

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/04/2026
NAME OF PROVIDER OR SUPPLIER COMMONS AT HONEY CREEK, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 1450 EAST CROSSING BOULEVARD, TERRE HAUTE, , 47802			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE	
R 0000	INITIAL COMMENTS This visit was for the Investigation of Intake 471311. Intake 471311- State deficiencies related to the allegations are cited at R0064. Survey date: September 4, 2026 Facility number: 015282 Residential Census: 69 This State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on September 17, 2026.	R 0000			
R 0064	Residents' Rights- Noncompliance 410 IAC 16.2-5-1.2(hh) (hh) The facility shall exercise reasonable care for the protection of residents ' property from loss and theft. The administrator or his	R 0064	R064 – It is the policy of The Commons at Honey Creek that Residents' Rights are observed and upheld in accordance with state and local requirements, including 410 IAC 16.2-5-1.2(hh). It is the policy of	09/22/2026	

or her designee is responsible for investigating reports of lost or stolen resident property and that the results of the investigation are reported to the resident.

Based on record review and interview, the facility failed to ensure residents' property was free from loss and/or theft (Residents B, C, D, E, F, and G).

Findings include:

On 9/4/26 at 10:00 a.m., a review of an Indiana Department of Health (IDOH) Reportable Incident document, dated 8/9/26 at 12:01 a.m., indicated Registered Nurse (RN) 3 had some concerns related to the documentation of several residents' as needed (PRN) medications that were signed off by RN 4 on their narcotic sheets. RN 3 notified the Director of Nursing (DON) on the morning of 8/9/26 and an investigation began. The preliminary investigations indicated residents denied requesting or receiving the PRN medication that was signed off by RN 4 on their narcotic sheets.

1. Resident B's record was reviewed on 9/4/26 at 10:05 a.m. The profile indicated the resident's diagnoses included, but were not limited to, generalized anxiety disorder (a

The Commons at Honey Creek that the community shall exercise reasonable care for the protection of residents' property from loss and theft.

1. What corrective action will be accomplished for those residents found to be affected by the deficient practice?
 1. Investigation was immediately initiated including record reviews, staff interviews, and resident interviews. Suspected staff member was suspended pending investigation. All notifications were complete to include resident, family, PCP, pharmacy, IDOH, Vigo Co. Sheriffs Dept., Medicaid Waiver Incident reports for each resident, APS reports, and AG notification. All staff members were educated on Abuse Identification, Prevention, and Reporting, Shift to Shift Narcotic Counts, and Controlled Medication Guidance. Medications identified were replaced via

mental health condition marked as constant, extreme worry, and panic about everyday things like work, health, or money that is hard to control) and radiculopathy, lumbar region (pinched or irritated nerve root in the lower back that causes pain, numbness, or weakness radiating down the leg).

An assisted living Brief Interview for Mental Status (BIMS) assessment, completed on 8/3/26, indicated the resident was cognitively intact.

A Controlled Substance Record for Resident B, dated 8/1/26, indicated the facility had received 30 tablets of hydrocodone-Acetaminophen (pain medication) 5/325mg (milligram). RN 4 signed off one tablet of the pain medication on 8/9/26 at 3:00 a.m. The resident's Medication Administration Record (MAR) lacked documentation that the pain medication had been administered to the resident on 8/9/26 at 3:00 am. by RN 4 or any other licensed staff.

A Controlled Substance Record for Resident B, dated 4/15/26, indicated the facility had received 30 tablets of alprazolam (anti-anxiety medication) 0.25mg. RN 4 had signed off one tablet of the medication on 8/8/26 at 12:00 a.m. The Controlled Substance

physician order at the community's expense.

2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?
 1. A complete record review was completed to identify any additional PRN narcotics administered
 2. Staff member suspended pending investigation and ultimately terminated for refusing to cooperate with investigation.
3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not re-occur?
 1. All staff members were educated on Abuse Identification, Prevention, and Reporting, Shift to Shift Narcotic Counts, and Controlled Medication Guidance.
 2. New hires receive education during General Orientation.
4. How the corrective action will be monitored to

Record indicated the last time the resident received the anti-anxiety medication was on 5/31/26. The resident's MAR lacked documentation that the anti-anxiety medication had been administered to the resident on 8/8/26 at 12:00 a.m. by RN 4 or any other licensed staff.

Review of a written statement on 8/8/26, Resident B indicated she did not ask for or receive any pain or anti-anxiety medication from RN 4. She denied ever requesting PRN medications on the night of 8/8/26 to the morning of 8/9/26.

2. Resident C's record was reviewed on 9/4/26 at 10:40 a.m. The profile indicated the resident's diagnoses included, but were not limited to, multiple fractures of ribs, left side, pain in right shoulder, and chronic viral hepatitis C (a long-term liver infection caused by a virus that stays in the body for longer than 6 months).

An assisted living Brief Interview for Mental Status (BIMS) assessment, completed on 5/4/26, indicated the resident was cognitively intact.

A Controlled Substance Record for Resident C, dated 7/24/26, indicated the facility had received 30 tablets of oxycodone-acetaminophen

ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?

1. The Executive Director, Director of Nursing will complete the Drug Diversion Quality Tool for review weekly for 4 weeks and monthly for 3 months and reviewed at the QAPI meeting.
5. By what date the systemic changes will be completed?
 1. All systemic changes, staff education, and implementation of monitoring process was completed 8/29/26.

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(pain medication) 5/325 mg (milligram). RN 4 signed off one tablet on 8/9/26 at 1:13 a.m. and a second tablet on 8/9/26 at 5:45 a.m. The resident's Medication Administration Record (MAR) lacked documentation that the pain medication was administered to Resident C on 8/9/26 at 1:13 a.m. or 5:45 a.m. by RN 4 or any other licensed staff.

Review of a written statement on 8/9/26, Resident C indicated he did not request or receive any pain medication from RN 4. He indicated he normally refused it because it made him constipated. He further indicated he never requested pain medication.

3. Resident D's record was reviewed on 9/4/26 at 11:00 a.m. The profiled indicated the resident's diagnoses included, but were not limited to, depression (a common or serious mood disorder that causes on going sadness and loss of interest in things you once enjoyed), presence of left artificial knee(a person that undergoes knee replacement surgery and now has a medical implant, or prothesis, inside their body replacing parts of the natural knee), and anxiety (a normal human emotion characterized by feelings of tension, worried thoughts, and

physical changes like a fast heartbeat).

Review of a Brief Interview for Mental Status (BIMS) assessment, dated 5/1/26, indicated the resident had moderate cognitive impairment.

Review of a Narcotic Count Sheet for Resident D dated 8/1/26, indicated the facility had 42 tablets of oxycodone-acetaminophen (pain medication) 10/325 mg (milligram). RN 4 signed off one tablet on 8/9/26 at 12:13 a.m. and one tablet on 8/9/26 at 4:30 a.m. The Medication Administration Record (MAR) for the resident lacked documentation that the pain medication was administered to Resident D on 8/9/26 at 12:13 a.m. or 8/9/26 at 4:30 a.m. by RN 4 or another licensed staff. The MAR did show one was administered at 12:37 a.m. on 8/9/26 by RN 4.

Review of a Narcotic Count Sheet for Resident D dated 8/3/26 indicated the facility had 29 tablets of alprazolam (anti-anxiety medication) 1mg. RN 4 signed off one tablet on 8/7/26 at 11:15 p.m. and one tablet on 8/8/26 at 11:45 p.m. The MAR lacked document that the anti-anxiety medication had been administered to Resident D on 8/7/26 at 11:15 p.m. or 8/8/26 at 11:45 p.m. The facility

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time sheet lacked documentation that RN 4 worked on the night of 8/7/26.

Review of a written statement on 8/9/26, Resident D indicated she did not request or receive any pain medication from RN 4. The resident did verify she received an anti-anxiety medication on 8/8/26 at around 11:15 p.m. from RN 4.

4. Resident E's record was reviewed on 9/4/26 at 11:10 a.m. The profile indicated the resident's diagnoses included, but were not limited to, generalized anxiety disorder (a mental health condition marked by chronic, excessive, and uncontrollable worry about everyday things like work, health, family or money), major depressive disorder (a common and serious mood disorder that causes a persistent feeling of sadness, emptiness, and loss of interest in activities you once enjoyed), and chronic obstructive pulmonary disease (COPD- a long-term lung condition that makes breathing hard by blocking airflow and damaging lung tissue).

Review of a Brief Interview for Mental Status (BIMS) assessment, dated 5/7/26, indicated the resident was cognitively intact.

Review of a Narcotic Count

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Sheet for Resident E, dated 8/5/26, indicated the facility had 90 tablets of alprazolam (anti-anxiety medication) 0.25 mg (milligram). RN 4 signed off one tablet on 8/9/26 at 2:00 a.m. The Medication Administration Record (MAR) for Resident E lacked documentation that the anti-anxiety was administered to the resident on 8/9/26 at 2:00 a.m. by RN 4 or any other licensed staff.

Review of a Narcotic Count Sheet for Resident E, dated 5/4/26, indicated the facility had 21 tablets of Hydrocodone-Acetaminophen (pain medication) 5/325mg (milligram). RN 4 had signed off one tablet on 8/9/26 at 2:15 a.m. The Medication Administration Record (MAR) for Resident E lacked documentation that the pain medication was administered to the resident on 8/9/26 at 2:14 a.m. by RN 4 or any other licensed staff.

Review of a written statement on 8/9/26, Resident E indicated she did not request or receive an anti-anxiety medication from RN 4 on 8/9/26 at 2:15 a.m. because it was ordered as a scheduled mediation and she takes it at 8 p.m. She did not have an as needed (PRN) order. Resident E indicated she

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did not request or receive any pain medication from RN 4 on 8/9/26. The last pain medication should could remember taking was on Thursday night 8/6/26.

5. Resident Fs record was reviewed on 9/4/26 at 11:20 a.m. The profile indicated the resident's diagnoses included, but were not limited to, localized edema (swelling to a particular area), fusion of spine, cervical region (permanently joining two mor more neck bones together so they heal into a single solid piece of bone), and sciatica (describes pain, numbness, or tingling caused by compression, irritation, or inflammation of a nerve root in the lower back).

Review of a Brief Interview for Mental Status (BIMS) assessment, dated 6/16/26, indicated the resident was cognitively intact.

A Controlled Substance Record for Resident F, dated 7/13/26, indicated the facility had received 52 tablets of Alprazolam (anti-anxiety medication) 0.25mg (milligram). RN 4 signed off one tablet on 8/8/26 at 11:30 p.m. The Medication Administration Record (MAR) for Resident F lacked documentation that the anti-anxiety medication was administered to the resident on 8/8/26 at 11:30 p.m. by RN 4 or any other licensed staff. There

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was one Alprazolam administered to Resident F by RN 4 at 7:29 p.m. on 8/8/26.

Review of a written statement on 8/9/26, Resident F indicated she did receive one anti-anxiety medication from RN 4 on 8/8/26 at around 8:30-9:00 p.m. to help her sleep.

6. Resident Gs record was reviewed on 9/4/26 at 11:30 a.m. The profile indicated the resident's diagnoses included, but were not limited to, age related osteoporosis (a condition where bones become thin, weak, and more likely to break because old bone breaks down faster than the body can build new ones) and chronic obstructive pulmonary disease (COPD- a long-term lung condition that makes breathing hard by blocking airflow and damaging lung tissue).

An assisted living Brief Interview for Mental Status (BIMS) assessment completed on 8/3/26, indicated the resident was cognitively intact.

A Controlled Substance Record for Resident G dated 7/23/26 indicated the facility had received 90 tablets of Oxycodone-Acetaminophen (pain medication) 5/325mg (milligram). RN 4 signed off one tablet on 8/8/26 at 4:00 a.m. The Medication Administration

Record (MAR) for Resident G lacked documentation that the pain medication was administered to the resident on 8/8/26 at 4:00 a.m. by RN 4 or any other licensed staff. The facility time sheet also lacked documentation that RN 4 was at work on 8/8/26 at 4:00 a.m.

Review of a written statement on 8/9/26, Resident G indicated she did request or receive any pain medication from RN 4 on the night of 8/8/26 or the morning of 8/9/26.

During an interview with the Director of Nursing (DON) on 9/4/26 at 10:17 a.m., the DON indicated she had received a phone call from RN 3 (who was the weekend nurse) on 8/9/26 at around 8:30 a.m. RN 3 was concerned that some of the medications that were signed off by RN 4 on the narcotic sheets were not usually given or requested by the residents and was outside of the normal routine. The DON proceeded to alert the Executive Director (ED) of the concerns, and they requested RN 3 to go through all the narcotic sheets and begin to interview residents and staff. The DON and ED indicated they came into the facility that morning to assist with the investigation. RN 4 was suspended pending an investigation on 8/9/26. All

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residents who were involved were interviewed. A police report was also filed because during their investigation they found that narcotics were signed off by RN 4 but were not documented as being administered on the residents' MAR record. All residents denied requesting or receiving the medication as signed off on the narcotic sheet by RN 4. The DON and ED made several attempts to reach RN 4 and have her return to the facility so they could discuss the pending investigation and for a drug test. The RN did not outright refuse to come back to the facility, but she never showed up either as requested. The RN was terminated from her employment with the facility on 8/11/26. During the investigation the facility discovered there were 6 residents affected and 12 medications were signed out as given.

During an interview with the ED on 9/4/26 at 10:45 a.m., the ED indicated RN 4 had been out on leave for a while due to an injury not associated with work and she had to have surgery. The ED indicated she had admitted being on pain medication due to her arm. The nurse had returned to the facility on day shift after her leave and worked two days a week 16-hour shifts. She had picked up a night shift

on 8/8/26 which was not her usual shift to work.

Review of pay period sheet, dated 8/2/26 to 8/15/26, indicated RN 4 clocked in on 8/8/26 at 10:18 p.m. and clocked out at 6:12 a.m. She worked a total of 7.9 hours.

A signed statement, dated 8/9/26, indicated RN 3 noticed that several narcotics were signed out and they did not have orders for those times. Resident D requested a PRN pain medication at 7:30 a.m. on 8/9/26 and the narcotic record showed there was one already signed out at 4:30 a.m. Resident D denied she got a dose at 4:30 a.m.

A signed statement, dated 8/9/26, indicated Qualified Medication Aide (QMA) 5 indicated she had noticed Resident E had an anxiety medication signed off at 2:00 a.m. and when she gave the resident her 8:00 a.m. medication she asked if she had received one at 2:00 a.m. from RN 4, the resident denied that she received one at 2:00 a.m.

On 9/4/26 at 4:04 p.m., the ED provided a document with a revised date of 12/17. Titled, "Resident Bill of Rights," and indicated it was the current policy being used by the facility. The policy indicated, " ...(hh)

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	The Community shall exercise reasonable care for the protection of residents' property from loss and theft. The General Manager/Executive Director or his or her designee is responsible for investigation reports of lost or stolen resident property and that the results of the investigation are reported to the residents"			
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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 SIGNATUREErin Brown	TITLE9/29/26	(X6) DATE09/29/2026
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