STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN SENIOR LIVING, LLC	1675 W SEVENTH STREET, AUBURN, , 46706

(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 Intake 469008. Intake 469008- State deficiencies related to the allegations are cited at R036, R052, R349, and R354. Survey dates: April 6, 7, and 8, 2026 Facility number: 14775 Residential Census: 86 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed April 9, 2026	R 0000		
R 0036	Residents' Rights- Deficiency 410 IAC 16.2-5-1.2(k)(1-2) (k) The facility must immediately	R 0036	**How corrective action will be accomplished for those residents found to have been affected by the deficient**	04/30/2026

	consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on interview and record review,the facility failed to ensure a physician was notified of a resident leaving the facility unsupervised for 1 of 3 residents reviewed (Resident A). Findings include: In a record review, on 4/7/26 at 2:48 PM, a document, titled Investigation, provided by the Executive Director (ED) on 4/7/26 at 2:48 PM, indicated on 4/1/26, the ED received a phone call, placed from the facility front door, by the local police department. The police officer indicated he had picked up Resident A, who had been found at a hotel parking lot located across the highway from the facility. The document indicated Resident A was identified leaving the memory care unit by the unit door		**practice.** RA- Physician was notified of residents leaving the facility. Resident has not had any further occurrences. **How the facility will identify other residents having the potential to be affected by the same deficient practice.** Residents who have been identified as elopement risk have the potential to be affected. **What measures will be put into place, or systemic changes will be made, to ensure that the deficient practice will not recur.** • Nursing associates will be reinserviced by DON/Designee on physician notification of residents leaving the facility unsupervised. • Residents who leave the facility unsupervised will continue to have appropriate measures taken to ensure proper notification to the physician is made.	

	leading to the assisted living area of the building at 9:39 PM, then leaving the facility using the door to the independent living portion of the facility at 9:41 PM. A police report, dated 4/2/26, indicated officers responded to a call from a local hotel requesting a welfare check on a man, identified as Resident A observed walking in their parking lot. The report indicated the police transported Resident A back to the facility and Resident A was later transported to the hospital. Resident A's record was reviewed on 4/7/26 at 9:01 AM. Diagnoses included vascular dementia, unspecified severity, without behavior disturbance. Resident A's current Brief Interview for Mental Status (BIMS) assessment, dated 10/22/25, had a score of 1, indicating severe cognitive impairment. Resident A's current service plan, titled Elopement Risk, indicated the resident had a problem of elopement risk, with a goal date of 9/15/26. Interventions included routinely observing Resident A's location in the building and recognizing triggers. Resident A's current service plan, titled Behaviors, indicated Resident A had a		**How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.** Don/designee will audit any elopements and ensure proper notification is made for 6 months and ongoing. All audits will be reviewed during quarterly QAPI meeting, and the results will be evaluated on the need for continued or modified monitoring.	

problem of wandering aimlessly, and manic type behavior patterns, with a goal date of 9/15/26. Interventions included one-to-one supervision, reporting changes from baseline behaviors to the nurse, and using redirection from wandering to busy type activities.

Physician orders, dated 4/23/25, indicated Resident A should reside in the Memory Care Unit.

Physician orders, dated 4/23/25, indicated Resident A could leave the facility with supervision.

A review of progress notes, on 4/7/26 at 9:01 AM, did not include any documentation of Resident A leaving the building unattended.

A document, titled Wandering Risk Scale, dated 10/29/25, indicated Resident A was ambulatory, unable to follow instructions and had a history of wandering in the last 30 days. The document indicated Resident A was high risk for wandering.

In an interview, on 4/7/26 at 10:04 AM, the Director of Nursing (DON) indicated she was told Resident A had left the building unattended the following morning when she reported to work. The DON

	indicated the incident had occurred because the door to the memory unit was not locking. The DON indicated she did not assess Resident A, document the occurrence, or notify the physician. In an interview, on 4/7/26 at 3:00 PM, the ED indicated she became aware of Resident A leaving the facility unattended when the police called from the front door a little after 10:00 PM on 4/1/26. The ED indicated she called QMA 8, who was on duty in the building, instructed her to let the officer and Resident A in the building, initiate a head count of all dementia unit residents, and ensure the unit doors were secure. The ED indicated the DON was on call, but she did not notify her until the following morning when the DON reported to work. The ED indicated the DON should have been notified to come to the facility, perform an assessment, and complete documentation, including a transfer form, at the time of discovery. In an interview, on 4/7/26 at 4:11 PM, QMA 8 indicated she was notified, by the ED, a little after 10:00 PM on April 1, Resident A was outside the building with the police. QMA 8 indicated she did not notify a nurse of the occurrence, and indicated nurses were			

	responsible for assessments and physician notification. In an interview, on 4/8/26 at 2:12 PM, the ED indicated the physician should have been notified of the occurrence. No documentation of physician notification was available for review at the time of facility exit. A current policy, titled Elopements and Wandering Residents, dated 3/1/21, provided by the ED on 4/7/26 at 2:00 PM, indicated risk for elopement and individualized interventions to prevent elopement should be communicated to staff. The policy indicated a nurse should assess the resident, document findings and report the occurrence to the physician, following any subsequent orders. This citation is related to Intake 469008			
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse;	R 0052	**How corrective action will be accomplished for those residents found to have been affected by the deficient practice.** RA- Safety has been maintained. The main front door of memory care has been fixed and functioning properly. Has	04/30/2026

	(4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on interview and record review the facility failed to protect the resident's rights to be free from elopement and neglect for 1 of 3 residents reviewed (Resident A). Resident A was unsupervised and walked approximately 0.4 miles across a busy main highway. Findings include:		not had any further episodes of leaving the facility unsupervised. **How the facility will identify other residents having the potential to be affected by the same deficient practice.** Residents who are at an elopement risk have the potential to be affected. **What measures will be put into place, or systemic changes will be made, to ensure that the deficient practice will not recur.** • Staff have will be reinserviced by ED/Designee on proper protection of residents' rights to be free from elopement and neglect. • The nursing staff will continue to provide proper awareness of residents' locations to maintain the residents' rights related to elopement and neglect. • Maintenance will ensure doors are latching appropriately to ensure compliance. **How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.**	

	In a record review, on 4/7/26 at 2:48 PM, a document, titled Investigation, provided by the Executive Director (ED) on 4/7/26 at 2:48 PM, indicated on 4/1/26 at about 10:00 PM, the ED had received a phone call, placed from the facility front door, by the local police department. The police officer indicated he had picked up Resident A, who had been found at a hotel parking lot located across the highway from the facility. The document indicated Resident A was identified by video leaving the memory care unit by the unit door leading to the assisted living area of the building at 9:39 PM on 4/1/26, then leaving the facility using the door to the independent living portion of the facility at 9:41 PM. A police report, dated 4/2/26, indicated officers responded to a call from a local hotel requesting a welfare check on a man, identified as Resident A observed walking in their parking lot. The report indicated the police transported Resident A back to the facility and Resident A was later transported to the hospital. The police report was vague and did not include dispatch time to the hotel nor arrival time. According to Google earth, Resident A would have walked		Maintenance director will perform audits of all exit doors on memory care unit weekly x4 and then monthly for 5 months. All audits will be reviewed during quarterly QAPI meeting. The results will be evaluated on the need for continued or modified monitoring.	

	0.4 miles, crossing a main, heavily traveled highway from the facility to the hotel parking lot where he was found by the police. According to timeanddate.com, the ambient temperature on 4/1/26 at 10:00 PM in the city of the facility location was 37 degrees Farenheit. In an observation, on 4/7/26 at 11:02 AM, 2 unidentified dietary staff members were observed pushing a meal cart through the memory care unit doors. As the doors swung shut, the employees walked off the unit with thier backs to the doors and did not ensure the doors had latched as they left. Resident A's record was reviewed on 4/7/26 at 9:01 AM. Diagnoses included vascular dementia, unspecified severity, without behavior disturbance. Resident A's current Brief Interview for Mental Status (BIMS) assessment, dated 10/22/25, had a score of 1, indicating severe cognitive impairment. Resident A's current service plan, titled Elopement Risk, indicated the resident had a problem of elopement risk, with a goal date of 9/15/26. Interventions included routinely observing Resident A's location			

	in the building and recognizing triggers for unsafe wandering. Resident A's current service plan, titled Behaviors, indicated Resident A had a problem of wandering aimlessly, and manic type behavior patterns, with a goal date of 9/15/26. Interventions included one-to-one supervision, reporting changes from baseline behaviors to the nurse, and using redirection from wandering to busy type activities. Physician orders, dated 4/23/25, indicated Resident A should reside in the Memory Care Unit. Physician orders, dated 4/23/25, indicated Resident A may leave the facility with supervision. A review of progress notes, on 4/7/26 at 9:01 AM, did not include any documentation of Resident A leaving the building unattended. A document, titled Wandering Risk Scale, dated 10/29/25, indicated Resident A was ambulatory, unable to follow instructions and had a history of wandering in the last 30 days. The document indicated Resident A was high risk for unsafe wandering. A current Nurse Aide assignment sheet, provided by the Director of Nursing (DON)			

	on 4/7/26 at 11:11 AM, did not identify Resident A as an elopement risk or list any interventions to prevent unsafe wandering. In an interview, on 4/7/26 9:27 AM, Certified Nurse Aide (CNA) 2 indicated staff should always ensure the unit door closed completely so the locking mechanism engaged to keep the unit secure. CNA 2 indicated she was not aware of any recent elopements on the unit and had not been given any recent updates or special instructions for unit security. In an interview, on 4/7/26 at 9:35 AM, CNA 3 indicated staff should check on residents posing a high risk of wandering or seeking exit every 15 minutes. CNA 3 indicated another employee told her Resident A had left the building unattended and walked across the highway. She indicated she had not received any additional information or instructions from any supervisor. In an interview, on 4/7/26 at 9:48 AM, Qualified Medicine Aide (QMA) 4 indicated staff should watch residents who routinely wander and look for them if they had not been seen in a while. QMA 4 indicated a staff member told her Resident A eloped recently. QMA 4			

	indicated she was told in report the door had malfunctioned and did not latch. QMA 4 indicated the ED should be notified immediately if someone was missing and follow whatever instructions she would give. In an interview, on 4/7/26 at 10:04 AM, the Director of Nursing (DON) indicated she was told Resident A had left the building unattended the following morning when she reported to work. The DON indicated the incident had occurred because the door was not locking. The DON indicated she discussed the situation with the staff on 1st and 2nd shift on 4/2/26. The DON indicated she did not normally talk to 3rd shift staff and expected information to be passed on by staff in report. The DON indicated she did not, assess Resident A, document the occurrence, or notify the physician. In an interview, on 4/7/26 at 11:12 AM, the Maintainence Director indicated he was notified of the memory care unit doors malfunctioning when he came to work on 4/2/26. He indicated the door was manually taken out of order and locked. The door was not making contact with the magnet system, the malfunctioning door was taken out of service and locked. There was a consultation with			

	the corporation about the door on 4/3/26. The Maintenance Director made corrections to the door, but agreed to take the malfunctioning door out of service until further repairs could be made. In an interview, on 4/7/26 at 3:00 PM, the ED indicated she became aware of Resident A leaving the facility unattended when the police called from the front door a little after 10:00 PM on 4/1/26. The ED indicated she called QMA 8, who was on duty in the building, instructed her to let the officer and Resident A in the building, initiate a head count of all dementia unit residents, and ensure the unit doors were secure. The ED indicated the DON was on call, but she did not notify her until the following morning when the DON reported to work. The ED indicated the DON should have been notified to come to the facility, perform an assessment, and complete documentation, including a transfer form, at the time of discovery. In an interview, on 4/7/26 at 4:11 PM, QMA 8 indicated she was notified, by the ED, a little after 10:00 PM on April 1, Resident A was outside the building with the police. QMA 8 indicated the ED instructed her to do a head count in the memory care unit. QMA 8			

	indicated the door to the memory care unit door was not latched when she entered the unit. QMA 8 indicated when she visualized Resident A, with the police at the front door, Resident A was wearing a long sleeved knit shirt, sweatpants, white socks, and no shoes. QMA 8 indicated it was cold outside at the time. A current policy, titled Elopements and Wandering Residents, dated 3/1/21, provided by the ED on 4/7/26 at 2:00 PM, indicated risk for elopement and individualized interventions to prevent elopement should be communicated to staff. The policy indicated a nurse should assess the resident, document findings and report the occurrence to the physician, following any subsequent orders. This citation is related to Intake 469008			
R 0144	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(a) (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents.	R 0144	**How corrective action will be accomplished for those residents found to have been affected by the deficient practice.** No residents were found to be adversely affected by this deficient practice.	04/30/2026

	Based on observation, interview, and record review, the facility failed to ensure clean, and dry floors for 30 of 30 residents residing in the memory care unit, and a clean, odor-free resident room for 1 of 3 resident rooms observed (Resident B). Findings include: 1. In an observation, on 4/6/2026 at 11:40 AM, a wet streak, about two inches wide, along about 80% of the length of the main walkway adjacent to the dining area of the memory care dining area was observed. A wet floor sign was sitting outside the housekeeping closet next to the end of the walkway, and no other signs were marking the wet floor area. The walkway served two large dining areas and a kitchenette with a service bar. Residents of the memory care unit were observed walking in the area preparing for the lunch meal. In an interview, on 4/6/2026 at 11:41 AM, Qualified Medicine Aide (QMA) 4 indicated the housekeeper had used the carpet cleaner in a room nearby and some fluid leaked from the machine when the machine was pushed back to the housekeeping closet. QMA 2 indicated the floor should be dry soon and staff were watching it.		**How the facility will identify other residents having the potential to be affected by the same deficient practice.** All residents residing in the community had the potential to be affected by this same deficient practice. **What measures will be put into place, or systemic changes will be made, to ensure that the deficient practice will not recur.** • To ensure that the deficient practice does not recur, staff will be reinserviced by ED/Designee on expectations related to maintaining a clean and safe environment, including timely identification and response to environmental concerns such as wet floors, debris, and resident room cleanliness. • Housekeeping and nursing processes will be reviewed to ensure accountability for maintaining cleanliness and odor control in resident care areas. **How the facility will monitor**	

	QMA 4 indicated the housekeeper should have cleaned up the wet floor before leaving the unit. In an interview, on 4/7/26 at 3:29 PM, the Executive Director (ED) indicated nursing staff had access to mops and wet floor signs and should have cleaned the floor if housekeeping was not available. In an interview, on 4/8/26 at 12:08 PM, Housekeeper 8 indicated a wet floor should have been dry mopped, then mopped with disinfecting floor cleaner, then dry mopped again, with wet floor signs in place throughout the wet area. 2. In an observation, on 4/7/26 at 10:40 AM, white fluffy pieces of debris between 0.5 cm to 3 cm in length, too many to count were observed on the floor outside Resident B's room door in hallway, in Resident B's room in front of Resident B's recliner, in front of Resident B's bed, in the bathroom and scattered around the living space of the room. A strong urine odor was present in the room, and the room floor was sticky with a slightly darkened discoloration scattered throughout. In an interview, on 4/7/26 at 10:41 AM, a family member visiting Resident B indicated upon her arrival at the facility		**its corrective actions to ensure that the deficient practice is being corrected and will not recur** To monitor the corrective actions and ensure the deficient practice will not recur, the Executive Director (ED)/Designee will conduct routine environmental rounds 2x weekly x4 weeks and then weekly x 5 months to ensure resident care areas are clean, dry, and free of hazards. Audit results will be reviewed during quarterly QAPI meeting, and the results will be evaluated on the need for continued or modified monitoring.	

	that morning, Resident B's incontinent brief was saturated, partially torn, and partially in her pant leg and slipper. The family member indicated large pieces of the saturated incontinent brief material had fallen out onto the floor. The family member indicated she smelled a strong urine odor throughout Resident B's room. The family member indicated Certified Nurse Aide staff picked up the large pieces of the brief, but indicated there was no housekeeper on the unit to properly clean the area. In an interview, on 4/7/26 at 3:29 PM, the Executive Director (ED) indicated the housekeeper on the memory care unit had quit in the middle of her shift on 4/6/26. The ED indicated nursing staff had access to cleaing supplies and should have cleaned the area thoroughly. In an observation, on 4/8/26 at 11:55 AM, white fluffy debris and a urine odor remained in Resident B's room. A current policy, titled Enrivornmental Services and Laundry Standards of Operation, undated, provided by the ED on 4/8/26 at 9:28 AM, indicated spot cleaning should be performed as needed.			

R 0155	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(l) (l) The facility shall have an effective garbage and waste disposal program in accordance with 410 IAC 7-24. Provision shall be made for the safe and sanitary disposal of solid waste, including dressings, needles, syringes, and similar items. Based on observation, interview and record review, the facility failed to ensure sanitary disposal of trash for 1 of 2 dumpsters located outside the facility. Findings include: On 4/6/26 at 10:40 AM, the kitchen was toured with the Dietary Manager (DM). During a tour of the outside trash disposal area, the dumpster lid was observed to be open. Multiple wet, white, clumps measuring approximately 0.5 centimeters (cm) to 3 cm in length, littered the ground surrounding the dumpster area. A wet, empty, transparent trash bag was lying on the ground beside the outside dumpster. The DM indicated the dumpster lid should be always closed. The DM indicated there should be no trash on the ground.	R 0155	**How corrective action will be accomplished for those residents found to have been affected by the deficient practice.** No residents were found to be affected by this deficient practice. **How the facility will identify other residents having the potential to be affected by the same deficient practice.** All residents residing in the community had the potential to be affected by this same deficient practice. **What measures will be put into place, or systemic changes will be made, to ensure that the deficient practice will not recur.** • To ensure that the deficient practice does not recur all departments that utilize the trash disposal area will be reinserviced by ED/Designee on proper sanitary disposal of trash.	04/30/2026

	In an interview, on 4/6/26 at 1:50 PM, the Administrator indicated the outside dumpster lids should always be closed. The Administrator indicated there should be no trash on the ground. On 4/7/26 at 8:50 AM, the outside dumpster lid was observed to be open. On 4/8/26 at 1:45 PM, the outside dumpster lid was observed to be open. A current undated facility policy indicated trash bags were to be sealed before removing them from the facility. The policy indicated the sealed trash bags were to be placed in a covered dumpster outside the facility.		**How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.** To monitor the corrective actions and ensure the deficient practice will not recur, the dining director or designee will audit trash disposal area. This audit will be completed daily for 2 months and then weekly for 4 months. Audit results will be reviewed at quarterly QAPI meeting, and the results will be evaluated on the need for continued or modified monitoring.	
R 0156	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(m) (m) The facility's food supplies shall meet the standards of 410 IAC 7-24. Based on observation, interview and record review, the facility failed to ensure proper storage and handling of food. 86 of 86 residents residing in the facility consumed food prepared in the kitchen.	R 0156	**How corrective action will be accomplished for those residents found to have been affected by the deficient practice.** No residents were found to be affected by this deficient practice. **How the facility will identify other residents having the potential to be affected by the same deficient practice.** All residents residing in the	04/30/2026

	Findings include: On 4/6/26 at 10:40 AM, the kitchen was toured with the Dietary Manager (DM). During the tour of a walk-in cooler, an undated container of white chocolate syrup was observed to be without a cap. Multiple clusters of white, raised clumps were observed around the uncovered opening of the container. Multiple clusters of white, raised clumps were observed in a trail leading from the uncovered opening down 1/3 of 1 side of the container. The DM indicated the container should have a cap. The DM indicated the container should have an open date. The DM removed the container and discarded it into the trash. A current facility policy, dated 10/25/22, indicated all food items should be labeled with a date. The policy indicated all food items should be sealed tightly with a sealable plastic bag or a tight-fitting lid.		community had the potential to be affected by this same deficient practice. **What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.** • The Dining Service Director/ Designee will in-service the dining service associates on the following topics: 1.Proper Food Storage 2. Labeling and Dating food products **How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.** To ensure that this deficient practice does not recur, the Dining Service Director/Designee will audit food storage ensuring all food is properly stored and labeled. This audit will be completed daily for 2 weeks and then weekly for 6 months. Audit results will be reviewed at quarterly QAPI meeting, and the results will be evaluated on the need for continued or modified	

			monitoring.	
R 0247	Health Services - Deficiency 410 IAC 16.2-5-4(e)(7) (7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident. Based on interview and record review, the facility failed to ensure notification of the physician related to missed doses of medication for 1 o2 residents reviewed (Resident 70). Findings include: Resident 70's record was reviewed on 4/7/26 at 10:00 AM. Diagnoses included insulin dependent diabetes, hypothyroidism (low thyroid hormone) and dementia. Resident 70's service plan, dated 9/22/23, indicated the resident did not know the names of their medications, the reasons for taking their medications, or the times their medications were to be taken. Resident 70's service plan, dated 3/22/24, indicated Resident 70 required assistance	R 0247	**How corrective action will be accomplished for those residents found to have been affected by the deficient practice.** R70- Physician was notified of residents' meditations not being administered. Residents 70 have had no negative effect. R 70 is currently taking medications as scheduled. **How the facility will identify other residents having the potential to be affected by the same deficient practice.** All residents have the potential to be affected. **What measures will be put into place, or systemic changes will be made, to ensure that the deficient practice will not recur.** • Nursing associates will be reinserviced by DON/Designee on physician notification related to missed medications.	04/30/2026

	with diabetes management. The target goal was for Resident 70 to maintain normal blood sugar levels through 3/11/26. The intervention was for the staff to provide injections. Resident 70's service plan, dated 4/4/24, indicated the resident required full administration of oral medications by the facility staff. A physician order, dated 12/13/24, indicated Resident 70 was to be administered 75 micrograms of levothyroxine sodium (Synthroid) every day. Resident 70's medication administration record (MAR), dated 3/1/26 through 3/31/26, indicated the resident's Synthroid was to be administered daily at 5:00 AM. The MAR indicated the resident's Synthroid had not been administered on the following dates: 3/2/26 3/12/26 3/13/26 3/14/26 3/15/26 3/22/26		• The nursing associates will continue to administer medications as ordered. Proper notifications will be given for medications that have been identified as not being administered. **How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.** Don or designee will audit non administered medications 3x weekly x 4 weeks then weekly x 5 months to ensure proper notifications are made timely. All audits will be reviewed at quarterly QAPI meeting, and the results will be evaluated on the need for continued or modified monitoring.	

	3/24/26 3/26/26 3/31/26 A physician order, dated 6/19/24, indicated Resident 70 was to be administered insulin on a sliding scale at bedtime. Resident 70's medication administration record (MAR), dated 3/1/26 through 3/31/26, indicated the resident had not had their blood sugar checked or their insulin administered on the following dates: 3/2/26 3/14/26 3/24/26 3/28/26 3/29/26 A physician order, dated 6/19/24, indicated Resident 70 was to be administered insulin on a sliding scale before meals. Resident 70's medication administration record (MAR), dated 3/1/26 through 3/31/26, indicated the resident was to have their blood sugar checked and administered insulin on a sliding scale at 7:00 AM, 11:00 AM and 4:00 PM. Resident 70's medication			

	administration record (MAR) dated 3/1/26 through 3/31/26, indicated the resident had not had their blood sugar checked or their insulin administered at 4:00 PM on the following dates: 3/24/26 3/29/26 Resident 70's progress notes, dated 3/8/26 through 4/7/26, did not indicate the resident had missed any doses of medication. There was no indication the physician had been notified of the missed doses. In an interview, on 4/7/26 at 1:20 PM, Licensed Practical Nurse (LPN) 26 indicated a missed medication dose or a resident's refusal of a medication should be documented in the MAR and the progress notes. LPN 26 indicated missed insulin doses had probably been administered but not signed. LPN 26 indicated that occasionally, a licensed staff member had to float to other units to administer insulin injections. LPN 26 indicated some Qualified Medication Aides were not certified to administer insulin injections. LPN 26 indicated blank dates on the MAR means a medication had not been administered. LPN 26 indicated Resident 70 did not have a			

	history of refusing medications. In an interview, on 4/8/26 at 9:20 AM, the Administrator indicated they were unaware of any missed medication doses. The Administrator indicated the facility did not have a Director of Nursing since 4/6/26. A current facility policy, no date, indicated a medication omission error is the failure to dispense a medication as prescribed by the physician. The policy indicated medication errors should be reported to the resident's physician and the resident's representative.			
R 0349	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(a)(1-4) (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on interview and record review, the facility failed to ensure complete and accurate	R 0349	**How corrective action will be accomplished for those residents found to have been affected by the deficient practice.** RA- Documentation was corrected. RA has not had any further episodes of leaving the facility. **How the facility will identify other residents having the potential to be affected by the same deficient practice.** Residents who are at an elopement risk have the potential to be affected.	04/30/2026

	documentation of a resident leaving the facility unsupervised for 1 of 3 residents reviewed (Resident A). Findings include: In a record review, on 4/7/26 at 2:48 PM, a document, titled Investigation, provided by the Executive Director (ED) on 4/7/26 at 2:48 PM, indicated on 4/1/26, the ED had received a phone call, placed from the facility front door, by the local police department. The police officer indicated he had picked up Resident A, who had been found at a hotel parking lot located across the highway from the facility. The document indicated Resident A was identified leaving the memory care unit by the unit door leading to the assisted living area of the building at 9:39 PM, then leaving the facility using the door to the independent living portion of the facility at 9:41 PM. A police report, dated 4/2/26, indicated officers responded to a call from a local hotel requesting a welfare check on a man, identified as Resident A observed walking in their parking lot. The report indicated the police transported Resident A back to the facility and Resident A was later transported to the hospital.		**What measures will be put into place, or systemic changes will be made, to ensure that the deficient practice will not recur.** • Nursing Associates will be reinserviced by DON/Designee to ensure complete and accurate documentation of residents leaving the facility unsupervised. • Residents will continue to have complete and accurate documentation as needed for occurrences. • The nursing associates will continue to be responsible for complete and accurate documentation of residents who leave the facility unsupervised. **How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.** The Don/Designee will conduct audits 5x weekly x4 weeks, then three x weekly x 4 weeks, then twice weekly for 4 months. DON/designee will review elopement risk on all memory care residents and update service plans as needed. If any elopements should occur, documentation will be reviewed	

	According to Google earth, Resident A would have walked 0.4 miles, crossing a main, heavily traveled highway from the facility to the hotel parking lot where he was found by the police. Resident A's record was reviewed on 4/7/26 at 9:01 AM. Diagnoses included vascular dementia, unspecified severity, without behavior disturbance. Resident A's current Brief Interview for Mental Status (BIMS) assessment, dated 10/22/25, had a score of 1, indicating severe cognitive impairment. Resident A's current service plan, titled Elopement Risk, indicated the resident had a problem of elopement risk, with a goal date of 9/15/26. Interventions included routinely observing Resident A's location in the building and recognizing triggers. Resident A's current service plan, titled Behaviors, indicated Resident A had a problem of wandering aimlessly, and manic type behavior patterns, with a goal date of 9/15/26. Interventions included one-to-one supervision, reporting changes from baseline behaviors to the nurse, and using redirection from wandering to busy type activities.		immediately. Audits and elopements will be reviewed at the QAPI meeting, and the results will be evaluated on the need for continued or modified monitoring.	

	Physician orders, dated 4/23/25, indicated Resident A should reside in the Memory Care Unit. A review of progress notes, on 4/7/26 at 9:01 AM, did not include any documentation of Resident A leaving the building unattended. In an interview, on 4/7/26 at 10:04 AM, the Director of Nursing (DON) indicated she was told Resident A had left the building unattended the following morning when she reported to work. The DON indicated she did not, assess Resident A, document the occurrence, or notify the physician. In an interview, on 4/7/26 at 3:00 PM, the ED indicated she became aware of Resident A leaving the facility unattended when the police called from the front door a little after 10:00 PM on 4/1/26. The ED indicated she called QMA 8, who was on duty in the building, instructed her to let the officer and Resident A in the building, initiate a head count of all dementia unit residents, and ensure the unit doors were secure. The ED indicated the DON was on call, but she did not notify her until the following morning when the DON reported to work. The ED indicated the DON should have been notified to come to the			

	facility, perform an assessment, and complete documentation, including a transfer form, at the time of discovery. In an interview, on 4/7/26 at 4:11 PM, QMA 8 indicated she was notified, by the ED, a little after 10:00 PM on April 1, Resident A was outside the building with the police. QMA 8 indicated she did not notify a nurse of the occurrence, and indicated nurses were responsible for assessments and physician notification. A progress note, recorded as a late entry for 4/1/26 at 10:28 PM, with a creation date of 4/7/26 at 10:38 PM, by QMA 8, indicated Resident A had exited the building unattended and returned by the police. The note indicated the ED, family, and nurse were aware. In an interview, on 4/8/26 at 2:12 PM, the ED indicated a nurse had not been aware of the occurence on 4/1/26 at 10:28 PM. A current policy, titled Elopements and Wandering Residents, dated 3/1/21, provided by the ED on 4/7/26 at 2:00 PM, indicated documentation of an elopement event should include nurse assessments, physician and family notification, care plan discussions, and any consultant			

	information if applicable. This citation is related to Intake 469008			
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. (6) Diagnosis. (7) Date of chest x-ray and skin test for tuberculosis. 2. Resident 40's record was	R 0354	**How corrective action will be accomplished for those residents found to have been affected by the deficient practice.** RA- Has not had any further occurrences or hospitalizations. R40- Has not had any further hospitalizations. **How the facility will identify other residents having the potential to be affected by the same deficient practice.** All residents have the potential to be affected. **What measures will be put into place, or systemic changes will be made, to ensure that the deficient practice will not recur.** • Nursing Associates will be reinserviced by DON/Designee on ensuring clinical documentation related to continuity of care for hospital transfers. • Residents who require hospitalization will continue to have	04/30/2026

	reviewed on 4/8/26 at 10:00 AM. Diagnoses included lung necrosis and emphysema. A progress note, dated 3/19/26 at 12:35 AM, indicated Resident 40 had been transferred to the hospital after being found on the floor in the resident's room. The Director of Nursing and Resident 40's family were notified. The progress note did not indicate the required information was sent to the hospital or provided to the resident's family. A progress note, dated 3/19/26 at 10:20 AM, indicated Resident 40 was admitted to the hospital due to a left hip fracture. The progress note did not indicate the required information was sent to the hospital or provided to the resident's family. In an interview, on 4/8/26 at 10:30 AM, the Administrator indicated they were unaware of transfer forms being used by the facility. The Administrator indicated the facility should document and relay required information to the receiving facility when a resident required a transfer to the hospital. In an interview, on 4/8/26 at 2:05 PM, the Administrator indicated they were unable to locate Resident 40's transfer form. The Administrator indicated the facility had been		appropriate measures taken to ensure proper clinical documentation related to care for hospital transfer is properly provided. • The nursing associates will continue to be responsible for clinical documentation related to continuity of care for hospital transfer for compliance. **How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.** DON or designee will conduct audits of all transfers weekly x4 weeks then monthly x 5 months. All audits will be reviewed at quarterly QAPI meeting. These results will be evaluated on the need for continued or modified monitoring.	

without a Director of Nursing since 4/6/26 and they were unaware of where much of the documentation was filed.

A current facility policy, dated 6/1/21, indicated a discharge instruction form would be provided to the receiving facility. The policy indicated copies of the resident's medication list, code status, face sheet and immunization status would be provided to the resident or the resident's representative.

This citation is related to Intake 469008

Based on interview and record review, the facility failed to ensure clinical documentation related to continuity of care for a hospital transfer for 2 of 2 residents reviewed (Resident A and Resident 40).

Findings include:

1.In a record review, on 4/7/26 at 2:48 PM, a document, titled Investigation, provided by the Executive Director (ED) on 4/7/26 at 2:48 PM, indicated on 4/1/26, the ED had received a phone call, placed from the facility front door, by the local police department. The police officer indicated he had picked up Resident A, who had been found at a hotel parking lot located across the highway from the facility. The document

indicated Resident A was identified leaving the memory care unit by the unit door leading to the assisted living area of the building at 9:39 PM, then leaving the facility using the door to the independent living portion of the facility at 9:41 PM.

A police report, dated 4/2/26, indicated officers responded to a call from a local hotel, requesting a welfare check on a man, identified as Resident A, observed walking in their parking lot. The report indicated the police transported Resident A back to the facility and Resident A was later transported to the hospital.

Resident A's record was reviewed on 4/7/26 at 9:01 AM. Diagnoses included vascular dementia, unspecified severity, without behavior disturbance.

Resident A's current Brief Interview for Mental Status (BIMS) assessment, dated 10/22/25, had a score of 1, indicating severe cognitive impairment.

In an interview, on 4/7/26 at 3:00 PM, the ED indicated she became aware of Resident A leaving the facility unattended when the police called from the front door a little after 10:00 PM on 4/1/26. The ED indicated she called QMA 8, who was on duty

	in the building, instructed her to let the officer and Resident A in the building, initiate a head count of all dementia unit residents, and ensure the unit doors were secure. The ED indicated she the DON was on call, but she did not notify her until the following morning when the DON reported to work. The ED indicated the DON should have been notified to come to the facility, perform an assessment, and complete documentation, including a transfer form, at the time of discovery. In an interview, on 4/7/26 at 4:11 PM, QMA 8 indicated the ED notfiied her, a little after 10:00 PM on 4/1/26, Resident A was outside the front door with the police. QMA 8 indicated the ED instructed her to let the officer and Resident A into the building, perform a head count on the dementia unit, and ensure doors were secure. QMA 8 indicated she did not notify the DON of the occurrence and did not send any transfer paperwork with Resident 8 when he left the facility by ambulance to go to the hospital.			

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 SIGNATUREGrace Faurote	TITLEExecutive Director	(X6) DATE04/30/2026