STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/07/2025

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 a State Residential Licensure Survey. This visit included the Investigation of Intake IN00465161. Intake IN00465161 - No deficiencies related to the allegations are cited. Survey dates: October 6 and 7, 2025 Facility number: 014959 Residential Census: 66 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on October 22, 2025.	R 0000	**The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation.** **This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests Desk Review in lieu a Post Survey Review.**	
R 0090	Administration and Management - Deficiency 410 IAC 16.2-5-1.3(g)(1-6) (g) The administrator is responsible	R 0090	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:**	12/06/2025

	for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that		No residents were adversely affected. **How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents had the potential to be affected. No other residents were identified to be affected. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** Nursing staff will receive education on the requirement to immediately notify the Executive Director, Director of Nursing or Harmony Square Director of any resident injury or incident. The education will emphasize timely and complete communication of all occurrences that may impact resident safety or care. **How the corrective actions will be monitored to ensure the deficient practice will not recur—i.e., what quality**	

	indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request Based on observation, interview, and record review, the facility failed to ensure the staff reported to the Executive Director (ED) a new injury to a resident (Resident 20) that was sustained while staff pushed him in his wheelchair for 1 of 6 residents reviewed. Findings include: On 10/6/25 at 11:45 a.m., Resident 20 was observed as he was assisted into the dining room. A gauze pad was taped to his left elbow and the tape had begun to peel away. There was no date on the bandage.		**assurance program will be put into place:** The Director of Nursing or designee will audit incident reports twice weekly for four weeks, weekly for four weeks, every other week for four cycles, monthly for four months, and then randomly thereafter. Findings will be logged and corrective action will be taken as needed. **By what date the systemic changes will be put into place:** 12/6/2025	

	On 10/7/25 at 10:00 a.m., Resident 20 was observed in his room with his spouse. There was a new bandage in place on his left elbow. Resident 20 indicated, about a week ago, someone started to push him in his wheelchair from the dining room back up to his room. Upon pushing his wheelchair into the room, the staff member accidently pushed him too close to the door frame. Resident 20 hit his elbow on the door which caused a skin tear. He complained of pain at that time and the skin tear was bleeding, but the staff member just said "sorry," as they continued on their way without stopping to help. On 10/7/25 at 10:15 a.m., Resident 20's record was reviewed. A nursing progress note, dated 9/23/25 at 9:12 p.m., indicated, " ... the resident reported that being assisted back to his room from lunch by a staff member, the staff member forcefully pushed him into the room ... as a result, the resident hit his elbow on the door, causing it to bleed. The resident stated that the staff member apologized and walked away without offering further assistance. A therapist who notice the resident bleeding elbow later encouraged him to call for help. The resident said			

	he pressed his call light, but no staff responded. He then decided to come down to the nursing station during dinner to report the incident. Upon being informed, the writer cleaned the resident's bleeding elbow and applied a bandage." The record lacked documentation of Executive Director notification. The record lacked documentation of a treatment order. The record lacked documentation that the Director of Nursing (DON) was notified. During an interview on 10/7/25 at 1:30 p.m., the DON indicated she had not been notified of the skin tear, and could not find evidence the physician had been notified, so she would call as get an order for a treatment.			

	During an interview on 10/7/25 at 2:20 p.m., the ED indicated he had not been notified of the skin tear. Upon reading the nursing note, the ED indicated he would have immediately reported the incident to the Indiana Department of Health and investigated the incident. The staff member who caused the injury, the therapist, and/or the nurse who put the note in should have notified him of the injury. On 10/7/25 at 2:20 p.m., the ED provided a copy of current facility policy titled, "Incident/Accident Reporting (Resident)," revised 3/2022. The policy indicated, "All incidents/accidents in the community or on community property must be reported immediately ... An incident report must be completed on the shift that the incident occurred. Incidents and accidents are to be immediately reported by the person most directly involved or by those who observed, have direct knowledge of or discovered the event or the near-miss situation ...." Based on observation, interview, and record review, the facility failed to ensure the staff reported to the Executive Director (ED) a new injury to a resident (Resident 20) that was sustained while staff pushed him in his wheelchair for 1 of 6			

residents reviewed.

Findings include:

On 10/6/25 at 11:45 a.m., Resident 20 was observed as he was assisted into the dining room. A gauze pad was taped to his left elbow and the tape had begun to peel away. There was no date on the bandage.

On 10/7/25 at 10:00 a.m., Resident 20 was observed in his room with his spouse. There was a new bandage in place on his left elbow. Resident 20 indicated, about a week ago, someone started to push him in his wheelchair from the dining room back up to his room. Upon pushing his wheelchair into the room, the staff member accidently pushed him too close to the door frame. Resident 20 hit his elbow on the door which caused a skin tear. He complained of pain at that time and the skin tear was bleeding, but the staff member just said "sorry," as they continued on their way without stopping to help.

On 10/7/25 at 10:15 a.m., Resident 20's record was reviewed. A nursing progress note, dated 9/23/25 at 9:12 p.m., indicated, " ... the resident reported that being assisted back to his room from lunch by a staff member, the staff member forcefully pushed him

into the room ... as a result, the resident hit his elbow on the door, causing

it to bleed. The resident stated that the staff member apologized and walked away without offering further assistance. A therapist who notice the resident bleeding elbow later encouraged him to call for help. The resident said he pressed his call light, but no staff responded. He then decided to come down to the nursing station during dinner

to report the incident. Upon being informed, the writer cleaned the resident's bleeding elbow and applied a bandage."

The record lacked documentation of Executive Director notification.

The record lacked documentation of a treatment order.

The record lacked documentation that the Director of Nursing (DON) was notified.

During an interview on 10/7/25 at 1:30 p.m., the DON indicated she had not been notified of the skin tear, and could not find evidence the physician had been notified, so she would call as get an order for a treatment.

During an interview on 10/7/25 at 2:20 p.m., the ED indicated

	he had not been notified of the skin tear. Upon reading the nursing note, the ED indicated he would have immediately reported the incident to the Indiana Department of Health and investigated the incident. The staff member who caused the injury, the therapist, and/or the nurse who put the note in should have notified him of the injury. On 10/7/25 at 2:20 p.m., the ED provided a copy of current facility policy titled, "Incident/Accident Reporting (Resident)," revised 3/2022. The policy indicated, "All incidents/accidents in the community or on community property must be reported immediately ... An incident report must be completed on the shift that the incident occurred. Incidents and accidents are to be immediately reported by the person most directly involved or by those who observed, have direct knowledge of or discovered the event or the near-miss situation ...."			
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,	R 0120	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** No residents were adversely affected.	12/06/2025

	residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the 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.		**How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents had the potential to be affected. No other residents were identified to be affected. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** All current employees will be audited to confirm completion of dementia-specific training. Any missing training will be completed promptly. Going forward, all new employees will be required to complete dementia-specific in-service education as part of their orientation and annual training program. **How the corrective actions will be monitored to ensure the deficient practice will not recur—i.e., what quality assurance program will be put into place:** The Business Office Manager or	

	The employee will acknowledge attendance by written signature. Based on record review and interview, the facility failed to ensure and/or provide verification for dementia-specific in-service training for 6 of 6 employee files reviewed. Findings include: On 10/7/25 at 10:00 a.m., six randomly selected employee files were reviewed. Three employees who had been hired more that a year ago, had an annual Dementia-Specific quiz but there was no accompanying documentation to verify they had received a minimum of three hours of dementia specific training. Three employees who had been recently hired, had a document which indicated they had completed Dementia-Specific training, but there was no accompanying documentation to verify they had received a minimum of six hours within the first six months of their hire. During an interview on 10/7/25 at 10:30 a.m., the Business Office Manager, (BOM) indicated, she was unable to find additional documentation for employee training. During an interview on 10/7/25		designee will audit staff training files weekly for four weeks, every other week for four cycles, monthly for four months, and then randomly thereafter. Findings will be tracked and corrective action taken when needed. **By what date the systemic changes will be put into place:** 12/6/2025	

at 2:50 p.m. the Executive Director (ED) indicated there was not a specific policy for dementia-specific training, but the facility followed the residential regulations and state rules.

Based on record review and interview, the facility failed to ensure and/or provide verification for dementia-specific in-service training for 6 of 6 employee files reviewed.

Findings include:

On 10/7/25 at 10:00 a.m., six randomly selected employee files were reviewed.

Three employees who had been hired more that a year ago, had an annual Dementia-Specific quiz but there was no accompanying documentation to verify they had received a minimum of three hours of dementia specific training.

Three employees who had been recently hired, had a document which indicated they had completed Dementia-Specific training, but there was no accompanying documentation to verify they had received a minimum of six hours within the first six months of their hire.

During an interview on 10/7/25 at 10:30 a.m., the Business Office Manager, (BOM) indicated, she was unable to

	find additional documentation for employee training. During an interview on 10/7/25 at 2:50 p.m. the Executive Director (ED) indicated there was not a specific policy for dementia-specific training, but the facility followed the residential regulations and state rules.			
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 interview and record review, the facility failed to ensure a resident's (Resident	R 0216	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** Resident #22 – Semiannual assessment completed on 10/27/25. **How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents had the potential to be affected. No additional residents were identified to be affected.	12/06/2025

	22) semiannual assessment was obtained and kept on file during a new electronic medical record system launch for 1 of 6 residents reviewed. Findings include: On 10/7/25 at 11:30 a.m. Resident 22's medical record was reviewed. She was a long-term care resident whose diagnoses included but were not limited to dementia and frequent falls. The medical record lacked documentation of a semiannual assessment for Resident 22. During an interview on 10/7/25 at 1:42 p.m. the Director of Nursing (DON) indicated they had done the semiannual assessment, but due to system malfunctions it had gotten deleted. She indicated her regional support advised her to not redo the assessment and instead wait for the new electronic medical record system to launch. A policy regarding semiannual assessments was requested but was not provided at the time of exit. Based on interview and record review, the facility failed to ensure a resident's (Resident 22) semiannual assessment was obtained and kept on file		**What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** Missing documentation issue identified with EHR provider (Yardi). Entered assessments have been lost within the Yardi database. Yardi continues to work on a solution to this issue. In the interim, staff will print completed assessments and upload into resident digital documents file within the EHR as documentation of completion. HCD/HSD or designee re-educated on use of Yardi dashboard to identify pending, due, past due resident assessments. HCD/HSD or designee will review Yardi dashboard daily within normal business hours to identify any resident with upcoming or due assessment(s). Assessments will be completed by eligible personnel within state regulations/requirements. **How the corrective actions will be monitored to ensure the deficient practice will not**	

	during a new electronic medical record system launch for 1 of 6 residents reviewed. Findings include: On 10/7/25 at 11:30 a.m. Resident 22's medical record was reviewed. She was a long-term care resident whose diagnoses included but were not limited to dementia and frequent falls. The medical record lacked documentation of a semiannual assessment for Resident 22. During an interview on 10/7/25 at 1:42 p.m. the Director of Nursing (DON) indicated they had done the semiannual assessment, but due to system malfunctions it had gotten deleted. She indicated her regional support advised her to not redo the assessment and instead wait for the new electronic medical record system to launch. A policy regarding semiannual assessments was requested but was not provided at the time of exit.		**recur—i.e., what quality assurance program will be put into place:** Ongoing The Healthcare Director/Harmony Square Director or designee will utilize Yardi dashboard to monitor upcoming/due assessments. The HCD/HSD or designee will review Yardi dashboard daily during normal business hours to identify which resident(s) are due for a required assessment. Assessments will be completed within state regulatory guidelines. The ED will review Yardi dashboard weekly for compliance x4 weeks, every two weeks x2 cycles and monthly for 2 cycles to ensure ongoing compliance with assessment completion. Ongoing ED to review randomly and PRN. **By what date the systemic changes will be put into place:** 12/6/2025	
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5)	R 0217	**What corrective actions will be accomplished for those residents found to have been**	12/06/2025

	(e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and		**affected by the deficient practice:** Residents #6, #20 and #22 – Service plans were reviewed for accuracy and Care Conferences conducted/scheduled with resident and/or responsible party as applicable to review and obtain required signatures acknowledging the plan. **How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents had the potential to be affected. No other residents were identified to be affected. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** The community is currently completing updated assessments and service plans for all residents as part of the electronic health record implementation initiative. A notification will be generated when assessments	

	documentation of the services to be provided. Based on record review and interview, the facility failed to ensure resident's service plans were signed and kept on file or have provisions in place for back-up during a medical record charting switch over which resulted in service plans and evaluations being lost for 4 of 6 residents reviewed. Findings include: On 10/7/ 25 at 10:30 a.m., Resident 20 and Resident 6's records were reviewed and lacked documentation of their most recent signed service plans. On 10/7/25 at 11:30 a.m. Resident 22's medical record was reviewed and lacked documentation of their most recent signed service plans. During an interview on 10/7/25 at 1:30 p.m., the Director of Nursing (DON) indicated during the switch from a previous charting system to a new system, several assessments and service plans had been lost. There were no hard copies or back ups on file. She had been advised to re-start baseline assessments and service plans for all residents. Signed service plans for		and service plans are completed and ready for review. The service plans will be reviewed by appropriate clinical or administrative leadership to identify any changes from prior plans. Service plans will then be reviewed with the resident and/or responsible party, as applicable, and signatures acknowledging the review will be obtained. **How the corrective actions will be monitored to ensure the deficient practice will not recur—i.e., what quality assurance program will be put into place:** The HCD/HSD or designee will review Yardi dashboard daily during regular business hours for Assessments Pending Approval and Incomplete Service Plans. Incomplete Service Plans will be reviewed/completed and printed for resident/responsible party review and signature of acknowledgment. The ED will review Yardi dashboard weekly for compliance x4 weeks, every two weeks x2 cycles and monthly for 2 cycles to ensure ongoing compliance with assessment	

	Resident 20, 22, and 6 were unable to be provided before the survey exit on 10/7/25. Based on record review and interview, the facility failed to ensure resident's service plans were signed and kept on file or have provisions in place for back-up during a medical record charting switch over which resulted in service plans and evaluations being lost for 4 of 6 residents reviewed. Findings include: On 10/7/ 25 at 10:30 a.m., Resident 20 and Resident 6's records were reviewed and lacked documentation of their most recent signed service plans. On 10/7/25 at 11:30 a.m. Resident 22's medical record was reviewed and lacked documentation of their most recent signed service plans. During an interview on 10/7/25 at 1:30 p.m., the Director of Nursing (DON) indicated during the switch from a previous charting system to a new system, several assessments and service plans had been lost. There were no hard copies or back ups on file. She had been advised to re-start baseline assessments and service plans for all residents. Signed service plans for		completion. Ongoing ED to review randomly and PRN. **By what date the systemic changes will be put into place:** 12/6/2025	

	Resident 20, 22, and 6 were unable to be provided before the survey exit on 10/7/25.			
R 0302	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(6) (6) Over-the-counter medications must be identified with the following: (A) Resident name. (B) Physician name. (C) Expiration date. (D) Name of drug. (E) Strength. Based on observation and interview, the facility failed to date inhalers and eye drops when opened, and failed to label over the counter medications with required information for 2 of 4 medication carts and 1 of 2 medication refrigerators. Findings include: 1. On 10/6/25 at 11:27 a.m., the medication cart for AL was observed. Resident 16 had a bottle of Sustane eye drops without a date to indicate when they were opened. She had another bottle of Sustane eye drops that was	R 0302	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** 302-1: Residents #15,16 and 17 – improperly labeled medications were destroyed 302-2: Resident #6 and Res #4's OTC medications were validated against physician orders and MAR and properly labeled. 302-3: Residents #9,10,11,12,13,14,23 Medications were destroyed	12/06/2025

not opened. Both bottles only contained an apartment number.

Resident 17 had a Trelegy inhaler with no date to indicate when it was opened.

Resident 15 had three bottles of latanoprost in the refrigerator. One was opened and lacked a date to indicate when it was opened.

2. On 10/6/25 at 12:30 p.m., observed unlabeled medications in the cart.

Resident 6 had over the counter medications in the cart that lacked required information on the bottles. They were AREDS 2 (a multivitamin), neuriva (a supplement), calcium 600 mg (milligram), fish oil 1200 mg, multivitamin, and senna plus 8.6 mg (for constipation).

Resident 4 had centrum (a vitamin supplement), ferrous sulfate 325mg, lutein 20 mg, folic acid 800 mg, vitamin C 500 mg, aspirin (ASA) 81 mg, Tylenol 500 mg, melatonin 10 mg, turmeric curcumin (a supplement) 500 mg, vitamin E 180 mg, vitamin B12 1000 mcg (microgram), and CO-Q10 (a supplement). They all lacked information required.

3. On 10/6/25 at 12:51 p.m., the memory care cart was observed. The Pharmacist was

How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:

Med Cart audits were completed by pharmacy representative. All residents had the potential to be affected. No other residents were identified to be affected.

What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:

All nursing staff will be re-educated on proper labeling and dating of medications, including inhalers, eye drops, and over-the-counter items. Education will emphasize compliance with pharmaceutical labeling standards and ongoing verification during medication administration and storage checks.

How the corrective actions will be monitored to ensure the deficient practice will not recur—i.e., what quality assurance program will be put into place:

HCD/HSD or designee will

	present and reviewing the cart for discrepancies. She indicated that it was her first time at the facility and was provided with findings from the AL cart. Resident 23 had latanoprost eye drops in the cart with a date opened of 6/7/25. Resident 9 had a bottle of fluticasone (for allergies) in the cart and it lacked a date to indicate when it was opened. Resident 10 had a bottle of Visine eye drops without a date to indicate when it was opened. Resident 11 had a tube of erythromycin (an antibiotic) eye ointment without a date to indicate when it was opened. Resident 12 had a bottle of ketotifen fum. 0.035% (for itchy eyes) without a date to indicate when it was opened. Resident 13 had over the counter medications in the cart without appropriate labels. She had Tylenol 500 mg, and Imodium (used to treat diarrhea). Resident 14 had over the counter medications in the cart without appropriate labels. She had Imodium 2 mg, Tylenol 500 mg, vitamin B12 1000 mcg, Preservision (a supplement), AREDS 2, acetaminophen (used to treat pain) 500 mg, and		assign Weekly Medication Cart Audits to Qulified Medication Aids. QMAs will complete weekly medication cart audits utilizing the community Weekly Medication Cart Audit form and will provide HCD/HSD or designee results on the day audits are completed. HCD/HSD or designee will review weekly QM audits for trends and educational opportunities. HCD/HSD or designee will complete monthly medication cart audits utilizing the community Monthly Medication Cart Audit form. HCD/HSD or designee will review for trends and educational opportunities. Trends and concerns will be reviewed with staff and may be added to ongoing QAPI initiatives. **By what date the systemic changes will be put into place:** 12/6/2025	

ASA.

On 10/6/25 at 12:49 p.m., Qualified Medication Assistant (QMA) 4 indicated she usually dated items when they were opened. She indicated she would get appropriate labels on the over-the-counter medications.

A policy titled "Medication Storage" was provided by the Executive Director (ED) on 10/7/25 at 1:27 p.m. It indicated, medication should be labeled.

Based on observation and interview, the facility failed to date inhalers and eye drops when opened, and failed to label over the counter medications with required information for 2 of 4 medication carts and 1 of 2 medication refrigerators.

Findings include:

1. On 10/6/25 at 11:27 a.m., the medication cart for AL was observed.

Resident 16 had a bottle of Sustane eye drops without a date to indicate when they were opened. She had another bottle of Sustane eye drops that was not opened. Both bottles only contained an apartment number.

Resident 17 had a Trelegy inhaler with no date to indicate

when it was opened.

Resident 15 had three bottles of latanoprost in the refrigerator. One was opened and lacked a date to indicate when it was opened.

2. On 10/6/25 at 12:30 p.m., observed unlabeled medications in the cart.

Resident 6 had over the counter medications in the cart that lacked required information on the bottles. They were AREDS 2 (a multivitamin), neuriva (a supplement), calcium 600 mg (milligram), fish oil 1200 mg, multivitamin, and senna plus 8.6 mg (for constipation).

Resident 4 had centrum (a vitamin supplement), ferrous sulfate 325mg, lutein 20 mg, folic acid 800 mg, vitamin C 500 mg, aspirin (ASA) 81 mg, Tylenol 500 mg, melatonin 10 mg, turmeric curcumin (a supplement) 500 mg, vitamin E 180 mg, vitamin B12 1000 mcg (microgram), and CO-Q10 (a supplement). They all lacked information required.

3. On 10/6/25 at 12:51 p.m., the memory care cart was observed. The Pharmacist was present and reviewing the cart for discrepancies. She indicated that it was her first time at the facility and was provided with findings from the AL cart.

Resident 23 had latanoprost eye drops in the cart with a date opened of 6/7/25.

Resident 9 had a bottle of fluticasone (for allergies) in the cart and it lacked a date to indicate when it was opened.

Resident 10 had a bottle of Visine eye drops without a date to indicate when it was opened.

Resident 11 had a tube of erythromycin (an antibiotic) eye ointment without a date to indicate when it was opened.

Resident 12 had a bottle of ketotifen fum. 0.035% (for itchy eyes) without a date to indicate when it was opened.

Resident 13 had over the counter medications in the cart without appropriate labels. She had Tylenol 500 mg, and Imodium (used to treat diarrhea).

Resident 14 had over the counter medications in the cart without appropriate labels. She had Imodium 2 mg, Tylenol 500 mg, vitamin B12 1000 mcg, Preservision (a supplement), AREDS 2, acetaminophen (used to treat pain) 500 mg, and ASA.

On 10/6/25 at 12:49 p.m., Qualified Medication Assistant (QMA) 4 indicated she usually dated items when they were

	opened. She indicated she would get appropriate labels on the over-the-counter medications. A policy titled "Medication Storage" was provided by the Executive Director (ED) on 10/7/25 at 1:27 p.m. It indicated, medication should be labeled.			

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 SIGNATURECharles	TITLEBoswell	(X6) DATE11/06/2025