STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARHURST OF DYER	1763 CALUMET AVENUE, DYER, , 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00457475 and IN00458996. Complaint IN00457475 - State deficiencies related to the allegations are cited at R0240, R0295, and R0349. Complaint IN00458996 - State deficiencies related to the allegations are cited at R0217 and R0240. Survey dates: July 14 and 15, 2025 Facility number: 014415 Residential Census: 76 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 7/21/25.	R 0000		

R 0029	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(d) (d) Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality. Based on observation, record review, and interview, the facility failed to ensure a resident's dignity was maintained related to covering urinary drainage bags for 2 of 11 residents reviewed for dignity. (Residents C and D) Findings include: 1. During observations on 7/14/25 at 1:00 p.m. and 6:00 p.m., Resident C was observed in bed. At those times, an indwelling Foley catheter was hanging on the side of the bed without a dignity bag, allowing the urine inside the bag to be visible. During an observation on 7/15/25 at 11:00 a.m., the resident was observed in bed. At that time an indwelling foley catheter was hanging on the side of the bed without a dignity bag, allowing the urine inside the bag to be visible. The record for Resident C was reviewed on 7/15/25 at 9:20 a.m. Diagnoses included but were not limited to neurogenic bladder, renal impairment and	R 0029	**R029** **Resident Rights:** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident C and D have been issued dignity bags for storing/covering their urinary drainage bags. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken**; All residents with urinary drainage bags, that are not properly covered, have the potential to be affected by the same deficient practice. **What measures will**	07/30/2025

	high blood pressure. The current Service Plan indicated the resident's catheter care was to be provided daily at 7:00 a.m., 3:00 p.m., and 11:00 p.m. and the urinary drainage bag was to be emptied every shift. The 7/2025 Physician Order Sheet indicated catheter care was to be provided every shift. During an interview on 7/15/25 at 11:25 a.m., the Director of Nursing indicated the foley catheter bag should be covered, and she thought hospice changed the bag monthly. 2. During observations on 7/14/25 at 4:15 p.m. and 5:00 p.m., Resident D was observed sitting in a chair in her room. An indwelling Foley catheter bag tubing were observed on the floor in a pillow case. At 5:55 p.m., the urinary drainage bag was now attached to the side of the chair and out of the pillow case. The urine in the bag could be seen by anyone entering the room. The record for Resident D was reviewed on 7/14/25 at 5:00 p.m. Diagnoses included but were not limited to, dementia, anxiety, major depressive disorder and diabetes. A Service Plan, dated 7/14/25,		**be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** DON/Designee will ensure dignity bags are consistently in place for all residents with drainage bags. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** All staff were in-serviced on maintaining resident's dignity as it pertains to Resident Rights. All staff were in-serviced on proper storage/covering urinary drainage bags to support and maintain resident dignity. DON/Designee will implement Visual Rounding Checklist to ensure dignity bags are in use. Rounding will be	

	indicated foley catheter care to be completed every shift. During an interview on 7/15/25 at 11:30 a.m., the Director of Nursing indicated she was aware the urinary drainage bag was not in a dignity bag and changed it out the previous evening on 7/14/25. Based on observation, record review, and interview, the facility failed to ensure a resident's dignity was maintained related to covering urinary drainage bags for 2 of 11 residents reviewed for dignity. (Residents C and D) Findings include: 1. During observations on 7/14/25 at 1:00 p.m. and 6:00 p.m., Resident C was observed in bed. At those times, an indwelling Foley catheter was hanging on the side of the bed without a dignity bag, allowing the urine inside the bag to be visible. During an observation on 7/15/25 at 11:00 a.m., the resident was observed in bed. At that time an indwelling foley catheter was hanging on the side of the bed without a dignity bag, allowing the urine inside the bag to be visible. The record for Resident C was reviewed on 7/15/25 at 9:20 a.m. Diagnoses included but		conducted upon admission and monthly thereafter. DON/Designee will update service plan to reflect the need for a dignity bag. **By what date the systemic changes will be completed.** 7/30/25	

	were not limited to neurogenic bladder, renal impairment and high blood pressure. The current Service Plan indicated the resident's catheter care was to be provided daily at 7:00 a.m., 3:00 p.m., and 11:00 p.m. and the urinary drainage bag was to be emptied every shift. The 7/2025 Physician Order Sheet indicated catheter care was to be provided every shift. During an interview on 7/15/25 at 11:25 a.m., the Director of Nursing indicated the foley catheter bag should be covered, and she thought hospice changed the bag monthly. 2. During observations on 7/14/25 at 4:15 p.m. and 5:00 p.m., Resident D was observed sitting in a chair in her room. An indwelling Foley catheter bag tubing were observed on the floor in a pillow case. At 5:55 p.m., the urinary drainage bag was now attached to the side of the chair and out of the pillow case. The urine in the bag could be seen by anyone entering the room.			

	The record for Resident D was reviewed on 7/14/25 at 5:00 p.m. Diagnoses included but were not limited to, dementia, anxiety, major depressive disorder and diabetes. A Service Plan, dated 7/14/25, indicated foley catheter care to be completed every shift. During an interview on 7/15/25 at 11:30 a.m., the Director of Nursing indicated she was aware the urinary drainage bag was not in a dignity bag and changed it out the previous evening on 7/14/25.			
R 0035	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(j)(1-7) (j) Residents have the right to the following: (1) Participate in the development of his or her service plan and in any updates of that service plan. (2) Choose the attending physician and other providers of services, including arranging for on-site health care services unless contrary to facility policy. Any limitation on the resident ' s right to choose the attending physician or service provider, or both, shall be clearly stated in the admission agreement. Other providers of services, within the content of this subsection, may include home health care agencies, hospice care services, or hired individuals.	R 0035	**R035** **Resident Rights:** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 12’s dog has updated vaccination record on file as of 7/19/25. The dog received Rabies Canine/Feline 3-year vaccination on 7/19/25.	07/30/2025

	(3) Have a pet of his or her choice, so long as the pet does not pose a health or safety risk to residents, staff, or visitors or a risk to property unless prohibited by facility policy. Any limitation on the resident ' s right to have a pet of his or her choice shall be clearly stated in the admission agreement. (4) Refuse any treatment or service, including medication. (5) Be informed of the medical consequences of a refusal under subdivision (4) and have such data recorded in his or her clinical record if treatment or medication is administered by the facility. (6) Be afforded confidentiality of treatment. (7) Participate or refuse to participate in experimental research. There must be written acknowledgement of informed consent prior to participation in research activities. Based on record review and interview, the facility failed to ensure a rabies vaccine was up to date for 1 of 11 sampled residents who housed a dog. (Resident 12) Finding includes: The vaccinations for the pets who resided in the facility were reviewed on 7/15/25 at 8:32 a.m. Resident 12's dog had an		**How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken**; All current residents housing pets have the potential to be affected by the same deficient practice. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** ED/Designee implement Pet Immunization Tracking Log. Each vaccination record will be logged based on expiration date. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur,**	

	expired rabies vaccine dated 11/8/24. During an interview on 7/15/25 at 11:00 a.m., the Executive Director indicated she was unaware the dog's rabies vaccine had expired. Based on record review and interview, the facility failed to ensure a rabies vaccine was up to date for 1 of 11 sampled residents who housed a dog. (Resident 12) Finding includes: The vaccinations for the pets who resided in the facility were reviewed on 7/15/25 at 8:32 a.m. Resident 12's dog had an expired rabies vaccine dated 11/8/24. During an interview on 7/15/25 at 11:00 a.m., the Executive Director indicated she was unaware the dog's rabies vaccine had expired.		**i.e., what quality assurance program will be put into place; and** ED/Designee will review and update the Pet Immunization Tracking Log upon admission and annually thereafter. **By what date the systemic changes will be completed.** 7/30/25	

R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential	R 0217	**R217** **Evaluation:** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The service plan for Resident M was reviewed and signed by Resident M on 7/15/25. Resident M service plan was updated on 7/16/25 to reflect the intervention of checking Resident M's blood sugar. Resident was notified of the update to the service plan and verbalized agreement. The service plan for Resident G was updated on 7/30/25 to reflect the Physician Order referring to the use of Lorazepam for Resident G's diagnosis of Anxiety. POA was notified of the update to the service plan and verbalized agreement. DON reviewed Service Plan for Resident B with POA on 7/30/25. POA requested	07/30/2025

	nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on observation, record review, and interview, the facility failed to ensure the resident's service plan was up to date and signed by the resident related to blood glucose, antianxiety medication, padded armrests and feet elevated on leg rests for 3 of 11 sampled residents. (Residents B, G, and H) Findings include: 1. During observations on 7/14/25 at 1:12 p.m., 4:30 p.m. and 5:30 p.m., Resident B was observed dressed and sitting up in a wheelchair with the legs rests down but both of her feet were behind them. During an observation on 7/15/25 at 11:00 a.m., the resident was observed sitting up in her wheelchair with her feet on both leg rests, however, the left leg was sliding down between them causing a reddened area and an indentation in the left lower leg. The arm rests on the wheelchair were not padded. On 7/15/25 at 11:42 a.m., the Director of Nursing (DON) in training was asked to take the resident into her room. At that		armrests be removed from interventions. Service plan updated to reflect the same. POA in agreement with placing pillow under legs of Resident B to prevent them from sliding off. This intervention was added to the revised service plan on 7/30/25. POA verbalized agreement to the updated service plan. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents have the potential to be affected by the same deficient practice. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur.** DON/Designee will audit residents Service	

	time, the DON in training was asked to remove the resident's left leg from in between the leg rests. There was an indentation and redness observed to the leg. The DON in training placed a pillow under the legs to prevent them from sliding off. The record for Resident B was reviewed on 7/14/25 at 2:15 p.m. Diagnoses included, but were not limited to, heart disease, high blood pressure, osteoarthritis, and dementia. The Service Plan, dated 3/11/25, indicated the resident was dependent on staff for transfers and a Hoyer (mechanical) lift was needed for all transfers. The nursing approaches were to make sure the leg rests were on the wheelchair at all times. A Nurse's Note, dated 5/5/25 at 6:30 a.m., indicated the resident's left elbow was observed with edema and bruising and the resident had complaints of pain. A Nurse's Note, dated 5/5/25 at 7:45 a.m., indicated orders were received to obtain a stat (immediate) x-ray of the left elbow.		Plans monthly ensure Service Plan is signed and revised to reflect current needs and preferences of residents. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** Ongoing Service Plans will be updated upon change of condition, every 6 months and annually. **By what date the systemic changes will be completed.** 7/30/25	

Nurse's Notes, dated 5/5/25 at 11:15 a.m., indicated the x-ray results showed an acute fracture of the left elbow and orders for a sling were obtained.

An Incident Report prepared by the facility indicated the resident sustained a left elbow fracture. The interventions were to pad the wheelchair armrests to prevent further injury.

During an interview on 7/15/25 at 1:15 p.m., the Director of Nursing had no additional information to provide.

2. The record for Resident G was reviewed on 7/14/25 at 5:40 p.m. Diagnoses included, but were not limited to, anxiety, dementia and depression.

A Physician's Order, dated 2/10/25, indicated Lorazepam (an antianxiety medication) 0.5 milligrams (mg) three times a day prn (as needed) for anxiety.

A Service Plan, dated 6/5/25, indicated there was no documentation of the resident's anxiety and the use of the Lorazepam.

The Medication Administration Record (MAR) indicated the Lorazepam was administered by nursing staff on the following days:

March 2025

	- 3/26/25 at 11:45 p.m., 3/28/25 at 10:39 p.m., and 3/30/25 at 2:14 a.m. April 2025 - 4/3/25 at 10:08 p.m., 4/4/25 at 7:12 p.m., 4/5/25 at 10:52 p.m., 4/6/25 at 7:42 p.m., 4/7/25 at 8:30 p.m., 4/11/25 at 3:04 a.m., and 4/14/25 at 8:13 p.m. June 2025 - 6/2/25 at 12:15 a.m., 6/11/25 at 4:54 p.m., 6/24/25 at 10:25 p.m., 6/25/25 at 7:18 p.m., and 6/26/25 at 8:15 p.m. During an interview on 7/15/25 at 1:50 p.m., the Director of Nursing had no additional information to provide. 3. The record for Resident H was reviewed on 7/14/25 at 1:40 p.m. Diagnoses included, but were not limited to, chronic kidney disease, liver cancer, and diabetes. The 4/30/25 Admission Assessment indicated the resident was cognitively intact for daily decision making and required minimal assistance with activities of daily living. A 5/1/25 Physician's Order indicated the resident was to receive insulin per a sliding scale based on her blood sugar three times a day.			

The June and July 2025 Medication Administration Records indicated the nursing staff had been checking the resident's blood sugar three times a day.

The 4/30/25 Service Plan was not signed until 7/15/25 and lacked the intervention of checking the resident's blood sugar.

During an interview on 7/15/25 at 1:50 p.m., the Director of Nursing indicated the residents usually signed their service plans on admission, but it was missed. When informed of the lack of blood sugar checks on the service plan, no further information was received.

This citation relates to Complaint IN00458996.

Based on observation, record review, and interview, the facility failed to ensure the resident's service plan was up to date and signed by the resident related to blood glucose, antianxiety medication, padded armrests and feet elevated on leg rests for 3 of 11 sampled residents. (Residents B, G, and H)

Findings include:

1. During observations on 7/14/25 at 1:12 p.m., 4:30 p.m. and 5:30 p.m., Resident B was observed dressed and sitting up in a wheelchair with the legs

rests down but both of her feet were behind them.

During an observation on 7/15/25 at 11:00 a.m., the resident was observed sitting up in her wheelchair with her feet on both leg rests, however, the left leg was sliding down between them causing a reddened area and an indentation in the left lower leg. The arm rests on the wheelchair were not padded.

On 7/15/25 at 11:42 a.m., the Director of Nursing (DON) in training was asked to take the resident into her room. At that time, the DON in training was asked to remove the resident's left leg from in between the leg rests. There was an indentation and redness observed to the leg. The DON in training placed a pillow under the legs to prevent them from sliding off.

The record for Resident B was reviewed on 7/14/25 at 2:15 p.m. Diagnoses included, but were not limited to, heart disease, high blood pressure, osteoarthritis, and dementia.

The Service Plan, dated 3/11/25, indicated the resident was dependent on staff for transfers and a Hoyer (mechanical) lift was needed for all transfers. The nursing approaches were to make sure the leg rests were on the

	wheelchair at all times. A Nurse's Note, dated 5/5/25 at 6:30 a.m., indicated the resident's left elbow was observed with edema and bruising and the resident had complaints of pain. A Nurse's Note, dated 5/5/25 at 7:45 a.m., indicated orders were received to obtain a stat (immediate) x-ray of the left elbow. Nurse's Notes, dated 5/5/25 at 11:15 a.m., indicated the x-ray results showed an acute fracture of the left elbow and orders for a sling were obtained. An Incident Report prepared by the facility indicated the resident sustained a left elbow fracture. The interventions were to pad the wheelchair armrests to prevent further injury. During an interview on 7/15/25 at 1:15 p.m., the Director of Nursing had no additional information to provide. 2. The record for Resident G was reviewed on 7/14/25 at 5:40 p.m. Diagnoses included, but were not limited to, anxiety, dementia and depression.			

	A Physician's Order, dated 2/10/25, indicated Lorazepam (an antianxiety medication) 0.5 milligrams (mg) three times a day prn (as needed) for anxiety. A Service Plan, dated 6/5/25, indicated there was no documentation of the resident's anxiety and the use of the Lorazepam. The Medication Administration Record (MAR) indicated the Lorazepam was administered by nursing staff on the following days: March 2025 - 3/26/25 at 11:45 p.m., 3/28/25 at 10:39 p.m., and 3/30/25 at 2:14 a.m. April 2025 - 4/3/25 at 10:08 p.m., 4/4/25 at 7:12 p.m., 4/5/25 at 10:52 p.m., 4/6/25 at 7:42 p.m., 4/7/25 at 8:30 p.m., 4/11/25 at 3:04 a.m., and 4/14/25 at 8:13 p.m. June 2025 - 6/2/25 at 12:15 a.m., 6/11/25 at 4:54 p.m., 6/24/25 at 10:25 p.m., 6/25/25 at 7:18 p.m., and 6/26/25 at 8:15 p.m. During an interview on 7/15/25 at 1:50 p.m., the Director of Nursing had no additional information to provide.			

	3. The record for Resident H was reviewed on 7/14/25 at 1:40 p.m. Diagnoses included, but were not limited to, chronic kidney disease, liver cancer, and diabetes. The 4/30/25 Admission Assessment indicated the resident was cognitively intact for daily decision making and required minimal assistance with activities of daily living. A 5/1/25 Physician's Order indicated the resident was to receive insulin per a sliding scale based on her blood sugar three times a day. The June and July 2025 Medication Administration Records indicated the nursing staff had been checking the resident's blood sugar three times a day. The 4/30/25 Service Plan was not signed until 7/15/25 and lacked the intervention of checking the resident's blood sugar. During an interview on 7/15/25 at 1:50 p.m., the Director of Nursing indicated the residents usually signed their service plans on admission, but it was missed. When informed of the lack of blood sugar checks on the service plan, no further information was received. This citation relates to			

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During an observation on 7/15/25 at 11:00 a.m., the resident was observed sitting up in her wheelchair with her feet on both leg rests, however, the left leg was sliding down between them causing a reddened area and an indentation in the left lower leg. The arm rests on the wheelchair were not padded.

On 7/15/25 at 11:42 a.m., the Director of Nursing (DON) in training was asked to take the resident into her room. At that time, the DON in training was asked to remove the resident's left leg from in between the leg rests. There was an indentation and redness observed to the

leg. The DON in training placed a pillow under the legs to prevent them from sliding off.

The record for Resident B was reviewed on 7/14/25 at 2:15 p.m. Diagnoses included, but were not limited to, heart disease, high blood pressure, osteoarthritis, and dementia.

The Service Plan, dated 3/11/25, indicated the resident was dependent on staff for transfers and a Hoyer (mechanical) lift was needed for all transfers. The nursing approaches were to make sure the leg rests were on the wheelchair at all times.

A Nurse's Note, dated 5/5/25 at 6:30 a.m., indicated the resident's left elbow was observed with edema and bruising and the resident had complaints of pain.

A Nurse's Note, dated 5/5/25 at 7:45 a.m., indicated orders were received to obtain a stat (immediate) x-ray of the left elbow.

Nurse's Notes, dated 5/5/25 at 11:15 a.m., indicated the x-ray results showed an acute fracture of the left elbow and orders for a sling were obtained.

An Incident Report prepared by the facility indicated the resident sustained a left elbow fracture. The interventions were to pad

	the wheelchair armrests to prevent further injury. During an interview on 7/15/25 at 1:15 p.m., the Director of Nursing had no additional information to provide. 2. The record for Resident G was reviewed on 7/14/25 at 5:40 p.m. Diagnoses included, but were not limited to, anxiety, dementia and depression. A Physician's Order, dated 2/10/25, indicated Lorazepam (an antianxiety medication) 0.5 milligrams (mg) three times a day prn (as needed) for anxiety. A Service Plan, dated 6/5/25, indicated there was no documentation of the resident's anxiety and the use of the Lorazepam. The Medication Administration Record (MAR) indicated the Lorazepam was administered by nursing staff on the following days: March 2025 - 3/26/25 at 11:45 p.m., 3/28/25 at 10:39 p.m., and 3/30/25 at 2:14 a.m. April 2025 - 4/3/25 at 10:08 p.m., 4/4/25 at 7:12 p.m., 4/5/25 at 10:52 p.m., 4/6/25 at 7:42 p.m., 4/7/25 at 8:30 p.m., 4/11/25 at 3:04 a.m.,			

	and 4/14/25 at 8:13 p.m. June 2025 - 6/2/25 at 12:15 a.m., 6/11/25 at 4:54 p.m., 6/24/25 at 10:25 p.m., 6/25/25 at 7:18 p.m., and 6/26/25 at 8:15 p.m. During an interview on 7/15/25 at 1:50 p.m., the Director of Nursing had no additional information to provide. 3. The record for Resident H was reviewed on 7/14/25 at 1:40 p.m. Diagnoses included, but were not limited to, chronic kidney disease, liver cancer, and diabetes. The 4/30/25 Admission Assessment indicated the resident was cognitively intact for daily decision making and required minimal assistance with activities of daily living. A 5/1/25 Physician's Order indicated the resident was to receive insulin per a sliding scale based on her blood sugar three times a day. The June and July 2025 Medication Administration Records indicated the nursing staff had been checking the resident's blood sugar three times a day. The 4/30/25 Service Plan was not signed until 7/15/25 and lacked the intervention of			

checking the resident's blood sugar.

During an interview on 7/15/25 at 1:50 p.m., the Director of Nursing indicated the residents usually signed their service plans on admission, but it was missed. When informed of the lack of blood sugar checks on the service plan, no further information was received.

This citation relates to Complaint IN00458996.

Based on observation, record review, and interview, the facility failed to ensure the resident's service plan was up to date and signed by the resident related to blood glucose, antianxiety medication, padded armrests and feet elevated on leg rests for 3 of 11 sampled residents. (Residents B, G, and H)

Findings include:

1. During observations on 7/14/25 at 1:12 p.m., 4:30 p.m. and 5:30 p.m., Resident B was observed dressed and sitting up in a wheelchair with the legs rests down but both of her feet were behind them.

During an observation on 7/15/25 at 11:00 a.m., the resident was observed sitting up in her wheelchair with her feet on both leg rests, however, the left leg was sliding down between them causing a

reddened area and an indentation in the left lower leg. The arm rests on the wheelchair were not padded.

On 7/15/25 at 11:42 a.m., the Director of Nursing (DON) in training was asked to take the resident into her room. At that time, the DON in training was asked to remove the resident's left leg from in between the leg rests. There was an indentation and redness observed to the leg. The DON in training placed a pillow under the legs to prevent them from sliding off.

The record for Resident B was reviewed on 7/14/25 at 2:15 p.m. Diagnoses included, but were not limited to, heart disease, high blood pressure, osteoarthritis, and dementia.

The Service Plan, dated 3/11/25, indicated the resident was dependent on staff for transfers and a Hoyer (mechanical) lift was needed for all transfers. The nursing approaches were to make sure the leg rests were on the wheelchair at all times.

A Nurse's Note, dated 5/5/25 at 6:30 a.m., indicated the resident's left elbow was observed with edema and bruising and the resident had complaints of pain.

A Nurse's Note, dated 5/5/25 at 7:45 a.m., indicated orders were

	received to obtain a stat (immediate) x-ray of the left elbow. Nurse's Notes, dated 5/5/25 at 11:15 a.m., indicated the x-ray results showed an acute fracture of the left elbow and orders for a sling were obtained. An Incident Report prepared by the facility indicated the resident sustained a left elbow fracture. The interventions were to pad the wheelchair armrests to prevent further injury. During an interview on 7/15/25 at 1:15 p.m., the Director of Nursing had no additional information to provide. 2. The record for Resident G was reviewed on 7/14/25 at 5:40 p.m. Diagnoses included, but were not limited to, anxiety, dementia and depression. A Physician's Order, dated 2/10/25, indicated Lorazepam (an antianxiety medication) 0.5 milligrams (mg) three times a day prn (as needed) for anxiety. A Service Plan, dated 6/5/25, indicated there was no documentation of the resident's anxiety and the use of the Lorazepam. The Medication Administration Record (MAR) indicated the Lorazepam was administered by nursing staff on the following			

days:

March 2025

- 3/26/25 at 11:45 p.m., 3/28/25 at 10:39 p.m., and 3/30/25 at 2:14 a.m.

April 2025

- 4/3/25 at 10:08 p.m., 4/4/25 at 7:12 p.m., 4/5/25 at 10:52 p.m., 4/6/25 at 7:42 p.m., 4/7/25 at 8:30 p.m., 4/11/25 at 3:04 a.m., and 4/14/25 at 8:13 p.m.

June 2025

- 6/2/25 at 12:15 a.m., 6/11/25 at 4:54 p.m., 6/24/25 at 10:25 p.m., 6/25/25 at 7:18 p.m., and 6/26/25 at 8:15 p.m.

During an interview on 7/15/25 at 1:50 p.m., the Director of Nursing had no additional information to provide.

3. The record for Resident H was reviewed on 7/14/25 at 1:40 p.m. Diagnoses included, but were not limited to, chronic kidney disease, liver cancer, and diabetes.

The 4/30/25 Admission Assessment indicated the resident was cognitively intact for daily decision making and required minimal assistance with activities of daily living.

A 5/1/25 Physician's Order indicated the resident was to

	receive insulin per a sliding scale based on her blood sugar three times a day. The June and July 2025 Medication Administration Records indicated the nursing staff had been checking the resident's blood sugar three times a day. The 4/30/25 Service Plan was not signed until 7/15/25 and lacked the intervention of checking the resident's blood sugar. During an interview on 7/15/25 at 1:50 p.m., the Director of Nursing indicated the residents usually signed their service plans on admission, but it was missed. When informed of the lack of blood sugar checks on the service plan, no further information was received. This citation relates to Complaint IN00458996.			
R 0240	Health Services - Deficiency 410 IAC 16.2-5-4(d) (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. 2. During an observation on 7/14/25 at 1:00 p.m., Resident C was observed in bed. During an interview at that time, the	R 0240	**R240** **Health Services:**	07/30/2025

	resident indicated he stayed in bed most of the time, because he could not get up by himself anymore. He had to use the Hoyer lift if he wanted to get up. He also indicated he could not move in the bed my himself and needed assistance to be repositioned. The record for Resident C was reviewed on 7/15/25 at 9:20 a.m. Diagnoses included but were not limited to neurogenic bladder, renal impairment and high blood pressure. The current Service Plan indicated the resident needed full assistance with dressing, bathing, and personal hygiene. The nursing interventions were to check on the resident and provide care needs every two hours as well as turn and reposition the resident every 2 hours while in bed. The current 7/2025 Physician Order Statement, indicated "Safety Check, please check on me and provide care needs every 2 hours. Please turn and reposition me every 2 hours while I am in bed. Dressing Assistance, please help me get dressed and ready for the day. Please help me get undressed and ready for bed. I am a Hoyer lift for all transfers. Personal Hygiene, I need someone to assist with all aspects of my personal hygiene. Skin		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident E Resident C Resident B Resident D **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents have the potential to be affected by the same deficient practice. All nursing personnel were in-serviced on maintaining regulatory compliance ensuring accurate, thorough,	

	Breakdown Risk, please turn and reposition me every 2 hours while in bed. Please make sure I have my heel protectors on while in bed." The care task section completed by the CNAs on the Treatment Record indicated the following: - Safety Checks were blank and not completed on 3/14 at 1:00 p.m., 3/20 at 1:00 p.m., 3:00 p.m. and 5:00 p.m., 3/21 and 3/22 at 1:00 p.m., 3/26 at 9:00 a.m., 11:00 a.m. and 1:00 p.m., 3/27 at 3:00 p.m., and 9:00 p.m., 4/15 at 9:00 p.m., 4/16 at 5:00 p.m., 7:00 p.m., 9:00 p.m., and 11:00 p.m., 4/17 at 1:00 a.m., 3:00 a.m., 5:00 a.m., 4/26 at 11:00 p.m., 4/27 at 1:00 a.m., 3:00 a.m., 5:00 a.m., 4/29 at 5:00 a.m., 5/1 at 11:00 p.m., 5/9 at 11:00 p.m., 5/10 at 1:00 a.m., 3:00 a.m. and 5:00 a.m., 7:00 p.m. 9:00 p.m. 11:00 p.m., 5/11 at 1:00 a.m., 3:00 a.m., 5:00 a.m., 6/4 at 11:00 p.m., 6/5 at 1:00 a.m., 3:00 a.m. 5:00 a.m., 6/7 at 11:00 p.m., 6/8 at 1:00 a.m., 3:00 a.m., 5:00 a.m., 6/9 at 3:00 p.m., 5:00 p.m., 7:00 p.m., 9:00 p.m., 6/10 at 7:00 p.m., 9:00 p.m., 6/12 at 11:00 p.m., 6/12 at 1:00 a.m., 3:00 a.m., 5:00 a.m., 6/14 at 5:00 p.m., 7:00 p.m., 6/15 at 5:00 a.m. and 9:00 p.m., 6/20 at 11:00 p.m., 6/21 at 1:00 a.m., 3:00 a.m., 5:00 a.m., 6/22 at 7:00 a.m., 9:00 a.m.,11:00 a.m., 1:00 p.m., 6/23 at 11:00 p.m.,		and timely clinical documentation to support continuity of care. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** All nursing personnel were in-serviced on maintaining regulatory compliance ensuring accurate, thorough, and timely clinical documentation to support continuity of care. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** DON/Designee will conduct ongoing monitoring of compliance via audit tool to ensure adherence,	

	6/25 at 1:00 a.m., 3:00 a.m., 5:00 a.m., 11:00 p.m., 6/26 at 1:00 a.m., 3:00 a.m., 5:00 a.m., 6/27 at 1:00 a.m., 3:00 a.m., 5:00 a.m.,11:00 p.m., and 6/28/25 at 1:00 a.m., 3:00 a.m., and 5:00 a.m. - Personal Hygiene was not documented as being completed at 7:30 a.m. on 6/22/25, and at 8:30 p.m. on 3/7, 3/27, 4/15, 4/16, 5/10, 6/9, 6/10, and 6/15/25. - Dressing Assistance was not documented as being completed at 7:00 a.m. on 6/22/25 and at 8:00 p.m. on 3/3, 3/7, 3/27, 4/16, 5/10, 6/9, and 6/10/25. - Skin Breakdown Risk was not documented as being completed at 3:00 p.m. on 3/27 and 6/9/25 and at 11:00 p.m. on 3/19, 4/16, 4/26, 5/1, 5/9, 5/10, 6/4, 6/7, 6/12, 6/20, 6/23, 6/24, and 6/27/25. During an interview on 7/15/25 at 1:15 p.m., the Director of Nursing had no additional information to provide. 3. The record for Resident B was reviewed on 7/14/25 at 2:15 p.m. Diagnoses included, but were not limited to, heart disease, high blood pressure, osteoarthritis, and dementia. The Service Plan, dated 3/11/25, indicated the resident		with follow-up education and counseling provided as needed to address any gaps in compliance. **By what date the systemic changes will be completed.** **7/30/25**	

	was dependent on staff for transfers and a Hoyer lift was needed for all transfer. The nursing approaches were to make sure the leg rests were on the wheelchair at all times. The resident also needed full assistance with all aspects of using the bathroom. The resident was to be assisted with using the toilet daily at 7:00 a.m., 11:00 a.m., 1:00 p.m., 3:00 p.m., 5:00 p.m., 7:00 p.m., and 9:00 p.m. The care section completed by the CNAs on the Treatment Record indicated the use of the bathroom was not blank and not documented on the following dates and times: - 7:00 a.m. at 6/21, and 6/29/25 - 11:00 a.m. at 5/20, 6/6, 6/21, and 6/29/25 - 1:00 p.m. at 5/20, 6/4, 6/6, 6/19, 6/21, and 6/29/25 - 3:00 p.m. at 5/22/25 - 5:00 p.m. at 5/22, and 7/6/25 - 7:00 p.m. at 5/22, and 7/6/25 - 9:00 p.m. at 5/22, 6/13, 6/29, and 7/6/25 During an interview on 7/15/25 at 1:15 p.m., the Director of Nursing had no additional information to provide.			

	4. During an observation on 7/14/25 at 4:15 p.m. and 5:00 p.m., Resident D was observed sitting in a chair in her room. An indwelling Foley catheter bag and tubing were observed on the floor in a pillow case. The record for Resident D was reviewed on 7/14/25 at 5:00 p.m. Diagnoses included but were not limited to, dementia, anxiety, major depressive disorder, and diabetes. The resident returned to the facility on 7/3/25 from a rehabilitation center with a Foley catheter. A Service Plan, dated 7/14/25, indicated Foley catheter care was to be completed every shift. The care task section completed by the CNAs on the Treatment Record indicated catheter care had not been completed from 7/3-7/14/25. During an interview on 7/15/25 at 1:30 p.m., the Director of Nursing indicated she had put the catheter care orders in the computer the previous evening on 7/14/25. This citation relates to Complaints IN00457475 and IN00458996. Based on observation, record review and interview, personal care and assistance with			

activities of daily living (ADLs) related to Foley (urinary) catheter care, dressing, safety checks, skin checks, incontinence care, and personal hygiene were not documented as being completed for 4 of 11 sampled residents. (Residents E, C, B, and D)

Findings include:

1. The record for Resident E was reviewed on 7/14/25 at 4:47 p.m. Diagnoses included, but were not limited to, type 2 diabetes and hypertension.

The current Physician's Order Summary (POS) indicated the resident was to receive Foley catheter care every shift.

The July 2025 Treatment Administration Record (TAR) indicated the resident did not receive Foley catheter care on the following dates and times:

- 7/11/25 at 11:00 p.m.

- 7/12/25 at 1:00 a.m., 3:00 a.m., 5:00 a.m., 3:00 p.m., 5:00 p.m., 7:00 p.m. and 9:00 p.m.

- 7/13/25 at 7:00 a.m., 9:00 a.m., 11:00 a.m. and 1:00 p.m.

During an interview on 7/15/25 at 3:15 p.m., Director of Nursing indicated the catheter care should have been signed out as ordered.

	2. During an observation on 7/14/25 at 1:00 p.m., Resident C was observed in bed. During an interview at that time, the resident indicated he stayed in bed most of the time, because he could not get up by himself anymore. He had to use the Hoyer lift if he wanted to get up. He also indicated he could not move in the bed my himself and needed assistance to be repositioned. The record for Resident C was reviewed on 7/15/25 at 9:20 a.m. Diagnoses included but were not limited to neurogenic bladder, renal impairment and high blood pressure. The current Service Plan indicated the resident needed full assistance with dressing, bathing, and personal hygiene. The nursing interventions were to check on the resident and provide care needs every two hours as well as turn and reposition the resident every 2 hours while in bed. The current 7/2025 Physician Order Statement, indicated "Safety Check, please check on me and provide care needs every 2 hours. Please turn and reposition me every 2 hours while I am in bed. Dressing Assistance, please help me get dressed and ready for the day. Please help me get undressed and ready for bed. I am a Hoyer			

	lift for all transfers. Personal Hygiene, I need someone to assist with all aspects of my personal hygiene. Skin Breakdown Risk, please turn and reposition me every 2 hours while in bed. Please make sure I have my heel protectors on while in bed." The care task section completed by the CNAs on the Treatment Record indicated the following: - Safety Checks were blank and not completed on 3/14 at 1:00 p.m., 3/20 at 1:00 p.m., 3:00 p.m. and 5:00 p.m., 3/21 and 3/22 at 1:00 p.m., 3/26 at 9:00 a.m., 11:00 a.m. and 1:00 p.m., 3/27 at 3:00 p.m., and 9:00 p.m., 4/15 at 9:00 p.m., 4/16 at 5:00 p.m., 7:00 p.m., 9:00 p.m., and 11:00 p.m., 4/17 at 1:00 a.m., 3:00 a.m., 5:00 a.m., 4/26 at 11:00 p.m., 4/27 at 1:00 a.m., 3:00 a.m., 5:00 a.m., 4/29 at 5:00 a.m., 5/1 at 11:00 p.m., 5/9 at 11:00 p.m., 5/10 at 1:00 a.m., 3:00 a.m. and 5:00 a.m., 7:00 p.m. 9:00 p.m. 11:00 p.m., 5/11 at 1:00 a.m., 3:00 a.m., 5:00 a.m., 6/4 at 11:00 p.m., 6/5 at 1:00 a.m., 3:00 a.m. 5:00 a.m., 6/7 at 11:00 p.m., 6/8 at 1:00 a.m., 3:00 a.m., 5:00 a.m., 6/9 at 3:00 p.m., 5:00 p.m., 7:00 p.m., 9:00 p.m., 6/10 at 7:00 p.m., 9:00 p.m., 6/12 at 11:00 p.m., 6/12 at 1:00 a.m., 3:00 a.m., 5:00 a.m., 6/14 at 5:00 p.m., 7:00 p.m., 6/15 at 5:00 a.m. and 9:00 p.m., 6/20 at			

	11:00 p.m., 6/21 at 1:00 a.m., 3:00 a.m., 5:00 a.m., 6/22 at 7:00 a.m., 9:00 a.m.,11:00 a.m., 1:00 p.m., 6/23 at 11:00 p.m., 6/25 at 1:00 a.m., 3:00 a.m., 5:00 a.m., 11:00 p.m., 6/26 at 1:00 a.m., 3:00 a.m., 5:00 a.m., 6/27 at 1:00 a.m., 3:00 a.m., 5:00 a.m.,11:00 p.m., and 6/28/25 at 1:00 a.m., 3:00 a.m., and 5:00 a.m. - Personal Hygiene was not documented as being completed at 7:30 a.m. on 6/22/25, and at 8:30 p.m. on 3/7, 3/27, 4/15, 4/16, 5/10, 6/9, 6/10, and 6/15/25. - Dressing Assistance was not documented as being completed at 7:00 a.m. on 6/22/25 and at 8:00 p.m. on 3/3, 3/7, 3/27, 4/16, 5/10, 6/9, and 6/10/25. - Skin Breakdown Risk was not documented as being completed at 3:00 p.m. on 3/27 and 6/9/25 and at 11:00 p.m. on 3/19, 4/16, 4/26, 5/1, 5/9, 5/10, 6/4, 6/7, 6/12, 6/20, 6/23, 6/24, and 6/27/25. During an interview on 7/15/25 at 1:15 p.m., the Director of Nursing had no additional information to provide. 3. The record for Resident B was reviewed on 7/14/25 at 2:15 p.m. Diagnoses included, but were not limited to, heart disease, high blood pressure,			

	osteoarthritis, and dementia. The Service Plan, dated 3/11/25, indicated the resident was dependent on staff for transfers and a Hoyer lift was needed for all transfer. The nursing approaches were to make sure the leg rests were on the wheelchair at all times. The resident also needed full assistance with all aspects of using the bathroom. The resident was to be assisted with using the toilet daily at 7:00 a.m., 11:00 a.m., 1:00 p.m., 3:00 p.m., 5:00 p.m., 7:00 p.m., and 9:00 p.m. The care section completed by the CNAs on the Treatment Record indicated the use of the bathroom was not blank and not documented on the following dates and times: - 7:00 a.m. at 6/21, and 6/29/25 - 11:00 a.m. at 5/20, 6/6, 6/21, and 6/29/25 - 1:00 p.m. at 5/20, 6/4, 6/6, 6/19, 6/21, and 6/29/25 - 3:00 p.m. at 5/22/25 - 5:00 p.m. at 5/22, and 7/6/25 - 7:00 p.m. at 5/22, and 7/6/25 - 9:00 p.m. at 5/22, 6/13, 6/29, and 7/6/25 During an interview on 7/15/25			

	at 1:15 p.m., the Director of Nursing had no additional information to provide. 4. During an observation on 7/14/25 at 4:15 p.m. and 5:00 p.m., Resident D was observed sitting in a chair in her room. An indwelling Foley catheter bag and tubing were observed on the floor in a pillow case. The record for Resident D was reviewed on 7/14/25 at 5:00 p.m. Diagnoses included but were not limited to, dementia, anxiety, major depressive disorder, and diabetes. The resident returned to the facility on 7/3/25 from a rehabilitation center with a Foley catheter. A Service Plan, dated 7/14/25, indicated Foley catheter care was to be completed every shift. The care task section completed by the CNAs on the Treatment Record indicated catheter care had not been completed from 7/3-7/14/25. During an interview on 7/15/25 at 1:30 p.m., the Director of Nursing indicated she had put the catheter care orders in the computer the previous evening on 7/14/25.			

	This citation relates to Complaints IN00457475 and IN00458996. Based on observation, record review and interview, personal care and assistance with activities of daily living (ADLs) related to Foley (urinary) catheter care, dressing, safety checks, skin checks, incontinence care, and personal hygiene were not documented as being completed for 4 of 11 sampled residents. (Residents E, C, B, and D) Findings include: 1. The record for Resident E was reviewed on 7/14/25 at 4:47 p.m. Diagnoses included, but were not limited to, type 2 diabetes and hypertension. The current Physician's Order Summary (POS) indicated the resident was to receive Foley catheter care every shift. The July 2025 Treatment Administration Record (TAR) indicated the resident did not receive Foley catheter care on the following dates and times: - 7/11/25 at 11:00 p.m. - 7/12/25 at 1:00 a.m., 3:00 a.m., 5:00 a.m., 3:00 p.m., 5:00 p.m., 7:00 p.m. and 9:00 p.m.			

- 7/13/25 at 7:00 a.m., 9:00 a.m., 11:00 a.m. and 1:00 p.m.

During an interview on 7/15/25 at 3:15 p.m., Director of Nursing indicated the catheter care should have been signed out as ordered.

2. During an observation on 7/14/25 at 1:00 p.m., Resident C was observed in bed. During an interview at that time, the resident indicated he stayed in bed most of the time, because he could not get up by himself anymore. He had to use the Hoyer lift if he wanted to get up. He also indicated he could not move in the bed my himself and needed assistance to be repositioned.

The record for Resident C was reviewed on 7/15/25 at 9:20 a.m. Diagnoses included but were not limited to neurogenic bladder, renal impairment and high blood pressure.

The current Service Plan indicated the resident needed full assistance with dressing, bathing, and personal hygiene. The nursing interventions were to check on the resident and provide care needs every two hours as well as turn and reposition the resident every 2 hours while in bed.

The current 7/2025 Physician Order Statement, indicated "Safety Check, please check on

	me and provide care needs every 2 hours. Please turn and reposition me every 2 hours while I am in bed. Dressing Assistance, please help me get dressed and ready for the day. Please help me get undressed and ready for bed. I am a Hoyer lift for all transfers. Personal Hygiene, I need someone to assist with all aspects of my personal hygiene. Skin Breakdown Risk, please turn and reposition me every 2 hours while in bed. Please make sure I have my heel protectors on while in bed." The care task section completed by the CNAs on the Treatment Record indicated the following: - Safety Checks were blank and not completed on 3/14 at 1:00 p.m., 3/20 at 1:00 p.m., 3:00 p.m. and 5:00 p.m., 3/21 and 3/22 at 1:00 p.m., 3/26 at 9:00 a.m., 11:00 a.m. and 1:00 p.m., 3/27 at 3:00 p.m., and 9:00 p.m., 4/15 at 9:00 p.m., 4/16 at 5:00 p.m., 7:00 p.m., 9:00 p.m., and 11:00 p.m., 4/17 at 1:00 a.m., 3:00 a.m., 5:00 a.m., 4/26 at 11:00 p.m., 4/27 at 1:00 a.m., 3:00 a.m., 5:00 a.m., 4/29 at 5:00 a.m., 5/1 at 11:00 p.m., 5/9 at 11:00 p.m., 5/10 at 1:00 a.m., 3:00 a.m. and 5:00 a.m., 7:00 p.m. 9:00 p.m. 11:00 p.m., 5/11 at 1:00 a.m., 3:00 a.m., 5:00 a.m., 6/4 at 11:00 p.m., 6/5 at 1:00 a.m., 3:00 a.m. 5:00 a.m., 6/7 at 11:00 p.m., 6/8 at 1:00			

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- 3:00 p.m. at 5/22/25

- 5:00 p.m. at 5/22, and 7/6/25

- 7:00 p.m. at 5/22, and 7/6/25

- 9:00 p.m. at 5/22, 6/13, 6/29, and 7/6/25

During an interview on 7/15/25 at 1:15 p.m., the Director of Nursing had no additional information to provide.

4. During an observation on 7/14/25 at 4:15 p.m. and 5:00 p.m., Resident D was observed sitting in a chair in her room. An indwelling Foley catheter bag and tubing were observed on the floor in a pillow case.

The record for Resident D was reviewed on 7/14/25 at 5:00 p.m. Diagnoses included but were not limited to, dementia, anxiety, major depressive disorder, and diabetes.

The resident returned to the facility on 7/3/25 from a rehabilitation center with a Foley catheter.

A Service Plan, dated 7/14/25, indicated Foley catheter care was to be completed every shift.

The care task section completed by the CNAs on the Treatment Record indicated catheter care had not been completed from 7/3-7/14/25.

	During an interview on 7/15/25 at 1:30 p.m., the Director of Nursing indicated she had put the catheter care orders in the computer the previous evening on 7/14/25. This citation relates to Complaints IN00457475 and IN00458996. Based on observation, record review and interview, personal care and assistance with activities of daily living (ADLs) related to Foley (urinary) catheter care, dressing, safety checks, skin checks, incontinence care, and personal hygiene were not documented as being completed for 4 of 11 sampled residents. (Residents E, C, B, and D) Findings include: 1. The record for Resident E was reviewed on 7/14/25 at 4:47 p.m. Diagnoses included, but were not limited to, type 2 diabetes and hypertension. The current Physician's Order Summary (POS) indicated the resident was to receive Foley catheter care every shift. The July 2025 Treatment Administration Record (TAR) indicated the resident did not receive Foley catheter care on the following dates and times:			

- 7/11/25 at 11:00 p.m.

- 7/12/25 at 1:00 a.m., 3:00 a.m., 5:00 a.m., 3:00 p.m., 5:00 p.m., 7:00 p.m. and 9:00 p.m.

- 7/13/25 at 7:00 a.m., 9:00 a.m., 11:00 a.m. and 1:00 p.m.

During an interview on 7/15/25 at 3:15 p.m., Director of Nursing indicated the catheter care should have been signed out as ordered.

2. During an observation on 7/14/25 at 1:00 p.m., Resident C was observed in bed. During an interview at that time, the resident indicated he stayed in bed most of the time, because he could not get up by himself anymore. He had to use the Hoyer lift if he wanted to get up. He also indicated he could not move in the bed my himself and needed assistance to be repositioned.

The record for Resident C was reviewed on 7/15/25 at 9:20 a.m. Diagnoses included but were not limited to neurogenic bladder, renal impairment and high blood pressure.

The current Service Plan indicated the resident needed full assistance with dressing, bathing, and personal hygiene. The nursing interventions were to check on the resident and provide care needs every two hours as well as turn and

	reposition the resident every 2 hours while in bed. The current 7/2025 Physician Order Statement, indicated "Safety Check, please check on me and provide care needs every 2 hours. Please turn and reposition me every 2 hours while I am in bed. Dressing Assistance, please help me get dressed and ready for the day. Please help me get undressed and ready for bed. I am a Hoyer lift for all transfers. Personal Hygiene, I need someone to assist with all aspects of my personal hygiene. Skin Breakdown Risk, please turn and reposition me every 2 hours while in bed. Please make sure I have my heel protectors on while in bed." The care task section completed by the CNAs on the Treatment Record indicated the following: - Safety Checks were blank and not completed on 3/14 at 1:00 p.m., 3/20 at 1:00 p.m., 3:00 p.m. and 5:00 p.m., 3/21 and 3/22 at 1:00 p.m., 3/26 at 9:00 a.m., 11:00 a.m. and 1:00 p.m., 3/27 at 3:00 p.m., and 9:00 p.m., 4/15 at 9:00 p.m., 4/16 at 5:00 p.m., 7:00 p.m., 9:00 p.m., and 11:00 p.m., 4/17 at 1:00 a.m., 3:00 a.m., 5:00 a.m., 4/26 at 11:00 p.m., 4/27 at 1:00 a.m., 3:00 a.m., 5:00 a.m., 4/29 at 5:00 a.m., 5/1 at 11:00 p.m., 5/9 at 11:00 p.m., 5/10 at 1:00 a.m.,			

	3:00 a.m. and 5:00 a.m., 7:00 p.m. 9:00 p.m. 11:00 p.m., 5/11 at 1:00 a.m., 3:00 a.m., 5:00 a.m., 6/4 at 11:00 p.m., 6/5 at 1:00 a.m., 3:00 a.m. 5:00 a.m., 6/7 at 11:00 p.m., 6/8 at 1:00 a.m., 3:00 a.m., 5:00 a.m., 6/9 at 3:00 p.m., 5:00 p.m., 7:00 p.m., 9:00 p.m., 6/10 at 7:00 p.m., 9:00 p.m., 6/12 at 11:00 p.m., 6/12 at 1:00 a.m., 3:00 a.m., 5:00 a.m., 6/14 at 5:00 p.m., 7:00 p.m., 6/15 at 5:00 a.m. and 9:00 p.m., 6/20 at 11:00 p.m., 6/21 at 1:00 a.m., 3:00 a.m., 5:00 a.m., 6/22 at 7:00 a.m., 9:00 a.m.,11:00 a.m., 1:00 p.m., 6/23 at 11:00 p.m., 6/25 at 1:00 a.m., 3:00 a.m., 5:00 a.m., 11:00 p.m., 6/26 at 1:00 a.m., 3:00 a.m., 5:00 a.m., 6/27 at 1:00 a.m., 3:00 a.m., 5:00 a.m.,11:00 p.m., and 6/28/25 at 1:00 a.m., 3:00 a.m., and 5:00 a.m. - Personal Hygiene was not documented as being completed at 7:30 a.m. on 6/22/25, and at 8:30 p.m. on 3/7, 3/27, 4/15, 4/16, 5/10, 6/9, 6/10, and 6/15/25. - Dressing Assistance was not documented as being completed at 7:00 a.m. on 6/22/25 and at 8:00 p.m. on 3/3, 3/7, 3/27, 4/16, 5/10, 6/9, and 6/10/25. - Skin Breakdown Risk was not documented as being completed at 3:00 p.m. on 3/27			

	and 6/9/25 and at 11:00 p.m. on 3/19, 4/16, 4/26, 5/1, 5/9, 5/10, 6/4, 6/7, 6/12, 6/20, 6/23, 6/24, and 6/27/25. During an interview on 7/15/25 at 1:15 p.m., the Director of Nursing had no additional information to provide. 3. The record for Resident B was reviewed on 7/14/25 at 2:15 p.m. Diagnoses included, but were not limited to, heart disease, high blood pressure, osteoarthritis, and dementia. The Service Plan, dated 3/11/25, indicated the resident was dependent on staff for transfers and a Hoyer lift was needed for all transfer. The nursing approaches were to make sure the leg rests were on the wheelchair at all times. The resident also needed full assistance with all aspects of using the bathroom. The resident was to be assisted with using the toilet daily at 7:00 a.m., 11:00 a.m., 1:00 p.m., 3:00 p.m., 5:00 p.m., 7:00 p.m., and 9:00 p.m. The care section completed by the CNAs on the Treatment Record indicated the use of the bathroom was not blank and not documented on the following dates and times: - 7:00 a.m. at 6/21, and 6/29/25 - 11:00 a.m. at 5/20, 6/6, 6/21,			

	and 6/29/25 - 1:00 p.m. at 5/20, 6/4, 6/6, 6/19, 6/21, and 6/29/25 - 3:00 p.m. at 5/22/25 - 5:00 p.m. at 5/22, and 7/6/25 - 7:00 p.m. at 5/22, and 7/6/25 - 9:00 p.m. at 5/22, 6/13, 6/29, and 7/6/25 During an interview on 7/15/25 at 1:15 p.m., the Director of Nursing had no additional information to provide. 4. During an observation on 7/14/25 at 4:15 p.m. and 5:00 p.m., Resident D was observed sitting in a chair in her room. An indwelling Foley catheter bag and tubing were observed on the floor in a pillow case. The record for Resident D was reviewed on 7/14/25 at 5:00 p.m. Diagnoses included but were not limited to, dementia, anxiety, major depressive disorder, and diabetes. The resident returned to the facility on 7/3/25 from a rehabilitation center with a Foley catheter. A Service Plan, dated 7/14/25, indicated Foley catheter care was to be completed every shift. The care task section completed			

by the CNAs on the Treatment Record indicated catheter care had not been completed from 7/3-7/14/25.

During an interview on 7/15/25 at 1:30 p.m., the Director of Nursing indicated she had put the catheter care orders in the computer the previous evening on 7/14/25.

This citation relates to Complaints IN00457475 and IN00458996.

Based on observation, record review and interview, personal care and assistance with activities of daily living (ADLs) related to Foley (urinary) catheter care, dressing, safety checks, skin checks, incontinence care, and personal hygiene were not documented as being completed for 4 of 11 sampled residents. (Residents E, C, B, and D)

Findings include:

1. The record for Resident E was reviewed on 7/14/25 at 4:47 p.m. Diagnoses included, but were not limited to, type 2 diabetes and hypertension.

The current Physician's Order Summary (POS) indicated the resident was to receive Foley catheter care every shift.

The July 2025 Treatment Administration Record (TAR)

	indicated the resident did not receive Foley catheter care on the following dates and times: - 7/11/25 at 11:00 p.m. - 7/12/25 at 1:00 a.m., 3:00 a.m., 5:00 a.m., 3:00 p.m., 5:00 p.m., 7:00 p.m. and 9:00 p.m. - 7/13/25 at 7:00 a.m., 9:00 a.m., 11:00 a.m. and 1:00 p.m. During an interview on 7/15/25 at 3:15 p.m., Director of Nursing indicated the catheter care should have been signed out as ordered.			
R 0246	Health Services - Deficiency 410 IAC 16.2-5-4(e)(6) (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. 2. The record for Resident D was reviewed on 7/14/25 at 5:00 p.m. Diagnoses included but were not limited to, dementia, anxiety, major	R 0246	**R246** **Health Services:** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** failure to ensure QMAs received authorization from a licensed nurse prior to administering as needed (PRN) antianxiety medications for(Residents F, D, and G)	07/30/2025

	depressive disorder, and diabetes. A Physician's Order, dated 7/3/25, indicated Lorazepam (an antianxiety medication) 2 milligrams (mg)/milliliter (ml), give 0.25 ml every four hours as needed (prn) for agitation and restlessness. The 7/2025 Medication Administration Record (MAR) indicated QMA 2 administered the Lorazepam on 7/10/25 at 8:05 p.m. There was no documentation the QMA received prior authorization from a licensed nurse before administering the prn medication. During an interview on 7/15/25 at 1:50 p.m., the Director of Nursing indicated the QMA should have asked the nurse prior to the administration of the prn Lorazepam. 3. The record for Resident G was reviewed on 7/14/25 at 5:40 p.m. Diagnoses included, but were not limited to, anxiety, dementia, and depression. A Physician's Order, dated 2/10/25, indicated Lorazepam 0.5 milligrams (mg) three times a day prn for anxiety. The Medication Administration Record (MAR) indicated the Lorazepam was administered by		**How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents have the potential to be affected by the same deficient practice. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** All QMAs and LPNs were in-serviced and re-educated on administering PRN medications.	

	a QMA on the following dates without prior authorization from a licensed nurse: March 2025 - 3/26/25 at 11:45 p.m., 3/28/25 at 10:39 p.m., and 3/30/25 at 2:14 a.m. April 2025 - 4/3/25 at 10:08 p.m., 4/4/25 at 7:12 p.m., 4/5/25 at 10:52 p.m., 4/6/25 at 7:42 p.m., 4/7/25 at 8:30 p.m., 4/11/25 at 3:04 a.m., and 4/14/25 at 8:13 p.m. June 2025 - 6/2/25 at 12:15 a.m., 6/11/25 at 4:54 p.m., 6/24/25 at 10:25 p.m., 6/25/25 at 7:18 p.m., and 6/26/25 at 8:15 p.m. During an interview on 7/15/25 at 1:50 p.m., the Director of Nursing indicated the QMA should have asked the nurse prior to the administration of the prn Lorazepam. Based on record review and interview, the facility failed to ensure QMAs received authorization from a licensed nurse prior to administering as needed (PRN) antianxiety medications for 3 of 11 sampled residents. (Residents F, D, and G) Findings include:		EMR system has been revised to populate a prompted questionnaire during administration of all PRN medications to ensure consistent documentation and clinical reasoning. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** DON/Designee to conduct monthly audits for 3 months, then quarterly thereafter in February and May. **By what date the systemic changes will be completed.** 7/30/25	

	1. The record for Resident F was reviewed on 7/14/25 at 2:51 p.m. Diagnoses included, but were not limited to, mild dementia without behavior disturbance, chronic obstructive pulmonary disease, and sepsis. A Physician's Order, dated 6/20/25, indicated the resident was to receive Lorazepam (an antianxiety medication) 2 milligrams (mg) per milliliter (ml), give 0.25 ml by mouth or under the tongue every 4 hours as needed for agitation/restlessness. The June 2025 Medication Administration Record (MAR), indicated QMAs administered the resident's PRN Lorazepam on the following dates and times without prior authorization from a licensed nurse: - 6/7/25 at 2:11 p.m. - 6/8/25 at 3:28 p.m. - 6/11/25 at 9:30 p.m. - 6/15/25 at 6:13 p.m. - 6/17/25 at 11:20 p.m. - 6/20/25 at 7:07 p.m. - 6/25/25 at 5:44 p.m. - 6/28/25 at 8:57 p.m. The July 2025 MAR, indicated QMA 2 administered the			

resident's PRN Lorazepam on July 13, 2025 without prior authorization from a licensed nurse.

During an interview on 7/15/25 at 3:15 p.m., Director of Nursing (DON) 1 indicated the QMAs should have received authorization from a nurse prior to giving the PRN Lorazepam.

2. The record for Resident D was reviewed on 7/14/25 at 5:00 p.m. Diagnoses included but were not limited to, dementia, anxiety, major depressive disorder, and diabetes.

A Physician's Order, dated 7/3/25, indicated Lorazepam (an antianxiety medication) 2 milligrams (mg)/milliliter (ml), give 0.25 ml every four hours as needed (prn) for agitation and restlessness.

The 7/2025 Medication Administration Record (MAR) indicated QMA 2 administered the Lorazepam on 7/10/25 at 8:05 p.m.

There was no documentation the QMA received prior authorization from a licensed nurse before administering the prn medication.

During an interview on 7/15/25 at 1:50 p.m., the Director of Nursing indicated the QMA should have asked the nurse

prior to the administration of the prn Lorazepam.

3. The record for Resident G was reviewed on 7/14/25 at 5:40 p.m. Diagnoses included, but were not limited to, anxiety, dementia, and depression.

A Physician's Order, dated 2/10/25, indicated Lorazepam 0.5 milligrams (mg) three times a day prn for anxiety.

The Medication Administration Record (MAR) indicated the Lorazepam was administered by a QMA on the following dates without prior authorization from a licensed nurse:

March 2025

- 3/26/25 at 11:45 p.m., 3/28/25 at 10:39 p.m., and 3/30/25 at 2:14 a.m.

April 2025

- 4/3/25 at 10:08 p.m., 4/4/25 at 7:12 p.m., 4/5/25 at 10:52 p.m., 4/6/25 at 7:42 p.m., 4/7/25 at 8:30 p.m., 4/11/25 at 3:04 a.m., and 4/14/25 at 8:13 p.m.

June 2025

- 6/2/25 at 12:15 a.m., 6/11/25 at 4:54 p.m., 6/24/25 at 10:25 p.m., 6/25/25 at 7:18 p.m., and 6/26/25 at 8:15 p.m.

During an interview on 7/15/25 at 1:50 p.m., the Director of

	Nursing indicated the QMA should have asked the nurse prior to the administration of the prn Lorazepam. Based on record review and interview, the facility failed to ensure QMAs received authorization from a licensed nurse prior to administering as needed (PRN) antianxiety medications for 3 of 11 sampled residents. (Residents F, D, and G) Findings include: 1. The record for Resident F was reviewed on 7/14/25 at 2:51 p.m. Diagnoses included, but were not limited to, mild dementia without behavior disturbance, chronic obstructive pulmonary disease, and sepsis. A Physician's Order, dated 6/20/25, indicated the resident was to receive Lorazepam (an antianxiety medication) 2 milligrams (mg) per milliliter (ml), give 0.25 ml by mouth or under the tongue every 4 hours as needed for agitation/restlessness. The June 2025 Medication Administration Record (MAR), indicated QMAs administered the resident's PRN Lorazepam on the following dates and times without prior authorization from a licensed nurse:			

	- 6/7/25 at 2:11 p.m. - 6/8/25 at 3:28 p.m. - 6/11/25 at 9:30 p.m. - 6/15/25 at 6:13 p.m. - 6/17/25 at 11:20 p.m. - 6/20/25 at 7:07 p.m. - 6/25/25 at 5:44 p.m. - 6/28/25 at 8:57 p.m. The July 2025 MAR, indicated QMA 2 administered the resident's PRN Lorazepam on July 13, 2025 without prior authorization from a licensed nurse. During an interview on 7/15/25 at 3:15 p.m., Director of Nursing (DON) 1 indicated the QMAs should have received authorization from a nurse prior to giving the PRN Lorazepam. 2. The record for Resident D was reviewed on 7/14/25 at 5:00 p.m. Diagnoses included but were not limited to, dementia, anxiety, major depressive disorder, and diabetes. A Physician's Order, dated 7/3/25, indicated Lorazepam (an antianxiety medication) 2 milligrams (mg)/milliliter (ml), give 0.25 ml every four hours as needed (prn) for agitation and			

	restlessness. The 7/2025 Medication Administration Record (MAR) indicated QMA 2 administered the Lorazepam on 7/10/25 at 8:05 p.m. There was no documentation the QMA received prior authorization from a licensed nurse before administering the prn medication. During an interview on 7/15/25 at 1:50 p.m., the Director of Nursing indicated the QMA should have asked the nurse prior to the administration of the prn Lorazepam. 3. The record for Resident G was reviewed on 7/14/25 at 5:40 p.m. Diagnoses included, but were not limited to, anxiety, dementia, and depression. A Physician's Order, dated 2/10/25, indicated Lorazepam 0.5 milligrams (mg) three times a day prn for anxiety. The Medication Administration Record (MAR) indicated the Lorazepam was administered by a QMA on the following dates without prior authorization from a licensed nurse: March 2025			

	- 3/26/25 at 11:45 p.m., 3/28/25 at 10:39 p.m., and 3/30/25 at 2:14 a.m. April 2025 - 4/3/25 at 10:08 p.m., 4/4/25 at 7:12 p.m., 4/5/25 at 10:52 p.m., 4/6/25 at 7:42 p.m., 4/7/25 at 8:30 p.m., 4/11/25 at 3:04 a.m., and 4/14/25 at 8:13 p.m. June 2025 - 6/2/25 at 12:15 a.m., 6/11/25 at 4:54 p.m., 6/24/25 at 10:25 p.m., 6/25/25 at 7:18 p.m., and 6/26/25 at 8:15 p.m. During an interview on 7/15/25 at 1:50 p.m., the Director of Nursing indicated the QMA should have asked the nurse prior to the administration of the prn Lorazepam. Based on record review and interview, the facility failed to ensure QMAs received authorization from a licensed nurse prior to administering as needed (PRN) antianxiety medications for 3 of 11 sampled residents. (Residents F, D, and G) Findings include: 1. The record for Resident F was reviewed on 7/14/25 at 2:51 p.m. Diagnoses included, but were not limited to, mild dementia without behavior disturbance, chronic obstructive			

pulmonary disease, and sepsis.

A Physician's Order, dated 6/20/25, indicated the resident was to receive Lorazepam (an antianxiety medication) 2 milligrams (mg) per milliliter (ml), give 0.25 ml by mouth or under the tongue every 4 hours as needed for agitation/restlessness.

The June 2025 Medication Administration Record (MAR), indicated QMAs administered the resident's PRN Lorazepam on the following dates and times without prior authorization from a licensed nurse:

- 6/7/25 at 2:11 p.m.

- 6/8/25 at 3:28 p.m.

- 6/11/25 at 9:30 p.m.

- 6/15/25 at 6:13 p.m.

- 6/17/25 at 11:20 p.m.

- 6/20/25 at 7:07 p.m.

- 6/25/25 at 5:44 p.m.

- 6/28/25 at 8:57 p.m.

The July 2025 MAR, indicated QMA 2 administered the resident's PRN Lorazepam on July 13, 2025 without prior authorization from a licensed nurse.

During an interview on 7/15/25

at 3:15 p.m., Director of Nursing (DON) 1 indicated the QMAs should have received authorization from a nurse prior to giving the PRN Lorazepam.

2. The record for Resident D was reviewed on 7/14/25 at 5:00 p.m. Diagnoses included but were not limited to, dementia, anxiety, major depressive disorder, and diabetes.

A Physician's Order, dated 7/3/25, indicated Lorazepam (an antianxiety medication) 2 milligrams (mg)/milliliter (ml), give 0.25 ml every four hours as needed (prn) for agitation and restlessness.

The 7/2025 Medication Administration Record (MAR) indicated QMA 2 administered the Lorazepam on 7/10/25 at 8:05 p.m.

There was no documentation the QMA received prior authorization from a licensed nurse before administering the prn medication.

During an interview on 7/15/25 at 1:50 p.m., the Director of Nursing indicated the QMA should have asked the nurse prior to the administration of the prn Lorazepam.

3. The record for Resident G was reviewed on 7/14/25 at 5:40 p.m. Diagnoses included,

but were not limited to, anxiety, dementia, and depression.

A Physician's Order, dated 2/10/25, indicated Lorazepam 0.5 milligrams (mg) three times a day prn for anxiety.

The Medication Administration Record (MAR) indicated the Lorazepam was administered by a QMA on the following dates without prior authorization from a licensed nurse:

March 2025

- 3/26/25 at 11:45 p.m., 3/28/25 at 10:39 p.m., and 3/30/25 at 2:14 a.m.

April 2025

- 4/3/25 at 10:08 p.m., 4/4/25 at 7:12 p.m., 4/5/25 at 10:52 p.m., 4/6/25 at 7:42 p.m., 4/7/25 at 8:30 p.m., 4/11/25 at 3:04 a.m., and 4/14/25 at 8:13 p.m.

June 2025

- 6/2/25 at 12:15 a.m., 6/11/25 at 4:54 p.m., 6/24/25 at 10:25 p.m., 6/25/25 at 7:18 p.m., and 6/26/25 at 8:15 p.m.

During an interview on 7/15/25 at 1:50 p.m., the Director of Nursing indicated the QMA should have asked the nurse prior to the administration of the prn Lorazepam.

Based on record review and

	interview, the facility failed to ensure QMAs received authorization from a licensed nurse prior to administering as needed (PRN) antianxiety medications for 3 of 11 sampled residents. (Residents F, D, and G) Findings include: 1. The record for Resident F was reviewed on 7/14/25 at 2:51 p.m. Diagnoses included, but were not limited to, mild dementia without behavior disturbance, chronic obstructive pulmonary disease, and sepsis. A Physician's Order, dated 6/20/25, indicated the resident was to receive Lorazepam (an antianxiety medication) 2 milligrams (mg) per milliliter (ml), give 0.25 ml by mouth or under the tongue every 4 hours as needed for agitation/restlessness. The June 2025 Medication Administration Record (MAR), indicated QMAs administered the resident's PRN Lorazepam on the following dates and times without prior authorization from a licensed nurse: - 6/7/25 at 2:11 p.m. - 6/8/25 at 3:28 p.m. - 6/11/25 at 9:30 p.m.			

	- 6/15/25 at 6:13 p.m. - 6/17/25 at 11:20 p.m. - 6/20/25 at 7:07 p.m. - 6/25/25 at 5:44 p.m. - 6/28/25 at 8:57 p.m. The July 2025 MAR, indicated QMA 2 administered the resident's PRN Lorazepam on July 13, 2025 without prior authorization from a licensed nurse. During an interview on 7/15/25 at 3:15 p.m., Director of Nursing (DON) 1 indicated the QMAs should have received authorization from a nurse prior to giving the PRN Lorazepam.			
R 0295	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(a) (a) Residents who self-medicate may keep and use prescription and nonprescription medications in their unit as long as they keep them secured from other residents. Based on observation, record review, and interview, the facility failed to ensure medications and medicated creams were stored securely and a self administration of medication assessment was completed for 1 of 11 sampled residents.	R 0295	**R295:** **Pharmaceitical Services:** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** All medications and creams have	07/30/2025

	(Resident C) Finding includes: During observations on 7/14/25 at 1:00 p.m. and 6:00 p.m., Resident C was observed lying in bed in the living room of his apartment. At that time, there were 2 boxes of Triamcinolone cream (a steroid cream) on the night stand. In the bedroom, there was a basin full of over-the-counter creams and a large box with 4 boxes of Fluticasone propionate nasal spray, 2 boxes of Diclofenac gel (Voltarin), 1 box of Santyl (a cream used to debride wounds), 2 boxes of Triamcinolone cream and 2 tubes of hemorrhoid cream. None of the medications or creams were stored securely. During an observation on 7/15/25 at 11:15 a.m., the resident was observed lying in his bed. At that time, the Director of Nursing (DON) entered the room. The medicated creams and nasal spray were still observed in the same place. The cabinet above the microwave was opened and there was 1 bottle of Tylenol, 1 bottle of Excedrin, 1 bottle of Naproxen, and 2 boxes of Immodium. There was a container of an over the counter laxative as well. All of the medications and creams from		been removed from Resident C's apartment. POA and resident verbalized understanding of Medication Administration Policy. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** All residents have the potential to be affected by the same deficient practice. All current residents, who self-administer medications, were reminded to securely store medications and medicated creams. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;**	

	7/14/25 were all observed in the same place. The DON boxed up all of the medication and removed them from the room. During an interview at that time, Resident C indicated the Tylenol was there for his wife to take if she had a headache. During an interview on 7/15/25 at 11:25 a.m., the DON indicated she had thought the resident's wife took those medications home with her and she was aware the medicated creams and pills should not have been in the room. The record for Resident C was reviewed on 7/15/25 at 9:20 a.m. Diagnoses included but were not limited to neurogenic bladder, renal impairment and high blood pressure. The current Service Plan lacked documentation the resident could self-administer his own medications or keep over-the-counter medications in the room for his spouse to take. The service plan indicated staff would manage the resident's medication effective 2/21/25, There was no self-administration of medication assessment or physician's order for any of the creams or medications found in the resident's room. This citation relates to		All staff were in-serviced and educated on Self-Administration and Medication Storage Policies and Procedures. All staff were reminded and re-educated to notify DON or nurse on duty should any medications be observed in an apartment of a resident that does not self-administer their medications. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** Leadership personnel will conduct ongoing weekly Angel Rounds notating if medications were observed in assigned apartments. Each manager is responsible for auditing 5-10 apartments per week.	

	Complaint IN00457475. Based on observation, record review, and interview, the facility failed to ensure medications and medicated creams were stored securely and a self administration of medication assessment was completed for 1 of 11 sampled residents. (Resident C) Finding includes: During observations on 7/14/25 at 1:00 p.m. and 6:00 p.m., Resident C was observed lying in bed in the living room of his apartment. At that time, there were 2 boxes of Triamcinolone cream (a steroid cream) on the night stand. In the bedroom, there was a basin full of over-the-counter creams and a large box with 4 boxes of Fluticasone propionate nasal spray, 2 boxes of Diclofenac gel (Voltarin), 1 box of Santyl (a cream used to debride wounds), 2 boxes of Triamcinolone cream and 2 tubes of hemorrhoid cream. None of the medications or creams were stored securely. During an observation on 7/15/25 at 11:15 a.m., the resident was observed lying in his bed. At that time, the Director of Nursing (DON) entered the room. The medicated creams and nasal spray were still observed in the		**By what date the systemic changes will be completed.** 7/30/25	

	same place. The cabinet above the microwave was opened and there was 1 bottle of Tylenol, 1 bottle of Excedrin, 1 bottle of Naproxen, and 2 boxes of Immodium. There was a container of an over the counter laxative as well. All of the medications and creams from 7/14/25 were all observed in the same place. The DON boxed up all of the medication and removed them from the room. During an interview at that time, Resident C indicated the Tylenol was there for his wife to take if she had a headache. During an interview on 7/15/25 at 11:25 a.m., the DON indicated she had thought the resident's wife took those medications home with her and she was aware the medicated creams and pills should not have been in the room. The record for Resident C was reviewed on 7/15/25 at 9:20 a.m. Diagnoses included but were not limited to neurogenic bladder, renal impairment and high blood pressure. The current Service Plan lacked documentation the resident could self-administer his own medications or keep over-the-counter medications in the room for his spouse to take. The service plan indicated staff would manage the resident's			

	medication effective 2/21/25, There was no self-administration of medication assessment or physician's order for any of the creams or medications found in the resident's room. This citation relates to Complaint IN00457475.			
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 observation, record review, and interview, the facility failed to maintain clinical records that were complete and accurately documented related to treatment orders, follow-up documentation after a fall, and orders for Foley catheter care for 4 of 11 sampled residents. (Residents E, F, C, and D)	R 0349	**R349** **Clinical Records:** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident E Resident F Resident C Resident D **How the facility will identify other residents**	07/30/2025

	Findings include: 1. The record for Resident E was reviewed on 7/14/25 at 4:47 p.m. Diagnoses included, but were not limited to, type 2 diabetes and hypertension. The resident was receiving hospice services and was identified by Director of Nursing (DON) 1 as having a wound. The current Physician's Order Summary (POS) did not list any orders for wound care. A Wound Record Report, provided by the hospice agency on 7/15/25, indicated the resident had a Stage 4 pressure ulcer (full thickness tissue loss with exposed bone, tendon, or muscle) to the coccyx and a right knee abscess. Hospice documentation, dated 7/4/25, indicated the coccyx area was to be cleansed with normal saline, wound cleanser, pat dry with gauze and pack with iodine soaked gauze. Cover with a foam dressing and change three times weekly and as needed (PRN) for drainage or dislodgement per hospice care. The right knee abscess was to be cleansed with normal saline, wound cleanser, pat dry with gauze and pack with iodine soaked gauze. Cover with a foam dressing and change three times weekly and PRN for drainage or dislodgement per		**having the potential to be affected by the same deficient practice and what corrective action will be taken;** All current residents have the potential to be affected by the same deficient practice. All current residents requiring catheter care and wound care treatments have active orders in place. These orders have been added to each resident’s service plan and POS. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** All staff were in-serviced and re-educated on maintaining complete and accurate documentation related to treatment orders, follow-up documentation after a fall, and	

	hospice care. During an interview on 7/15/25 at 3:15 p.m., DON indicated the treatment orders should have been listed on the current POS. 2. The record for Resident F was reviewed on 7/14/25 at 2:51 p.m. Diagnoses included, but were not limited to, mild dementia without behavior disturbance, chronic obstructive pulmonary disease, and sepsis. A Nurse's Note, dated 6/11/25 at 6:45 p.m., indicated the resident had a fall and was observed lying on the floor in front of her recliner. She was unable to state how she fell. The resident was complaining of back pain and her as needed (PRN) Morphine (a pain medication) was given. Hospice, the Director of Nursing (DON), and her Power of Attorney (POA) were notified. The next documented entry in the nurse's notes was on 6/18/25 at 5:30 p.m. and there was no further documentation related to the resident's fall. During an interview on 7/15/25 at 3:15 p.m., DON indicated follow-up documentation should have been completed after the resident's fall on 6/11/25. 3. During an interview on 7/14/25 at 1:00 p.m., Resident C indicated he had wounds on		catheter care orders. All admissions or re-admissions, with catheters or wounds in place, will be required to have orders stating to provide catheter and/or wound care. All catheter and wound care orders will be added to the POS and ISP upon admission or re-admission. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and**	

	his legs and feet that hospice took care of on Monday, Wednesday, and Friday. The resident indicated the staff at the facility did not take care of the treatments. The record for Resident C was reviewed on 7/15/25 at 9:20 a.m. Diagnoses included but were not limited to neurogenic bladder, renal impairment and high blood pressure. The current Service Plan indicated the resident had wounds to his legs for which hospice provided the care and treatments. There were no physician's orders for any of the wounds on the current Physician Order Summary. During an interview on 7/15/25 at 11:25 a.m., the Director of Nursing indicated she was not aware the wound treatments should have been on Physician Order Summary. 4. During observations on 7/14/25 at 4:15 p.m. and 5:00 p.m., Resident D was observed sitting in a chair in her room. An indwelling Foley catheter bag and tubing were observed on the floor in a pillow case. The record for Resident D was reviewed on 7/14/25 at 5:00 p.m. Diagnoses included but were not limited to, dementia,		DON/Designee will conduct weekly monitoring of falls, catheter care, and wound care compliance via audit tool to ensure adherence, with follow-up education and counseling provided as needed to address any gaps in compliance. **By what date the systemic changes will be completed.** 7/30/25	

anxiety, major depressive disorder, and diabetes.

The resident returned to the facility on 7/3/25 from a rehabilitation center with a Foley catheter.

A Service Plan, dated 7/14/25, indicated Foley catheter care was to be completed every shift.

There were no physician's orders for the Foley catheter.

During an interview on 7/15/25 at 11:30 a.m., the Director of Nursing indicated there were no physician's orders for the catheter at the time of readmission.

This citation relates to Complaint IN00457475.

Based on observation, record review, and interview, the facility failed to maintain clinical records that were complete and accurately documented related to treatment orders, follow-up documentation after a fall, and orders for Foley catheter care for 4 of 11 sampled residents. (Residents E, F, C, and D)

Findings include:

1. The record for Resident E was reviewed on 7/14/25 at 4:47 p.m. Diagnoses included, but were not limited to, type 2 diabetes and hypertension.

The resident was receiving hospice services and was identified by Director of Nursing (DON) 1 as having a wound.

The current Physician's Order Summary (POS) did not list any orders for wound care.

A Wound Record Report, provided by the hospice agency on 7/15/25, indicated the resident had a Stage 4 pressure ulcer (full thickness tissue loss with exposed bone, tendon, or muscle) to the coccyx and a right knee abscess.

Hospice documentation, dated 7/4/25, indicated the coccyx area was to be cleansed with normal saline, wound cleanser, pat dry with gauze and pack with iodine soaked gauze. Cover with a foam dressing and change three times weekly and as needed (PRN) for drainage or dislodgement per hospice care. The right knee abscess was to be cleansed with normal saline, wound cleanser, pat dry with gauze and pack with iodine soaked gauze. Cover with a foam dressing and change three times weekly and PRN for drainage or dislodgement per hospice care.

During an interview on 7/15/25 at 3:15 p.m., DON indicated the treatment orders should have been listed on the current POS.

2. The record for Resident F

was reviewed on 7/14/25 at 2:51 p.m. Diagnoses included, but were not limited to, mild dementia without behavior disturbance, chronic obstructive pulmonary disease, and sepsis.

A Nurse's Note, dated 6/11/25 at 6:45 p.m., indicated the resident had a fall and was observed lying on the floor in front of her recliner. She was unable to state how she fell. The resident was complaining of back pain and her as needed (PRN) Morphine (a pain medication) was given. Hospice, the Director of Nursing (DON), and her Power of Attorney (POA) were notified.

The next documented entry in the nurse's notes was on 6/18/25 at 5:30 p.m. and there was no further documentation related to the resident's fall.

During an interview on 7/15/25 at 3:15 p.m., DON indicated follow-up documentation should have been completed after the resident's fall on 6/11/25.

3. During an interview on 7/14/25 at 1:00 p.m., Resident C indicated he had wounds on his legs and feet that hospice took care of on Monday, Wednesday, and Friday. The resident indicated the staff at the facility did not take care of the treatments.

The record for Resident C was

	reviewed on 7/15/25 at 9:20 a.m. Diagnoses included but were not limited to neurogenic bladder, renal impairment and high blood pressure. The current Service Plan indicated the resident had wounds to his legs for which hospice provided the care and treatments. There were no physician's orders for any of the wounds on the current Physician Order Summary. During an interview on 7/15/25 at 11:25 a.m., the Director of Nursing indicated she was not aware the wound treatments should have been on Physician Order Summary. 4. During observations on 7/14/25 at 4:15 p.m. and 5:00 p.m., Resident D was observed sitting in a chair in her room. An indwelling Foley catheter bag and tubing were observed on the floor in a pillow case. The record for Resident D was reviewed on 7/14/25 at 5:00 p.m. Diagnoses included but were not limited to, dementia, anxiety, major depressive disorder, and diabetes. The resident returned to the facility on 7/3/25 from a rehabilitation center with a Foley catheter.			

	A Service Plan, dated 7/14/25, indicated Foley catheter care was to be completed every shift. There were no physician's orders for the Foley catheter. During an interview on 7/15/25 at 11:30 a.m., the Director of Nursing indicated there were no physician's orders for the catheter at the time of readmission. This citation relates to Complaint IN00457475. Based on observation, record review, and interview, the facility failed to maintain clinical records that were complete and accurately documented related to treatment orders, follow-up documentation after a fall, and orders for Foley catheter care for 4 of 11 sampled residents. (Residents E, F, C, and D) Findings include: 1. The record for Resident E was reviewed on 7/14/25 at 4:47 p.m. Diagnoses included, but were not limited to, type 2 diabetes and hypertension. The resident was receiving hospice services and was identified by Director of Nursing (DON) 1 as having a wound.			

	The current Physician's Order Summary (POS) did not list any orders for wound care. A Wound Record Report, provided by the hospice agency on 7/15/25, indicated the resident had a Stage 4 pressure ulcer (full thickness tissue loss with exposed bone, tendon, or muscle) to the coccyx and a right knee abscess. Hospice documentation, dated 7/4/25, indicated the coccyx area was to be cleansed with normal saline, wound cleanser, pat dry with gauze and pack with iodine soaked gauze. Cover with a foam dressing and change three times weekly and as needed (PRN) for drainage or dislodgement per hospice care. The right knee abscess was to be cleansed with normal saline, wound cleanser, pat dry with gauze and pack with iodine soaked gauze. Cover with a foam dressing and change three times weekly and PRN for drainage or dislodgement per hospice care. During an interview on 7/15/25 at 3:15 p.m., DON indicated the treatment orders should have been listed on the current POS. 2. The record for Resident F was reviewed on 7/14/25 at 2:51 p.m. Diagnoses included, but were not limited to, mild dementia without behavior			

disturbance, chronic obstructive pulmonary disease, and sepsis.

A Nurse's Note, dated 6/11/25 at 6:45 p.m., indicated the resident had a fall and was observed lying on the floor in front of her recliner. She was unable to state how she fell. The resident was complaining of back pain and her as needed (PRN) Morphine (a pain medication) was given. Hospice, the Director of Nursing (DON), and her Power of Attorney (POA) were notified.

The next documented entry in the nurse's notes was on 6/18/25 at 5:30 p.m. and there was no further documentation related to the resident's fall.

During an interview on 7/15/25 at 3:15 p.m., DON indicated follow-up documentation should have been completed after the resident's fall on 6/11/25.

3. During an interview on 7/14/25 at 1:00 p.m., Resident C indicated he had wounds on his legs and feet that hospice took care of on Monday, Wednesday, and Friday. The resident indicated the staff at the facility did not take care of the treatments.

The record for Resident C was reviewed on 7/15/25 at 9:20 a.m. Diagnoses included but were not limited to neurogenic bladder, renal impairment and

high blood pressure.

The current Service Plan indicated the resident had wounds to his legs for which hospice provided the care and treatments.

There were no physician's orders for any of the wounds on the current Physician Order Summary.

During an interview on 7/15/25 at 11:25 a.m., the Director of Nursing indicated she was not aware the wound treatments should have been on Physician Order Summary.

4. During observations on 7/14/25 at 4:15 p.m. and 5:00 p.m., Resident D was observed sitting in a chair in her room. An indwelling Foley catheter bag and tubing were observed on the floor in a pillow case.

The record for Resident D was reviewed on 7/14/25 at 5:00 p.m. Diagnoses included but were not limited to, dementia, anxiety, major depressive disorder, and diabetes.

The resident returned to the facility on 7/3/25 from a rehabilitation center with a Foley catheter.

A Service Plan, dated 7/14/25, indicated Foley catheter care was to be completed every shift.

There were no physician's orders for the Foley catheter.

During an interview on 7/15/25 at 11:30 a.m., the Director of Nursing indicated there were no physician's orders for the catheter at the time of readmission.

This citation relates to Complaint IN00457475.

Based on observation, record review, and interview, the facility failed to maintain clinical records that were complete and accurately documented related to treatment orders, follow-up documentation after a fall, and orders for Foley catheter care for 4 of 11 sampled residents. (Residents E, F, C, and D)

Findings include:

1. The record for Resident E was reviewed on 7/14/25 at 4:47 p.m. Diagnoses included, but were not limited to, type 2 diabetes and hypertension.

The resident was receiving hospice services and was identified by Director of Nursing (DON) 1 as having a wound.

The current Physician's Order Summary (POS) did not list any orders for wound care.

A Wound Record Report, provided by the hospice agency on 7/15/25, indicated the

	resident had a Stage 4 pressure ulcer (full thickness tissue loss with exposed bone, tendon, or muscle) to the coccyx and a right knee abscess. Hospice documentation, dated 7/4/25, indicated the coccyx area was to be cleansed with normal saline, wound cleanser, pat dry with gauze and pack with iodine soaked gauze. Cover with a foam dressing and change three times weekly and as needed (PRN) for drainage or dislodgement per hospice care. The right knee abscess was to be cleansed with normal saline, wound cleanser, pat dry with gauze and pack with iodine soaked gauze. Cover with a foam dressing and change three times weekly and PRN for drainage or dislodgement per hospice care. During an interview on 7/15/25 at 3:15 p.m., DON indicated the treatment orders should have been listed on the current POS. 2. The record for Resident F was reviewed on 7/14/25 at 2:51 p.m. Diagnoses included, but were not limited to, mild dementia without behavior disturbance, chronic obstructive pulmonary disease, and sepsis. A Nurse's Note, dated 6/11/25 at 6:45 p.m., indicated the resident had a fall and was observed lying on the floor in			

	front of her recliner. She was unable to state how she fell. The resident was complaining of back pain and her as needed (PRN) Morphine (a pain medication) was given. Hospice, the Director of Nursing (DON), and her Power of Attorney (POA) were notified. The next documented entry in the nurse's notes was on 6/18/25 at 5:30 p.m. and there was no further documentation related to the resident's fall. During an interview on 7/15/25 at 3:15 p.m., DON indicated follow-up documentation should have been completed after the resident's fall on 6/11/25. 3. During an interview on 7/14/25 at 1:00 p.m., Resident C indicated he had wounds on his legs and feet that hospice took care of on Monday, Wednesday, and Friday. The resident indicated the staff at the facility did not take care of the treatments. The record for Resident C was reviewed on 7/15/25 at 9:20 a.m. Diagnoses included but were not limited to neurogenic bladder, renal impairment and high blood pressure.			

	The current Service Plan indicated the resident had wounds to his legs for which hospice provided the care and treatments. There were no physician's orders for any of the wounds on the current Physician Order Summary. During an interview on 7/15/25 at 11:25 a.m., the Director of Nursing indicated she was not aware the wound treatments should have been on Physician Order Summary. 4. During observations on 7/14/25 at 4:15 p.m. and 5:00 p.m., Resident D was observed sitting in a chair in her room. An indwelling Foley catheter bag and tubing were observed on the floor in a pillow case. The record for Resident D was reviewed on 7/14/25 at 5:00 p.m. Diagnoses included but were not limited to, dementia, anxiety, major depressive disorder, and diabetes. The resident returned to the facility on 7/3/25 from a rehabilitation center with a Foley catheter. A Service Plan, dated 7/14/25, indicated Foley catheter care was to be completed every shift.			

	There were no physician's orders for the Foley catheter. During an interview on 7/15/25 at 11:30 a.m., the Director of Nursing indicated there were no physician's orders for the catheter at the time of readmission. This citation relates to Complaint IN00457475.			
R 0354	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(g)(1-7) (g) A transfer form shall include the following: (1) Identification data. (2) Name of the transferring institution. (3) Name of the receiving institution and date of transfer. (4) Resident ' s personal property when transferred to an acute care facility. (5) Nurses ' notes relating to the resident ' s: (A) functional abilities and physical limitations; (B) nursing care; (C) medications; (D) treatment; and (E) current diet and condition on transfer.	R 0354	**R354:** **Clinical Records:** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** Resident H readmitted to the community without any adverse effects resulting from failure to ensure transfer form was completed upon transfer in May 2025. **How the facility will identify other residents having the potential to be affected by the same**	07/30/2025

	(6) Diagnosis. (7) Date of chest x-ray and skin test for tuberculosis. Based on record review and interview, the facility failed to ensure a transfer form was completed for 1 of 11 resident records reviewed. (Resident H) Finding includes: The record for Resident H was reviewed on 7/14/25 at 1:40 p.m. Diagnoses included, but were not limited to, chronic kidney disease, liver cancer, and diabetes. The 4/30/25 Admission Assessment indicated the resident was cognitively intact for daily decision making and required minimal assistance with activities of daily living. The resident's admission record indicated they were transferred to the hospital on 5/27/25 and returned on 5/30/25. The record lacked documentation of a completed transfer form being sent to the hospital. During an interview on 7/15/25 at 1:50 p.m., the Administrator indicated they never did transfer forms when a resident went to the hospital.		**deficient practice and what corrective action will be taken** All residents being transferred out of the community have the potential to be affected by the same deficient practice **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** Effective immediately, face sheet containing perinate information related to transfer will be sent with each resident upon transfer. All nursing personnel were informed of the updated transfer process. All nursing personnel were informed and	

	Based on record review and interview, the facility failed to ensure a transfer form was completed for 1 of 11 resident records reviewed. (Resident H) Finding includes: The record for Resident H was reviewed on 7/14/25 at 1:40 p.m. Diagnoses included, but were not limited to, chronic kidney disease, liver cancer, and diabetes. The 4/30/25 Admission Assessment indicated the resident was cognitively intact for daily decision making and required minimal assistance with activities of daily living. The resident's admission record indicated they were transferred to the hospital on 5/27/25 and returned on 5/30/25. The record lacked documentation of a completed transfer form being sent to the hospital. During an interview on 7/15/25 at 1:50 p.m., the Administrator indicated they never did transfer forms when a resident went to the hospital.		educated on this process. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** Nurse/designee will document in the medical records that the emergency packet and the resident's transferred location were communicated to the appropriate party. All nursing personnel were informed and educated on this process. **By what date the systemic changes will be**	

			completed. 7/30/25	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE