STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MELROSE ASSISTED LIVING LLC	7101 HIGHWAY 41 NORTH, EVANSVILLE, , 47725

(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. Survey dates: October 15 and 16, 2025 Facility number: 014866 Residential Census: 53 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on October 27, 2025.	R 0000	Preparation and execution of this plan of correction does not constitute admission or agreement by provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies this plan of correction is submitted timely and in accordance with state and federal regulations and guidelines In this document we have outlined specific actions in response to identifying issues we remain committed to providing the best care and will continue to make changes and improvements to achieve desired results. This facility is requesting a desk review for compliance in these areas.	
R 0119	Personnel - Noncompliance	R 0119	While staff had begun working	11/19/2025

	410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3- (d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following: (1) Instructions on the needs of the specialized populations: (A) aged; (B) developmentally disabled; (C) mentally ill; (D) dementia; or (E) children; served in the facility. (2) A review of the facility's policy manual and applicable procedures, including: (A) organization chart; (B) personnel policies; (C) appearance and grooming policies for employees; and (D) residents' rights. (3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures. (4) Review of ethical considerations and confidentiality in resident care and records.		in the community without completing appropriate checklist all employees were very familiar with their job and their duties. QMA 3 and 9 both immediately received proper education with checklist being completed. All residents had the potential to be affected. After a thorough audit no negative adverse effects were found. All staff personnel files were audited to ensure that the facility was 100% compliance. All onboarding staff will complete training requirements within their training window and job specific checklist will be completed. Annually training thereafter will be completed monthly via our training program. This will be audited 1x monthly by the administrator or designee to ensure compliance is achieved.	

(5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care.

(6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation.

Based on interview and record review, the facility failed to ensure Qualified Medication Aides (QMA) received a job specific orientation to the facility after hire for 2 of 2 QMA employee files reviewed. (QMA 3 and QMA 9)

Finding includes:

On 10/16/25 at 9:00 A.M., employee files were reviewed. QMA 3 began employment at the facility on 6/23/25. QMA 9 began employment at the facility on 5/27/25.

QMA 3 and QMA 9 lacked documentation that a job specific orientation had been completed.

On 10/16/25 at 1:01 P.M., the Director of Nursing (DON) provided a QMA Orientation Checklist that indicated "the orientation form will be given upon hire. The new employee is responsible for returning the completed form to the Human Resources/Clinical Nurse

	Leader within 30 days of the hire date". At that time, the DON indicated all employees completed the orientation checklist specific to their job upon hire and the instructor signed off when each procedure was completed. On 10/16/25 at 1:11 P.M., the DON indicated it was the policy of the facility to follow state regulations in regard to QMA orientation. On 10/16/25 at 1:32 P.M., the DON indicated she was unable to find a QMA Orientation Checklist for QMA 3 and QMA 9. Based on interview and record review, the facility failed to ensure Qualified Medication Aides (QMA) received a job specific orientation to the facility after hire for 2 of 2 QMA employee files reviewed. (QMA 3 and QMA 9) Finding includes: On 10/16/25 at 9:00 A.M., employee files were reviewed. QMA 3 began employment at the facility on 6/23/25. QMA 9 began employment at the facility on 5/27/25. QMA 3 and QMA 9 lacked documentation that a job specific orientation had been completed.			

	On 10/16/25 at 1:01 P.M., the Director of Nursing (DON) provided a QMA Orientation Checklist that indicated "the orientation form will be given upon hire. The new employee is responsible for returning the completed form to the Human Resources/Clinical Nurse Leader within 30 days of the hire date". At that time, the DON indicated all employees completed the orientation checklist specific to their job upon hire and the instructor signed off when each procedure was completed. On 10/16/25 at 1:11 P.M., the DON indicated it was the policy of the facility to follow state regulations in regard to QMA orientation. On 10/16/25 at 1:32 P.M., the DON indicated she was unable to find a QMA Orientation Checklist for QMA 3 and QMA 9.			
R 0120	Personnel - Noncompliance 410 IAC 16.2-5-1.4(e)(1-3) (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the	R 0120	All staff is being educated on dementia. All residents with dementia diagnosis had the potential to be affected. Dementia training was held live in the community on 11/5 and	11/19/2025

	needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature.		11/7. Any staff that was unable to attend was able to complete training online. Dementia training has also been added to our training program upon hire and annually thereafter. Human Resources/Administrator/Designee will audit new employee files and training program reports monthly to ensure compliance is achieved.	

R 0216	Evaluation - Noncompliance 410 IAC 16.2-5-2(c)(1-4)(d) (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on observation, interview, and record review, the facility failed to ensure an assessment was completed for residents to self-administer medications for 2 of 2 residents reviewed for self-administration of medications. Residents were administering medications to themselves without assessments to ensure they could do it safely. (Resident 8, Resident 9) Findings include: 1. On 10/15/25 at 9:50 A.M.,	R 0216	LPN 20 was immediately reeducated on proper administration of all medications as it pertains to our policies. All residents had the potential to be affected by deficient practice. After investigating no other residents were found to have been affected by deficient practice. All appropriate staff have been reeducated on how to properly administer all medications. The clinical nurse leader or designee will conduct an audit of med pass2 X weekly for 4 weeks then 1X month for 5 months or until compliance is achieved.	11/19/2025

	Licensed Practical Nurse (LPN) 20 was observed while she prepped and administered medications to Resident 8. LPN 20 entered Resident 8's room and handed the resident a Breztri Aerosphere 10.7 gram inhaler (a maintenance medication used to treat chronic obstructive pulmonary disease). LPN 20 went outside the room to get a cup from the medication cart for the resident to rinse her mouth. LPN 20 did not observe Resident 8 administering two puffs from the inhaler by herself. When the nurse came back, the resident told the nurse it was hard to push the canister down all the way. On 10/16/25 at 8:30 A.M., Resident 8's clinical record was reviewed. Diagnoses included, but were not limited to, asthma and chronic obstructive pulmonary disease (COPD). The most recent Service Plan, dated 4/15/25, indicated all the resident's medications would be given by the nurse or Qualified Medication Aide (QMA). The clinical record lacked a physician's order and an assessment of Resident 8's ability to self-administer an inhaler. 2. On 10/15/25 at 9:25 A.M., LPN 20 prepped Resident 9's medications and took them into			

	the resident's room. She handed the resident a Symbicort 160 microgram (mcg)/4.5 mcg inhaler (a maintenance medication used to treat chronic obstructive pulmonary disease) and exited the room to get the blood pressure cuff from the medication cart. LPN 20 left the resident's medications on the nightstand. The resident administered two puffs from the inhaler to herself, opened a Caltrate chewable (calcium supplement), and took it while the nurse was out of the room. After getting the resident's blood pressure, LPN 20 left the room and left all remaining medications in the room with the resident to self-administer. On 10/16/25 at 9:00 A.M., Resident 9's clinical record was reviewed. Diagnoses included, but were not limited to, dementia, asthma, and COPD. Current Physician's Orders for Resident 9's 8:00 A.M. medications included the following: Aspirin 81 milligram (mg) (antiplatelet), give one tablet by mouth Symbicort 160 mcg/4.5 mcg inhaler, inhale two puffs by mouth rinsing mouth after use to avoid oral thrush			

	Buspar 15 mg (anxiety), give one tablet by mouth Caltrate 600 mg and vitamin D3 800 mg chew, give one by mouth Culturelle chew (probiotic), give one by mouth Prestiq 100 mg ER (antidepressant), give one by mouth glipizide/metformin 2.5 mg/250 mg (diabetes), give one by mouth lisinopril 20 mg (blood pressure), give one by mouth loratadine 10 mg (allergies), give one by mouth metformin 500 mg (diabetes), give one by mouth metoprolol succinate 100 mg ER (blood pressure), give one by mouth vitamin B12 1000 mcg (anemia), give one by mouth The most recent Service Plan, dated 6/9/25, indicated all the resident's medications would be given by the nurse or QMA. The clinical record lacked a physician's order and an assessment of Resident 9's ability to self-administer an inhaler and her other			

medications.

On 10/15/25 at 8:50 A.M., the Administrator indicated there was no one in the facility that self-administered medications.

On 10/16/25 at 8:56 A.M., LPN 18 indicated nursing staff should observe residents taking all medications. She indicated they allowed residents to perform inhalations from inhalers, but they had to be observed. Residents had not been assessed to self-administer medications.

On 10/16/25 at 1:11 P.M., the Director of Nursing (DON) indicated they did not have a policy for self-administration of medications or medication administration. She indicated they would follow regulations.

Based on observation, interview, and record review, the facility failed to ensure an assessment was completed for residents to self-administer medications for 2 of 2 residents reviewed for self-administration of medications. Residents were administering medications to themselves without assessments to ensure they could do it safely. (Resident 8, Resident 9)

Findings include:

1. On 10/15/25 at 9:50 A.M., Licensed Practical Nurse (LPN)

	20 was observed while she prepped and administered medications to Resident 8. LPN 20 entered Resident 8's room and handed the resident a Breztri Aerosphere 10.7 gram inhaler (a maintenance medication used to treat chronic obstructive pulmonary disease). LPN 20 went outside the room to get a cup from the medication cart for the resident to rinse her mouth. LPN 20 did not observe Resident 8 administering two puffs from the inhaler by herself. When the nurse came back, the resident told the nurse it was hard to push the canister down all the way. On 10/16/25 at 8:30 A.M., Resident 8's clinical record was reviewed. Diagnoses included, but were not limited to, asthma and chronic obstructive pulmonary disease (COPD). The most recent Service Plan, dated 4/15/25, indicated all the resident's medications would be given by the nurse or Qualified Medication Aide (QMA). The clinical record lacked a physician's order and an assessment of Resident 8's ability to self-administer an inhaler. 2. On 10/15/25 at 9:25 A.M., LPN 20 prepped Resident 9's medications and took them into the resident's room. She			

handed the resident a Symbicort 160 microgram (mcg)/4.5 mcg inhaler (a maintenance medication used to treat chronic obstructive pulmonary disease) and exited the room to get the blood pressure cuff from the medication cart. LPN 20 left the resident's medications on the nightstand. The resident administered two puffs from the inhaler to herself, opened a Caltrate chewable (calcium supplement), and took it while the nurse was out of the room. After getting the resident's blood pressure, LPN 20 left the room and left all remaining medications in the room with the resident to self-administer.

On 10/16/25 at 9:00 A.M., Resident 9's clinical record was reviewed. Diagnoses included, but were not limited to, dementia, asthma, and COPD.

Current Physician's Orders for Resident 9's 8:00 A.M. medications included the following:

Aspirin 81 milligram (mg) (antiplatelet), give one tablet by mouth

Symbicort 160 mcg/4.5 mcg inhaler, inhale two puffs by mouth rinsing mouth after use to avoid oral thrush

Buspar 15 mg (anxiety), give one tablet by mouth

	Caltrate 600 mg and vitamin D3 800 mg chew, give one by mouth Culturelle chew (probiotic), give one by mouth Prestiq 100 mg ER (antidepressant), give one by mouth glipizide/metformin 2.5 mg/250 mg (diabetes), give one by mouth lisinopril 20 mg (blood pressure), give one by mouth loratadine 10 mg (allergies), give one by mouth metformin 500 mg (diabetes), give one by mouth metoprolol succinate 100 mg ER (blood pressure), give one by mouth vitamin B12 1000 mcg (anemia), give one by mouth The most recent Service Plan, dated 6/9/25, indicated all the resident's medications would be given by the nurse or QMA. The clinical record lacked a physician's order and an assessment of Resident 9's ability to self-administer an inhaler and her other medications. On 10/15/25 at 8:50 A.M., the			

	Administrator indicated there was no one in the facility that self-administered medications. On 10/16/25 at 8:56 A.M., LPN 18 indicated nursing staff should observe residents taking all medications. She indicated they allowed residents to perform inhalations from inhalers, but they had to be observed. Residents had not been assessed to self-administer medications. On 10/16/25 at 1:11 P.M., the Director of Nursing (DON) indicated they did not have a policy for self-administration of medications or medication administration. She indicated they would follow regulations.			
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	R 0217	The one resident affected by the deficient practice was discharged from the community on 9/28/25. All residents had the potential to be affected by the deficient practice. After a thorough audit all service plans have been updated and signed for current residents.	11/19/2025

	(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 nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on interview and record review, the facility failed to ensure resident service plans were signed and dated for 1 of 2 discharged residents reviewed for service plans. (Resident 6) Finding includes: On 10/15/25 at 1:31 P.M., Resident 6's clinical record was reviewed. Resident 6 was admitted to the facility on 7/2/25		An assessment and care plan tracker has been created and will be followed to ensure compliance is achieved. The administrator or designee will conduct an audit of the assessment tracker and care plan updates weekly for four weeks and then monthly for three months or until compliance is achieved.	

	and was discharged to a skilled facility on 9/28/25. Diagnoses included, but were not limited to, atrial fibrillation. An admission service plan was completed on 7/2/25. The service plan was not signed by the resident. On 10/16/25 at 11:06 A.M., the Director of Nursing (DON) indicated that Resident 6 did not sign her service plan. On 10/16/25 at 11:24 A.M., the DON indicated that service plans were completed, reviewed, and signed on admission. On 10/16/25 at 1:01 P.M., the DON provided a Resident Care Plan policy, revised 1/18/24, that indicated "The resident and/or responsible party will sign and date his or her Service Plan after review and discussion, indicating his or her agreement with the plan". Based on interview and record review, the facility failed to ensure resident service plans were signed and dated for 1 of 2 discharged residents reviewed for service plans. (Resident 6) Finding includes: On 10/15/25 at 1:31 P.M., Resident 6's clinical record was reviewed. Resident 6 was admitted to the facility on 7/2/25			

	and was discharged to a skilled facility on 9/28/25. Diagnoses included, but were not limited to, atrial fibrillation. An admission service plan was completed on 7/2/25. The service plan was not signed by the resident. On 10/16/25 at 11:06 A.M., the Director of Nursing (DON) indicated that Resident 6 did not sign her service plan. On 10/16/25 at 11:24 A.M., the DON indicated that service plans were completed, reviewed, and signed on admission. On 10/16/25 at 1:01 P.M., the DON provided a Resident Care Plan policy, revised 1/18/24, that indicated "The resident and/or responsible party will sign and date his or her Service Plan after review and discussion, indicating his or her agreement with the plan".			
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	R 0246	QMA's were in-serviced immediately on 10/17/25 by the CNL on regulations and requirements for authorization from a licensed nurse prior to administering any PRN medications. All residents had the potential to	11/14/2025

	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. 4. On 10/15/25 at 10:13 A.M., Resident 3's clinical record was reviewed. Diagnoses included, but were not limited to, fibromyalgia, irritable bowel syndrome (IBS), and asthma. Physician orders included, but were not limited to: tramadol (a narcotic pain reliever) 50 milligram (mg) tablet - Give one tablet by mouth twice daily as needed, dated 7/2/25 acetaminophen (a pain reliever) 500 mg tablet - Take one or two tablets by mouth twice daily as needed for pain, do not exceed 2000mg per day, dated 6/30/25 loperamide (an antidiarrheal) 2 mg capsule - Give two capsules by mouth four times a day as needed after each loose stool, max daily eight capsules, dated 6/26/25 hyoscyamine (a medication used to treat irritable bowel syndrome) 0.125 mg tablet - Give one to two tablets by mouth every four hours as needed for irritable bowel syndrome, dated 6/26/25 albuterol (a bronchodilator)		be affected by the deficient practice. Guidelines were created to ensure that QMA are educated on who to obtain approval from and where to document it. CNL or designee will audit PRN usage daily for 2 weeks to ensure guidelines are being followed. Then they will audit nurses' notes 1X for 4 weeks. 1X monthly for 3 months or until compliance is achieved.	

	0.083% nebulizer - Inhale 3 milliliter (mL) unit dose vial via medication nebulizer every six hours as needed, dated 6/26/25 Resident 6's Medication Administration Record (MAR) from 9/1/25 through 10/15/25 included, but was not limited to, the following dates that tramadol 50 mg PRN was administered by a QMA without authorization from a licensed nurse: 9/1/25 at 7:39 A.M. (given by QMA 5) 9/3/25 at 12:00 A.M. (given by QMA 11) 9/4/25 at 7:55 A.M. (given by QMA 3) 9/8/25 at 8:19 P.M. (given by QMA 9) 9/9/25 at 12:00 A.M. (given by QMA 9) 9/14/25 at 6:13 A.M. (given by QMA 7) 9/17/25 at 11:40 A.M. (given by QMA 5) 9/25/25 at 12:00 A.M. (given by QMA 3) 9/26/25 at 4:41 P.M. (given by QMA 3) 9/27/25 at 8:27 A.M. (given by QMA 3)			

	10/8/25 at 11:59 P.M. (given by QMA 7) 10/9/25 at 8:36 P.M. (given by QMA 3) Resident 6's Medication Administration Record (MAR) from 9/1/25 through 10/15/25 included, but was not limited to, the following dates that acetaminophen 500 mg PRN was administered by a QMA without authorization from a licensed nurse: 9/24/25 at 4:30 A.M. (two tablets given by QMA 7) Resident 6's Medication Administration Record (MAR) from 9/1/25 through 10/15/25 included, but was not limited to, the following dates that loperamide 2 mg PRN was administered by a QMA without authorization from a licensed nurse: 9/7/25 at 10:11 A.M. (given by QMA 5) Resident 6's Medication Administration Record (MAR) from 9/1/25 through 10/15/25 included, but was not limited to, the following dates that hyoscyamine 0.125 mg PRN was administered by a QMA without authorization from a licensed nurse:			

	9/24/25 at 4:30 A.M. (given by QMA 7) Resident 6's Medication Administration Record (MAR) from 9/1/25 through 10/15/25 included, but was not limited to, the following dates that albuterol 0.083% PRN was administered by a QMA without authorization from a licensed nurse: 9/8/25 at 8:19 P.M. (given by QMA 9) During an interview on 10/16/25 at 9:42 A.M., Licensed Practical Nurse (LPN) 20 indicated when a resident requested a PRN medication, QMAs should ask a nurse for permission, the nurse would give permission, and the QMA should write in the EMAR notes which nurse gave permission for the medication. On 10/16/25 at 1:25 P.M., the Director of Nursing (DON) indicated there was not a policy for administration of as needed medications by QMAs. She indicated staff should be following their scope of practice. At that time, the QMA scope of practice was reviewed with the DON that indicated "Administer previously ordered pro re nata (PRN) medication only if authorization is obtained from the facility's licensed nurse on duty or on call. If authorization is obtained, the QMA must do the following: ... (B) Document in			

	the resident record that the facility's licensed nurse was contacted, symptoms were described, and permission was granted to administer the medication, including the time of contact". She indicated at that time she was under the impression that only consents obtained over the phone needed to be documented. Based on interview and record review, the facility failed to ensure Qualified Medication Aides (QMA) that administered as needed medications obtained authorization from a licensed nurse prior to administration for 4 of 5 active resident records reviewed. (Resident 1, Resident 5, Resident 4, Resident 3) Findings include: 1. On 10/15/25 at 10:30 A.M., Resident 1's clinical record was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease and gastro-esophageal reflux. Current physician orders included, but were not limited to: oxycodone/apap (narcotic pain medication) 10-325mg (milligram) every 4 hours as needed, dated 9/19/25. Resident 1's October 2025 medication administration record (MAR) indicated on			

	10/5/25 at 12:00 A.M., QMA 3 administered an as needed dose of oxycodone/apap without prior authorization from a licensed nurse. Resident 1's nursing notes lacked documentation that authorization from a licensed nurse was obtained prior to authorization of the as needed medication. 2. On 10/16/25 at 9:00 A.M., Resident 5's clinical record was reviewed. Diagnosis included, but was not limited to, chronic obstructive pulmonary disease. Current physician orders included, but were not limited to: Albuterol nebulizer 0.083%, inhale contents 1 unit dose vial via nebulizer every 4 hours as needed, dated 8/7/25. Albuterol HFA inhaler 8.5g (gram), 2 puffs every 4 hours as needed, dated 2/13/25. Resident 5's August MAR indicated on 8/13/25, the following as needed medications were administered by QMA 3 without prior authorization from a licensed nurse: Albuterol nebulizer at 12:00 A.M.			

Albuterol HFA inhaler at 6:29 P.M.

Resident 5's nursing notes lacked documentation that authorization from a licensed nurse was obtained prior to authorization of the as needed medications.

3. On 10/15/25 at 10:59 A.M., Resident 4's clinical record was reviewed. Resident 4 was admitted on 9/7/23. Diagnoses included, but were not limited to, type 2 diabetes mellitus.

Current physician orders included, but were not limited to:

Hydrocodone (a narcotic pain medication) 7.5-325 MG (milligrams) Take one tablet by mouth every four hours as needed for pain, start date 9/22/25

Lorazepam 0.5 MG Take one tablet by mouth three times daily as needed for anxiety, start date 9/15/25

The electronic medication administration record (EMAR) indicated a QMA administered as needed (PRN) medications without documentation of nurse approval the following dates and times during October 2025:

10/1/25 8:32 P.M. Hydrocodone 7.5-325 MG

10/1/25 8:32 P.M. Lorazepam

	0.5 MG 10/9/25 4:38 A.M. Hydrocodone 7.5-325 MG 4. On 10/15/25 at 10:13 A.M., Resident 3's clinical record was reviewed. Diagnoses included, but were not limited to, fibromyalgia, irritable bowel syndrome (IBS), and asthma. Physician orders included, but were not limited to: tramadol (a narcotic pain reliever) 50 milligram (mg) tablet - Give one tablet by mouth twice daily as needed, dated 7/2/25 acetaminophen (a pain reliever) 500 mg tablet - Take one or two tablets by mouth twice daily as needed for pain, do not exceed 2000mg per day, dated 6/30/25 loperamide (an antidiarrheal) 2 mg capsule - Give two capsules by mouth four times a day as needed after each loose stool, max daily eight capsules, dated 6/26/25 hyoscyamine (a medication used to treat irritable bowel syndrome) 0.125 mg tablet - Give one to two tablets by mouth every four hours as needed for irritable bowel syndrome, dated 6/26/25 albuterol (a bronchodilator) 0.083% nebulizer - Inhale 3 milliliter (mL) unit dose vial via			

	medication nebulizer every six hours as needed, dated 6/26/25 Resident 6's Medication Administration Record (MAR) from 9/1/25 through 10/15/25 included, but was not limited to, the following dates that tramadol 50 mg PRN was administered by a QMA without authorization from a licensed nurse: 9/1/25 at 7:39 A.M. (given by QMA 5) 9/3/25 at 12:00 A.M. (given by QMA 11) 9/4/25 at 7:55 A.M. (given by QMA 3) 9/8/25 at 8:19 P.M. (given by QMA 9) 9/9/25 at 12:00 A.M. (given by QMA 9) 9/14/25 at 6:13 A.M. (given by QMA 7) 9/17/25 at 11:40 A.M. (given by QMA 5) 9/25/25 at 12:00 A.M. (given by QMA 3) 9/26/25 at 4:41 P.M. (given by QMA 3) 9/27/25 at 8:27 A.M. (given by QMA 3)			

	10/8/25 at 11:59 P.M. (given by QMA 7) 10/9/25 at 8:36 P.M. (given by QMA 3) Resident 6's Medication Administration Record (MAR) from 9/1/25 through 10/15/25 included, but was not limited to, the following dates that acetaminophen 500 mg PRN was administered by a QMA without authorization from a licensed nurse: 9/24/25 at 4:30 A.M. (two tablets given by QMA 7) Resident 6's Medication Administration Record (MAR) from 9/1/25 through 10/15/25 included, but was not limited to, the following dates that loperamide 2 mg PRN was administered by a QMA without authorization from a licensed nurse: 9/7/25 at 10:11 A.M. (given by QMA 5) Resident 6's Medication Administration Record (MAR) from 9/1/25 through 10/15/25 included, but was not limited to, the following dates that hyoscyamine 0.125 mg PRN was administered by a QMA without authorization from a licensed nurse:			

	9/24/25 at 4:30 A.M. (given by QMA 7) Resident 6's Medication Administration Record (MAR) from 9/1/25 through 10/15/25 included, but was not limited to, the following dates that albuterol 0.083% PRN was administered by a QMA without authorization from a licensed nurse: 9/8/25 at 8:19 P.M. (given by QMA 9) During an interview on 10/16/25 at 9:42 A.M., Licensed Practical Nurse (LPN) 20 indicated when a resident requested a PRN medication, QMAs should ask a nurse for permission, the nurse would give permission, and the QMA should write in the EMAR notes which nurse gave permission for the medication. On 10/16/25 at 1:25 P.M., the Director of Nursing (DON) indicated there was not a policy for administration of as needed medications by QMAs. She indicated staff should be following their scope of practice. At that time, the QMA scope of practice was reviewed with the DON that indicated "Administer previously ordered pro re nata (PRN) medication only if authorization is obtained from the facility's licensed nurse on duty or on call. If authorization is obtained, the QMA must do the following: ... (B) Document in			

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	10/5/25 at 12:00 A.M., QMA 3 administered an as needed dose of oxycodone/apap without prior authorization from a licensed nurse. Resident 1's nursing notes lacked documentation that authorization from a licensed nurse was obtained prior to authorization of the as needed medication. 2. On 10/16/25 at 9:00 A.M., Resident 5's clinical record was reviewed. Diagnosis included, but was not limited to, chronic obstructive pulmonary disease. Current physician orders included, but were not limited to: Albuterol nebulizer 0.083%, inhale contents 1 unit dose vial via nebulizer every 4 hours as needed, dated 8/7/25. Albuterol HFA inhaler 8.5g (gram), 2 puffs every 4 hours as needed, dated 2/13/25. Resident 5's August MAR indicated on 8/13/25, the following as needed medications were administered by QMA 3 without prior authorization from a licensed nurse: Albuterol nebulizer at 12:00 A.M.			

Albuterol HFA inhaler at 6:29 P.M.

Resident 5's nursing notes lacked documentation that authorization from a licensed nurse was obtained prior to authorization of the as needed medications.

3. On 10/15/25 at 10:59 A.M., Resident 4's clinical record was reviewed. Resident 4 was admitted on 9/7/23. Diagnoses included, but were not limited to, type 2 diabetes mellitus.

Current physician orders included, but were not limited to:

Hydrocodone (a narcotic pain medication) 7.5-325 MG (milligrams) Take one tablet by mouth every four hours as needed for pain, start date 9/22/25

Lorazepam 0.5 MG Take one tablet by mouth three times daily as needed for anxiety, start date 9/15/25

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	9/24/25 at 4:30 A.M. (given by QMA 7) Resident 6's Medication Administration Record (MAR) from 9/1/25 through 10/15/25 included, but was not limited to, the following dates that albuterol 0.083% PRN was administered by a QMA without authorization from a licensed nurse: 9/8/25 at 8:19 P.M. (given by QMA 9) During an interview on 10/16/25 at 9:42 A.M., Licensed Practical Nurse (LPN) 20 indicated when a resident requested a PRN medication, QMAs should ask a nurse for permission, the nurse would give permission, and the QMA should write in the EMAR notes which nurse gave permission for the medication. On 10/16/25 at 1:25 P.M., the Director of Nursing (DON) indicated there was not a policy for administration of as needed medications by QMAs. She indicated staff should be following their scope of practice. At that time, the QMA scope of practice was reviewed with the DON that indicated "Administer previously ordered pro re nata (PRN) medication only if authorization is obtained from the facility's licensed nurse on duty or on call. If authorization is obtained, the QMA must do the following: ... (B) Document in			

	the resident record that the facility's licensed nurse was contacted, symptoms were described, and permission was granted to administer the medication, including the time of contact". She indicated at that time she was under the impression that only consents obtained over the phone needed to be documented. Based on interview and record review, the facility failed to ensure Qualified Medication Aides (QMA) that administered as needed medications obtained authorization from a licensed nurse prior to administration for 4 of 5 active resident records reviewed. (Resident 1, Resident 5, Resident 4, Resident 3) Findings include: 1. On 10/15/25 at 10:30 A.M., Resident 1's clinical record was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease and gastro-esophageal reflux. Current physician orders included, but were not limited to: oxycodone/apap (narcotic pain medication) 10-325mg (milligram) every 4 hours as needed, dated 9/19/25. Resident 1's October 2025 medication administration record (MAR) indicated on			

	10/5/25 at 12:00 A.M., QMA 3 administered an as needed dose of oxycodone/apap without prior authorization from a licensed nurse. Resident 1's nursing notes lacked documentation that authorization from a licensed nurse was obtained prior to authorization of the as needed medication. 2. On 10/16/25 at 9:00 A.M., Resident 5's clinical record was reviewed. Diagnosis included, but was not limited to, chronic obstructive pulmonary disease. Current physician orders included, but were not limited to: Albuterol nebulizer 0.083%, inhale contents 1 unit dose vial via nebulizer every 4 hours as needed, dated 8/7/25. Albuterol HFA inhaler 8.5g (gram), 2 puffs every 4 hours as needed, dated 2/13/25. Resident 5's August MAR indicated on 8/13/25, the following as needed medications were administered by QMA 3 without prior authorization from a licensed nurse: Albuterol nebulizer at 12:00 A.M.			

Albuterol HFA inhaler at 6:29 P.M.

Resident 5's nursing notes lacked documentation that authorization from a licensed nurse was obtained prior to authorization of the as needed medications.

3. On 10/15/25 at 10:59 A.M., Resident 4's clinical record was reviewed. Resident 4 was admitted on 9/7/23. Diagnoses included, but were not limited to, type 2 diabetes mellitus.

Current physician orders included, but were not limited to:

Hydrocodone (a narcotic pain medication) 7.5-325 MG (milligrams) Take one tablet by mouth every four hours as needed for pain, start date 9/22/25

Lorazepam 0.5 MG Take one tablet by mouth three times daily as needed for anxiety, start date 9/15/25

The electronic medication administration record (EMAR) indicated a QMA administered as needed (PRN) medications without documentation of nurse approval the following dates and times during October 2025:

10/1/25 8:32 P.M. Hydrocodone 7.5-325 MG

10/1/25 8:32 P.M. Lorazepam

	0.5 MG 10/9/25 4:38 A.M. Hydrocodone 7.5-325 MG			
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 observation, interview, and record review, the facility failed to ensure residents received medications according to physician's orders for 2 of 5 residents observed for medication administration. A resident's new inhaler was not primed prior to administration and an incorrect dose of medication was administered. (Resident 8, Resident 9) Findings include:	R 0247	LPN 20 was immediately pulled and educated on deficient findings. Nurse was educated on the proper procedure to be followed for administering all medications. All residents had potential to be affected by the deficient practice. Upon investigating the deficient practice, it was found that residents 8 and residents 9 were the only findings that were affected. Reeducation was given to all nursing staff on proper the procedure of checking medications prior to administering, and the importance of following all manufacturer’s instructions. The clinical nurse leader or designee will conduct an audit 2X weekly for 4 weeks then 1X month for 5 months or until compliance is achieved.	11/14/2025

	1. On 10/15/25 at 9:50 A.M., Licensed Practical Nurse (LPN) 20 was observed while she prepped medications for Resident 8. LPN 20 was observed putting one hydralazine 25 mg tablet (for blood pressure) into the medication cup from the medication card to administer to Resident 8. On 10/16/25 at 8:30 A.M., Resident 8's clinical record was reviewed. Diagnoses included, but were not limited to, asthma, hypertension (high blood pressure), and chronic obstructive pulmonary disease (COPD). Current physician's orders included, but were not limited to, hydralazine 50 mg tablet, give one tablet by mouth three times daily, ordered 10/6/25. The most recent Service Plan, dated 4/15/25, indicated all the resident's medications would be given by the nurse or Qualified Medication Aide (QMA). On 10/15/25 at 10:00 A.M., LPN 20 indicated Resident 8 was recently in the hospital. The dosage must have changed but the medication card in the medication cart was not updated with the current physician's order. 2. On 10/15/25 at 9:50 A.M., Licensed Practical Nurse (LPN)			

20 was observed while she prepped and administered medications to Resident 9. LPN 20 opened a new Symbicort 160 microgram (mcg)/4.5 mcg inhaler (a maintenance medication used to treat chronic obstructive pulmonary disease) and handed it to the resident to administer without priming it to ensure an accurate dose of medicine was delivered.

On 10/16/25 at 8:30 A.M., Resident 9's clinical record was reviewed. Diagnoses included, but were not limited to, asthma and COPD.

The most recent Service Plan, dated 6/9/25, indicated all the resident's medications would be given by the nurse or QMA.

Symbicort manufacturer's package insert, last revised June 2010, indicated, " ... Prime Symbicort before using for the first time by releasing two test sprays into the air away from the face, shaking well for 5 seconds before each spray ... "

On 10/16/25 at 8:56 A.M., LPN 18 indicated nursing staff should follow physician's orders and new inhalers should be primed before use.

On 10/16/25 at 1:11 P.M., the Director of Nursing (DON) indicated they did not have a policy for medication administration. She indicated

they would follow regulations.

Based on observation, interview, and record review, the facility failed to ensure residents received medications according to physician's orders for 2 of 5 residents observed for medication administration. A resident's new inhaler was not primed prior to administration and an incorrect dose of medication was administered. (Resident 8, Resident 9)

Findings include:

1. On 10/15/25 at 9:50 A.M., Licensed Practical Nurse (LPN) 20 was observed while she prepped medications for Resident 8. LPN 20 was observed putting one hydralazine 25 mg tablet (for blood pressure) into the medication cup from the medication card to administer to Resident 8.

On 10/16/25 at 8:30 A.M., Resident 8's clinical record was reviewed. Diagnoses included, but were not limited to, asthma, hypertension (high blood pressure), and chronic obstructive pulmonary disease (COPD).

Current physician's orders included, but were not limited to, hydralazine 50 mg tablet, give one tablet by mouth three times daily, ordered 10/6/25.

The most recent Service Plan, dated 4/15/25, indicated all the resident's medications would be given by the nurse or Qualified Medication Aide (QMA).

On 10/15/25 at 10:00 A.M., LPN 20 indicated Resident 8 was recently in the hospital. The dosage must have changed but the medication card in the medication cart was not updated with the current physician's order.

2. On 10/15/25 at 9:50 A.M., Licensed Practical Nurse (LPN) 20 was observed while she prepped and administered medications to Resident 9. LPN 20 opened a new Symbicort 160 microgram (mcg)/4.5 mcg inhaler (a maintenance medication used to treat chronic obstructive pulmonary disease) and handed it to the resident to administer without priming it to ensure an accurate dose of medicine was delivered.

On 10/16/25 at 8:30 A.M., Resident 9's clinical record was reviewed. Diagnoses included, but were not limited to, asthma and COPD.

The most recent Service Plan, dated 6/9/25, indicated all the resident's medications would be given by the nurse or QMA.

Symbicort manufacturer's package insert, last revised June 2010, indicated, " ... Prime

	Symbicort before using for the first time by releasing two test sprays into the air away from the face, shaking well for 5 seconds before each spray ... " On 10/16/25 at 8:56 A.M., LPN 18 indicated nursing staff should follow physician's orders and new inhalers should be primed before use. On 10/16/25 at 1:11 P.M., the Director of Nursing (DON) indicated they did not have a policy for medication administration. She indicated they would follow regulations.			
R 0273	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(f) (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to ensure food items in the kitchen were properly labeled and stored or removed after the expiration date for 1 of 1 observations of the kitchen. (Kitchen) Finding includes: On 10/15/25 at 8:42 A.M., the	R 0273	All items that were not labeled correctly or stored improperly were immediately thrown out. All residents had the potential to be affected by the deficient practice. Upon investigating no residents were found to be affected negatively. Staff were re-educated on policy and procedure for labeling and storage.	11/14/2025

	following items were observed in the facility kitchen: In the dry storage room: Bag of granola dated 8/6/25 use by 10/6/25 Vanilla wafers dated 7/25/25 use by 9/25/25 Bag of brownie mix use by 8/18/25 Bag of marshmallows dated 7/22/25 Carton of instant mashed potatoes opened, undated Bag of white rice opened, undated Bag of pudding mix opened, undated Bag of jello mix use by 9/27/25 In the walk-in freezer: Lemon cake use by 9/19/25 In the walk-in refrigerator: Cake in a pan, open to air, undated Container labeled 'noodle', use by 10/8 Cake slices on plates, open to air, undated		A guide has been created to ensure proper storage and labeling practices. The dietary director/designee will complete an audit of the kitchen 1x week for 4 weeks, 2x per month for 3 months or until compliance is achieved.	

	Ground beef labeled prepped 9/29/25, no use by date Bag of chicken labeled prepped 10/5, no use by date In the reach-in refrigerator: One pitcher of orange juice, no label or date One pitcher of milk, no label or date During an interview on 10/16/25 at 1:45 P.M., the Dietary Manager indicated the facility did not have a guideline or policy to indicate how long something should be used after opening. On 10/16/25 at 1:01 P.M., the Director of Nursing (DON) provided a policy titled Label Products, dated 1/2024, that indicated "The director maintains labeling system is to ensure food safety, compliance with regulations and efficient kitchen management. Management use dots daily and mark clearly with markers for labeling food items accurately and efficiently."			

	Based on observation, interview, and record review, the facility failed to ensure food items in the kitchen were properly labeled and stored or removed after the expiration date for 1 of 1 observations of the kitchen. (Kitchen) Finding includes: On 10/15/25 at 8:42 A.M., the following items were observed in the facility kitchen: In the dry storage room: Bag of granola dated 8/6/25 use by 10/6/25 Vanilla wafers dated 7/25/25 use by 9/25/25 Bag of brownie mix use by 8/18/25 Bag of marshmallows dated 7/22/25 Carton of instant mashed potatoes opened, undated Bag of white rice opened, undated Bag of pudding mix opened, undated Bag of jello mix use by 9/27/25 In the walk-in freezer: Lemon cake use by 9/19/25			

	In the walk-in refrigerator: Cake in a pan, open to air, undated Container labeled 'noodle', use by 10/8 Cake slices on plates, open to air, undated Ground beef labeled prepped 9/29/25, no use by date Bag of chicken labeled prepped 10/5, no use by date In the reach-in refrigerator: One pitcher of orange juice, no label or date One pitcher of milk, no label or date During an interview on 10/16/25 at 1:45 P.M., the Dietary Manager indicated the facility did not have a guideline or policy to indicate how long something should be used after opening. On 10/16/25 at 1:01 P.M., the Director of Nursing (DON) provided a policy titled Label Products, dated 1/2024, that indicated "The director maintains labeling system is to ensure food safety, compliance with regulations and efficient kitchen management. Management use dots daily and mark clearly with markers for			

	labeling food items accurately and efficiently."			
R 0382	Mental Health Screening - Noncompliance 410 IAC 16.2-5-11.1(f) (f) Each resident with a major mental illness must have a comprehensive care plan that is developed within thirty (30) days after admission to the residential care facility. 2. On 10/15/25 at 10:13 A.M., Resident 3's clinical record was reviewed. Diagnoses included, but were not limited to, depressive disorder and depression with anxiety. Resident 3 was admitted to the facility on 6/26/25 and her payor source was Medicaid. Physician orders included, but were not limited to: buspirone (an antianxiety medication) 5 milligrams (mg) tablet - Give one tablet by mouth three times daily, dated 6/26/25 Trintellix (an antidepressant) 20 mg tablet - Give one tablet by mouth once daily, dated 6/26/25	R 0382	The two residents that were found to be effective by deficient practice were immediately care planned and placed with appropriate services. Any resident with the diagnosis of a major mental illness had the potential to be affected. A thorough audit was completed and all residents with major mental illnesses were identified. Those residents identified were care planned and placed with appropriate services. All new admitting residents will be audited and screened for major mental illness diagnosis. Before they are admitted facility will ensure that appropriate services are in place and care planned properly. CNL or designee will audit all new admissions for major mental illness diagnosis and ensure proper services are in place. The audits of all new admissions will be	11/07/2025

	Vraylar (a medication used to treat Major Depressive Disorder) 1.5 mg capsule - Give one capsule by mouth once daily, dated 6/26/25 A pre-admission physician assessment, dated 6/19/25, indicated Resident 3 was receiving treatment for psychiatric condition. The clinical record lacked a comprehensive care plan addressing Resident 3's major mental illness or service and treatments received to treat the mental illness. On 10/16/25 at 8:56 A.M., the Director of Nursing (DON) indicated Resident 3 received mental health services outside of the facility, but she could not find any documentation about what type or how often. On 10/15/25 at 8:50 A.M., the Administrator indicated that there were no residents in the facility with major mental illness diagnoses. On 10/16/25 at 10:01 A.M., the DON indicated that mental health diagnoses and services provided were not addressed on the residents' care plans and she was unaware of the regulation requiring the facility to develop a comprehensive care plan addressing major mental illness and services provided.		conducted at weekly meetings. Quarterly audits of current resident diagnosis will be conducted.	

On 10/16/25 at 1:11 P.M., the DON indicated it was the policy of the facility to follow state regulations in regard to mental health screenings and services.

Based on interview and record review, the facility failed to ensure a comprehensive care plan was developed after admission for residents with a major mental illness for 2 of 2 residents reviewed with major mental illness. (Resident 2 and Resident 3)

Findings include:

1. On 10/15/25 at 10:06 A.M., Resident 2's clinical record was reviewed. Resident 2 was admitted on 1/27/25. Diagnoses included, but were not limited to, major depressive disorder.

The comprehensive care plan did not include the diagnosis of major depressive disorder or services offered related to mental illness.

2. On 10/15/25 at 10:13 A.M., Resident 3's clinical record was reviewed. Diagnoses included, but were not limited to, depressive disorder and depression with anxiety. Resident 3 was admitted to the facility on 6/26/25 and her payor source was Medicaid.

Physician orders included, but were not limited to:

buspirone (an antianxiety medication) 5 milligrams (mg) tablet - Give one tablet by mouth three times daily, dated 6/26/25

Trintellix (an antidepressant) 20 mg tablet - Give one tablet by mouth once daily, dated 6/26/25

Vraylar (a medication used to treat Major Depressive Disorder) 1.5 mg capsule - Give one capsule by mouth once daily, dated 6/26/25

A pre-admission physician assessment, dated 6/19/25, indicated Resident 3 was receiving treatment for psychiatric condition.

The clinical record lacked a comprehensive care plan addressing Resident 3's major mental illness or service and treatments received to treat the mental illness.

On 10/16/25 at 8:56 A.M., the Director of Nursing (DON) indicated Resident 3 received mental health services outside of the facility, but she could not find any documentation about what type or how often.

On 10/15/25 at 8:50 A.M., the Administrator indicated that there were no residents in the facility with major mental illness diagnoses.

On 10/16/25 at 10:01 A.M., the

DON indicated that mental health diagnoses and services provided were not addressed on the residents' care plans and she was unaware of the regulation requiring the facility to develop a comprehensive care plan addressing major mental illness and services provided.

On 10/16/25 at 1:11 P.M., the DON indicated it was the policy of the facility to follow state regulations in regard to mental health screenings and services.

Based on interview and record review, the facility failed to ensure a comprehensive care plan was developed after admission for residents with a major mental illness for 2 of 2 residents reviewed with major mental illness. (Resident 2 and Resident 3)

Findings include:

1. On 10/15/25 at 10:06 A.M., Resident 2's clinical record was reviewed. Resident 2 was admitted on 1/27/25. Diagnoses included, but were not limited to, major depressive disorder.

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Vraylar (a medication used to treat Major Depressive Disorder) 1.5 mg capsule - Give one capsule by mouth once daily, dated 6/26/25

A pre-admission physician assessment, dated 6/19/25, indicated Resident 3 was receiving treatment for psychiatric condition.

The clinical record lacked a comprehensive care plan addressing Resident 3's major mental illness or service and treatments received to treat the mental illness.

On 10/16/25 at 8:56 A.M., the Director of Nursing (DON) indicated Resident 3 received mental health services outside of the facility, but she could not

find any documentation about what type or how often.

On 10/15/25 at 8:50 A.M., the Administrator indicated that there were no residents in the facility with major mental illness diagnoses.

On 10/16/25 at 10:01 A.M., the DON indicated that mental health diagnoses and services provided were not addressed on the residents' care plans and she was unaware of the regulation requiring the facility to develop a comprehensive care plan addressing major mental illness and services provided.

On 10/16/25 at 1:11 P.M., the DON indicated it was the policy of the facility to follow state regulations in regard to mental health screenings and services.

Based on interview and record review, the facility failed to ensure a comprehensive care plan was developed after admission for residents with a major mental illness for 2 of 2 residents reviewed with major mental illness. (Resident 2 and Resident 3)

Findings include:

1. On 10/15/25 at 10:06 A.M., Resident 2's clinical record was reviewed. Resident 2 was admitted on 1/27/25. Diagnoses included, but were not limited to, major depressive disorder.

The comprehensive care plan did not include the diagnosis of major depressive disorder or services offered related to mental illness.

2. On 10/15/25 at 10:13 A.M., Resident 3's clinical record was reviewed. Diagnoses included, but were not limited to, depressive disorder and depression with anxiety. Resident 3 was admitted to the facility on 6/26/25 and her payor source was Medicaid.

Physician orders included, but were not limited to:

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Trintellix (an antidepressant) 20 mg tablet - Give one tablet by mouth once daily, dated 6/26/25

Vraylar (a medication used to treat Major Depressive Disorder) 1.5 mg capsule - Give one capsule by mouth once daily, dated 6/26/25

A pre-admission physician assessment, dated 6/19/25,

indicated Resident 3 was receiving treatment for psychiatric condition.

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On 10/16/25 at 1:11 P.M., the DON indicated it was the policy of the facility to follow state regulations in regard to mental health screenings and services.

Based on interview and record review, the facility failed to

	ensure a comprehensive care plan was developed after admission for residents with a major mental illness for 2 of 2 residents reviewed with major mental illness. (Resident 2 and Resident 3) Findings include: 1. On 10/15/25 at 10:06 A.M., Resident 2's clinical record was reviewed. Resident 2 was admitted on 1/27/25. Diagnoses included, but were not limited to, major depressive disorder. The comprehensive care plan did not include the diagnosis of major depressive disorder or services offered related to mental illness.			

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 SIGNATURELeslie Head-Bethel	TITLEAdministrator	(X6) DATE11/07/2025