STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY AT AVON	2141 NORTH DAN JONES ROAD, AVON, , 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Intake 465765. Intake 465765 - State deficiencies related to the allegations are cited at R041 and R241. Survey date: November 20, and 21, 2025 Facility number: 014959 Residential Census: 64 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on December 5, 2025.	R 0000		

R 0027	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(b) (b) Residents have the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. Residents have the right to exercise their rights as a resident of the facility and as a citizen or resident of the United States. Based on observation, interview, and record review, the facility failed to provide a dignified existence for a resident (Resident B) by maintaining a safe and sanitary environment for 1 of 3 residents observed for cleanliness. Findings include: A confidential interview during the survey process indicated the resident representative for Resident B was upset when the resident's bed linens had not been changed and the facility refused to wash the mattress pad. The apartment carpet had dark stains from the resident being incontinent of feces and had a urine smell. On 11/20/25 at 2:00 p.m., and 11/20/25 at 2:40 p.m., Resident B was observed in his bedroom lying on a standard full-sized bed sleeping. There were gray sheets and a green blanket	R 0027	On 12/10/2025 - A meeting was held with the hospice provider for resident B and the HCD/HSD to discuss change in care plans and proper communication of them to the community staff. On 12/10/2025 – Hospice provider ordered new bed for Resident B. On 12/10/2025 – All Staff were re-educated on dignity, sanitation standards and timely response to resident needs. A 100% test of all resident call pendants was completed by the HCD to ensure proper function and transmittal of alert to community call pendant system. Completed on 12/17/2025. A 100% review of all residents receiving incontinence care was completed by the HCD on 12/15/2025. Resident Service Plans were reviewed for this same census and all necessary updates to Service Plans were implemented. Re-education on the Health Service Evaluation (HSE) was	12/31/2025

	partially covering the bed, and the mattress could not be visualized. There were random dark spots observed on the carpet in the living room and bedroom without smell. On 11/21/25 at 12:09 p.m., Resident B was observed lying on a partially made bed, and a blue plastic protective pad was positioned underneath his body. There was a smell of urine in the room. During an interview with the Ombudsman, she indicated during a visit on 11/12/25, the resident representative indicated Resident B had been administered the wrong medication and staff refused to listen to her which ultimately led to the resident having a mental decline, being more incontinent, and requiring more assistance for daily care. Resident B indicated he was needing more help and had missed breakfast that morning as staff had not come to take him to the dining room. The resident's call light cord in the bedroom was observed to be broken off and hanging over the call box, and the resident's call pendant hanging from a black shoestring was found tied to the toilet paper roll in the bathroom. The resident indicated he had been looking for the call pendant. Concern/Grievance Forms,		provided to the HCD/HSD on 11/18/2025 by the VP of Clinical Practice and Education in conjunction with deployment of Carestream documentation module in the EHR database (Yardi). The revised HSE contains a section on determination if a resident is capable of utilizing a pendant and/or pull cord emergency alert system that is available within the community. This HSE item is then reflected in the resident service plan with resident specific instructions related to use for the direct care givers. In conjunction with preplanned software augmentation, laundry schedules were reviewed and updated to mirror laundry process by the HCD/HSD and designees. Carestream Task assignment was implemented on 12/2/2025 for staff documentation of laundry completion. Staff providing medication administration will be provided re-educated on pertinent components of the Medication Oversight Program by the HCD/HSD or designee by 12/31/2025.	

	dated 9/27/25, 10/1/25, and 10/24/25, indicated Resident B's resident representative was concerned about the resident's cleanliness, incontinence care related to increased incontinent episodes, his shower schedule, and requesting copies of his medication lists. The grievance forms were indecipherable, and the Executive Director (ED) was required to explain the concerns. During an interview on 11/20/25 at 10:10 a.m., resident representative for Resident B indicated, on 9/17/25, Resident B was admitted to hospice services. Hospice Care Manager RN 6 had discontinued 5 of the resident's medications, to include tamsulosin HCL (Flomax - used to treat an enlarged prostate) 0.4 milligrams (mg) and since that time the resident had become more incontinent of urine. Discontinuing the tamsulosin had caused more frequent urination, resulting in the resident needing more showers and the ruining of his bed mattress when staff had thrown away his mattress protector versus washing it. The resident representative had also asked that the resident's Senna 0.4 mg (a stimulant laxative) be discontinued as he was having bowel movement accidents soiling himself and the carpet in his apartment. The resident		Marketing/sales staff were re-educated on the community policy related to resident provision of mattress pads on 12/19/2025 by ED. Move in checklist was reviewed for inclusion of mattress pad verification at time of occupancy. Ongoing – All staff will be educated on hire and at a minimum annually on resident rights, including dignity and on infection control processes. HCD/HSD or designee will conduct a weekly random audit/inspection of resident rooms for compliance and cleanliness. Weekly inspections will be completed for 90 days. Deficiencies from standards will be immediately addressed as a corrective action and re-education will be provided.	

	representative indicated she had gone to management staff with her concerns regarding the resident's medications, him needing more assistance with incontinence care and showers, the bedding needing laundered when soiled, and the carpets needing shampooed. Nursing assistants had finally showered the resident the prior Friday and washed his sheets. But the resident representative had to clean the feces from the carpets, although there were still dark spots on the carpet, she purchased a new mattress protector, and she would be required to replace his mattress. The resident representative indicated she had reached out to the area Ombudsman (a resident advocate who helped consumers voice concerns and address complaints) to help resolve her concerns regarding Resident B's lack of care. A confidential interview indicated the resident representative had entered Resident B's apartment for a visit on 11/24/25 and immediately smelled feces. The resident was observed sitting in a wheelchair talking incoherently and did not recognize the resident representative. There was a copious amount of feces smeared and tracked throughout the living room, bedroom, and bathroom, and			

	she had taken photos of the apartment as proof. When nursing assistants arrived in the apartment in response to the resident representative pushing his call button, they indicated they had known about the mess in the apartment, but it was not their job to clean carpets. The nursing assistants indicated Resident B had been throwing his feces everywhere in his room over the weekend and falling. The resident representative indicated she had not been notified, and the Healthcare Director was not in the facility to discuss the situation. The resident representative contacted Care Manager RN 6, who indicated she was aware of what was happening with Resident B and had ordered Ativan 2.5 (lorazepam - used to treat anxiety) mg to calm him down. On 11/21/25 at 3:00 p.m., the Healthcare Director provided a Resident Rights and Complaint Procedures policy, dated 3/2022, and indicated the policy was the one currently being used by the facility. The policy indicated, "Prior to and upon admission, each resident and, if applicable, the resident's designated person, shall be informed of the resident's rights to lodge complaints without intimidation, retaliation, or threats of retaliation of the home or its staff persons against the			

	reporter ... 1. The community shall permit and respond to oral and written complaints from any source ...3. The community shall conduct an investigation and resolution of complaints ...4. Within two [2] business days after the submission of a written complaint, a status report shall be provided by the community to the complainant ...5. Within seven [7] days after the submission of a written complaint, the community shall give the complainant, the resident [and the resident's authorized representative if applicable] a written decision explaining the investigation findings and the action the community shall take to resolve the complaint ..." Long-Term Care Facilities From the Nursing Home Reform Act of 1987, Resident Rights, indicated residents have the right to be treated with respect and dignity, and they have the right to make choices about their care and living environment. Cross Reference R0041 and R0241. This citation relates to Intake 465765. Based on observation, interview, and record review, the facility failed to provide a dignified existence for a resident			

(Resident B) by maintaining a safe and sanitary environment for 1 of 3 residents observed for cleanliness.

Findings include:

A confidential interview during the survey process indicated the resident representative for Resident B was upset when the resident's bed linens had not been changed and the facility refused to wash the mattress pad. The apartment carpet had dark stains from the resident being incontinent of feces and had a urine smell.

On 11/20/25 at 2:00 p.m., and 11/20/25 at 2:40 p.m., Resident B was observed in his bedroom lying on a standard full-sized bed sleeping. There were gray sheets and a green blanket partially covering the bed, and the mattress could not be visualized. There were random dark spots observed on the carpet in the living room and bedroom without smell.

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During an interview with the Ombudsman, she indicated during a visit on 11/12/25, the resident representative

	indicated Resident B had been administered the wrong medication and staff refused to listen to her which ultimately led to the resident having a mental decline, being more incontinent, and requiring more assistance for daily care. Resident B indicated he was needing more help and had missed breakfast that morning as staff had not come to take him to the dining room. The resident's call light cord in the bedroom was observed to be broken off and hanging over the call box, and the resident's call pendant hanging from a black shoestring was found tied to the toilet paper roll in the bathroom. The resident indicated he had been looking for the call pendant. Concern/Grievance Forms, dated 9/27/25, 10/1/25, and 10/24/25, indicated Resident B's resident representative was concerned about the resident's cleanliness, incontinence care related to increased incontinent episodes, his shower schedule, and requesting copies of his medication lists. The grievance forms were indecipherable, and the Executive Director (ED) was required to explain the concerns. During an interview on 11/20/25 at 10:10 a.m., resident representative for Resident B indicated, on 9/17/25, Resident B was admitted to hospice			

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R 0041	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(o)(4) (4) The facility shall develop and implement policies for investigating and responding to complaints when made known and grievances made by: (A) an individual resident; (B) a resident council or family council, or both; (C) a family member; (D) family groups; or (E) other individuals. Based on interview and record review, the facility failed to address grievances in a manner	R 0041	On 12/04/2025 – the ED completed documentation of all Resident B's concerns in accordance with the community Grievance Process. The process was reviewed with Resident B's representative via written communication. The ED conducted a meeting with Resident B's representative to review concerns that had been documented. Corrective actions were implemented in conjunction with the concerns. On 12/04/2025 all documented grievances were reviewed by the ED to ensure resolution had	12/31/2025

	which could be tracked for 3 of 3 months reviewed for grievance resolutions for the facility's grievance log (Resident B). Findings include: A confidential interview during the survey process indicated, on 9/17/25, while reviewing Resident B's medication list with Registered Nurse (RN) 6 Care Manager for hospice, the resident representative informed RN 6 that Resident B had no order for Abilify (aripiprazole - an antipsychotic medication used to treat mental health conditions). The resident representative was upset Resident B received Abilify from 8/27/25 until 10/1/25 without a physician's order, causing him to experience hallucinations, delirium, and increased weakness. Resident B's clinical record was reviewed on 11/21/25 at 10:00 a.m. Diagnoses on Resident B's profile included dementia, transient ischemic attack (TIA - mini stroke), and urinary incontinence. A Neurology Progress Note, dated 8/27/25, indicated Resident B presented for a follow up evaluation after having a TIA in June 2024. The resident had not had any further TIA- like symptoms or neurologic concerns. A		been completed. On 12/04/2025 residents and representatives were provided re-education, by the ED, on the process to file a grievance All staff were re-educated on the grievance process on 12/19/2025by the HCD And the Grievance Tracking Log was reviewed with all management staff Ongoing - The ED will review the resident grievance log with the management team at daily stand up meetings. Grievance will be addressed by the appropriate management team member and documentation of resolution will be recorded according to grievance process guidelines. Patterns with grievances may be reviewed with additional interventions applied during QAPI Meetings.	

	comparative MRI on 5/29/25 showed no acute findings. The resident had experienced balance issues, but therapy had helped his balance, strength and ambulation, and he was independent using a front wheeled walker. The resident had some short-term memory changes, but his long-term memory seemed to be fairly intact. The resident completed cognitive testing which showed marked improvement. He agreed to Aricept and orders were given to start with Aricept 5 milligrams (mg) daily for 30 days, then Aricept 10 mg daily. Resident B's clinical record lacked documentation Aricept 10 mg had been added to his orders, or eMAR documentation the medication had been administered per physician's orders, start date 9/28/25. Electronic Medication Administration Records (eMARs) for Resident B, dated 8/29/25 through 9/30/25, indicated an order for Ability 10 mg take 1 tablet by mouth once daily in the evening for 90 days. The Abilify was documented as having been administered to the resident daily. Resident B's clinical record lacked documentation a physician had written an order for Abilify 10 mg.			

	A time stamped screen shot of a text from the resident representative to the Healthcare Director, dated 9/17/25 at 11:53 a.m., indicated the resident representative questioned who had prescribed Abilify for Resident B. During an interview with the Ombudsman, she indicated during a visit on 11/12/25, the resident representative indicated Resident B had been administered the wrong medication and staff refused to listen to her which ultimately led to the resident having a mental decline, being more incontinent, and requiring more assistance for daily care. Resident B indicated he was needing more help and had missed breakfast that morning as staff had not come to take him to the dining room. During an interview on 11/20/25 at 10:10 a.m., resident representative for Resident B indicated, on 8/27/25, Resident B had a follow up visit with the neurologist and was given new medication orders for Aricept 5 mg x 30 days, then increase to Aricept 10 mg for memory loss. The resident representative indicated she had been present at the neurology appointment and was given copies of the orders. On 9/17/25, Resident B was admitted to hospice, and when hospice Case Manager			

	RN 6 had called her to review Resident B's medication list, Abilify was on the list. The resident representative informed the hospice nurse that Resident B did not have orders for Ability. During an interview on 11/20/25 at 10:10 a.m., resident representative for Resident B indicated, since 9/19/25, she had pushed the Healthcare Director, hospice nurse, and ED about concerns with Resident B's care, his appetite, and his being given Abilify without an order. Despite being a "bulldog" and either coming in to see them in person, making phone calls, or sending messages by text or e-mail, she was constantly ignored, her calls and texts blocked, and she had been called names like "disrespectful." The Healthcare Director and hospice Case Manager RN 6 kept putting her off, giving her excuses like only the Primary Care Provider (PCP) or ordering physician could discontinue the Ability, but they could not tell her who ordered the medication. "The whole lot of them had attempted to sweep her concerns under the rug and hoped she'd go away." The resident representative indicated she herself had eventually contacted the neurologist to confirm he had not ordered the Abilify. The resident representative had also contacted the Registered			

	Pharmacist (RPh) In Charge of the facility pharmacy, who helped her confirm there had never been an order for Ability, instead a pharmacy technician had keyed in and filled Abilify instead of Aricept. Nursing staff had not caught the error and had administered the wrong medication. In her opinion, the Healthcare Director should have immediately taken her concerns seriously and investigated the issue, not brushed her off as being a "pest." On 10/28/25, the resident representative had requested the resident be moved to a 1st floor apartment after he became lost while on the elevator, and the facility had not yet responded to her request. During an interview on 11/20/25 at 3:19 p.m., a facility Pharmacy Representative indicated on 8/27/25 the pharmacy had received new orders for Resident B for Aricept 5 mg for 30 days, then increase the dosage to Aricept 10 mg daily. When transcribing the medication orders, a technician had keyed in Aricept 5 mg for 30 days, but the order for Aricept 10 mg was keyed in wrong, changing the medication from Aricept 10 mg to Abilify 10 mg. Both the Aricept 5 mg and Abilify 10 mg medications were sent to the facility at the same time, and both medications were initiated and administered daily.			

	On 10/1/25 the resident representative called the pharmacy and indicated the resident had no order for Abilify, the hospice nurse and facility staff would not listen to her, and after she had raised concerns to the facility staff, they had stopped taking her calls. The pharmacy representative indicated only after the resident representative called the pharmacy on 10/1/25 was the error identified, and by then the resident had received 33 doses of Abilify without a physician's order. The pharmacy representative indicated there was no documentation to indicate the facility had contacted the pharmacy regarding the Abilify. On 11/20/25 at 3:55 p.m., the ED provided Concern/Grievance Forms, dated August, September, and October 2025, there was no documentation Resident B's representative had concerns with the resident being administered Abilify without an order. During an interview on 11/21/25 at 9:51 a.m., the Healthcare Director indicated in October 2025, Resident B's representative started questioning the resident's physician's orders for Abilify, and demanded the medication be stopped immediately. The Healthcare Director had told the			

	resident representative the facility could not stop medications by request, instead to tell Resident B to pick the pill out of the cup and refuse the medication when offered. The resident representative had requested medication lists for the months of August, September, and October at the end of October, but the electronic system had been "messed up" and some of the documents were provided to her over time when they became available. The Healthcare Director indicated Resident B's representative had been in contact with her multiple times in person, by phone, email and text messages, but she had never documented the resident representatives concerns on grievance forms to track the issues. During an interview on 11/21/25 at 9:51 a.m., the Healthcare Director indicated, on an undetermined date, Resident B's representative had been in the front lobby attempting to take the resident to the emergency room (ER), stating "can't you see what he's like" and the resident did not want to go to the ER. The Healthcare Director indicated this had prompted her to suggest hospice services, she had not suggested requesting laboratory testing or a visit with the PCP to rule out an acute medical			

	reason for his decline and behaviors. On 9/17/25 hospice services were started in response to the resident representative concerns for Resident B's overall decline. The resident was not walking, and his requiring calls to get him up out of bed. The Healthcare Director indicated she had received texts from Resident B's representative and made inquiries to include, on 9/30/25, the resident representative stated to take Resident B off the Abilify "ASAP" and she expected to see a credit on the pharmacy bill. On 10/1/25, the resident representative provided a medication list, dated May 2025, and indicated that it was the residents correct medications. The Healthcare Director indicated she had been unaware the resident representative had a concern about the Abilify order until 9/30/25. During an interview on 11/21/25 at 10:39 a.m., a hospice representative indicated, on 9/17/25, Resident B was admitted to hospice services with the diagnoses of senile degeneration of the brain, and that same day the facility provided hospice with a current medication list. The medication list included order for Abilify 10 mg 1 tablet by mouth for 90 days, that had started on 8/27/25. On 9/17/25, Hospice			

	RN 6 contacted the resident representative to review the resident's medication list, and the resident representative informed her the resident had no order for Abilify. On 10/6/25, the resident representative was adamant the resident was taken off the Abilify immediately, and the hospice MD recommended to stop the Abilify. During an interview on 11/21/25 at 1:19 p.m., the ED indicated he'd had frequent conversations via phone call, text, email, and in-person with Resident B's representative regarding her concerns with care, his condition, and medications. The ED indicated he did not always documented his follow-up with the resident representative but had tried to address her concerns. The ED indicated the resident representative emailed him that his the Healthcare Director had blocked her calls. The ED indicated he had silenced the resident representatives text messages in attempts to set boundaries, but he had never blocked her messages or calls. The Healthcare Director had also denied blocking the resident representative's calls and texts. An email from the resident representative to the ED, dated 10/24/25, indicated, "The fax sent to [facility name] that I have been referring to for weeks			

	came directly from [pharmacy name] not a physician. It is the prescription for Abilify. Maybe they never faxed it. I will be contacting them next week. [Pharmacy name], Healthcare Director, and the hospice nurse are all saying Resident B's neurologist, prescribed Abilify. I called her office and spoke directly to her MA she confirmed that they would never prescribe Abilify and that they only prescribed Aricept ...I was at the appointment and know she only prescribed Aricept 5 mg for 30 days and then Aricept 10 mg going forward. Somehow that second prescription was changed to Abilify 10 mg. I don't know why [facility name] can't understand my concerns. What part don't you understand?" During an interview on 11/21/25 at 1:25 p.m., the Healthcare Director indicated she had called the pharmacy earlier in the day to request a copy of Resident B's physician's order for the Abilify, and they were going to send her a copy. If a family member brought forward a concern with a medication, the Healthcare Director or another nurse would contact the physician's office to resolve the concern. The Healthcare Director indicated to her knowledge, Resident B had a physician's order for Abilify, and she was awaiting a copy of the order from the pharmacy. When			

	it was explained to the Healthcare Director that Resident B never had an order for Abilify from a physician, instead the order had been input into the system in error by a pharmacy technician, and the pharmacy had been required to follow pharmacy policy with internal reporting and follow-up, she indicated, "that's news to me." On 11/21/25 at 3:12 p.m., the ED provided a script he indicated had been faxed to him that day from the facility contracted pharmacy. The script read, Aricept 10 mg tablet take 1 tablet oral once daily in the evening for 90 days, effective date 8/27/25. A handwritten note on the faxed copy indicated, "This is the script sent over, Abilify keyed instead." The ED indicated, there had never been an order for Ability On 11/21/25 at 3:00 p.m., the Healthcare Director provided a Resident Rights and Complaint Procedures policy, dated 3/2022, and indicated the policy was the one currently being used by the facility. The policy indicated, "Prior to and upon admission, each resident and, if applicable, the resident's designated person, shall be informed of the resident's rights to lodge complaints without intimidation, retaliation, or threats of retaliation of the home			

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intact. The resident completed cognitive testing which showed marked improvement. He agreed to Aricept and orders were given to start with Aricept 5 milligrams (mg) daily for 30 days, then Aricept 10 mg daily.

Resident B's clinical record lacked documentation Aricept 10 mg had been added to his orders, or eMAR documentation the medication had been administered per physician's orders, start date 9/28/25.

Electronic Medication Administration Records (eMARs) for Resident B, dated 8/29/25 through 9/30/25, indicated an order for Ability 10 mg take 1 tablet by mouth once daily in the evening for 90 days. The Abilify was documented as having been administered to the resident daily.

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During an interview with the Ombudsman, she indicated during a visit on 11/12/25, the

	resident representative indicated Resident B had been administered the wrong medication and staff refused to listen to her which ultimately led to the resident having a mental decline, being more incontinent, and requiring more assistance for daily care. Resident B indicated he was needing more help and had missed breakfast that morning as staff had not come to take him to the dining room. During an interview on 11/20/25 at 10:10 a.m., resident representative for Resident B indicated, on 8/27/25, Resident B had a follow up visit with the neurologist and was given new medication orders for Aricept 5 mg x 30 days, then increase to Aricept 10 mg for memory loss. The resident representative indicated she had been present at the neurology appointment and was given copies of the orders. On 9/17/25, Resident B was admitted to hospice, and when hospice Case Manager RN 6 had called her to review Resident B's medication list, Abilify was on the list. The resident representative informed the hospice nurse that Resident B did not have orders for Ability. During an interview on 11/20/25 at 10:10 a.m., resident representative for Resident B indicated, since 9/19/25, she had pushed the Healthcare			

	Director, hospice nurse, and ED about concerns with Resident B's care, his appetite, and his being given Abilify without an order. Despite being a "bulldog" and either coming in to see them in person, making phone calls, or sending messages by text or e-mail, she was constantly ignored, her calls and texts blocked, and she had been called names like "disrespectful." The Healthcare Director and hospice Case Manager RN 6 kept putting her off, giving her excuses like only the Primary Care Provider (PCP) or ordering physician could discontinue the Ability, but they could not tell her who ordered the medication. "The whole lot of them had attempted to sweep her concerns under the rug and hoped she'd go away." The resident representative indicated she herself had eventually contacted the neurologist to confirm he had not ordered the Abilify. The resident representative had also contacted the Registered Pharmacist (RPh) In Charge of the facility pharmacy, who helped her confirm there had never been an order for Ability, instead a pharmacy technician had keyed in and filled Abilify instead of Aricept. Nursing staff had not caught the error and had administered the wrong medication. In her opinion, the Healthcare Director should have immediately taken her concerns			

	seriously and investigated the issue, not brushed her off as being a "pest." On 10/28/25, the resident representative had requested the resident be moved to a 1st floor apartment after he became lost while on the elevator, and the facility had not yet responded to her request. During an interview on 11/20/25 at 3:19 p.m., a facility Pharmacy Representative indicated on 8/27/25 the pharmacy had received new orders for Resident B for Aricept 5 mg for 30 days, then increase the dosage to Aricept 10 mg daily. When transcribing the medication orders, a technician had keyed in Aricept 5 mg for 30 days, but the order for Aricept 10 mg was keyed in wrong, changing the medication from Aricept 10 mg to Abilify 10 mg. Both the Aricept 5 mg and Abilify 10 mg medications were sent to the facility at the same time, and both medications were initiated and administered daily. On 10/1/25 the resident representative called the pharmacy and indicated the resident had no order for Abilify, the hospice nurse and facility staff would not listen to her, and after she had raised concerns to the facility staff, they had stopped taking her calls. The pharmacy representative indicated only after the resident representative called the			

	pharmacy on 10/1/25 was the error identified, and by then the resident had received 33 doses of Abilify without a physician's order. The pharmacy representative indicated there was no documentation to indicate the facility had contacted the pharmacy regarding the Abilify. On 11/20/25 at 3:55 p.m., the ED provided Concern/Grievance Forms, dated August, September, and October 2025, there was no documentation Resident B's representative had concerns with the resident being administered Abilify without an order. During an interview on 11/21/25 at 9:51 a.m., the Healthcare Director indicated in October 2025, Resident B's representative started questioning the resident's physician's orders for Abilify, and demanded the medication be stopped immediately. The Healthcare Director had told the resident representative the facility could not stop medications by request, instead to tell Resident B to pick the pill out of the cup and refuse the medication when offered. The resident representative had requested medication lists for the months of August, September, and October at the end of October, but the electronic system had been			

	"messed up" and some of the documents were provided to her over time when they became available. The Healthcare Director indicated Resident B's representative had been in contact with her multiple times in person, by phone, email and text messages, but she had never documented the resident representatives concerns on grievance forms to track the issues. During an interview on 11/21/25 at 9:51 a.m., the Healthcare Director indicated, on an undetermined date, Resident B's representative had been in the front lobby attempting to take the resident to the emergency room (ER), stating "can't you see what he's like" and the resident did not want to go to the ER. The Healthcare Director indicated this had prompted her to suggest hospice services, she had not suggested requesting laboratory testing or a visit with the PCP to rule out an acute medical reason for his decline and behaviors. On 9/17/25 hospice services were started in response to the resident representative concerns for Resident B's overall decline. The resident was not walking, and his requiring calls to get him up out of bed. The Healthcare Director indicated she had received texts from Resident B's representative and made			

	inquiries to include, on 9/30/25, the resident representative stated to take Resident B off the Abilify "ASAP" and she expected to see a credit on the pharmacy bill. On 10/1/25, the resident representative provided a medication list, dated May 2025, and indicated that it was the residents correct medications. The Healthcare Director indicated she had been unaware the resident representative had a concern about the Abilify order until 9/30/25. During an interview on 11/21/25 at 10:39 a.m., a hospice representative indicated, on 9/17/25, Resident B was admitted to hospice services with the diagnoses of senile degeneration of the brain, and that same day the facility provided hospice with a current medication list. The medication list included order for Abilify 10 mg 1 tablet by mouth for 90 days, that had started on 8/27/25. On 9/17/25, Hospice RN 6 contacted the resident representative to review the resident's medication list, and the resident representative informed her the resident had no order for Abilify. On 10/6/25, the resident representative was adamant the resident was taken off the Abilify immediately, and the hospice MD recommended to stop the Abilify.			

	During an interview on 11/21/25 at 1:19 p.m., the ED indicated he'd had frequent conversations via phone call, text, email, and in-person with Resident B's representative regarding her concerns with care, his condition, and medications. The ED indicated he did not always documented his follow-up with the resident representative but had tried to address her concerns. The ED indicated the resident representative emailed him that his the Healthcare Director had blocked her calls. The ED indicated he had silenced the resident representatives text messages in attempts to set boundaries, but he had never blocked her messages or calls. The Healthcare Director had also denied blocking the resident representative's calls and texts. An email from the resident representative to the ED, dated 10/24/25, indicated, "The fax sent to [facility name] that I have been referring to for weeks came directly from [pharmacy name] not a physician. It is the prescription for Abilify. Maybe they never faxed it. I will be contacting them next week. [Pharmacy name], Healthcare Director, and the hospice nurse are all saying Resident B's neurologist, prescribed Abilify. I called her office and spoke directly to her MA she confirmed that they would never prescribe			

	Abilify and that they only prescribed Aricept ...I was at the appointment and know she only prescribed Aricept 5 mg for 30 days and then Aricept 10 mg going forward. Somehow that second prescription was changed to Abilify 10 mg. I don't know why [facility name] can't understand my concerns. What part don't you understand?"			

	During an interview on 11/21/25 at 1:25 p.m., the Healthcare Director indicated she had called the pharmacy earlier in the day to request a copy of Resident B's physician's order for the Abilify, and they were going to send her a copy. If a family member brought forward a concern with a medication, the Healthcare Director or another nurse would contact the physician's office to resolve the concern. The Healthcare Director indicated to her knowledge, Resident B had a physician's order for Abilify, and she was awaiting a copy of the order from the pharmacy. When it was explained to the Healthcare Director that Resident B never had an order for Abilify from a physician, instead the order had been input into the system in error by a pharmacy technician, and the pharmacy had been required to follow pharmacy policy with internal reporting and follow-up, she indicated, "that's news to me." On 11/21/25 at 3:12 p.m., the ED provided a script he indicated had been faxed to him that day from the facility contracted pharmacy. The script read, Aricept 10 mg tablet take 1 tablet oral once daily in the evening for 90 days, effective date 8/27/25. A handwritten note on the faxed copy indicated, "This is the script sent			

	over, Abilify keyed instead." The ED indicated, there had never been an order for Ability On 11/21/25 at 3:00 p.m., the Healthcare Director provided a Resident Rights and Complaint Procedures policy, dated 3/2022, and indicated the policy was the one currently being used by the facility. The policy indicated, "Prior to and upon admission, each resident and, if applicable, the resident's designated person, shall be informed of the resident's rights to lodge complaints without intimidation, retaliation, or threats of retaliation of the home or its staff persons against the reporter ... 1. The community shall permit and respond to oral and written complaints from any source ...3. The community shall conduct an investigation and resolution of complaints ...4. Within two [2] business days after the submission of a written complaint, a status report shall be provided by the community to the complainant ...5. Within seven [7] days after the submission of a written complaint, the community shall give the complainant, the resident [and the resident's authorized representative if applicable] a written decision explaining the investigation findings and the action the community shall take to resolve the complaint ...."			

	Cross reference R0027 and R0241. This citation relates to Intake 465765.			
R 0241	Health Services - Offense 410 IAC 16.2-5-4(e)(1) (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on observation, interview, and record review, the facility failed to administer medication in accordance with physician's orders and manufactures instructions for 1 of 3 residents reviewed for medication administration (Resident B) resulting in actual harm to the resident when he experienced hallucinations, weakness, and behaviors. Findings include: A confidential interview during the survey process indicated, on 9/17/25, while reviewing Resident B's medication list with Registered Nurse (RN) 6 Care	R 0241	On 9/17/25 – The pharmacy implemented a discontinuation order for Resident B's Abilify order that the pharmacy technician had inputted into the pharmacy system incorrectly causing a medication error for Resident B. Resident B's medications were reviewed by the pharmacy, the hospice provider and the primary care provider to ensure no other medications were incorrectly entered/provided. Re-education on the pertinent sections of the Medication Oversight Program, including medication verification, was completed with all staff that administer medications on 12/19/2025 by the HCD/HSD or designee. On 12/18/2025 the HCD conducted a meeting with the community pharmacy representative and asked for additional steps to be implemented with the pharmacy provider to mitigate any future medication	12/31/2025

	Manger for hospice, the resident representative informed RN 6 that Resident B had no order for Abilify (aripiprazole - an antipsychotic medication used to treat mental health conditions). The resident representative was upset Resident B received Abilify from 8/27/25 until 10/1/25 without a physician's order, causing him to experience hallucinations, delirium, and increased weakness. On 11/20/25 at 12:05 p.m., Resident B was observed sitting alone in the assisted living dining room. The resident displayed a flat affect and was not observed to interact with those around him. The resident was eating independently with no problems. On 11/20/25 at 2:00 p.m., 11/20/25 at 2:40 p.m., and 11/21/25 at 12:09 p.m., attempts to interview Resident B were unsuccessful, he was observed each time lying on a standard full sized bed sleeping. Resident B's clinical record was reviewed on 11/21/25 at 10:00 a.m. Diagnoses on Resident B's profile included dementia, transient ischemic attack (TIA - mini stroke), and urinary incontinence. A Primary Care Physician (PCP) Progress Note, dated 8/19/25,		errors from pharmacy. On 12/18/2025 pharmacy provider was asked to implement additional safeguards within their process of entering physician orders for processing as the medication error was a direct result of the pharmacy entering a wrong medication received directly from the attending provider. Ongoing – the HCD/HSD or designee will incorporate review of current medication during the resident Care Conference. Discrepancies will be discussed with the order provider(s) for clarification. HCD/HSD or designee will conduct monthly medication audits for a period of 90 days, then audit will be completed quarterly. Trends or noncompliance may be incorporated into community QAPI process.	

indicated Resident B was seen for an initial visit to establish services. The resident was alert and oriented to person, place and time with periods of confusion and forgetfulness. The resident used a front wheeled walker and wheelchair for ambulation. Although the resident continued to have some weakness and required assistance, he was showing improvement and his goal was to return home. There were no acute needs identified during the visit after assessment of the resident, and interviews with the resident representative and staff. Resident B had a follow-up appointment scheduled with the neurologist.

A progress note, dated 8/26/25 at 10:07 p.m., indicated the resident representative had called and requested staff assist Resident B with a shower that evening as he had an appointment the following day.

A Neurology Progress Note, dated 8/27/25, indicated Resident B presented for a follow up evaluation after having a TIA in June 2024. The resident had not had any further TIA- like symptoms or neurologic concerns. A comparative MRI on 5/29/25 showed no acute findings. The resident had experienced balance issues, but therapy had helped his balance, strength

and ambulation, and he was independent using a front wheeled walker. The resident had some short-term memory changes, but his long-term memory seemed to be fairly intact. The resident completed cognitive testing which showed marked improvement. He agreed to Aricept and orders were given to start with Aricept 5 milligrams (mg) daily for 30 days, then Aricept 10 mg daily.

A pharmacy script for Resident B, dated 8/27/25, indicated Aricept 5 mg 1 tablet by mouth for 30 days.

Electronic Medication Administration Records (eMARs), dated 8/29/25 through 9/27/25, indicated documentation Resident B had received Aricept 5 mg daily.

A pharmacy script for Resident B, dated 8/27/25, indicated Aricept 10 mg 1 tablet by mouth in the evening for 90 days.

Resident B's clinical record lacked documentation Aricept 10 mg had been added to his orders, or eMAR documentation the medication had been administered per physician's orders, start date 9/28/25.

eMARs for Resident B, dated 8/29/25 through 9/30/25, indicated an order for Ability 10 mg take 1 tablet by mouth once daily in the evening for 90 days.

The Abilify was documented as having been administered to the resident daily.

Resident B's clinical record lacked documentation a physician had written an order for Abilify 10 mg.

A time stamped screen shot of a text message from the resident representative to the Healthcare Director, dated 9/17/25 at 11:53 a.m., indicated the resident representative questioned who had prescribed Abilify for Resident B.

A progress note, dated 9/18/25 at 12:22 p.m., indicated Resident B had been admitted to hospice services.

A PCP Progress Note, dated 9/22/25, indicated Resident B's family was concerned about a decline in the resident's health and weight loss. The resident representative indicated the resident had called the police on her two weeks ago, thought she was his ex-wife, and mistaken her for her daughter who passed away 10 years ago. Resident B was also obsessed over his taxes and mail. The resident was known to wander and would go outside and try to get into other people's car. Per discussion with the Power of Attorney (POA), will taper off the Aricept as she feels it was causing bizarre behavior. The

resident was now receiving hospice services.

A progress note, dated 10/11/25 at 10:52 p.m., indicated Resident B had called 911 and stated he did not know where he was, was confused, and woke up from a dream looking for his girlfriend's dad.

An email from the resident representative to the ED, dated 10/24/25, indicated, "The fax sent to [facility name] that I have been referring to for weeks came directly from [pharmacy name] not a physician. It is the prescription for Abilify. Maybe they never faxed it. I will be contacting them next week. [Pharmacy name], Healthcare Director, and the hospice nurse are all saying Resident B's neurologist, prescribed Abilify. I called her office and spoke directly to her MA she confirmed that they would never prescribe Abilify and that they only prescribed Aricept ...I was at the appointment and know she only prescribed Aricept 5 mg for 30 days and then Aricept 10 mg going forward. Somehow that second prescription was changed to Abilify 10 mg. I don't know why [facility name] can't understand my concerns. What part don't you understand?"

A PCP Progress Note, dated 11/3/25, indicated during the visit with Resident B, he was

alert to person, place and time. He had intermittent confusion and seemed lost when the Nurse Practitioner (NP) was speaking with him. No other changes were made to the medication regiment or plan of care today.

A progress note, dated 11/5/25 at 7:59 p.m., indicated Resident B was observed to be confused and refused care. The resident had called 911 and reported an earthquake and was unable to get up without assistance. The resident was alert but disoriented, and his confusion appeared increased from his baseline. The resident complained of back pain and was unable to ambulate independently. Interventions included, providing reassurance and reorientation, ensuring resident safety with the call light within reach, bed in the lowest position, and side rails up per protocol, and follow up with physician for evaluation of back pain and confusion.

A Service Plan, dated 11/10/25, indicated the resident had severe cognitive impairment and was disorientated with time and situation. He required assistance with bathing, dressing, toileting, and transportation within the facility, and prompting and reminders for smaller tasks.

During an interview with the Ombudsman, she indicated during a visit on 11/12/25, the resident representative indicated Resident B had been administered the wrong medication and staff refused to listen to her which ultimately led to the resident having a mental decline, being more incontinent, and requiring more assistance for daily care. Resident B indicated he was needing more help and had missed breakfast that morning as staff had not come to take him to the dining room. The resident's call light cord in the bedroom was observed to be broken off and hanging over the call box, and the resident's call pendant hanging from a black shoestring was found tied to the toilet paper roll in the bathroom. The resident indicated he had been looking for the call pendant.

A progress note, dated 11/15/25 at 6:50 a.m., indicated Resident B was found on the floor in his room. The resident had hit his face on the floor, and it was "reddish."

A progress note, dated 11/18/25 at 6:35 a.m., indicated Resident B was found on the floor in his room, he'd been on his way to the bathroom. There were no injuries at the time of the incident.

During an interview on 11/20/25

at 10:10 a.m., resident representative for Resident B indicated the resident had moved into the current assisted living apartment on 10/1/24. At that time, the resident was independent with transfers, ambulation with a walker, toileting, and eating, and just needed oversight for dressing and bathing. On 8/27/25, Resident B had a follow up visit with the neurologist and was given new medication orders for Aricept 5 mg for 30 days, then increase to Aricept 10 mg for memory loss. The resident representative indicated she had been present at the neurology appointment and was given copies of the visit notes and medication orders. On 9/15/25 the resident started acting "kind of weird". The resident representative had contacted Resident B's outside PCP, and the PCP office had suggested she take the resident to the ER as there were no appointments available. When the resident representative attempted to take the resident to the ER he had refused to go, the Healthcare Director had observed the situation in the lobby and had suggested hospice. On 9/17/25, Resident B was admitted to hospice, and when hospice Case Manager RN 6 had called her to review Resident B's medication list, Abilify was on the list. The resident representative informed

the hospice nurse that Resident B did not have orders for Ability. By that time, Resident B had been receiving Abilify without an order for 2 weeks, and although the hospice nurse discontinued 5 other medications, she refused to discontinue the Abilify or to call it an error. The resident representative indicated to her knowledge, the Hospice Care Manager RN 6 had not reviewed the neurology orders, or she would have seen the error. The resident representative indicated Resident B could have died taking the Aricept and Abilify together, he was "out of his mind", so weak he could not walk, had become more incontinent, and had lost weight. On 10/1/25 the resident was taken off the Abilify, and had since improved "somewhat" but was not back to his baseline in caring for himself or cognitive abilities.

During an interview on 11/20/25 at 10:10 a.m., resident representative for Resident B indicated she herself had contacted the neurologist to confirm he had not ordered the Abilify. The resident representative had also contacted the Registered Pharmacist (RPh) In Charge of the facility pharmacy, who helped her confirm there had never been an order for Ability, instead a pharmacy technician

had keyed in and filled Abilify instead of Aricept. Nursing staff had not caught the error and had administered the wrong medication. The resident representative indicated she had increasing concern regarding Resident B's metal state and behaviors, and physical state as he could hardly walk due to weakness, and staff had started taking him to the dining room in a wheelchair. In her opinion, the Healthcare Director should have immediately taken her concerns seriously and investigated the issue, not brushed her off as being a "pest." Before taking the Aricept and Abilify, she would have considered Resident B to have had mild dementia. Now the resident was sundowning, was refusing care more often, calling 911, calling the resident representative by his 1st wife's name or by his deceased daughters name, and his dementia had progressed.

On 11/20/25 at 10:55 a.m., the Executive Director (ED) provided a typed statement that indicated there had been no medication errors or weight loss documented in the past 6 months.

Resident B's weight documentation indicated, on 6/4/25 a weight of 165.4 lbs., on 8/13/25 a weight of 159.4 lbs., and on 10/11/25 a weight of

156.0 lbs.

During an interview on 11/20/25 at 3:19 p.m., a Facility Pharmacy Representative indicated, on 8/27/25 the pharmacy had received new orders for Resident B for Aricept 5 mg for 30 days, then increase the dosage to Aricept 10 mg daily. When transcribing the medication orders, a technician had keyed in Aricept 5 mg for 30 days, but the order for Aricept 10 mg was keyed in wrong, changing the medication from Aricept 10 mg to Abilify 10 mg. Both the Aricept 5 mg and Abilify 10 mg medications were sent to the facility at the same time, and both medications were initiated and administered daily. On 10/1/25 the resident representative called the pharmacy and indicated the resident had no order for Abilify, the hospice nurse and facility staff would not listen to her, and after she had raised concerns to the facility staff, they had stopped taking her calls. The pharmacy representative indicated only after the resident representative called the pharmacy on 10/1/25 was the error identified, and by then the resident had received 33 doses of Abilify without a physician's order. The Registered Pharmacist (RPh) In Charge took the concern seriously, found the error in the electronic system, discontinued the Abilify

immediately, and entered the Aricept 10 mg order correctly. The pharmacy representative indicated Aricept was used to slow down the dementia process and help preserve mentation. Abilify was used more for behaviors, depression, mental issues, and would speed up the dementia process. The RPh In Charge documented the error as an external error (meaning it left the pharmacy and caused an issue) and reported to corporate compliance. The pharmacy technicians were required to review what had happened with Resident B's medication orders, provided additional education about the importance of verifying medication orders, and they discussed the harm that had been caused to Resident B by the situation. The pharmacy representative indicated there was no documentation to indicate the facility had contacted the pharmacy regarding the Abilify.

On 11/20/25 at 3:55 p.m., the ED provided Concern/Grievance Forms, dated August through October 2025, there was no documentation Resident B's representative had concerns with the resident being administered Abilify without an order.

During an interview on 11/21/25 at 9:51 a.m., the Healthcare

Director indicated in October 2025, Resident B's representative started questioning the resident's physician's orders for Abilify, and demanded the medication be stopped immediately. The Healthcare Director had told the resident representative the facility could not stop medications by request, instead to tell Resident B to pick the pill out of the cup and refuse the medication when offered. The Healthcare Director indicated she had contacted the PCP, neurologist, mobile MD psych, hospice nurse, and was told they had not ordered the medication. After being told by the resident representative that the neurologist had ordered new medication, the Healthcare Director contacted the neurologist office and was told they could not find documentation of an order for Abilify. The resident representative had requested medication lists for the months of August, September, and October at the end of October, but the electronic system had been "messed up" and some of the documents were provided to her over time when they became available. The Healthcare Director indicated Resident B's representative had been in contact with her multiple times in person, by phone, email and text messages, but she had never documented the resident

representatives concerns on grievance forms to track the issues.

During an interview on 11/21/25 at 9:51 a.m., the Healthcare Director indicated, on an undetermined date, Resident B's representative had been in the front lobby attempting to take the resident to the emergency room (ER), stating "can't you see what he's like" and the resident did not want to go to the ER. The Healthcare Director indicated this had prompted her to suggest hospice services, she had not suggested requesting laboratory testing or a visit with the PCP to rule out an acute medical reason for his decline and behaviors. On 9/17/25 hospice services were started in response to the resident representative concerns for Resident B's for overall decline, the resident not walking, and his requiring calls to get him up out of bed. The Healthcare Director indicated she had been unaware the resident representative had a concern about the Abilify order until 9/30/25.

The Healthcare Director indicated she had received texts from Resident B's representative to include, on 9/30/25, the resident representative stated to take Resident B off the Abilify

"ASAP" and she expected to see a credit on the pharmacy bill, on 10/1/25 the resident representative provided a medication list, dated May 2025, and indicated that it was the residents correct medications, and on 10/1/25 the resident representative had texted and was inquiring if the hospice MD could discontinue the Abilify. In response, on 10/1/25, the Healthcare Director spoke with the psych MD and asked if they had ordered the Abilify, and she had sent a note to the pharmacy requesting the Abilify be discontinued.

During an interview on 11/21/25 at 10:39 a.m., a Hospice Representative indicated, on 9/17/25, Resident B was admitted to hospice services with the diagnoses of senile degeneration of the brain, and that same day the facility provided hospice with a current medication list. The medication list included an order for Abilify 10 mg 1 tablet by mouth for 90 days, that had started on 8/27/25. The Hospice Medical Director reviewed Resident B's medication list, and there were no recommendation to discontinue the Abilify at that time as the resident had recently started the medication. On 9/17/25, Hospice RN 6 contacted the resident representative to review the resident's medication list, and

the resident representative informed her the resident had no order for Abilify. On 10/6/25, the resident representative was adamant the resident was taken off the Abilify immediately, and the hospice MD recommended to stop the Abilify.

During an interview on 11/21/25 at 1:19 p.m., the ED indicated he'd had frequent conversations via phone call, text, email, and in-person with Resident B's representative regarding her concerns with care, his condition, and medications.

During an interview on 11/21/25 at 1:25 p.m., the Healthcare Director indicated she had called the pharmacy that day to request a copy of Resident B's physician's order for the Abilify, and they were going to send her a copy. The Healthcare Director indicated, resident orders were reconciled every 6 months when she sent the orders to the PCP office and the office would sign the orders and send them back. All resident physician's orders were input and discontinued by the pharmacy. When a resident went to an outside physician's appointment, the resident or resident representative were asked to provide paperwork to the facility. Nursing staff did not routinely track resident appointments or request copies of documentation from those appointments. The pharmacy

only accepted new orders that were in a script, written on a physician's order and signed by a nurse, or faxed from an MD's office. If a family member brought forward a concern with a medication, the Healthcare Director or another nurse would contact the physician's office to resolve the concern. The Healthcare Director indicated, to her knowledge, Resident B had a physician's order for Abilify, and she was awaiting a copy of the order from the pharmacy. When it was explained to the Healthcare Director that Resident B never had an order for Abilify, the order had been input into the system in error by a pharmacy technician, and the pharmacy had been required to follow pharmacy policy with internal reporting and follow-up, she indicated, "that's news to me."

On 11/21/25 at 3:12 p.m., the ED provided a script he indicated had been faxed to him that day from the facility contracted pharmacy. The script read, Aricept 10 mg tablet take 1 tablet by oral once daily in the evening for 90 days, effective date 8/27/25. A handwritten note on the faxed copy indicated, "This is the script sent over, Abilify keyed instead." The ED indicated there had never been an order for Ability.

Food and Drug Administration

(FDA) Black Box Warning, 2016, indicated the FDA had issued a black box warning for Abilify (aripiprazole) due to the increased risk of mortality in elderly patients with dementia-related psychosis. This warning served as a strong reminder for doctors and caregivers to carefully consider the risks and benefits of prescribing Abilify to this population. The FDA's boxed warning served as a strong reminder for doctors and caregivers to carefully consider the risks and benefits of prescribing aripiprazole to elderly patients with dementia-related psychosis. "It is important to note that aripiprazole is still approved for the treatment of other conditions, such as schizophrenia, bipolar disorder, and major depressive disorder, but it should not be prescribed to patients with dementia-related psychosis." The use of aripiprazole for dementia was considered "off label," meaning it was not approved for this specific use by the FDA. Medical guidelines from organizations like the American Psychiatric Association and Alzheimer's Society stated that antipsychotics should only be considered under very specific, limited circumstances such as failed non-pharmacological interventions and severe and

dangerous symptoms.

On 11/21/25 at 3:00 p.m., the Healthcare Director provided a Medication Management Plan policy, dated 12/20214, and indicated the policy was the one currently being used by the facility. The policy indicated, "All medications to be administered to the residents living in the licensed area of [facility name] shall contain in the resident's clinical record: a. The physician or prescriber's written order or a dated notation of the physician or prescriber's oral order ...4. No medication, dietary supplement, diet, medical procedure or treatment shall be started, changed, or discontinued by the community without a valid order from the physician or other prescriber. All new or changed medication orders will be verified by the nurse prior to administering ... 13. The Healthcare Coordinator, licensed nurse or RMA is responsible for routinely communicating concerns or observations related to medication administration to the prescribing physician or other prescriber and following up with the resident and residents family as the need exists ...15. The oversight, management and supervision of the medication program on a day-to-day basis is the direct responsibility of the Healthcare Coordinator ...."

	On 11/21/25 at 3:40 p.m., the Healthcare Director provided a Quick Reference Guide/Processing Medication Orders guide, dated 11/2025, and indicated this guidance was the one currently being used by the facility. The intention statement indicated, "Quick Reference Guides are to provide general guidance to [company name] team members. They are not all inclusive and may not reflect state-specific requirements. Quick Reference Guides are to be used in conjunction with reasonable clinical and operational judgement ... Physician writes the order in an approved format for pharmacy to process. The order may be written and provided directly to the pharmacy by the physician ...Pharmacy will enter into [pharmacy name] system ...Input order into dispensing software ...Pharmacy will prepare and dispense ...Pharmacist verifies: double checks accuracy before dispensing ...Final Check & Delivery. Following the Pharmacist final verification to ensure correct drug, dose, patient, and instructions, medication[s] or treatments are delivered to the community in which the resident resides. When medications/treatments are received at the community they are verified by a qualified community staff member ... and				

	confirmed according to community EMAR procedures...." Cross reference R0027 and R0041. This citation relates to Intake 465765. Based on observation, interview, and record review, the facility failed to administer medication in accordance with physician's orders and manufactures instructions for 1 of 3 residents reviewed for medication administration (Resident B) resulting in actual harm to the resident when he experienced hallucinations, weakness, and behaviors. Findings include:			

A confidential interview during the survey process indicated, on 9/17/25, while reviewing Resident B's medication list with Registered Nurse (RN) 6 Care Manger for hospice, the resident representative informed RN 6 that Resident B had no order for Abilify (aripiprazole - an antipsychotic medication used to treat mental health conditions). The resident representative was upset Resident B received Abilify from 8/27/25 until 10/1/25 without a physician's order, causing him to experience hallucinations, delirium, and increased weakness.

On 11/20/25 at 12:05 p.m., Resident B was observed sitting alone in the assisted living dining room. The resident displayed a flat affect and was not observed to interact with those around him. The resident was eating independently with no problems.

On 11/20/25 at 2:00 p.m., 11/20/25 at 2:40 p.m., and 11/21/25 at 12:09 p.m., attempts to interview Resident B were unsuccessful, he was observed each time lying on a standard full sized bed sleeping.

Resident B's clinical record was reviewed on 11/21/25 at 10:00 a.m. Diagnoses on Resident B's profile included dementia, transient ischemic attack (TIA -

mini stroke), and urinary incontinence.

A Primary Care Physician (PCP) Progress Note, dated 8/19/25, indicated Resident B was seen for an initial visit to establish services. The resident was alert and oriented to person, place and time with periods of confusion and forgetfulness. The resident used a front wheeled walker and wheelchair for ambulation. Although the resident continued to have some weakness and required assistance, he was showing improvement and his goal was to return home. There were no acute needs identified during the visit after assessment of the resident, and interviews with the resident representative and staff. Resident B had a follow-up appointment scheduled with the neurologist.

A progress note, dated 8/26/25 at 10:07 p.m., indicated the resident representative had called and requested staff assist Resident B with a shower that evening as he had an appointment the following day.

A Neurology Progress Note, dated 8/27/25, indicated Resident B presented for a follow up evaluation after having a TIA in June 2024. The resident had not had any further TIA- like symptoms or neurologic concerns. A

comparative MRI on 5/29/25 showed no acute findings. The resident had experienced balance issues, but therapy had helped his balance, strength and ambulation, and he was independent using a front wheeled walker. The resident had some short-term memory changes, but his long-term memory seemed to be fairly intact. The resident completed cognitive testing which showed marked improvement. He agreed to Aricept and orders were given to start with Aricept 5 milligrams (mg) daily for 30 days, then Aricept 10 mg daily.

A pharmacy script for Resident B, dated 8/27/25, indicated Aricept 5 mg 1 tablet by mouth for 30 days.

Electronic Medication Administration Records (eMARs), dated 8/29/25 through 9/27/25, indicated documentation Resident B had received Aricept 5 mg daily.

A pharmacy script for Resident B, dated 8/27/25, indicated Aricept 10 mg 1 tablet by mouth in the evening for 90 days.

Resident B's clinical record lacked documentation Aricept 10 mg had been added to his orders, or eMAR documentation the medication had been administered per physician's orders, start date 9/28/25.

eMARs for Resident B, dated 8/29/25 through 9/30/25, indicated an order for Ability 10 mg take 1 tablet by mouth once daily in the evening for 90 days. The Abilify was documented as having been administered to the resident daily.

Resident B's clinical record lacked documentation a physician had written an order for Abilify 10 mg.

A time stamped screen shot of a text message from the resident representative to the Healthcare Director, dated 9/17/25 at 11:53 a.m., indicated the resident representative questioned who had prescribed Abilify for Resident B.

A progress note, dated 9/18/25 at 12:22 p.m., indicated Resident B had been admitted to hospice services.

A PCP Progress Note, dated 9/22/25, indicated Resident B's family was concerned about a decline in the resident's health and weight loss. The resident representative indicated the resident had called the police on her two weeks ago, thought she was his ex-wife, and mistaken her for her daughter who passed away 10 years ago. Resident B was also obsessed over his taxes and mail. The resident was known to wander and would go outside and try to

get into other people's car. Per discussion with the Power of Attorney (POA), will taper off the Aricept as she feels it was causing bizarre behavior. The resident was now receiving hospice services.

A progress note, dated 10/11/25 at 10:52 p.m., indicated Resident B had called 911 and stated he did not know where he was, was confused, and woke up from a dream looking for his girlfriend's dad.

An email from the resident representative to the ED, dated 10/24/25, indicated, "The fax sent to [facility name] that I have been referring to for weeks came directly from [pharmacy name] not a physician. It is the prescription for Abilify. Maybe they never faxed it. I will be contacting them next week. [Pharmacy name], Healthcare Director, and the hospice nurse are all saying Resident B's neurologist, prescribed Abilify. I called her office and spoke directly to her MA she confirmed that they would never prescribe Abilify and that they only prescribed Aricept ...I was at the appointment and know she only prescribed Aricept 5 mg for 30 days and then Aricept 10 mg going forward. Somehow that second prescription was changed to Abilify 10 mg. I don't know why [facility name] can't understand my concerns. What

part don't you understand?"

A PCP Progress Note, dated 11/3/25, indicated during the visit with Resident B, he was alert to person, place and time. He had intermittent confusion and seemed lost when the Nurse Practitioner (NP) was speaking with him. No other changes were made to the medication regiment or plan of care today.

A progress note, dated 11/5/25 at 7:59 p.m., indicated Resident B was observed to be confused and refused care. The resident had called 911 and reported an earthquake and was unable to get up without assistance. The resident was alert but disoriented, and his confusion appeared increased from his baseline. The resident complained of back pain and was unable to ambulate independently. Interventions included, providing reassurance and reorientation, ensuring resident safety with the call light within reach, bed in the lowest position, and side rails up per protocol, and follow up with physician for evaluation of back pain and confusion.

A Service Plan, dated 11/10/25, indicated the resident had severe cognitive impairment and was disorientated with time and situation. He required assistance with bathing,

dressing, toileting, and transportation within the facility, and prompting and reminders for smaller tasks.

During an interview with the Ombudsman, she indicated during a visit on 11/12/25, the resident representative indicated Resident B had been administered the wrong medication and staff refused to listen to her which ultimately led to the resident having a mental decline, being more incontinent, and requiring more assistance for daily care. Resident B indicated he was needing more help and had missed breakfast that morning as staff had not come to take him to the dining room. The resident's call light cord in the bedroom was observed to be broken off and hanging over the call box, and the resident's call pendant hanging from a black shoestring was found tied to the toilet paper roll in the bathroom. The resident indicated he had been looking for the call pendant.

A progress note, dated 11/15/25 at 6:50 a.m., indicated Resident B was found on the floor in his room. The resident had hit his face on the floor, and it was "reddish."

A progress note, dated 11/18/25 at 6:35 a.m., indicated Resident B was found on the floor in his room, he'd been on his way to

the bathroom. There were no injuries at the time of the incident.

During an interview on 11/20/25 at 10:10 a.m., resident representative for Resident B indicated the resident had moved into the current assisted living apartment on 10/1/24. At that time, the resident was independent with transfers, ambulation with a walker, toileting, and eating, and just needed oversight for dressing and bathing. On 8/27/25, Resident B had a follow up visit with the neurologist and was given new medication orders for Aricept 5 mg for 30 days, then increase to Aricept 10 mg for memory loss. The resident representative indicated she had been present at the neurology appointment and was given copies of the visit notes and medication orders. On 9/15/25 the resident started acting "kind of weird". The resident representative had contacted Resident B's outside PCP, and the PCP office had suggested she take the resident to the ER as there were no appointments available. When the resident representative attempted to take the resident to the ER he had refused to go, the Healthcare Director had observed the situation in the lobby and had suggested hospice. On 9/17/25, Resident B was admitted to hospice, and

when hospice Case Manager RN 6 had called her to review Resident B's medication list, Abilify was on the list. The resident representative informed the hospice nurse that Resident B did not have orders for Ability. By that time, Resident B had been receiving Abilify without an order for 2 weeks, and although the hospice nurse discontinued 5 other medications, she refused to discontinue the Abilify or to call it an error. The resident representative indicated to her knowledge, the Hospice Care Manager RN 6 had not reviewed the neurology orders, or she would have seen the error. The resident representative indicated Resident B could have died taking the Aricept and Abilify together, he was "out of his mind", so weak he could not walk, had become more incontinent, and had lost weight. On 10/1/25 the resident was taken off the Abilify, and had since improved "somewhat" but was not back to his baseline in caring for himself or cognitive abilities.

During an interview on 11/20/25 at 10:10 a.m., resident representative for Resident B indicated she herself had contacted the neurologist to confirm he had not ordered the Abilify. The resident representative had also contacted the Registered

Pharmacist (RPh) In Charge of the facility pharmacy, who helped her confirm there had never been an order for Ability, instead a pharmacy technician had keyed in and filled Abilify instead of Aricept. Nursing staff had not caught the error and had administered the wrong medication. The resident representative indicated she had increasing concern regarding Resident B's metal state and behaviors, and physical state as he could hardly walk due to weakness, and staff had started taking him to the dining room in a wheelchair. In her opinion, the Healthcare Director should have immediately taken her concerns seriously and investigated the issue, not brushed her off as being a "pest." Before taking the Aricept and Abilify, she would have considered Resident B to have had mild dementia. Now the resident was sundowning, was refusing care more often, calling 911, calling the resident representative by his 1st wife's name or by his deceased daughters name, and his dementia had progressed.

On 11/20/25 at 10:55 a.m., the Executive Director (ED) provided a typed statement that indicated there had been no medication errors or weight loss documented in the past 6 months.

Resident B's weight documentation indicated, on 6/4/25 a weight of 165.4 lbs., on 8/13/25 a weight of 159.4 lbs., and on 10/11/25 a weight of 156.0 lbs.

During an interview on 11/20/25 at 3:19 p.m., a Facility Pharmacy Representative indicated, on 8/27/25 the pharmacy had received new orders for Resident B for Aricept 5 mg for 30 days, then increase the dosage to Aricept 10 mg daily. When transcribing the medication orders, a technician had keyed in Aricept 5 mg for 30 days, but the order for Aricept 10 mg was keyed in wrong, changing the medication from Aricept 10 mg to Abilify 10 mg. Both the Aricept 5 mg and Abilify 10 mg medications were sent to the facility at the same time, and both medications were initiated and administered daily. On 10/1/25 the resident representative called the pharmacy and indicated the resident had no order for Abilify, the hospice nurse and facility staff would not listen to her, and after she had raised concerns to the facility staff, they had stopped taking her calls. The pharmacy representative indicated only after the resident representative called the pharmacy on 10/1/25 was the error identified, and by then the resident had received 33 doses of Abilify without a physician's

order. The Registered Pharmacist (RPh) In Charge took the concern seriously, found the error in the electronic system, discontinued the Abilify immediately, and entered the Aricept 10 mg order correctly. The pharmacy representative indicated Aricept was used to slow down the dementia process and help preserve mentation. Abilify was used more for behaviors, depression, mental issues, and would speed up the dementia process. The RPh In Charge documented the error as an external error (meaning it left the pharmacy and caused an issue) and reported to corporate compliance. The pharmacy technicians were required to review what had happened with Resident B's medication orders, provided additional education about the importance of verifying medication orders, and they discussed the harm that had been caused to Resident B by the situation. The pharmacy representative indicated there was no documentation to indicate the facility had contacted the pharmacy regarding the Abilify.

On 11/20/25 at 3:55 p.m., the ED provided Concern/Grievance Forms, dated August through October 2025, there was no documentation Resident B's representative had concerns with the resident being

administered Abilify without an order.

During an interview on 11/21/25 at 9:51 a.m., the Healthcare Director indicated in October 2025, Resident B's representative started questioning the resident's physician's orders for Abilify, and demanded the medication be stopped immediately. The Healthcare Director had told the resident representative the facility could not stop medications by request, instead to tell Resident B to pick the pill out of the cup and refuse the medication when offered. The Healthcare Director indicated she had contacted the PCP, neurologist, mobile MD psych, hospice nurse, and was told they had not ordered the medication. After being told by the resident representative that the neurologist had ordered new medication, the Healthcare Director contacted the neurologist office and was told they could not find documentation of an order for Abilify. The resident representative had requested medication lists for the months of August, September, and October at the end of October, but the electronic system had been "messed up" and some of the documents were provided to her over time when they became available. The Healthcare Director indicated

Resident B's representative had been in contact with her multiple times in person, by phone, email and text messages, but she had never documented the resident representatives concerns on grievance forms to track the issues.

During an interview on 11/21/25 at 9:51 a.m., the Healthcare Director indicated, on an undetermined date, Resident B's representative had been in the front lobby attempting to take the resident to the emergency room (ER), stating "can't you see what he's like" and the resident did not want to go to the ER. The Healthcare Director indicated this had prompted her to suggest hospice services, she had not suggested requesting laboratory testing or a visit with the PCP to rule out an acute medical reason for his decline and behaviors. On 9/17/25 hospice services were started in response to the resident representative concerns for Resident B's for overall decline, the resident not walking, and his requiring calls to get him up out of bed. The Healthcare Director indicated she had been unaware the resident representative had a concern about the Abilify order until 9/30/25.

The Healthcare Director indicated she had received texts

from Resident B's representative to include, on 9/30/25, the resident representative stated to take Resident B off the Abilify "ASAP" and she expected to see a credit on the pharmacy bill, on 10/1/25 the resident representative provided a medication list, dated May 2025, and indicated that it was the residents correct medications, and on 10/1/25 the resident representative had texted and was inquiring if the hospice MD could discontinue the Abilify. In response, on 10/1/25, the Healthcare Director spoke with the psych MD and asked if they had ordered the Abilify, and she had sent a note to the pharmacy requesting the Abilify be discontinued.

During an interview on 11/21/25 at 10:39 a.m., a Hospice Representative indicated, on 9/17/25, Resident B was admitted to hospice services with the diagnoses of senile degeneration of the brain, and that same day the facility provided hospice with a current medication list. The medication list included an order for Abilify 10 mg 1 tablet by mouth for 90 days, that had started on 8/27/25. The Hospice Medical Director reviewed Resident B's medication list, and there were no recommendation to discontinue the Abilify at that time as the resident had

recently started the medication. On 9/17/25, Hospice RN 6 contacted the resident representative to review the resident's medication list, and the resident representative informed her the resident had no order for Abilify. On 10/6/25, the resident representative was adamant the resident was taken off the Abilify immediately, and the hospice MD recommended to stop the Abilify.

During an interview on 11/21/25 at 1:19 p.m., the ED indicated he'd had frequent conversations via phone call, text, email, and in-person with Resident B's representative regarding her concerns with care, his condition, and medications.

During an interview on 11/21/25 at 1:25 p.m., the Healthcare Director indicated she had called the pharmacy that day to request a copy of Resident B's physician's order for the Abilify, and they were going to send her a copy. The Healthcare Director indicated, resident orders were reconciled every 6 months when she sent the orders to the PCP office and the office would sign the orders and send them back. All resident physician's orders were input and discontinued by the pharmacy. When a resident went to an outside physician's appointment, the resident or resident representative were asked to provide paperwork to

the facility. Nursing staff did not routinely track resident appointments or request copies of documentation from those appointments. The pharmacy only accepted new orders that were in a script, written on a physician's order and signed by a nurse, or faxed from an MD's office. If a family member brought forward a concern with a medication, the Healthcare Director or another nurse would contact the physician's office to resolve the concern. The Healthcare Director indicated, to her knowledge, Resident B had a physician's order for Abilify, and she was awaiting a copy of the order from the pharmacy. When it was explained to the Healthcare Director that Resident B never had an order for Abilify, the order had been input into the system in error by a pharmacy technician, and the pharmacy had been required to follow pharmacy policy with internal reporting and follow-up, she indicated, "that's news to me."

On 11/21/25 at 3:12 p.m., the ED provided a script he indicated had been faxed to him that day from the facility contracted pharmacy. The script read, Aricept 10 mg tablet take 1 tablet by oral once daily in the evening for 90 days, effective date 8/27/25. A handwritten note on the faxed copy indicated, "This is the script sent

over, Abilify keyed instead." The ED indicated there had never been an order for Ability.

Food and Drug Administration (FDA) Black Box Warning, 2016, indicated the FDA had issued a black box warning for Abilify (aripiprazole) due to the increased risk of mortality in elderly patients with dementia-related psychosis. This warning served as a strong reminder for doctors and caregivers to carefully consider the risks and benefits of prescribing Abilify to this population. The FDA's boxed warning served as a strong reminder for doctors and caregivers to carefully consider the risks and benefits of prescribing aripiprazole to elderly patients with dementia-related psychosis. "It is important to note that aripiprazole is still approved for the treatment of other conditions, such as schizophrenia, bipolar disorder, and major depressive disorder, but it should not be prescribed to patients with dementia-related psychosis." The use of aripiprazole for dementia was considered "off label," meaning it was not approved for this specific use by the FDA. Medical guidelines from organizations like the American Psychiatric Association and Alzheimer's Society stated that

antipsychotics should only be considered under very specific, limited circumstances such as failed non-pharmacological interventions and severe and dangerous symptoms.

On 11/21/25 at 3:00 p.m., the Healthcare Director provided a Medication Management Plan policy, dated 12/20214, and indicated the policy was the one currently being used by the facility. The policy indicated, "All medications to be administered to the residents living in the licensed area of [facility name] shall contain in the resident's clinical record: a. The physician or prescriber's written order or a dated notation of the physician or prescriber's oral order ...4. No medication, dietary supplement, diet, medical procedure or treatment shall be started, changed, or discontinued by the community without a valid order from the physician or other prescriber. All new or changed medication orders will be verified by the nurse prior to administering ... 13. The Healthcare Coordinator, licensed nurse or RMA is responsible for routinely communicating concerns or observations related to medication administration to the prescribing physician or other prescriber and following up with the resident and residents family as the need exists ...15. The oversight, management and

supervision of the medication program on a day-to-day basis is the direct responsibility of the Healthcare Coordinator ...."

On 11/21/25 at 3:40 p.m., the Healthcare Director provided a Quick Reference Guide/Processing Medication Orders guide, dated 11/2025, and indicated this guidance was the one currently being used by the facility. The intention statement indicated, "Quick Reference Guides are to provide general guidance to [company name] team members. They are not all inclusive and may not reflect state-specific requirements. Quick Reference Guides are to be used in conjunction with reasonable clinical and operational judgement ... Physician writes the order in an approved format for pharmacy to process. The order may be written and provided directly to the pharmacy by the physician ...Pharmacy will enter into [pharmacy name] system ...Input order into dispensing software ...Pharmacy will prepare and dispense ...Pharmacist verifies: double checks accuracy before dispensing ...Final Check & Delivery. Following the Pharmacist final verification to ensure correct drug, dose, patient, and instructions, medication[s] or treatments are delivered to the community in

	which the resident resides. When medications/treatments are received at the community they are verified by a qualified community staff member ... and confirmed according to community EMAR procedures...." Cross reference R0027 and R0041. This citation relates to Intake 465765.			

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 SIGNATUREDawn Horvat	TITLERDRC	(X6) DATE12/19/2025