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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALPARAISO SENIOR VILLAGE	74 E JOURNEY WAY, VALPARAISO, , 46383

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00457361 and IN00457391. Complaint IN00457361 - State deficiencies related to the allegations are cited at R0144, R0215, R0241, and R0245. Complaint IN00457391 - State deficiencies related to the allegations are cited at R0144, R0241, and R0245. Survey dates: July 14 and July 15, 2025 Facility number: 015221 Residential Census: 99 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 7/22/25.	R 0000		

R 0092	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(i)(1-2) (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on record review and interview, the facility failed to ensure the fire department was invited to attend fire drills every six months. This had the potential to affect all 99	R 0092	Maintenance Director will invite Fire Marshall twice a year via email. Executive Director and Maintenance director will discuss findings from fire drills during monthly QA meetings.	08/31/2025

	residents residing in the facility. Finding includes: The fire drill log for the past twelve months was reviewed on 7/14/25 at 11:50 a.m. The logs included the date, time and participants. There was no documentation the fire department had attended any of the drills. During an interview on 7/14/25 at 1:10 p.m., the Maintenance Director indicated the fire department had been to the facility in June at the request of residents for question and answers and to do training, but they had not attended or been invited to participate in any fire drills in the past twelve months. Based on record review and interview, the facility failed to ensure the fire department was invited to attend fire drills every six months. This had the potential to affect all 99 residents residing in the facility. Finding includes: The fire drill log for the past twelve months was reviewed on 7/14/25 at 11:50 a.m. The logs included the date, time and participants. There was no documentation the fire department had attended any of the drills. During an interview on 7/14/25			

	at 1:10 p.m., the Maintenance Director indicated the fire department had been to the facility in June at the request of residents for question and answers and to do training, but they had not attended or been invited to participate in any fire drills in the past twelve months.			
R 0144	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(a) (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation and interview, the facility failed to ensure the resident's environment was clean and in a state of good repair related to a black substance in the washing machines and an odor in the laundry rooms for 3 of 3 assisted living laundry rooms. (2nd floor, 3rd floor, and 4th floor Laundry Rooms) Findings include: 1. 2nd Floor Laundry Room During an observation on 7/14/25 at 10:45 a.m., the washer in the 2nd floor laundry room had a black substance on the rubber area inside the door. There was a musty odor in the	R 0144	Maintenance Director or designee will conduct monthly washer and dryer checks and provide preventive maintenance as needed. ED and Maintenance Director will discuss findings and interventions implemented or that may be needed during monthly QA meetings.	08/31/2025

	laundry room. 2. 3rd Floor Laundry Room During an observation on 7/14/25 at 10:52 a.m., one of the washers in the 3rd floor laundry room had a black substance on the rubber area inside the door. There was a musty odor in the laundry room. 3. 4th Floor Laundry Room During an observation on 7/14/25 at 10:57 a.m., the washer in the 4th floor laundry room had a black substance and a buildup of a slimy green substance on the rubber area inside the door. There was a musty odor in the laundry room. During an interview on 7/14/25 at 1:15 p.m., the Maintenance Director indicated he had asked for the washers to be replaced as they were getting old. He regularly used washer cleaning tablets in the washers, but there was no specific schedule for cleaning the washers or the rubber areas inside the doors. This citation relates to Complaints IN00457361 and IN00457391. Based on observation and interview, the facility failed to ensure the resident's environment was clean and in a state of good repair related to a black substance in the washing			

	machines and an odor in the laundry rooms for 3 of 3 assisted living laundry rooms. (2nd floor, 3rd floor, and 4th floor Laundry Rooms) Findings include: 1. 2nd Floor Laundry Room During an observation on 7/14/25 at 10:45 a.m., the washer in the 2nd floor laundry room had a black substance on the rubber area inside the door. There was a musty odor in the laundry room. 2. 3rd Floor Laundry Room During an observation on 7/14/25 at 10:52 a.m., one of the washers in the 3rd floor laundry room had a black substance on the rubber area inside the door. There was a musty odor in the laundry room. 3. 4th Floor Laundry Room During an observation on 7/14/25 at 10:57 a.m., the washer in the 4th floor laundry room had a black substance and a buildup of a slimy green substance on the rubber area inside the door. There was a musty odor in the laundry room. During an interview on 7/14/25 at 1:15 p.m., the Maintenance Director indicated he had asked for the washers to be replaced as they were getting old. He			

	regularly used washer cleaning tablets in the washers, but there was no specific schedule for cleaning the washers or the rubber areas inside the doors. This citation relates to Complaints IN00457361 and IN00457391.			
R 0149	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(f) (f) The facility shall have a pest control program in operation in compliance with 410 IAC 7-24. Based on observation, record review and interview, the facility failed to maintain an effective pest control program related to fruit flies in the main kitchen. This had the potential to affect all 99 residents of the facility. Finding includes: The initial kitchen tour was completed on 7/14/25 at 9:10 a.m. with the Dietary Manager (DM). There were fruit flies present in all areas of the kitchen. The DM indicated he was aware of them and they had been present for a couple weeks. During an interview on 7/14/25 at 9:24 a.m., the Administrator indicated she was aware of the fruit flies. They used a pest	R 0149	Dietary Director or designee will conduct weekly pest inspections and provide preventive maintenance as needed. Executive Director and Dietary Director will discuss findings and interventions implemented or that may be needed during monthly QA meetings.	08/31/2025

control company that came out monthly on every third Thursday and as needed.

The most recent service invoice from the pest company was dated 6/19/25. The service invoice noted treatment for ants and no mouse activity. The was nothing related to fruit flies.

A pest management policy was provided but did not pertain to the concern.

Based on observation, record review and interview, the facility failed to maintain an effective pest control program related to fruit flies in the main kitchen. This had the potential to affect all 99 residents of the facility.

Finding includes:

The initial kitchen tour was completed on 7/14/25 at 9:10 a.m. with the Dietary Manager (DM). There were fruit flies present in all areas of the kitchen. The DM indicated he was aware of them and they had been present for a couple weeks.

During an interview on 7/14/25 at 9:24 a.m., the Administrator indicated she was aware of the fruit flies. They used a pest control company that came out monthly on every third Thursday and as needed.

The most recent service invoice

	from the pest company was dated 6/19/25. The service invoice noted treatment for ants and no mouse activity. The was nothing related to fruit flies. A pest management policy was provided but did not pertain to the concern.			
R 0215	Evaluation - Deficiency 410 IAC 16.2-5-2(b) (b) The preadmission evaluation (interview) shall provide the baseline information for the initial evaluation. Subsequent evaluations shall compare the resident ' s current status to his or her status on admission and shall be used to assure that the care the resident requires is within the range of personal care and supervision provided by a residential care facility. Based on record review and interview, the facility failed to ensure Pre-Admission Evaluations were completed prior to admission to the facility for 4 of 11 records reviewed. (Residents H, G, F and D) Findings include: 1. Resident H's record was reviewed on 7/15/25 at 11:18 a.m. Diagnoses included, but were not limited to, diabetes mellitus, hypertension and cerebral infarction. The resident	R 0215	Wellness Director or designee will evaluate residents before admission and a pre-evaluation results will be transcribed into point click care. Results will be printed and presented to resident/ family at time of lease signing. Executive Director and Wellness Director will audit evaluations at Monthly QA meeting.	08/31/2025

	was admitted to the facility on 7/1/25. There was no evidence or documentation of a Pre-Admission Evaluation being completed. During an interview on 7/15/25 at 1:10 p.m., the Director of Nursing indicated all documents should be scanned into the computer. There was no additional information provided. 2. Resident G's record was reviewed on 7/15/25 at 10:27 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, hypertension, and congestive heart failure. The resident was admitted to the facility on 6/16/25. There was a lack of documentation that a Pre-Admission Evaluation had been completed prior to the resident being admitted to the facility. During an interview on 7/15/25 at 1:06 p.m., the Director of Nursing indicated she was unable to provide any further information. 3. Resident F's record was reviewed on 7/14/25 at 2:42 p.m. Diagnoses included, but were not limited to, chronic kidney disease and type 2 diabetes mellitus. The resident admitted to the facility on			

	8/8/24. The record lacked documentation of a completed Pre-Admission Evaluation. During an interview on 7/15/25 at 1:08 p.m., the Interim Director of Nursing indicated she had no further information to provide. 4. Resident D's record was reviewed on 7/15/25 at 10:09 a.m. Diagnoses included, but were not limited to, dementia, type 2 diabetes mellitus, and major depressive disorder. The resident admitted to the facility on 8/8/24. The record lacked documentation of a completed Pre-Admission Evaluation. During an interview on 7/15/25 at 1:08 p.m., the Interim Director of Nursing indicated she had no further information to provide. This citation relates to Complaint IN00457361. Based on record review and interview, the facility failed to ensure Pre-Admission Evaluations were completed prior to admission to the facility for 4 of 11 records reviewed. (Residents H, G, F and D) Findings include: 1. Resident H's record was reviewed on 7/15/25 at 11:18			

a.m. Diagnoses included, but were not limited to, diabetes mellitus, hypertension and cerebral infarction. The resident was admitted to the facility on 7/1/25.

There was no evidence or documentation of a Pre-Admission Evaluation being completed.

During an interview on 7/15/25 at 1:10 p.m., the Director of Nursing indicated all documents should be scanned into the computer. There was no additional information provided.

2. Resident G's record was reviewed on 7/15/25 at 10:27 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, hypertension, and congestive heart failure. The resident was admitted to the facility on 6/16/25.

There was a lack of documentation that a Pre-Admission Evaluation had been completed prior to the resident being admitted to the facility.

During an interview on 7/15/25 at 1:06 p.m., the Director of Nursing indicated she was unable to provide any further information.

3. Resident F's record was reviewed on 7/14/25 at 2:42 p.m. Diagnoses included, but

	were not limited to, chronic kidney disease and type 2 diabetes mellitus. The resident admitted to the facility on 8/8/24. The record lacked documentation of a completed Pre-Admission Evaluation. During an interview on 7/15/25 at 1:08 p.m., the Interim Director of Nursing indicated she had no further information to provide. 4. Resident D's record was reviewed on 7/15/25 at 10:09 a.m. Diagnoses included, but were not limited to, dementia, type 2 diabetes mellitus, and major depressive disorder. The resident admitted to the facility on 8/8/24. The record lacked documentation of a completed Pre-Admission Evaluation. During an interview on 7/15/25 at 1:08 p.m., the Interim Director of Nursing indicated she had no further information to provide. This citation relates to Complaint IN00457361. Based on record review and interview, the facility failed to ensure Pre-Admission Evaluations were completed prior to admission to the facility for 4 of 11 records reviewed. (Residents H, G, F and D)			

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This citation relates to Complaint IN00457361.

Based on record review and interview, the facility failed to ensure Pre-Admission Evaluations were completed prior to admission to the facility for 4 of 11 records reviewed. (Residents H, G, F and D)

Findings include:

1. Resident H's record was reviewed on 7/15/25 at 11:18 a.m. Diagnoses included, but were not limited to, diabetes mellitus, hypertension and cerebral infarction. The resident was admitted to the facility on 7/1/25.

There was no evidence or documentation of a Pre-Admission Evaluation being completed.

During an interview on 7/15/25 at 1:10 p.m., the Director of Nursing indicated all documents should be scanned into the computer. There was no additional information provided.

2. Resident G's record was reviewed on 7/15/25 at 10:27 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, hypertension, and congestive heart failure. The resident was admitted to the facility on 6/16/25.

There was a lack of

	documentation that a Pre-Admission Evaluation had been completed prior to the resident being admitted to the facility. During an interview on 7/15/25 at 1:06 p.m., the Director of Nursing indicated she was unable to provide any further information. 3. Resident F's record was reviewed on 7/14/25 at 2:42 p.m. Diagnoses included, but were not limited to, chronic kidney disease and type 2 diabetes mellitus. The resident admitted to the facility on 8/8/24. The record lacked documentation of a completed Pre-Admission Evaluation. During an interview on 7/15/25 at 1:08 p.m., the Interim Director of Nursing indicated she had no further information to provide. 4. Resident D's record was reviewed on 7/15/25 at 10:09 a.m. Diagnoses included, but were not limited to, dementia, type 2 diabetes mellitus, and major depressive disorder. The resident admitted to the facility on 8/8/24. The record lacked documentation of a completed Pre-Admission Evaluation. During an interview on 7/15/25			

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This citation relates to Complaint IN00457361.

Based on record review and interview, the facility failed to ensure Pre-Admission Evaluations were completed prior to admission to the facility for 4 of 11 records reviewed. (Residents H, G, F and D)

Findings include:

1. Resident H's record was reviewed on 7/15/25 at 11:18 a.m. Diagnoses included, but were not limited to, diabetes mellitus, hypertension and cerebral infarction. The resident was admitted to the facility on 7/1/25.

There was no evidence or documentation of a Pre-Admission Evaluation being completed.

During an interview on 7/15/25 at 1:10 p.m., the Director of Nursing indicated all documents should be scanned into the computer. There was no additional information provided.

2. Resident G's record was reviewed on 7/15/25 at 10:27 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, hypertension, and congestive heart failure.

	The resident was admitted to the facility on 6/16/25. There was a lack of documentation that a Pre-Admission Evaluation had been completed prior to the resident being admitted to the facility. During an interview on 7/15/25 at 1:06 p.m., the Director of Nursing indicated she was unable to provide any further information. 3. Resident F's record was reviewed on 7/14/25 at 2:42 p.m. Diagnoses included, but were not limited to, chronic kidney disease and type 2 diabetes mellitus. The resident admitted to the facility on 8/8/24. The record lacked documentation of a completed Pre-Admission Evaluation. During an interview on 7/15/25 at 1:08 p.m., the Interim Director of Nursing indicated she had no further information to provide. 4. Resident D's record was reviewed on 7/15/25 at 10:09 a.m. Diagnoses included, but were not limited to, dementia, type 2 diabetes mellitus, and major depressive disorder. The resident admitted to the facility on 8/8/24. The record lacked			

documentation of a completed Pre-Admission Evaluation.

During an interview on 7/15/25 at 1:08 p.m., the Interim Director of Nursing indicated she had no further information to provide.

This citation relates to Complaint IN00457361.

Based on record review and interview, the facility failed to ensure Pre-Admission Evaluations were completed prior to admission to the facility for 4 of 11 records reviewed. (Residents H, G, F and D)

Findings include:

1. Resident H's record was reviewed on 7/15/25 at 11:18 a.m. Diagnoses included, but were not limited to, diabetes mellitus, hypertension and cerebral infarction. The resident was admitted to the facility on 7/1/25.

There was no evidence or documentation of a Pre-Admission Evaluation being completed.

During an interview on 7/15/25 at 1:10 p.m., the Director of Nursing indicated all documents should be scanned into the computer. There was no additional information provided.

2. Resident G's record was reviewed on 7/15/25 at 10:27

a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, hypertension, and congestive heart failure. The resident was admitted to the facility on 6/16/25.

There was a lack of documentation that a Pre-Admission Evaluation had been completed prior to the resident being admitted to the facility.

During an interview on 7/15/25 at 1:06 p.m., the Director of Nursing indicated she was unable to provide any further information.

3. Resident F's record was reviewed on 7/14/25 at 2:42 p.m. Diagnoses included, but were not limited to, chronic kidney disease and type 2 diabetes mellitus. The resident admitted to the facility on 8/8/24.

The record lacked documentation of a completed Pre-Admission Evaluation.

During an interview on 7/15/25 at 1:08 p.m., the Interim Director of Nursing indicated she had no further information to provide.

4. Resident D's record was reviewed on 7/15/25 at 10:09 a.m. Diagnoses included, but were not limited to, dementia, type 2 diabetes mellitus, and major depressive disorder. The

	resident admitted to the facility on 8/8/24. The record lacked documentation of a completed Pre-Admission Evaluation. During an interview on 7/15/25 at 1:08 p.m., the Interim Director of Nursing indicated she had no further information to provide. This citation relates to Complaint IN00457361.			
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.	R 0216	Wellness Director or designee will schedule and conduct self-medication evaluations through point click care for every 90 days and change in condition. Executive Director and wellness Director will review and discuss findings of self-medication evaluations and interventions if applicable during the monthly QA meetings.	08/31/2025

	Based on record review and interview, the facility failed to ensure a resident was assessed for the ability to self-administer medications for 1 of 11 residents reviewed. (Resident G) Finding includes: Resident G's record was reviewed on 7/15/25 at 10:27 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, hypertension, and congestive heart failure. The resident was admitted to the facility on 6/16/25. A Service Plan, dated 6/17/25, indicated the resident was independent with medication administration. The Physician's Order Summary, dated 7/2025, indicated the resident may self-administer medications. There was a lack of any assessment for self-administration of medications. During an interview on 7/15/25 at 1:06 p.m., the Director of Nursing indicated she was unable to provide any further information. A policy, titled Medication-Resident Self Administration, received as current from the Director of			

Nursing, indicated "...The Wellness Leader or Designee will review the Self-Administration of Medication Evaluation with the resident to evaluate their ability to safely administer and store their own medications. Review shall be performed before the resident begins to self-administer medications..."

Based on record review and interview, the facility failed to ensure a resident was assessed for the ability to self-administer medications for 1 of 11 residents reviewed. (Resident G)

Finding includes:

Resident G's record was reviewed on 7/15/25 at 10:27 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, hypertension, and congestive heart failure. The resident was admitted to the facility on 6/16/25.

A Service Plan, dated 6/17/25, indicated the resident was independent with medication administration.

The Physician's Order Summary, dated 7/2025, indicated the resident may self-administer medications.

There was a lack of any assessment for self-administration of

	medications. During an interview on 7/15/25 at 1:06 p.m., the Director of Nursing indicated she was unable to provide any further information. A policy, titled Medication-Resident Self Administration, received as current from the Director of Nursing, indicated "...The Wellness Leader or Designee will review the Self-Administration of Medication Evaluation with the resident to evaluate their ability to safely administer and store their own medications. Review shall be performed before the resident begins to self-administer medications..."			
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and	R 0217	Wellness Director or designee will schedule and conduct a new assessment every six months and change in conditions per facility policy. Findings will be reviewed and discussed with residents and or family and service plan signatures will be collected at that time. Executive Director and Wellness director will audit service plans during monthly QA meetings.	08/31/2025

(D) preference;

of the resident.

(2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.

(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.

(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.

(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.

2. Resident 6's record was reviewed on 7/15/25 at 11:26 a.m. Diagnoses included, but were not limited to, adult failure to thrive, acute respiratory failure, metabolic encephalopathy, and altered mental status. The resident admitted in the facility on 10/28/24 and expired on 11/26/24.

There was no service plan available in the resident's record for review.

During an interview on 7/15/25 at 3:00 p.m., the Director of Nursing indicated she was unable to locate a signed service plan.

A policy titled, "Service Plan - Personal Care," indicated "...The agency will establish a service plan for each client, in consultation with agency staff, the client, and/or the client's responsible party, if applicable, or with members of the client's family, that outlines the services that will be provided to the client...The Service Plan shall be reviwed, signed, and dated by the following: client/responsible party, personal care director, and health care provider when required..."

Based on record review and interview, the facility failed to ensure service plans were updated with changes, complete and/ or signed by the resident or authorized representative for 2 of 11 records reviewed. (Residents H and 6)

Findings include:

1. Resident H's record was reviewed on 7/15/25 at 11:18 a.m. Diagnoses included, but were not limited to, diabetes mellitus, hypertension and

cerebral infarction.

The initial Service Plan was dated 7/1/25. There was no signature by the resident or authorized representative.

During an interview on 7/15/25 at 1:21 p.m., the Director of Nursing indicated she thought they had 30-days to have it signed.

2. Resident 6's record was reviewed on 7/15/25 at 11:26 a.m. Diagnoses included, but were not limited to, adult failure to thrive, acute respiratory failure, metabolic encephalopathy, and altered mental status. The resident admitted in the facility on 10/28/24 and expired on 11/26/24.

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	"...The agency will establish a service plan for each client, in consultation with agency staff, the client, and/or the client's responsible party, if applicable, or with members of the client's family, that outlines the services that will be provided to the client...The Service Plan shall be reviwed, signed, and dated by the following: client/responsible party, personal care director, and health care provider when required..." Based on record review and interview, the facility failed to ensure service plans were updated with changes, complete and/ or signed by the resident or authorized representative for 2 of 11 records reviewed. (Residents H and 6) Findings include: 1. Resident H's record was reviewed on 7/15/25 at 11:18 a.m. Diagnoses included, but were not limited to, diabetes mellitus, hypertension and cerebral infarction. The initial Service Plan was dated 7/1/25. There was no signature by the resident or authorized representative.			

	During an interview on 7/15/25 at 1:21 p.m., the Director of Nursing indicated she thought they had 30-days to have it signed.			
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, record review and interview, the facility failed to ensure physician's orders were followed related to insulin administration, blood sugar checks, oxygen, and the physician not notified for high blood sugars for 4 of 11 residents reviewed. (Residents C, E, D, and F) Findings include: 1. Record review for Resident C was completed on 7/14/25 at 11:53 a.m. Diagnoses included, but were not limited to, diabetes mellitus, and hypertension. The July 2025 Physician's Order	R 0241	Wellness Director or designee will in-service nursing staff to ensure they are following prescribed orders. Wellness Director will partner with providers for any changes in needs. Executive Director and Wellness Director will discuss any findings and audit residents orders at monthly QA meetings.	08/31/2025

	Summary (POS) indicated orders for the following medications: - Insulin degludec, inject 24 units at bedtime - Insulin aspart, inject 10 units daily at lunch - Insulin aspart, inject 5 units twice daily before breakfast and dinner The June and July 2025 Medication Administration Record (MAR) lacked documentation the insulin was administered on: - Insulin degludec, 24 units: 7/9/25 at bedtime - Insulin aspart, 10 units: 6/9, 6/14, 6/15, 6/18, and 7/2/25 at lunch - Insulin aspart, 5 units: 6/9, 6/14, 6/15, and 7/2/25 at breakfast - Insulin aspart, 5 units: 7/9/25 at dinner The record lacked any documentation the insulin was administered on the above dates and times. During an interview on 7/15/25 at 1:12 p.m., the Interim Director of Nursing (IDON) indicated she could not provide any documentation the insulin had			

	been administered to the resident on the above dates and times. 3. Resident D's record was reviewed on 7/15/25 at 10:09 a.m. Diagnoses included, but were not limited to, dementia, type 2 diabetes mellitus, and major depressive disorder. The Service Plan, dated 8/22/24, indicated the resident was alert and oriented. She required all medications and treatments to be administered by staff including diabetic medications and blood sugar checks. A Physician's Order, dated 11/4/24, indicated insulin lispro injection 100 units/milliliter, inject as directed per sliding scale four times a day. The sliding scale indicated blood sugar 111-150=4 units (U), 151-200=8 U, 201-250=10 U, 251-300=12 U, 301-350=14 U, 351-400=16 U. The May and June 2025 Medication Administration Record (MAR) indicated the insulin lispro injection was not signed out as administered on 5/23/25 at 7:00 a.m. and 11:00 a.m., 5/26/25 at 11 a.m., 5/31/25 at 7:00 a.m. and 11:00 a.m., 6/9/25 at 7:00 a.m. and 11:00 a.m., 6/14/25 at 7:00 a.m. and 11:00 a.m., 6/15/25 at 7 a.m. and 11:00 a.m., and			

6/26/25 at 4:00 p.m.

A Physician's Order, dated 11/4/24, indicated insulin glargine injection 100 units/milliliter, inject 39 units subcutaneously once daily at 7:00 a.m.

The May, June, and July 2025 MAR indicated the insulin glargine injection was blank at 7:00 a.m. on 5/23/25, 5/31/25, 6/9/25, 6/14/25, 6/15/25, and 7/2/25.

During an interview on 7/15/25 at 1:08 p.m., the Interim Director of Nursing indicated she had no further information to provide.

4. During an interview on 7/15/25 at 1:47 p.m., Resident F indicated she had oxygen, but she did not always wear it. She was observed sitting in her apartment in a motorized wheelchair at the time with no oxygen in use.

On 7/15/25 at 2:32 p.m., Resident F was observed in the hall way going towards the dining room with no oxygen in use.

Resident F's record was reviewed on 7/14/25 at 2:42 p.m. Diagnoses included, but were not limited to, asthma chronic kidney disease and type 2 diabetes mellitus.

The current Service Plan

indicated the resident was cognitively intact and independent with activities of daily living.

A Physician's Order, dated 5/22/25, indicated oxygen at 2 liters per minute per nasal cannula.

During an interview on 7/15/25 at 1:08 p.m., the Interim Director of Nursing indicated she had no further information to provide.

A facility policy titled, "Medication Administration," indicated "...Medications will be administered to residents as prescribed and by persons lawfully authorized to do so in a manner consistent with good infection control and standards of practice...Only licensed nursing or other lawfully authorized staff may prepare, administer, or record medication administration..."

This citation relates to Complaint IN00457361 and IN00457391.

2. Resident E's record was reviewed on 7/15/25 at 1:36 p.m. Diagnoses included, but were not limited to, type 1 diabetes mellitus, osteoporosis, and hypertension.

The Physician's Order Summary, dated 7/2025, indicated orders for: insulin aspart (fast acting insulin)

	sliding scale (amount of insulin given is based on blood sugar result) subcutaneously (injection) at 8:00 a.m., 11:00 a.m., and 4:00 p.m., insulin aspart 4 units subcutaneously every morning, and Tresiba (insulin degludec, long-acting insulin) 10 units daily. The 11:00 a.m. insulin aspart sliding scale order indicated to give 10 units of insulin and notify the Physician for a blood sugar greater than 401. The Medication Administration Records (MAR), dated 6/2025 and 7/2025, indicated the resident's blood sugar on 7/11/25 at 11:00 a.m. was 407 and 10 units of insulin were given. There was lack of documentation to indicate the Physician had been notified of the high blood sugar. There were blanks for the blood sugar results and the insulin administration on the following dates and times: - insulin aspart sliding scale at 8:00 a.m. on 6/9/25, 6/14/25, 6/15/25, and 7/2/25 - insulin aspart sliding scale at 11:00 a.m. on 6/9/25, 6/14/25, 6/15/25, and 7/2/25 - insulin aspart sliding scale at 4:00 p.m. on 6/26/25 and 7/9/25			

- insulin aspart 4 units at 8:00 a.m. on 6/9/25, 6/14/25, 6/15/25, and 7/2/25

- Tresiba 10 units at 7:00 a.m. on 6/9/25, 6/14/25, 6/15/25, and 7/2/25

During an interview on 7/15/25 at 2:04 p.m., the Director of Nursing was made aware of the lack of Physician notification of the high blood sugar and the blanks on the MAR. No further information was provided.

A policy, titled Physician Notification, received as current from the Director of Nursing, indicated "...Agencies providing nursing services by licensed staff notify the physician, under the following circumstances, as the agency becomes aware:...Worsening of chronic conditions [e.g. heart failure, diabetes]..."

Based on observation, record review and interview, the facility failed to ensure physician's orders were followed related to insulin administration, blood sugar checks, oxygen, and the physician not notified for high blood sugars for 4 of 11 residents reviewed. (Residents C, E, D, and F)

Findings include:

1. Record review for Resident C was completed on 7/14/25 at 11:53 a.m. Diagnoses included,

but were not limited to, diabetes mellitus, and hypertension.

The July 2025 Physician's Order Summary (POS) indicated orders for the following medications:

- Insulin degludec, inject 24 units at bedtime

- Insulin aspart, inject 10 units daily at lunch

- Insulin aspart, inject 5 units twice daily before breakfast and dinner

The June and July 2025 Medication Administration Record (MAR) lacked documentation the insulin was administered on:

- Insulin degludec, 24 units: 7/9/25 at bedtime

- Insulin aspart, 10 units: 6/9, 6/14, 6/15, 6/18, and 7/2/25 at lunch

- Insulin aspart, 5 units: 6/9, 6/14, 6/15, and 7/2/25 at breakfast

- Insulin aspart, 5 units: 7/9/25 at dinner

The record lacked any documentation the insulin was administered on the above dates and times.

During an interview on 7/15/25

	at 1:12 p.m., the Interim Director of Nursing (IDON) indicated she could not provide any documentation the insulin had been administered to the resident on the above dates and times. 3. Resident D's record was reviewed on 7/15/25 at 10:09 a.m. Diagnoses included, but were not limited to, dementia, type 2 diabetes mellitus, and major depressive disorder. The Service Plan, dated 8/22/24, indicated the resident was alert and oriented. She required all medications and treatments to be administered by staff including diabetic medications and blood sugar checks. A Physician's Order, dated 11/4/24, indicated insulin lispro injection 100 units/milliliter, inject as directed per sliding scale four times a day. The sliding scale indicated blood sugar 111-150=4 units (U), 151-200=8 U, 201-250=10 U, 251-300=12 U, 301-350=14 U, 351-400=16 U. The May and June 2025 Medication Administration Record (MAR) indicated the insulin lispro injection was not signed out as administered on 5/23/25 at 7:00 a.m. and 11:00 a.m., 5/26/25 at 11 a.m., 5/31/25 at 7:00 a.m. and 11:00			

a.m., 6/9/25 at 7:00 a.m. and 11:00 a.m., 6/14/25 at 7:00 a.m. and 11:00 a.m., 6/15/25 at 7 a.m. and 11:00 a.m., and 6/26/25 at 4:00 p.m.

A Physician's Order, dated 11/4/24, indicated insulin glargine injection 100 units/milliliter, inject 39 units subcutaneously once daily at 7:00 a.m.

The May, June, and July 2025 MAR indicated the insulin glargine injection was blank at 7:00 a.m. on 5/23/25, 5/31/25, 6/9/25, 6/14/25, 6/15/25, and 7/2/25.

During an interview on 7/15/25 at 1:08 p.m., the Interim Director of Nursing indicated she had no further information to provide.

4. During an interview on 7/15/25 at 1:47 p.m., Resident F indicated she had oxygen, but she did not always wear it. She was observed sitting in her apartment in a motorized wheelchair at the time with no oxygen in use.

On 7/15/25 at 2:32 p.m., Resident F was observed in the hall way going towards the dining room with no oxygen in use.

Resident F's record was reviewed on 7/14/25 at 2:42 p.m. Diagnoses included, but were not limited to, asthma

chronic kidney disease and type 2 diabetes mellitus.

The current Service Plan indicated the resident was cognitively intact and independent with activities of daily living.

A Physician's Order, dated 5/22/25, indicated oxygen at 2 liters per minute per nasal cannula.

During an interview on 7/15/25 at 1:08 p.m., the Interim Director of Nursing indicated she had no further information to provide.

A facility policy titled, "Medication Administration," indicated "...Medications will be administered to residents as prescribed and by persons lawfully authorized to do so in a manner consistent with good infection control and standards of practice...Only licensed nursing or other lawfully authorized staff may prepare, administer, or record medication administration..."

This citation relates to Complaint IN00457361 and IN00457391.

2. Resident E's record was reviewed on 7/15/25 at 1:36 p.m. Diagnoses included, but were not limited to, type 1 diabetes mellitus, osteoporosis, and hypertension.

	The Physician's Order Summary, dated 7/2025, indicated orders for: insulin aspart (fast acting insulin) sliding scale (amount of insulin given is based on blood sugar result) subcutaneously (injection) at 8:00 a.m., 11:00 a.m., and 4:00 p.m., insulin aspart 4 units subcutaneously every morning, and Tresiba (insulin degludec, long-acting insulin) 10 units daily. The 11:00 a.m. insulin aspart sliding scale order indicated to give 10 units of insulin and notify the Physician for a blood sugar greater than 401. The Medication Administration Records (MAR), dated 6/2025 and 7/2025, indicated the resident's blood sugar on 7/11/25 at 11:00 a.m. was 407 and 10 units of insulin were given. There was lack of documentation to indicate the Physician had been notified of the high blood sugar. There were blanks for the blood sugar results and the insulin administration on the following dates and times: - insulin aspart sliding scale at 8:00 a.m. on 6/9/25, 6/14/25, 6/15/25, and 7/2/25 - insulin aspart sliding scale at 11:00 a.m. on 6/9/25, 6/14/25, 6/15/25, and 7/2/25 - insulin aspart sliding scale at			

4:00 p.m. on 6/26/25 and 7/9/25

- insulin aspart 4 units at 8:00 a.m. on 6/9/25, 6/14/25, 6/15/25, and 7/2/25

- Tresiba 10 units at 7:00 a.m. on 6/9/25, 6/14/25, 6/15/25, and 7/2/25

During an interview on 7/15/25 at 2:04 p.m., the Director of Nursing was made aware of the lack of Physician notification of the high blood sugar and the blanks on the MAR. No further information was provided.

A policy, titled Physician Notification, received as current from the Director of Nursing, indicated "...Agencies providing nursing services by licensed staff notify the physician, under the following circumstances, as the agency becomes aware:...Worsening of chronic conditions [e.g. heart failure, diabetes]..."

Based on observation, record review and interview, the facility failed to ensure physician's orders were followed related to insulin administration, blood sugar checks, oxygen, and the physician not notified for high blood sugars for 4 of 11 residents reviewed. (Residents C, E, D, and F)

Findings include:

1. Record review for Resident C

	was completed on 7/14/25 at 11:53 a.m. Diagnoses included, but were not limited to, diabetes mellitus, and hypertension. The July 2025 Physician's Order Summary (POS) indicated orders for the following medications: - Insulin degludec, inject 24 units at bedtime - Insulin aspart, inject 10 units daily at lunch - Insulin aspart, inject 5 units twice daily before breakfast and dinner The June and July 2025 Medication Administration Record (MAR) lacked documentation the insulin was administered on: - Insulin degludec, 24 units: 7/9/25 at bedtime - Insulin aspart, 10 units: 6/9, 6/14, 6/15, 6/18, and 7/2/25 at lunch - Insulin aspart, 5 units: 6/9, 6/14, 6/15, and 7/2/25 at breakfast - Insulin aspart, 5 units: 7/9/25 at dinner			

The record lacked any documentation the insulin was administered on the above dates and times.

During an interview on 7/15/25 at 1:12 p.m., the Interim Director of Nursing (IDON) indicated she could not provide any documentation the insulin had been administered to the resident on the above dates and times.

3. Resident D's record was reviewed on 7/15/25 at 10:09 a.m. Diagnoses included, but were not limited to, dementia, type 2 diabetes mellitus, and major depressive disorder.

The Service Plan, dated 8/22/24, indicated the resident was alert and oriented. She required all medications and treatments to be administered by staff including diabetic medications and blood sugar checks.

A Physician's Order, dated 11/4/24, indicated insulin lispro injection 100 units/milliliter, inject as directed per sliding scale four times a day. The sliding scale indicated blood sugar 111-150=4 units (U), 151-200=8 U, 201-250=10 U, 251-300=12 U, 301-350=14 U, 351-400=16 U.

The May and June 2025 Medication Administration Record (MAR) indicated the

	insulin lispro injection was not signed out as administered on 5/23/25 at 7:00 a.m. and 11:00 a.m., 5/26/25 at 11 a.m., 5/31/25 at 7:00 a.m. and 11:00 a.m., 6/9/25 at 7:00 a.m. and 11:00 a.m., 6/14/25 at 7:00 a.m. and 11:00 a.m., 6/15/25 at 7 a.m. and 11:00 a.m., and 6/26/25 at 4:00 p.m. A Physician's Order, dated 11/4/24, indicated insulin glargine injection 100 units/milliliter, inject 39 units subcutaneously once daily at 7:00 a.m. The May, June, and July 2025 MAR indicated the insulin glargine injection was blank at 7:00 a.m. on 5/23/25, 5/31/25, 6/9/25, 6/14/25, 6/15/25, and 7/2/25. During an interview on 7/15/25 at 1:08 p.m., the Interim Director of Nursing indicated she had no further information to provide. 4. During an interview on 7/15/25 at 1:47 p.m., Resident F indicated she had oxygen, but she did not always wear it. She was observed sitting in her apartment in a motorized wheelchair at the time with no oxygen in use.			

On 7/15/25 at 2:32 p.m., Resident F was observed in the hall way going towards the dining room with no oxygen in use.

Resident F's record was reviewed on 7/14/25 at 2:42 p.m. Diagnoses included, but were not limited to, asthma chronic kidney disease and type 2 diabetes mellitus.

The current Service Plan indicated the resident was cognitively intact and independent with activities of daily living.

A Physician's Order, dated 5/22/25, indicated oxygen at 2 liters per minute per nasal cannula.

During an interview on 7/15/25 at 1:08 p.m., the Interim Director of Nursing indicated she had no further information to provide.

A facility policy titled, "Medication Administration," indicated "...Medications will be administered to residents as prescribed and by persons lawfully authorized to do so in a manner consistent with good infection control and standards of practice...Only licensed nursing or other lawfully authorized staff may prepare, administer, or record medication administration..."

This citation relates to

	Complaint IN00457361 and IN00457391. 2. Resident E's record was reviewed on 7/15/25 at 1:36 p.m. Diagnoses included, but were not limited to, type 1 diabetes mellitus, osteoporosis, and hypertension. The Physician's Order Summary, dated 7/2025, indicated orders for: insulin aspart (fast acting insulin) sliding scale (amount of insulin given is based on blood sugar result) subcutaneously (injection) at 8:00 a.m., 11:00 a.m., and 4:00 p.m., insulin aspart 4 units subcutaneously every morning, and Tresiba (insulin degludec, long-acting insulin) 10 units daily. The 11:00 a.m. insulin aspart sliding scale order indicated to give 10 units of insulin and notify the Physician for a blood sugar greater than 401.			

	The Medication Administration Records (MAR), dated 6/2025 and 7/2025, indicated the resident's blood sugar on 7/11/25 at 11:00 a.m. was 407 and 10 units of insulin were given. There was lack of documentation to indicate the Physician had been notified of the high blood sugar. There were blanks for the blood sugar results and the insulin administration on the following dates and times: - insulin aspart sliding scale at 8:00 a.m. on 6/9/25, 6/14/25, 6/15/25, and 7/2/25 - insulin aspart sliding scale at 11:00 a.m. on 6/9/25, 6/14/25, 6/15/25, and 7/2/25 - insulin aspart sliding scale at 4:00 p.m. on 6/26/25 and 7/9/25 - insulin aspart 4 units at 8:00 a.m. on 6/9/25, 6/14/25, 6/15/25, and 7/2/25 - Tresiba 10 units at 7:00 a.m. on 6/9/25, 6/14/25, 6/15/25, and 7/2/25 During an interview on 7/15/25 at 2:04 p.m., the Director of Nursing was made aware of the lack of Physician notification of the high blood sugar and the blanks on the MAR. No further information was provided. A policy, titled Physician Notification, received as current			

from the Director of Nursing, indicated "...Agencies providing nursing services by licensed staff notify the physician, under the following circumstances, as the agency becomes aware:...Worsening of chronic conditions [e.g. heart failure, diabetes]..."

Based on observation, record review and interview, the facility failed to ensure physician's orders were followed related to insulin administration, blood sugar checks, oxygen, and the physician not notified for high blood sugars for 4 of 11 residents reviewed. (Residents C, E, D, and F)

Findings include:

1. Record review for Resident C was completed on 7/14/25 at 11:53 a.m. Diagnoses included, but were not limited to, diabetes mellitus, and hypertension.

The July 2025 Physician's Order Summary (POS) indicated orders for the following medications:

- Insulin degludec, inject 24 units at bedtime

- Insulin aspart, inject 10 units daily at lunch

- Insulin aspart, inject 5 units twice daily before breakfast and dinner

	The June and July 2025 Medication Administration Record (MAR) lacked documentation the insulin was administered on: - Insulin degludec, 24 units: 7/9/25 at bedtime - Insulin aspart, 10 units: 6/9, 6/14, 6/15, 6/18, and 7/2/25 at lunch - Insulin aspart, 5 units: 6/9, 6/14, 6/15, and 7/2/25 at breakfast - Insulin aspart, 5 units: 7/9/25 at dinner The record lacked any documentation the insulin was administered on the above dates and times. During an interview on 7/15/25 at 1:12 p.m., the Interim Director of Nursing (IDON) indicated she could not provide any documentation the insulin had been administered to the resident on the above dates and times. 3. Resident D's record was reviewed on 7/15/25 at 10:09 a.m. Diagnoses included, but were not limited to, dementia, type 2 diabetes mellitus, and major depressive disorder. The Service Plan, dated 8/22/24, indicated the resident was alert and oriented. She			

	required all medications and treatments to be administered by staff including diabetic medications and blood sugar checks. A Physician's Order, dated 11/4/24, indicated insulin lispro injection 100 units/milliliter, inject as directed per sliding scale four times a day. The sliding scale indicated blood sugar 111-150=4 units (U), 151-200=8 U, 201-250=10 U, 251-300=12 U, 301-350=14 U, 351-400=16 U. The May and June 2025 Medication Administration Record (MAR) indicated the insulin lispro injection was not signed out as administered on 5/23/25 at 7:00 a.m. and 11:00 a.m., 5/26/25 at 11 a.m., 5/31/25 at 7:00 a.m. and 11:00 a.m., 6/9/25 at 7:00 a.m. and 11:00 a.m., 6/14/25 at 7:00 a.m. and 11:00 a.m., 6/15/25 at 7 a.m. and 11:00 a.m., and 6/26/25 at 4:00 p.m. A Physician's Order, dated 11/4/24, indicated insulin glargine injection 100 units/milliliter, inject 39 units subcutaneously once daily at 7:00 a.m. The May, June, and July 2025 MAR indicated the insulin glargine injection was blank at 7:00 a.m. on 5/23/25, 5/31/25, 6/9/25, 6/14/25, 6/15/25, and			

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	During an interview on 7/15/25 at 1:08 p.m., the Interim Director of Nursing indicated she had no further information to provide. A facility policy titled, "Medication Administration," indicated "...Medications will be administered to residents as prescribed and by persons lawfully authorized to do so in a manner consistent with good infection control and standards of practice...Only licensed nursing or other lawfully authorized staff may prepare, administer, or record medication administration..." This citation relates to Complaint IN00457361 and IN00457391. 2. Resident E's record was reviewed on 7/15/25 at 1:36 p.m. Diagnoses included, but were not limited to, type 1 diabetes mellitus, osteoporosis, and hypertension. The Physician's Order Summary, dated 7/2025, indicated orders for: insulin aspart (fast acting insulin) sliding scale (amount of insulin given is based on blood sugar result) subcutaneously (injection) at 8:00 a.m., 11:00 a.m., and 4:00 p.m., insulin aspart 4 units subcutaneously every morning, and Tresiba (insulin degludec, long-acting insulin) 10 units daily. The 11:00			

	a.m. insulin aspart sliding scale order indicated to give 10 units of insulin and notify the Physician for a blood sugar greater than 401. The Medication Administration Records (MAR), dated 6/2025 and 7/2025, indicated the resident's blood sugar on 7/11/25 at 11:00 a.m. was 407 and 10 units of insulin were given. There was lack of documentation to indicate the Physician had been notified of the high blood sugar. There were blanks for the blood sugar results and the insulin administration on the following dates and times: - insulin aspart sliding scale at 8:00 a.m. on 6/9/25, 6/14/25, 6/15/25, and 7/2/25 - insulin aspart sliding scale at 11:00 a.m. on 6/9/25, 6/14/25, 6/15/25, and 7/2/25 - insulin aspart sliding scale at 4:00 p.m. on 6/26/25 and 7/9/25 - insulin aspart 4 units at 8:00 a.m. on 6/9/25, 6/14/25, 6/15/25, and 7/2/25 - Tresiba 10 units at 7:00 a.m. on 6/9/25, 6/14/25, 6/15/25, and 7/2/25 During an interview on 7/15/25 at 2:04 p.m., the Director of Nursing was made aware of the lack of Physician notification of			

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daily at lunch

- Insulin aspart, inject 5 units twice daily before breakfast and dinner

The June and July 2025 Medication Administration Record (MAR) lacked documentation the insulin was administered on:

- Insulin degludec, 24 units: 7/9/25 at bedtime

- Insulin aspart, 10 units: 6/9, 6/14, 6/15, 6/18, and 7/2/25 at lunch

- Insulin aspart, 5 units: 6/9, 6/14, 6/15, and 7/2/25 at breakfast

- Insulin aspart, 5 units: 7/9/25 at dinner

The record lacked any documentation the insulin was administered on the above dates and times.

During an interview on 7/15/25 at 1:12 p.m., the Interim Director of Nursing (IDON) indicated she could not provide any documentation the insulin had been administered to the resident on the above dates and times.

3. Resident D's record was reviewed on 7/15/25 at 10:09 a.m. Diagnoses included, but were not limited to, dementia,

type 2 diabetes mellitus, and major depressive disorder.

The Service Plan, dated 8/22/24, indicated the resident was alert and oriented. She required all medications and treatments to be administered by staff including diabetic medications and blood sugar checks.

A Physician's Order, dated 11/4/24, indicated insulin lispro injection 100 units/milliliter, inject as directed per sliding scale four times a day. The sliding scale indicated blood sugar 111-150=4 units (U), 151-200=8 U, 201-250=10 U, 251-300=12 U, 301-350=14 U, 351-400=16 U.

The May and June 2025 Medication Administration Record (MAR) indicated the insulin lispro injection was not signed out as administered on 5/23/25 at 7:00 a.m. and 11:00 a.m., 5/26/25 at 11 a.m., 5/31/25 at 7:00 a.m. and 11:00 a.m., 6/9/25 at 7:00 a.m. and 11:00 a.m., 6/14/25 at 7:00 a.m. and 11:00 a.m., 6/15/25 at 7 a.m. and 11:00 a.m., and 6/26/25 at 4:00 p.m.

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	The May, June, and July 2025 MAR indicated the insulin glargine injection was blank at 7:00 a.m. on 5/23/25, 5/31/25, 6/9/25, 6/14/25, 6/15/25, and 7/2/25. During an interview on 7/15/25 at 1:08 p.m., the Interim Director of Nursing indicated she had no further information to provide. 4. During an interview on 7/15/25 at 1:47 p.m., Resident F indicated she had oxygen, but she did not always wear it. She was observed sitting in her apartment in a motorized wheelchair at the time with no oxygen in use. On 7/15/25 at 2:32 p.m., Resident F was observed in the hall way going towards the dining room with no oxygen in use. Resident F's record was reviewed on 7/14/25 at 2:42 p.m. Diagnoses included, but were not limited to, asthma chronic kidney disease and type 2 diabetes mellitus. The current Service Plan indicated the resident was cognitively intact and independent with activities of daily living.			

A Physician's Order, dated 5/22/25, indicated oxygen at 2 liters per minute per nasal cannula.

During an interview on 7/15/25 at 1:08 p.m., the Interim Director of Nursing indicated she had no further information to provide.

A facility policy titled, "Medication Administration," indicated "...Medications will be administered to residents as prescribed and by persons lawfully authorized to do so in a manner consistent with good infection control and standards of practice...Only licensed nursing or other lawfully authorized staff may prepare, administer, or record medication administration..."

This citation relates to Complaint IN00457361 and IN00457391.

2. Resident E's record was reviewed on 7/15/25 at 1:36 p.m. Diagnoses included, but were not limited to, type 1 diabetes mellitus, osteoporosis, and hypertension.

The Physician's Order Summary, dated 7/2025, indicated orders for: insulin aspart (fast acting insulin) sliding scale (amount of insulin given is based on blood sugar result) subcutaneously (injection) at 8:00 a.m., 11:00 a.m., and 4:00 p.m., insulin

	aspart 4 units subcutaneously every morning, and Tresiba (insulin degludec, long-acting insulin) 10 units daily. The 11:00 a.m. insulin aspart sliding scale order indicated to give 10 units of insulin and notify the Physician for a blood sugar greater than 401. The Medication Administration Records (MAR), dated 6/2025 and 7/2025, indicated the resident's blood sugar on 7/11/25 at 11:00 a.m. was 407 and 10 units of insulin were given. There was lack of documentation to indicate the Physician had been notified of the high blood sugar. There were blanks for the blood sugar results and the insulin administration on the following dates and times: - insulin aspart sliding scale at 8:00 a.m. on 6/9/25, 6/14/25, 6/15/25, and 7/2/25 - insulin aspart sliding scale at 11:00 a.m. on 6/9/25, 6/14/25, 6/15/25, and 7/2/25 - insulin aspart sliding scale at 4:00 p.m. on 6/26/25 and 7/9/25 - insulin aspart 4 units at 8:00 a.m. on 6/9/25, 6/14/25, 6/15/25, and 7/2/25 - Tresiba 10 units at 7:00 a.m. on 6/9/25, 6/14/25, 6/15/25, and 7/2/25			

During an interview on 7/15/25 at 2:04 p.m., the Director of Nursing was made aware of the lack of Physician notification of the high blood sugar and the blanks on the MAR. No further information was provided.

A policy, titled Physician Notification, received as current from the Director of Nursing, indicated "...Agencies providing nursing services by licensed staff notify the physician, under the following circumstances, as the agency becomes aware:...Worsening of chronic conditions [e.g. heart failure, diabetes]..."

Based on observation, record review and interview, the facility failed to ensure physician's orders were followed related to insulin administration, blood sugar checks, oxygen, and the physician not notified for high blood sugars for 4 of 11 residents reviewed. (Residents C, E, D, and F)

Findings include:

1. Record review for Resident C was completed on 7/14/25 at 11:53 a.m. Diagnoses included, but were not limited to, diabetes mellitus, and hypertension.

The July 2025 Physician's Order Summary (POS) indicated orders for the following medications:

	- Insulin degludec, inject 24 units at bedtime - Insulin aspart, inject 10 units daily at lunch - Insulin aspart, inject 5 units twice daily before breakfast and dinner The June and July 2025 Medication Administration Record (MAR) lacked documentation the insulin was administered on: - Insulin degludec, 24 units: 7/9/25 at bedtime - Insulin aspart, 10 units: 6/9, 6/14, 6/15, 6/18, and 7/2/25 at lunch - Insulin aspart, 5 units: 6/9, 6/14, 6/15, and 7/2/25 at breakfast - Insulin aspart, 5 units: 7/9/25 at dinner The record lacked any documentation the insulin was administered on the above dates and times. During an interview on 7/15/25 at 1:12 p.m., the Interim Director of Nursing (IDON) indicated she could not provide any documentation the insulin had been administered to the resident on the above dates and times.			

	3. Resident D's record was reviewed on 7/15/25 at 10:09 a.m. Diagnoses included, but were not limited to, dementia, type 2 diabetes mellitus, and major depressive disorder. The Service Plan, dated 8/22/24, indicated the resident was alert and oriented. She required all medications and treatments to be administered by staff including diabetic medications and blood sugar checks. A Physician's Order, dated 11/4/24, indicated insulin lispro injection 100 units/milliliter, inject as directed per sliding scale four times a day. The sliding scale indicated blood sugar 111-150=4 units (U), 151-200=8 U, 201-250=10 U, 251-300=12 U, 301-350=14 U, 351-400=16 U. The May and June 2025 Medication Administration Record (MAR) indicated the insulin lispro injection was not signed out as administered on 5/23/25 at 7:00 a.m. and 11:00 a.m., 5/26/25 at 11 a.m., 5/31/25 at 7:00 a.m. and 11:00 a.m., 6/9/25 at 7:00 a.m. and 11:00 a.m., 6/14/25 at 7:00 a.m. and 11:00 a.m., 6/15/25 at 7 a.m. and 11:00 a.m., and 6/26/25 at 4:00 p.m. A Physician's Order, dated 11/4/24, indicated insulin			

	glargine injection 100 units/milliliter, inject 39 units subcutaneously once daily at 7:00 a.m. The May, June, and July 2025 MAR indicated the insulin glargine injection was blank at 7:00 a.m. on 5/23/25, 5/31/25, 6/9/25, 6/14/25, 6/15/25, and 7/2/25. During an interview on 7/15/25 at 1:08 p.m., the Interim Director of Nursing indicated she had no further information to provide. 4. During an interview on 7/15/25 at 1:47 p.m., Resident F indicated she had oxygen, but she did not always wear it. She was observed sitting in her apartment in a motorized wheelchair at the time with no oxygen in use. On 7/15/25 at 2:32 p.m., Resident F was observed in the hall way going towards the dining room with no oxygen in use. Resident F's record was reviewed on 7/14/25 at 2:42 p.m. Diagnoses included, but were not limited to, asthma chronic kidney disease and type 2 diabetes mellitus.			

	The current Service Plan indicated the resident was cognitively intact and independent with activities of daily living. A Physician's Order, dated 5/22/25, indicated oxygen at 2 liters per minute per nasal cannula. During an interview on 7/15/25 at 1:08 p.m., the Interim Director of Nursing indicated she had no further information to provide. A facility policy titled, "Medication Administration," indicated "...Medications will be administered to residents as prescribed and by persons lawfully authorized to do so in a manner consistent with good infection control and standards of practice...Only licensed nursing or other lawfully authorized staff may prepare, administer, or record medication administration..." This citation relates to Complaint IN00457361 and IN00457391. 2. Resident E's record was reviewed on 7/15/25 at 1:36 p.m. Diagnoses included, but were not limited to, type 1 diabetes mellitus, osteoporosis, and hypertension. The Physician's Order Summary, dated 7/2025, indicated orders for: insulin			

	aspart (fast acting insulin) sliding scale (amount of insulin given is based on blood sugar result) subcutaneously (injection) at 8:00 a.m., 11:00 a.m., and 4:00 p.m., insulin aspart 4 units subcutaneously every morning, and Tresiba (insulin degludec, long-acting insulin) 10 units daily. The 11:00 a.m. insulin aspart sliding scale order indicated to give 10 units of insulin and notify the Physician for a blood sugar greater than 401. The Medication Administration Records (MAR), dated 6/2025 and 7/2025, indicated the resident's blood sugar on 7/11/25 at 11:00 a.m. was 407 and 10 units of insulin were given. There was lack of documentation to indicate the Physician had been notified of the high blood sugar. There were blanks for the blood sugar results and the insulin administration on the following dates and times: - insulin aspart sliding scale at 8:00 a.m. on 6/9/25, 6/14/25, 6/15/25, and 7/2/25 - insulin aspart sliding scale at 11:00 a.m. on 6/9/25, 6/14/25, 6/15/25, and 7/2/25 - insulin aspart sliding scale at 4:00 p.m. on 6/26/25 and 7/9/25 - insulin aspart 4 units at 8:00 a.m. on 6/9/25, 6/14/25,			

	6/15/25, and 7/2/25 - Tresiba 10 units at 7:00 a.m. on 6/9/25, 6/14/25, 6/15/25, and 7/2/25 During an interview on 7/15/25 at 2:04 p.m., the Director of Nursing was made aware of the lack of Physician notification of the high blood sugar and the blanks on the MAR. No further information was provided. A policy, titled Physician Notification, received as current from the Director of Nursing, indicated "...Agencies providing nursing services by licensed staff notify the physician, under the following circumstances, as the agency becomes aware:...Worsening of chronic conditions [e.g. heart failure, diabetes]..."			
R 0245	Health Services - Offense 410 IAC 16.2-5-4(e)(5) (5) Injectable medications shall be given only by licensed personnel. 2. Resident E's record was reviewed on 7/15/25 at 1:36 p.m. Diagnoses included, but were not limited to, type 1 diabetes mellitus, osteoporosis, and hypertension. The Physician's Order Summary, dated 7/2025,	R 0245	Wellness Director or designee will in-service nursing staff to ensure they are documenting medication administration under their own name in point click care within their scope of practice. Wellness Director will in-service QMA’s on their scope of practice. Executive Director and Wellness Director will review in service notes and MAR findings and monthly QA.	08/31/2025

indicated orders for insulin aspart (fast acting insulin) sliding scale (amount of insulin given is based on blood sugar result) subcutaneously (injection) at 4 p.m.

The Medication Administration Record, dated 6/2025, indicated QMA 2 had given 6 units of insulin aspart for a blood sugar of 261 on 6/28/25 at 4:00 p.m.

During an interview on 7/15/25 at 2:04 p.m., the Director of Nursing indicated QMA 2 was not approved to administer insulin, and she was unsure why the QMA had documented the insulin as given. No further information was provided.

Based on record review and interview, the facility failed to ensure insulin was not administered by QMAs without insulin administration certifications for 3 of 11 residents reviewed. (Residents C, E, and D)

Findings include:

1. Record review for Resident C was completed on 7/14/25 at 11:53 a.m. Diagnoses included, but were not limited to, diabetes mellitus, and hypertension.

The July 2025 Physician's Order Summary (POS) indicated an order for the following medication:

	- Insulin aspart, inject 5 units twice daily before breakfast and dinner The June 2025 Medication Administration Record (MAR) indicated the insulin was administered by unqualified QMAs on the following dates: - Insulin aspart, 5 units: 6/6/25 at dinner by QMA 3 - Insulin aspart, 5 units: 6/28/25 at dinner by QMA 2 The record lacked any documentation the above QMAs were certified to administer insulin. During an interview on 7/15/25 at 1:12 p.m., the Interim Director of Nursing (IDON) indicated the above QMAs were not certified to administer insulin. 3. Resident D's record was reviewed on 7/15/25 at 10:09 a.m. Diagnoses included, but were not limited to, dementia, type 2 diabetes mellitus, and major depressive disorder. The Service Plan, dated 8/22/24, indicated the resident was alert and oriented. She required all medications and treatments to be administered by staff including diabetic medications and blood sugar checks. A Physician's Order, dated			

	11/4/24, indicated insulin lispro injection 100 units/milliliter, inject as directed per sliding scale four times a day. The sliding scale indicated blood sugar 111-150=4 units (U), 151-200=8 U, 201-250=10 U, 251-300=12 U, 301-350=14 U, 351-400=16 U. The June 2025 Medication Administration Record (MAR) indicated 8 units of insulin lispro injection were administered by QMA 2 on 6/28/25 at 4:00 p.m. with a blood sugar of 166. During an interview on 7/15/25 at 1:08 p.m., the Interim Director of Nursing indicated QMA 2 did not have the appropriate certification to administer insulin. This citation relates to Complaints IN00457361 and IN00457391. 2. Resident E's record was reviewed on 7/15/25 at 1:36 p.m. Diagnoses included, but were not limited to, type 1 diabetes mellitus, osteoporosis, and hypertension. The Physician's Order Summary, dated 7/2025, indicated orders for insulin aspart (fast acting insulin) sliding scale (amount of insulin given is based on blood sugar result) subcutaneously (injection) at 4 p.m.			

	The Medication Administration Record, dated 6/2025, indicated QMA 2 had given 6 units of insulin aspart for a blood sugar of 261 on 6/28/25 at 4:00 p.m. During an interview on 7/15/25 at 2:04 p.m., the Director of Nursing indicated QMA 2 was not approved to administer insulin, and she was unsure why the QMA had documented the insulin as given. No further information was provided. Based on record review and interview, the facility failed to ensure insulin was not administered by QMAs without insulin administration certifications for 3 of 11 residents reviewed. (Residents C, E, and D) Findings include: 1. Record review for Resident C was completed on 7/14/25 at 11:53 a.m. Diagnoses included, but were not limited to, diabetes mellitus, and hypertension. The July 2025 Physician's Order Summary (POS) indicated an order for the following medication: - Insulin aspart, inject 5 units twice daily before breakfast and dinner The June 2025 Medication Administration Record (MAR) indicated the insulin was			

	administered by unqualified QMAs on the following dates: - Insulin aspart, 5 units: 6/6/25 at dinner by QMA 3 - Insulin aspart, 5 units: 6/28/25 at dinner by QMA 2 The record lacked any documentation the above QMAs were certified to administer insulin. During an interview on 7/15/25 at 1:12 p.m., the Interim Director of Nursing (IDON) indicated the above QMAs were not certified to administer insulin. 3. Resident D's record was reviewed on 7/15/25 at 10:09 a.m. Diagnoses included, but were not limited to, dementia, type 2 diabetes mellitus, and major depressive disorder. The Service Plan, dated 8/22/24, indicated the resident was alert and oriented. She required all medications and treatments to be administered by staff including diabetic medications and blood sugar checks. A Physician's Order, dated 11/4/24, indicated insulin lispro injection 100 units/milliliter, inject as directed per sliding scale four times a day. The sliding scale indicated blood sugar 111-150=4 units (U), 151-200=8 U, 201-250=10 U,			

	251-300=12 U, 301-350=14 U, 351-400=16 U. The June 2025 Medication Administration Record (MAR) indicated 8 units of insulin lispro injection were administered by QMA 2 on 6/28/25 at 4:00 p.m. with a blood sugar of 166. During an interview on 7/15/25 at 1:08 p.m., the Interim Director of Nursing indicated QMA 2 did not have the appropriate certification to administer insulin. This citation relates to Complaints IN00457361 and IN00457391. 2. Resident E's record was reviewed on 7/15/25 at 1:36 p.m. Diagnoses included, but were not limited to, type 1 diabetes mellitus, osteoporosis, and hypertension. The Physician's Order Summary, dated 7/2025, indicated orders for insulin aspart (fast acting insulin) sliding scale (amount of insulin given is based on blood sugar result) subcutaneously (injection) at 4 p.m. The Medication Administration Record, dated 6/2025, indicated QMA 2 had given 6 units of insulin aspart for a blood sugar of 261 on 6/28/25 at 4:00 p.m. During an interview on 7/15/25			

at 2:04 p.m., the Director of Nursing indicated QMA 2 was not approved to administer insulin, and she was unsure why the QMA had documented the insulin as given. No further information was provided.

Based on record review and interview, the facility failed to ensure insulin was not administered by QMAs without insulin administration certifications for 3 of 11 residents reviewed. (Residents C, E, and D)

Findings include:

1. Record review for Resident C was completed on 7/14/25 at 11:53 a.m. Diagnoses included, but were not limited to, diabetes mellitus, and hypertension.

The July 2025 Physician's Order Summary (POS) indicated an order for the following medication:

- Insulin aspart, inject 5 units twice daily before breakfast and dinner

The June 2025 Medication Administration Record (MAR) indicated the insulin was administered by unqualified QMAs on the following dates:

- Insulin aspart, 5 units: 6/6/25 at dinner by QMA 3

- Insulin aspart, 5 units: 6/28/25

at dinner by QMA 2

The record lacked any documentation the above QMAs were certified to administer insulin.

During an interview on 7/15/25 at 1:12 p.m., the Interim Director of Nursing (IDON) indicated the above QMAs were not certified to administer insulin.

3. Resident D's record was reviewed on 7/15/25 at 10:09 a.m. Diagnoses included, but were not limited to, dementia, type 2 diabetes mellitus, and major depressive disorder.

The Service Plan, dated 8/22/24, indicated the resident was alert and oriented. She required all medications and treatments to be administered by staff including diabetic medications and blood sugar checks.

A Physician's Order, dated 11/4/24, indicated insulin lispro injection 100 units/milliliter, inject as directed per sliding scale four times a day. The sliding scale indicated blood sugar 111-150=4 units (U), 151-200=8 U, 201-250=10 U, 251-300=12 U, 301-350=14 U, 351-400=16 U.

The June 2025 Medication Administration Record (MAR) indicated 8 units of insulin lispro injection were administered by

	QMA 2 on 6/28/25 at 4:00 p.m. with a blood sugar of 166. During an interview on 7/15/25 at 1:08 p.m., the Interim Director of Nursing indicated QMA 2 did not have the appropriate certification to administer insulin. This citation relates to Complaints IN00457361 and IN00457391. 2. Resident E's record was reviewed on 7/15/25 at 1:36 p.m. Diagnoses included, but were not limited to, type 1 diabetes mellitus, osteoporosis, and hypertension. The Physician's Order Summary, dated 7/2025, indicated orders for insulin aspart (fast acting insulin) sliding scale (amount of insulin given is based on blood sugar result) subcutaneously (injection) at 4 p.m. The Medication Administration Record, dated 6/2025, indicated QMA 2 had given 6 units of insulin aspart for a blood sugar of 261 on 6/28/25 at 4:00 p.m.			

During an interview on 7/15/25 at 2:04 p.m., the Director of Nursing indicated QMA 2 was not approved to administer insulin, and she was unsure why the QMA had documented the insulin as given. No further information was provided.

Based on record review and interview, the facility failed to ensure insulin was not administered by QMAs without insulin administration certifications for 3 of 11 residents reviewed. (Residents C, E, and D)

Findings include:

1. Record review for Resident C was completed on 7/14/25 at 11:53 a.m. Diagnoses included, but were not limited to, diabetes mellitus, and hypertension.

The July 2025 Physician's Order Summary (POS) indicated an order for the following medication:

- Insulin aspart, inject 5 units twice daily before breakfast and dinner

The June 2025 Medication Administration Record (MAR) indicated the insulin was administered by unqualified QMAs on the following dates:

- Insulin aspart, 5 units: 6/6/25 at dinner by QMA 3

- Insulin aspart, 5 units: 6/28/25 at dinner by QMA 2

The record lacked any documentation the above QMAs were certified to administer insulin.

During an interview on 7/15/25 at 1:12 p.m., the Interim Director of Nursing (IDON) indicated the above QMAs were not certified to administer insulin.

3. Resident D's record was reviewed on 7/15/25 at 10:09 a.m. Diagnoses included, but were not limited to, dementia, type 2 diabetes mellitus, and major depressive disorder.

The Service Plan, dated 8/22/24, indicated the resident was alert and oriented. She required all medications and treatments to be administered by staff including diabetic medications and blood sugar checks.

A Physician's Order, dated 11/4/24, indicated insulin lispro injection 100 units/milliliter, inject as directed per sliding scale four times a day. The sliding scale indicated blood sugar 111-150=4 units (U), 151-200=8 U, 201-250=10 U, 251-300=12 U, 301-350=14 U, 351-400=16 U.

The June 2025 Medication Administration Record (MAR) indicated 8 units of insulin lispro

injection were administered by QMA 2 on 6/28/25 at 4:00 p.m. with a blood sugar of 166.

During an interview on 7/15/25 at 1:08 p.m., the Interim Director of Nursing indicated QMA 2 did not have the appropriate certification to administer insulin.

This citation relates to Complaints IN00457361 and IN00457391.

2. Resident E's record was reviewed on 7/15/25 at 1:36 p.m. Diagnoses included, but were not limited to, type 1 diabetes mellitus, osteoporosis, and hypertension.

The Physician's Order Summary, dated 7/2025, indicated orders for insulin aspart (fast acting insulin) sliding scale (amount of insulin given is based on blood sugar result) subcutaneously (injection) at 4 p.m.

The Medication Administration Record, dated 6/2025, indicated QMA 2 had given 6 units of insulin aspart for a blood sugar of 261 on 6/28/25 at 4:00 p.m.

During an interview on 7/15/25 at 2:04 p.m., the Director of Nursing indicated QMA 2 was not approved to administer insulin, and she was unsure why the QMA had documented the insulin as given. No further

	information was provided. Based on record review and interview, the facility failed to ensure insulin was not administered by QMAs without insulin administration certifications for 3 of 11 residents reviewed. (Residents C, E, and D) Findings include: 1. Record review for Resident C was completed on 7/14/25 at 11:53 a.m. Diagnoses included, but were not limited to, diabetes mellitus, and hypertension. The July 2025 Physician's Order Summary (POS) indicated an order for the following medication: - Insulin aspart, inject 5 units twice daily before breakfast and dinner The June 2025 Medication Administration Record (MAR) indicated the insulin was administered by unqualified QMAs on the following dates: - Insulin aspart, 5 units: 6/6/25 at dinner by QMA 3 - Insulin aspart, 5 units: 6/28/25 at dinner by QMA 2			

	The record lacked any documentation the above QMAs were certified to administer insulin. During an interview on 7/15/25 at 1:12 p.m., the Interim Director of Nursing (IDON) indicated the above QMAs were not certified to administer insulin. 3. Resident D's record was reviewed on 7/15/25 at 10:09 a.m. Diagnoses included, but were not limited to, dementia, type 2 diabetes mellitus, and major depressive disorder. The Service Plan, dated 8/22/24, indicated the resident was alert and oriented. She required all medications and treatments to be administered by staff including diabetic medications and blood sugar checks. A Physician's Order, dated 11/4/24, indicated insulin lispro injection 100 units/milliliter, inject as directed per sliding scale four times a day. The sliding scale indicated blood sugar 111-150=4 units (U), 151-200=8 U, 201-250=10 U, 251-300=12 U, 301-350=14 U, 351-400=16 U.			

The June 2025 Medication Administration Record (MAR) indicated 8 units of insulin lispro injection were administered by QMA 2 on 6/28/25 at 4:00 p.m. with a blood sugar of 166.

During an interview on 7/15/25 at 1:08 p.m., the Interim Director of Nursing indicated QMA 2 did not have the appropriate certification to administer insulin.

This citation relates to Complaints IN00457361 and IN00457391.

2. Resident E's record was reviewed on 7/15/25 at 1:36 p.m. Diagnoses included, but were not limited to, type 1 diabetes mellitus, osteoporosis, and hypertension.

The Physician's Order Summary, dated 7/2025, indicated orders for insulin aspart (fast acting insulin) sliding scale (amount of insulin given is based on blood sugar result) subcutaneously (injection) at 4 p.m.

The Medication Administration Record, dated 6/2025, indicated QMA 2 had given 6 units of insulin aspart for a blood sugar of 261 on 6/28/25 at 4:00 p.m.

During an interview on 7/15/25 at 2:04 p.m., the Director of Nursing indicated QMA 2 was not approved to administer

insulin, and she was unsure why the QMA had documented the insulin as given. No further information was provided.

Based on record review and interview, the facility failed to ensure insulin was not administered by QMAs without insulin administration certifications for 3 of 11 residents reviewed. (Residents C, E, and D)

Findings include:

1. Record review for Resident C was completed on 7/14/25 at 11:53 a.m. Diagnoses included, but were not limited to, diabetes mellitus, and hypertension.

The July 2025 Physician's Order Summary (POS) indicated an order for the following medication:

- Insulin aspart, inject 5 units twice daily before breakfast and dinner

The June 2025 Medication Administration Record (MAR) indicated the insulin was administered by unqualified QMAs on the following dates:

- Insulin aspart, 5 units: 6/6/25 at dinner by QMA 3

- Insulin aspart, 5 units: 6/28/25 at dinner by QMA 2

The record lacked any

documentation the above QMAs were certified to administer insulin.

During an interview on 7/15/25 at 1:12 p.m., the Interim Director of Nursing (IDON) indicated the above QMAs were not certified to administer insulin.

3. Resident D's record was reviewed on 7/15/25 at 10:09 a.m. Diagnoses included, but were not limited to, dementia, type 2 diabetes mellitus, and major depressive disorder.

The Service Plan, dated 8/22/24, indicated the resident was alert and oriented. She required all medications and treatments to be administered by staff including diabetic medications and blood sugar checks.

A Physician's Order, dated 11/4/24, indicated insulin lispro injection 100 units/milliliter, inject as directed per sliding scale four times a day. The sliding scale indicated blood sugar 111-150=4 units (U), 151-200=8 U, 201-250=10 U, 251-300=12 U, 301-350=14 U, 351-400=16 U.

The June 2025 Medication Administration Record (MAR) indicated 8 units of insulin lispro injection were administered by QMA 2 on 6/28/25 at 4:00 p.m. with a blood sugar of 166.

	During an interview on 7/15/25 at 1:08 p.m., the Interim Director of Nursing indicated QMA 2 did not have the appropriate certification to administer insulin. This citation relates to Complaints IN00457361 and IN00457391.			
R 0246	Health Services - Deficiency 410 IAC 16.2-5-4(e)(6) (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on record review and interview, the facility failed to ensure qualified medication aides (QMA) received licensed nursing approval prior to giving as needed (PRN) medications for 2 of 11 records reviewed. (Residents 2 and 5) Findings include: 1. Resident 2's closed record was reviewed on 7/14/25 at	R 0246	Wellness Director or designee will in service QMA's about nurse approval before administering medications. Nursing staff will be educated on writing progress notes for effectiveness of medications. Executive Director and Wellness director will conduct monthly audits MAR during monthly QA meeting.	08/31/2025

11:00 a.m. Diagnoses included, but were not limited to, anxiety, hypertension and dementia.

A Physician's Order, dated 9/22/24, indicated to give acetaminophen 325 milligrams, 2 tablets, every six hours as needed for pain.

The April 2025 Medication Administration Record indicated the resident was given acetaminophen on 4/14/25 by QMA 1. The follow up note by QMA 1 indicated the medication had been effective. There was no documentation a licensed nurse had approved the medication.

During an interview on 7/15/25 at 1:10 p.m., the Director of Nursing indicated nurses should be signing off on medications as approved and or doing the follow up notes.

2. Resident 5's record was reviewed on 7/14/25 at 1:18 p.m. Diagnoses included, but were not limited to, depression, hypertension, and hyperlipidemia.

The Physician's Order Summary, dated 7/2025, indicated orders for genteal tears eye drops one drop in both eyes four times a day PRN (as needed) and acetaminophen 325 mg (milligrams) 2 tabs by mouth every 6 hours PRN for pain or

fever.

The Medication Administration Record, dated 6/2025, indicated QMA 1 had administered the genteal tears on 6/6/25 at 12:44 p.m. and the acetaminophen on 6/20/25 at 8:47 a.m. There was lack of documentation to indicate QMA 1 had received authorization from a licensed nurse prior to administering the PRN medications.

During an interview on 7/15/25 at 9:52 a.m., the Director of Nursing indicated when a QMA administered a PRN medication they were to receive authorization from the nurse prior to administering it. The QMA should have documented that in the progress notes. She was unable to provide any further information.

Based on record review and interview, the facility failed to ensure qualified medication aides (QMA) received licensed nursing approval prior to giving as needed (PRN) medications for 2 of 11 records reviewed. (Residents 2 and 5)

Findings include:

1. Resident 2's closed record was reviewed on 7/14/25 at 11:00 a.m. Diagnoses included, but were not limited to, anxiety, hypertension and dementia.

A Physician's Order, dated

9/22/24, indicated to give acetaminophen 325 milligrams, 2 tablets, every six hours as needed for pain.

The April 2025 Medication Administration Record indicated the resident was given acetaminophen on 4/14/25 by QMA 1. The follow up note by QMA 1 indicated the medication had been effective. There was no documentation a licensed nurse had approved the medication.

During an interview on 7/15/25 at 1:10 p.m., the Director of Nursing indicated nurses should be signing off on medications as approved and or doing the follow up notes.

2. Resident 5's record was reviewed on 7/14/25 at 1:18 p.m. Diagnoses included, but were not limited to, depression, hypertension, and hyperlipidemia.

The Physician's Order Summary, dated 7/2025, indicated orders for genteal tears eye drops one drop in both eyes four times a day PRN (as needed) and acetaminophen 325 mg (milligrams) 2 tabs by mouth every 6 hours PRN for pain or fever.

The Medication Administration Record, dated 6/2025, indicated QMA 1 had administered the

genteal tears on 6/6/25 at 12:44 p.m. and the acetaminophen on 6/20/25 at 8:47 a.m. There was lack of documentation to indicate QMA 1 had received authorization from a licensed nurse prior to administering the PRN medications.

During an interview on 7/15/25 at 9:52 a.m., the Director of Nursing indicated when a QMA administered a PRN medication they were to receive authorization from the nurse prior to administering it. The QMA should have documented that in the progress notes. She was unable to provide any further information.

Based on record review and interview, the facility failed to ensure qualified medication aides (QMA) received licensed nursing approval prior to giving as needed (PRN) medications for 2 of 11 records reviewed. (Residents 2 and 5)

Findings include:

1. Resident 2's closed record was reviewed on 7/14/25 at 11:00 a.m. Diagnoses included, but were not limited to, anxiety, hypertension and dementia.

A Physician's Order, dated 9/22/24, indicated to give acetaminophen 325 milligrams, 2 tablets, every six hours as needed for pain.

	The April 2025 Medication Administration Record indicated the resident was given acetaminophen on 4/14/25 by QMA 1. The follow up note by QMA 1 indicated the medication had been effective. There was no documentation a licensed nurse had approved the medication. During an interview on 7/15/25 at 1:10 p.m., the Director of Nursing indicated nurses should be signing off on medications as approved and or doing the follow up notes. 2. Resident 5's record was reviewed on 7/14/25 at 1:18 p.m. Diagnoses included, but were not limited to, depression, hypertension, and hyperlipidemia. The Physician's Order Summary, dated 7/2025, indicated orders for genteal tears eye drops one drop in both eyes four times a day PRN (as needed) and acetaminophen 325 mg (milligrams) 2 tabs by mouth every 6 hours PRN for pain or fever. The Medication Administration Record, dated 6/2025, indicated QMA 1 had administered the genteal tears on 6/6/25 at 12:44 p.m. and the acetaminophen on 6/20/25 at 8:47 a.m. There was lack of documentation to			

indicate QMA 1 had received authorization from a licensed nurse prior to administering the PRN medications.

During an interview on 7/15/25 at 9:52 a.m., the Director of Nursing indicated when a QMA administered a PRN medication they were to receive authorization from the nurse prior to administering it. The QMA should have documented that in the progress notes. She was unable to provide any further information.

Based on record review and interview, the facility failed to ensure qualified medication aides (QMA) received licensed nursing approval prior to giving as needed (PRN) medications for 2 of 11 records reviewed. (Residents 2 and 5)

Findings include:

1. Resident 2's closed record was reviewed on 7/14/25 at 11:00 a.m. Diagnoses included, but were not limited to, anxiety, hypertension and dementia.

A Physician's Order, dated 9/22/24, indicated to give acetaminophen 325 milligrams, 2 tablets, every six hours as needed for pain.

The April 2025 Medication Administration Record indicated the resident was given acetaminophen on 4/14/25 by

	QMA 1. The follow up note by QMA 1 indicated the medication had been effective. There was no documentation a licensed nurse had approved the medication. During an interview on 7/15/25 at 1:10 p.m., the Director of Nursing indicated nurses should be signing off on medications as approved and or doing the follow up notes. 2. Resident 5's record was reviewed on 7/14/25 at 1:18 p.m. Diagnoses included, but were not limited to, depression, hypertension, and hyperlipidemia. The Physician's Order Summary, dated 7/2025, indicated orders for genteal tears eye drops one drop in both eyes four times a day PRN (as needed) and acetaminophen 325 mg (milligrams) 2 tabs by mouth every 6 hours PRN for pain or fever. The Medication Administration Record, dated 6/2025, indicated QMA 1 had administered the genteal tears on 6/6/25 at 12:44 p.m. and the acetaminophen on 6/20/25 at 8:47 a.m. There was lack of documentation to indicate QMA 1 had received authorization from a licensed nurse prior to administering the PRN medications.			

	During an interview on 7/15/25 at 9:52 a.m., the Director of Nursing indicated when a QMA administered a PRN medication they were to receive authorization from the nurse prior to administering it. The QMA should have documented that in the progress notes. She was unable to provide any further information.			
R 0356	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(i)(1-8) (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies.	R 0356	Wellness Director or designee will create Emergency Binder documents for residents upon admission. Executive director and Wellness Director will audit Emergency binder at Monthly QA meetings.	08/31/2025

	(7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on record review and interview, the facility failed to ensure the Emergency Binder was complete and contained all the required information for 9 of 9 current residents reviewed. (Residents 3, 5, B, C, D, E, F, G and H) Finding includes: The Emergency Binder was reviewed on 7/15/25 at 10:48 a.m. The following items were missing: - Resident 3: photograph and hospital preference - Resident 5: hospital preference - Resident B: photograph and hospital preference - Resident C: no information available in Emergency Binder - Resident D: photograph and hospital preference - Resident E: photograph and hospital preference			

	- Resident F: physician contact information, photograph and hospital preference - Resident G: no information available in Emergency Binder - Resident H: no information available in Emergency Binder During an interview on 7/15/25 at 11:15 a.m., the Administrator was made aware of the missing items. No additional information was provided. Based on record review and interview, the facility failed to ensure the Emergency Binder was complete and contained all the required information for 9 of 9 current residents reviewed. (Residents 3, 5, B, C, D, E, F, G and H) Finding includes: The Emergency Binder was reviewed on 7/15/25 at 10:48 a.m. The following items were missing: - Resident 3: photograph and hospital preference - Resident 5: hospital preference - Resident B: photograph and hospital preference - Resident C: no information available in Emergency Binder			

	- Resident D: photograph and hospital preference - Resident E: photograph and hospital preference - Resident F: physician contact information, photograph and hospital preference - Resident G: no information available in Emergency Binder - Resident H: no information available in Emergency Binder During an interview on 7/15/25 at 11:15 a.m., the Administrator was made aware of the missing items. No additional information was provided.			
R 0357	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(j)(1-3) (j) If a death occurs, information concerning the resident ' s death shall include the following: (1) Notification of the physician, family, responsible person, and legal representative. (2) The disposition of the body, personal possessions, and medications. (3) A complete and accurate notation of the resident ' s condition and most recent vital signs and symptoms preceding death. Based on record review and	R 0357	Wellness Director or designee will update all progress notes when resident expires. Executive Director and Wellness Director will audit expired residents notes at monthly QA.	08/31/2025

	interview, the facility failed to ensure clinical records were complete and accurate related to a lack of information following a resident's death for 1 of 2 closed resident records reviewed (Resident 6). Finding includes: Diagnoses included, but were not limited to, adult failure to thrive, acute respiratory failure, metabolic encephalopathy, and altered mental status. The resident admitted in the facility on 10/28/24 and expired on 11/26/24. A Progress Note, dated 11/26/24 at 6:33 a.m., indicated at 5:50 a.m. staff were called to the resident's room due to a CNA finding the resident absent of vital signs. The nurse could not obtain any vital signs. The Assistant Director of Nursing (ADON) was notified and advised to initiate cardiopulmonary resuscitation (CPR). 911 call was made at approximately 5:55 a.m. Emergency Medical Services (EMS) arrived on scene at approximately 6:15 a.m. EMS assumed care of resident at that time. EMS declared time of death. Residents power of attorney (POA) and the ADON were notified. The record lacked documentation related to			

notification to the resident's physician, disposition of the body, personal possessions, and medications.

During an interview on 7/15/25 at 3:00 p.m., the Director of Nursing indicated the documentation should have been in a progress note and she had no further information to provide.

An applicable policy was requested and not received.

Based on record review and interview, the facility failed to ensure clinical records were complete and accurate related to a lack of information following a resident's death for 1 of 2 closed resident records reviewed (Resident 6).

Finding includes:

Diagnoses included, but were not limited to, adult failure to thrive, acute respiratory failure, metabolic encephalopathy, and altered mental status. The resident admitted in the facility on 10/28/24 and expired on 11/26/24.

A Progress Note, dated 11/26/24 at 6:33 a.m., indicated at 5:50 a.m. staff were called to the resident's room due to a CNA finding the resident absent of vital signs. The nurse could not obtain any vital signs. The Assistant Director of Nursing

	(ADON) was notified and advised to initiate cardiopulmonary resuscitation (CPR). 911 call was made at approximately 5:55 a.m. Emergency Medical Services (EMS) arrived on scene at approximately 6:15 a.m. EMS assumed care of resident at that time. EMS declared time of death. Residents power of attorney (POA) and the ADON were notified. The record lacked documentation related to notification to the resident's physician, disposition of the body, personal possessions, and medications. During an interview on 7/15/25 at 3:00 p.m., the Director of Nursing indicated the documentation should have been in a progress note and she had no further information to provide. An applicable policy was requested and not received.			
R 0409	Infection Control - Noncompliance 410 IAC 16.2-5-12(d) (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an	R 0409	Wellness Director or designee will assess residents and employees prior to admission and yearly thereafter. Executive Director and Wellness Director will assess and execute upcoming yearly health assessments at monthly QA .	08/31/2025

	infectious stage as verified upon admission and yearly thereafter. 2. Resident F's record was reviewed on 7/14/25 at 2:42 p.m. Diagnoses included, but were not limited to, chronic kidney disease and type 2 diabetes mellitus. The record lacked a health statement to indicate the resident was free of communicable diseases. During an interview on 7/15/25 at 1:08 p.m., the Interim Director of Nursing indicated she had no further information to provide. 3. Resident D's record was reviewed on 7/15/25 at 10:09 a.m. Diagnoses included, but were not limited to, dementia, type 2 diabetes mellitus, and major depressive disorder. The record lacked a health statement to indicate the resident was free of communicable diseases. During an interview on 7/15/25 at 1:08 p.m., the Interim Director of Nursing indicated she had no further information to provide. Based on record review and interview, the facility failed to maintain an effective infection control program related to annual Physician's statements that residents were free of			

infectious diseases for 3 of 11 records reviewed. (Residents H, F and D)

Findings include:

1. Resident H's record was reviewed on 7/15/25 at 11:18 a.m. Diagnoses included, but were not limited to, diabetes mellitus, hypertension and cerebral infarction. The resident was admitted to the facility on 7/1/25.

There was no evidence or documentation of a Physician's annual statement the resident was free of infectious diseases.

During an interview on 7/15/25 at 1:10 p.m., the Director of Nursing indicated all documents should be scanned into the computer. There was no additional information provided.

2. Resident F's record was reviewed on 7/14/25 at 2:42 p.m. Diagnoses included, but were not limited to, chronic kidney disease and type 2 diabetes mellitus.

The record lacked a health statement to indicate the resident was free of communicable diseases.

During an interview on 7/15/25 at 1:08 p.m., the Interim Director of Nursing indicated she had no further information to provide.

	3. Resident D's record was reviewed on 7/15/25 at 10:09 a.m. Diagnoses included, but were not limited to, dementia, type 2 diabetes mellitus, and major depressive disorder. The record lacked a health statement to indicate the resident was free of communicable diseases. During an interview on 7/15/25 at 1:08 p.m., the Interim Director of Nursing indicated she had no further information to provide. Based on record review and interview, the facility failed to maintain an effective infection control program related to annual Physician's statements that residents were free of infectious diseases for 3 of 11 records reviewed. (Residents H, F and D) Findings include: 1. Resident H's record was reviewed on 7/15/25 at 11:18 a.m. Diagnoses included, but were not limited to, diabetes mellitus, hypertension and cerebral infarction. The resident was admitted to the facility on 7/1/25. There was no evidence or documentation of a Physician's annual statement the resident was free of infectious diseases. During an interview on 7/15/25			

	at 1:10 p.m., the Director of Nursing indicated all documents should be scanned into the computer. There was no additional information provided. 2. Resident F's record was reviewed on 7/14/25 at 2:42 p.m. Diagnoses included, but were not limited to, chronic kidney disease and type 2 diabetes mellitus. The record lacked a health statement to indicate the resident was free of communicable diseases. During an interview on 7/15/25 at 1:08 p.m., the Interim Director of Nursing indicated she had no further information to provide. 3. Resident D's record was reviewed on 7/15/25 at 10:09 a.m. Diagnoses included, but were not limited to, dementia, type 2 diabetes mellitus, and major depressive disorder. The record lacked a health statement to indicate the resident was free of communicable diseases. During an interview on 7/15/25 at 1:08 p.m., the Interim Director of Nursing indicated she had no further information to provide. Based on record review and interview, the facility failed to maintain an effective infection control program related to			

annual Physician's statements that residents were free of infectious diseases for 3 of 11 records reviewed. (Residents H, F and D)

Findings include:

1. Resident H's record was reviewed on 7/15/25 at 11:18 a.m. Diagnoses included, but were not limited to, diabetes mellitus, hypertension and cerebral infarction. The resident was admitted to the facility on 7/1/25.

There was no evidence or documentation of a Physician's annual statement the resident was free of infectious diseases.

During an interview on 7/15/25 at 1:10 p.m., the Director of Nursing indicated all documents should be scanned into the computer. There was no additional information provided.

2. Resident F's record was reviewed on 7/14/25 at 2:42 p.m. Diagnoses included, but were not limited to, chronic kidney disease and type 2 diabetes mellitus.

The record lacked a health statement to indicate the resident was free of communicable diseases.

During an interview on 7/15/25 at 1:08 p.m., the Interim Director of Nursing indicated she had no

	further information to provide. 3. Resident D's record was reviewed on 7/15/25 at 10:09 a.m. Diagnoses included, but were not limited to, dementia, type 2 diabetes mellitus, and major depressive disorder. The record lacked a health statement to indicate the resident was free of communicable diseases. During an interview on 7/15/25 at 1:08 p.m., the Interim Director of Nursing indicated she had no further information to provide. Based on record review and interview, the facility failed to maintain an effective infection control program related to annual Physician's statements that residents were free of infectious diseases for 3 of 11 records reviewed. (Residents H, F and D) Findings include: 1. Resident H's record was reviewed on 7/15/25 at 11:18 a.m. Diagnoses included, but were not limited to, diabetes mellitus, hypertension and cerebral infarction. The resident was admitted to the facility on 7/1/25.			

	There was no evidence or documentation of a Physician's annual statement the resident was free of infectious diseases. During an interview on 7/15/25 at 1:10 p.m., the Director of Nursing indicated all documents should be scanned into the computer. There was no additional information provided.			
R 0410	Infection Control - Noncompliance 410 IAC 16.2-5-12(e)(f)(g) (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.	R 0410	Wellness Director collect TB upon admission to the community. Executive Director and Wellness Director will audit yearly assessments needed and update in point click care during monthly QA meetings.	08/31/2025

Based on record review and interview, the facility failed to maintain an effective infection control program related to incomplete tuberculosis (TB) testing for 1 of 11 records reviewed. (Resident 3)

Finding includes:

Resident 3's record was reviewed on 7/14/25 at 1:28 p.m. Diagnoses included, but were not limited to, congestive heart failure, anemia and chronic kidney disease. The resident was admitted to the facility on 8/21/24.

A TB test was administered on 8/21/24. The test indicated the results should be checked in 48-72 hours. There was no indication or documentation the test results had been checked.

During an interview on 7/15/25 at 10:30 a.m., the Director of Nursing indicated they had no additional information for the resident.

Based on record review and interview, the facility failed to maintain an effective infection control program related to incomplete tuberculosis (TB) testing for 1 of 11 records reviewed. (Resident 3)

Finding includes:

	Resident 3's record was reviewed on 7/14/25 at 1:28 p.m. Diagnoses included, but were not limited to, congestive heart failure, anemia and chronic kidney disease. The resident was admitted to the facility on 8/21/24. A TB test was administered on 8/21/24. The test indicated the results should be checked in 48-72 hours. There was no indication or documentation the test results had been checked. During an interview on 7/15/25 at 10:30 a.m., the Director of Nursing indicated they had no additional information for the resident.			

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

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