous sulfate, check blood pressure and heart rate twice daily, Lasix, omeprazole, potassium chloride, and Xarelto.

2. On 10/22/25 at 10:00 A.M., Resident D's clinical record was reviewed. The diagnoses included, but were not limited to, diabetes mellitus and hypertension.

Current physician orders included, but were not limited to:

- hydralizine (anti-hypertensive medication) 50 mg by mouth three times a day, dated 9/21/23.

- acidophilus capsule (probiotic medication) by mouth twice daily, dated 10/14/24.

- antifungal 2% powder, apply under bilateral breast folds daily, dated 10/14/24.

- Arthritis pain 650-I, 1 tablet four times daily, dated 11/19/24.

- Aspirin 81 mg once daily, dated 10/14/24.

- cetrizine (allergy medication) 10 mg once daily, dated 10/14/24.

- docusate (stool softner) 100 mg once daily, dated 9/21/23.

- doxycyline 100-I (antibiotic), take 1 tablet daily for 7 days, dated 10/2/25 through 10/9/25.

- folic acid (supplement) 1 mg once daily, dated 9/21/23.

- Lasix 20 mg once daily, dated 9/21/23.

- Incruse ellipta (inhaled medication used treat chronic obstructive pulmonary disease) 62.5 mcg (microgram), inhale 1 puff daily, dated 10/14/24.

- levothyroxine (thyroid medication) 325 mcg, 1 tablet in the morning at 7:00 A.M., dated 9/21/23.

- metoprolol (heart medication) 25 mg once daily, dated 9/21/23.

- Miralax powder (stool softner), mix 17gm (gram) with liquid and take daily, dated 6/6/25.

- potassium chloride 20meq daily, dated 9/21/23.

- triad wound dressing paste, apply to bilateral buttocks daily, dated 10/14/24.

The following were left blank on Resident D's October 2025 MAR:

On 10/8/25 at 8:00 A.M.:

hydralizine, acidophilus capsule, antifungal 2% powder, Arthritis pain, aspirin, cetrizine, docusate, doxycyline, folic acid, Lasix, Incruse ellipta, levothyroxine, metoprolol, Miralax, potassium chloride, and triad wound dressing paste.

Resident D's October MAR included the following that were left blank

On 10/8/25 at 12:00 P.M., arthritis pain

Hydralizine was blank on 10/3/25 at 11:00 P.M., 10/4/25 at 7:00 A.M., 10/8/25 at 3:00 P.M., 10/12/25 at 11:00 P.M., 10/17/25 at 11:00 P.M., 10/18/25 at 11:00 P.M., and 10/20/25 at 11:00 P.M.

3. On 10/22/25 at 1:00 P.M., Resident E's clinical record was reviewed. The diagnoses included, but were not limited to, diabetes mellitus and hypertension.

Current physician orders included, but were not limited to:

- Humalog 100U (units)/ml (milliliters) Kwik pen, inject 5 units subcutaneous three times a day with meals, dated 8/6/24.

- Humalog 100U/ml Kwik pen, inject per sliding scale three times daily: 150-200=2U; 201-250=4U; 251-300=6U; 301-350=8U; 351-400=10U,

dated 1/3/24.

- Lantus solostar 100U/ml, inject 25 units subcutaneous daily, dated 9/12/25.

- lisinopril - hydrochlorothiazide (anti hypertensive medication) 20-25 tablet, take one daily, dated 9/2/25.

- metformin extended release (oral anti-diabetic) 500-I, take two tablets twice daily, dated 9/17/25.

- pioglitazone (oral anti-diabetic) 15 mg, take one tablet once daily, dated 12/11/23.

- Trajenta (anti-diabetic) 5 mg once daily, dated 10/17/23.

The following were left blank on Resident E's October 2025 MAR:

On 10/8/25 at 8:00 A.M.: Humalog 5 units, Humalog sliding scale, Lantus solostar, lisinopril - hydrochlorothiazide, metformin extended release, pioglitazone, and Trajenta

Resident E's October MAR also included the following that were left blank:

Humalog per sliding scale on 10/4/25 at 12:00 P.M., 10/8/25 at 12:00 P.M., 10/15/25 at 8:00 A.M., and 10/15/25 at 4:00 P.M.

Lantus solostar on 10/15/25 at

8:00 A.M.

4. On 10/22/25 at 10:23 A.M., Resident B's clinical record was reviewed. The diagnoses included, but were not limited to, dementia, hypertension, hypothyroidism, asthma, malignant neoplasm of part of the bronchus, and diabetes mellitus type II.

Current Physician's Orders included, but were not limited to, the following:

- Humalog 100 units (U)/milliliter (ML) KwikPen insulin, inject subcutaneously per sliding scale before meals and at bedtime (8:00 A.M., 12:00 P.M., 4:00 P.M., 8:00 P.M.), under 100=0 U; 101-150=2 U; 151-200=4 U; 201-300=5 U; 301-350=6 U; 351-400=7 U; above 400=8 U and call Medical Doctor (MD), ordered 9/4/25 and discontinued 10/15/25

- Humalog 100 U/ML KwikPen insulin, inject 6 units subcutaneously three times daily before meals (8:00 A.M., 12:00 P.M., 4:00 P.M.), ordered 9/8/25 and discontinued 10/15/25

- Lantus Solostar 100 U/ML insulin, inject 10 units subcutaneously twice daily (8:00 A.M., 8:00 P.M.), give half dose under 140 and skip dose if under 80, ordered 9/8/25 and discontinued 10/15/25

- Humalog 100 U/ML KwikPen insulin, inject subcutaneously three times daily before meals (8:00 A.M., 12:00 P.M., 4:00 P.M.) per sliding scale, 150-199=1 U; 200-249=2U; 250-299=3 U; > (greater than) 300=4 U and repeat next scheduled time. For consecutive blood sugars >300 mg/dl call MD, ordered 10/16/25

- Humalog 100 U/ML KwikPen insulin, inject 5 units subcutaneously three times daily before meals (8:00 AM, 12:00 PM, 4:00 PM), ordered 10/16/25

- Lantus Solostar 100 U/ML insulin, inject 12 units subcutaneously twice daily (8:00 A.M., 8:00 P.M.), ordered 10/16/25

The October 2025 Medication Administration Record (MAR) indicated Resident B's last blood sugar was checked on 10/12/25 at 7:35 P.M., and documented as 66 milligram (mg)/deciliter (dl). The clinical record indicated no blood sugars were tested and no insulin was given on 10/13/25.

The Progress Notes lacked documentation about the resident's vital signs, symptoms, and physician notification about the resident's condition.

During an interview on 10/24/25 at 8:25 A.M., the Director of Nursing (DON) indicated at approximately 7:00 P.M. on 10/13/25, Qualified Medication Aide (QMA) 20 called her at home because Resident B's Dexcom G7 monitor was reading "high". She indicated she told QMA 20 to give routine insulin and then get an accucheck machine, calibrate it, and recheck the resident's blood sugar. The QMA reported to her that the accucheck still read high. The DON called the Medical Doctor (MD) and after 15 minutes, she had not heard back from him so the DON told them to send Resident B to the ER. Later that evening, upon reviewing the lack of documentation, the DON called QMA 8 who was responsible for the resident from 6:00 A.M. until 6:00 P.M. that day. QMA 8 reported that the Resident's blood sugar was 326 at dinner, she gave her the insulin, and when she left, the resident was in her room eating dinner. The DON educated her about the lack of documentation, and at that time, QMA 8 was suspended pending an investigation. The DON indicated she was not sure why

the MAR didn't include the actual unit of insulin given to the resident and insulin administration was monitored for being unavailable or refused, but not "missed" medications on a daily basis.

On 10/24/25 at 11:51 A.M., the DON indicated the blank spots in the resident's MARs indicated the staff member had forgotten to document that the medication had been administered.

During an interview on 10/24/25 at 11:58 A.M., the DON indicated she would expect the QMA/nurse to document notification and any change in the resident's condition. At that time, she indicated staff had gotten too relaxed with documentation and they needed to educate and develop a plan going forward for staff with documentation.

On 10/23/25 at 2:37 P.M., a current Medication Administration Policy, last revised January 2024, was provided by the Director of Nursing (DON) and indicated, " ... Medication administration will be administered as ordered by the resident's provider and will be administered by a licensed nurse or a QMA.1. Rights of Medication Administration: All medication will be administered by licensed nursing personnel or QMAs. The rights of medication

administration will be adhered to at all times and includes: right resident, right medication, right dose, right route, right time, right response, and right documentation ... At the time of administration, the licensed nurse or QMA administering the medication will document the administration in the medication (or treatment) administration record that includes the following: a. Resident Name b. Name of Medication or Treatment c. Date, Time d. Route e. Dosage (if applicable) f. Name or initials of the person administering the drug or treatment ... "

This citation relates to Intake IN00465438.

Based on interview and record review, the facility failed to maintain complete and accurate clinical records for each resident for 4 of 4 resident records reviewed. Medications and treatments were left blank in the clinical records. (Resident C, Resident D, Resident E, Resident B)

Findings include:

1. On 10/22/25 at 10:15 A.M., Resident C's clinical record was reviewed. The diagnoses included, but were not limited to, depressive disorder and hypertension.

Physician orders included, but

were not limited to:

- Vraylar (an antipsychotic) 1.5 mg (milligrams) daily, dated 9/9/25 through 10/10/25.

- Carvedilol (heart medication) 6.25 mg, take 1 tablet twice daily, dated 6/20/23 - 10/10/25.

- Aspirin (non-steroidal anti-inflammatory medication) 81 mg, chew 1 tablet daily, dated 2/24/23.

- atorvastatin (medication used to lower cholesterol) 80 mg once daily, dated 2/24/23.

- Citracal+D (supplement) take 2 tablets daily, dated 7/15/25.

- escitalopram (antidepressant) 20 mg once daily, dated 9/9/25.

- ezetimibe (medication used to lower cholesterol) 10 mg once daily, dated 2/24/23.

- ferrous sulfate (iron supplement) 325 mg, 1 tablet in the morning with breakfast, dated 12/6/23.

- check blood pressure and heart rate twice daily, dated 5/12/23.

- Lasix (diuretic medication) 40 mg once daily, dated 8/17/23.

- omeprazole (medication used to treat reflux) 20 mg once daily, dated 3/6/23.

- potassium chloride (potassium supplement) 10 meq (milliequivalent) once daily, dated 9/13/24.

- Xarelto (blood thinner) 20 mg once daily, dated 2/24/23.

The following were left blank on Resident C's October 2025 medication administration record (MAR):

On 10/8/25 at 8:00 am: Vraylar, Carvedilol, Aspirin, atorvastatin, Citracal+D, escitalopram, ezetimibe, ferrous sulfate, check blood pressure and heart rate twice daily, Lasix, omeprazole, potassium chloride, and Xarelto.

2. On 10/22/25 at 10:00 A.M., Resident D's clinical record was reviewed. The diagnoses included, but were not limited to, diabetes mellitus and hypertension.

Current physician orders included, but were not limited to:

- hydralizine (anti-hypertensive medication) 50 mg by mouth three times a day, dated 9/21/23.

- acidophilus capsule (probiotic medication) by mouth twice daily, dated 10/14/24.

- antifungal 2% powder, apply under bilateral breast folds daily, dated 10/14/24.

- Arthritis pain 650-I, 1 tablet four times daily, dated 11/19/24.

- Aspirin 81 mg once daily, dated 10/14/24.

- cetrizine (allergy medication) 10 mg once daily, dated 10/14/24.

- docusate (stool softner) 100 mg once daily, dated 9/21/23.

- doxycyline 100-I (antibiotic), take 1 tablet daily for 7 days, dated 10/2/25 through 10/9/25.

- folic acid (supplement) 1 mg once daily, dated 9/21/23.

- Lasix 20 mg once daily, dated 9/21/23.

- Incruse ellipta (inhaled medication used treat chronic obstructive pulmonary disease) 62.5 mcg (microgram), inhale 1 puff daily, dated 10/14/24.

- levothyroxine (thyroid medication) 325 mcg, 1 tablet in the morning at 7:00 A.M., dated 9/21/23.

- metoprolol (heart medication) 25 mg once daily, dated 9/21/23.

- Miralax powder (stool softner), mix 17gm (gram) with liquid and

take daily, dated 6/6/25.

- potassium chloride 20meq daily, dated 9/21/23.

- triad wound dressing paste, apply to bilateral buttocks daily, dated 10/14/24.

The following were left blank on Resident D's October 2025 MAR:

On 10/8/25 at 8:00 A.M.: hydralizine, acidophilus capsule, antifungal 2% powder, Arthritis pain, aspirin, cetrizine, docusate, doxycyline, folic acid, Lasix, Incruse ellipta, levothyroxine, metoprolol, Miralax, potassium chloride, and triad wound dressing paste.

Resident D's October MAR included the following that were left blank

On 10/8/25 at 12:00 P.M., arthritis pain

Hydralizine was blank on 10/3/25 at 11:00 P.M., 10/4/25 at 7:00 A.M., 10/8/25 at 3:00 P.M., 10/12/25 at 11:00 P.M., 10/17/25 at 11:00 P.M., 10/18/25 at 11:00 P.M., and 10/20/25 at 11:00 P.M.

3. On 10/22/25 at 1:00 P.M., Resident E's clinical record was reviewed. The diagnoses included, but were not limited to, diabetes mellitus and hypertension.

Current physician orders included, but were not limited to:

- Humalog 100U (units)/ml (milliliters) Kwik pen, inject 5 units subcutaneous three times a day with meals, dated 8/6/24.

- Humalog 100U/ml Kwik pen, inject per sliding scale three times daily: 150-200=2U; 201-250=4U; 251-300=6U; 301-350=8U; 351-400=10U, dated 1/3/24.

- Lantus solostar 100U/ml, inject 25 units subcutaneous daily, dated 9/12/25.

- lisinopril - hydrochlorothiazide (anti hypertensive medication) 20-25 tablet, take one daily, dated 9/2/25.

- metformin extended release (oral anti-diabetic) 500-I, take two tablets twice daily, dated 9/17/25.

- pioglitazone (oral anti-diabetic) 15 mg, take one tablet once daily, dated 12/11/23.

- Trajenta (anti-diabetic) 5 mg once daily, dated 10/17/23.

The following were left blank on

Resident E's October 2025 MAR:

On 10/8/25 at 8:00 A.M.: Humalog 5 units, Humalog sliding scale, Lantus solostar, lisinopril - hydrochlorothiazide, metformin extended release, pioglitazone, and Trajenta

Resident E's October MAR also included the following that were left blank:

Humalog per sliding scale on 10/4/25 at 12:00 P.M., 10/8/25 at 12:00 P.M., 10/15/25 at 8:00 A.M., and 10/15/25 at 4:00 P.M.

Lantus solostar on 10/15/25 at 8:00 A.M.

4. On 10/22/25 at 10:23 A.M., Resident B's clinical record was reviewed. The diagnoses included, but were not limited to, dementia, hypertension, hypothyroidism, asthma, malignant neoplasm of part of the bronchus, and diabetes mellitus type II.

Current Physician's Orders included, but were not limited to, the following:

- Humalog 100 units (U)/milliliter (ML) KwikPen insulin, inject subcutaneously per sliding scale before meals and at bedtime (8:00 A.M., 12:00 P.M., 4:00 P.M., 8:00 P.M.), under 100=0 U; 101-150=2 U; 151-200=4 U; 201-300=5 U; 301-350=6 U;

351-400=7 U; above 400=8 U and call Medical Doctor (MD), ordered 9/4/25 and discontinued 10/15/25

- Humalog 100 U/ML KwikPen insulin, inject 6 units subcutaneously three times daily before meals (8:00 A.M., 12:00 P.M., 4:00 P.M.), ordered 9/8/25 and discontinued 10/15/25

- Lantus Solostar 100 U/ML insulin, inject 10 units subcutaneously twice daily (8:00 A.M., 8:00 P.M.), give half dose under 140 and skip dose if under 80, ordered 9/8/25 and discontinued 10/15/25

- Humalog 100 U/ML KwikPen insulin, inject subcutaneously three times daily before meals (8:00 A.M., 12:00 P.M., 4:00 P.M.) per sliding scale, 150-199=1 U; 200-249=2U; 250-299=3 U; > (greater than) 300=4 U and repeat next scheduled time. For consecutive blood sugars >300 mg/dl call MD, ordered 10/16/25

- Humalog 100 U/ML KwikPen insulin, inject 5 units subcutaneously three times daily before meals (8:00 AM, 12:00 PM, 4:00 PM), ordered 10/16/25

- Lantus Solostar 100 U/ML insulin, inject 12 units subcutaneously twice daily (8:00 A.M., 8:00 P.M.), ordered

10/16/25

The October 2025 Medication Administration Record (MAR) indicated Resident B's last blood sugar was checked on 10/12/25 at 7:35 P.M., and documented as 66 milligram (mg)/deciliter (dl). The clinical record indicated no blood sugars were tested and no insulin was given on 10/13/25.

The Progress Notes lacked documentation about the resident's vital signs, symptoms, and physician notification about the resident's condition.

During an interview on 10/24/25 at 8:25 A.M., the Director of Nursing (DON) indicated at approximately 7:00 P.M. on 10/13/25, Qualified Medication Aide (QMA) 20 called her at home because Resident B's Dexcom G7 monitor was reading "high". She indicated she told QMA 20 to give routine insulin and then get an accucheck machine, calibrate it, and recheck the resident's blood sugar. The QMA reported to her that the accucheck still read high. The DON called the Medical Doctor (MD) and after 15 minutes, she had not heard back from him so the DON told them to send Resident B to the ER. Later that evening, upon reviewing the lack of documentation, the DON called QMA 8 who was responsible for

the resident from 6:00 A.M. until 6:00 P.M. that day. QMA 8 reported that the Resident's blood sugar was 326 at dinner, she gave her the insulin, and when she left, the resident was in her room eating dinner. The DON educated her about the lack of documentation, and at that time, QMA 8 was suspended pending an investigation. The DON indicated she was not sure why the MAR didn't include the actual unit of insulin given to the resident and insulin administration was monitored for being unavailable or refused, but not "missed" medications on a daily basis.

On 10/24/25 at 11:51 A.M., the DON indicated the blank spots in the resident's MARs indicated the staff member had forgotten to document that the medication had been administered.

During an interview on 10/24/25 at 11:58 A.M., the DON indicated she would expect the QMA/nurse to document notification and any change in the resident's condition. At that time, she indicated staff had gotten too relaxed with documentation and they needed to educate and develop a plan going forward for staff with documentation.

On 10/23/25 at 2:37 P.M., a current Medication

	Administration Policy, last revised January 2024, was provided by the Director of Nursing (DON) and indicated, " ... Medication administration will be administered as ordered by the resident's provider and will be administered by a licensed nurse or a QMA.1. Rights of Medication Administration: All medication will be administered by licensed nursing personnel or QMAs. The rights of medication administration will be adhered to at all times and includes: right resident, right medication, right dose, right route, right time, right response, and right documentation ... At the time of administration, the licensed nurse or QMA administering the medication will document the administration in the medication (or treatment) administration record that includes the following: a. Resident Name b. Name of Medication or Treatment c. Date, Time d. Route e. Dosage (if applicable) f. Name or initials of the person administering the drug or treatment ... " This citation relates to Intake IN00465438.				

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 SIGNATUREJanie Swedenburg	TITLEExecutive Director	(X6) DATE11/14/2025