STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITA OF GREENFIELD	1683 COMMUNITY WAY, GREENFIELD, , 46140

(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 Intakes IN00465531, IN00465540 and IN00465661. Intake IN00465531 - State deficiencies related to the allegations are cited at R0091, R0241 and R0349. Intake IN00465540 - State deficiency related to the allegations is cited at R0052. Intake IN00465661 - State deficiency related to the allegations is cited at R0052. Survey dates: October 22, 23 and 24, 2025 Facility number: 016063 Residential Census: 87 These State Residential findings are cited in accordance with 410 IAC 16.2-5.	R 0000	Preparation and submission of this Plan of Correction is not an admission of wrongdoing or agreement with the survey findings. It describes the steps Vita has taken or will take to achieve and maintain compliance.	

	Quality review completed on October 31, 2025.			
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on observation, interview, and record review, the facility failed to prevent the neglect of Resident C, due to lack of appropriate supervision when a resident followed a staff member out of a secured door of the memory care unit (MCU) which allowed him to exit the building and later be found by a member of the community 0.8 miles from the facility. The facility staff were unaware of Resident C being missing for over one hour. This lack of appropriate supervision had the potential to place this resident at risk of injury, exposure or death. (Resident C) Findings include:	R 0052	Residents affected: All MC residents are potentially affected. ED/ DON/ Maintenance/ Designee will perform elopement drills quarterly or more often as needed to ensure safety of MC residents. All staff with resident contact will receive in-service training on: Elopement prevention and response. Responsibilities for monitoring at risk residents and for not permitting residents to exit with them. Immediate steps to take if a resident is missing DON/Designee will complete a weekly audit for 4 weeks, then monthly for 3 months to ensure: All residents have a current elopement risk assessment per policy.	11/24/2025

	The clinical record of Resident C was reviewed on 10-22-25 at 12:40 p.m. His diagnoses included, but were not limited to vascular dementia, mild cognitive impairment, mononeuropathy of the lower extremities and legally blind. It indicated he was admitted to the facility on 10-13-25. It indicated his SLUMS (Saint Louis University Mental Status) score, dated 10-15-25, was indicative of mild cognitive impairment. It indicated he was a moderate risk for elopement. It indicated he was ambulatory without balance issues but did use a wheelchair. It indicated he was a moderate fall risk with a history of one to two falls in the last year. His initial/ pre-admission, individualized service plan, dated 10-15-25, indicated he was admitted to the facility's secured memory care unit, would be monitored for elopement, would be redirected and reminded of surroundings as needed to keep the resident safe and happy, required assistance as needed to decrease his anxiety and agitation to promote his quality of life, required stand-by assistance for transfers with standing as needed and indicated he was legally blind in the left eye. The facility submitted an initial report of an unusual occurrence to the Indiana Department of		Door/exit alarms are completed and checked per schedule, and any issues are followed up promptly Residents that are identified as at-risk have appropriate interventions on their care/service plan The community has made arrangements to have Wander Guard system installed on 11/24/25. MC staff are completing hourly checks on residents from 6am to 10pm with head count . From 10pm - 6am, 2 hour rounding on MC unit. Checks and head count will continue until Wander Guard installed.	

	Health's (IDOH) Long Term Care Division on 10-17-25 at 7:42 p.m., which indicated Resident C had eloped (left the nursing facility without the nursing staff's permission or knowledge, usually related to a resident's impaired cognition which can place the resident at risk of injury, exposure or death) from the facility's secured MCU earlier the same evening as he "followed [an] employee out of side door." It did not indicate the particular circumstances of the elopement. However, it did indicate he did not have any injuries and the resident's POA (power of attorney), medical provider and the police and fire department were notified of the event. In an interview on 10-22-25 at 2:24 p.m., with the Regional Director of Operations (RDO), she indicated Resident C was found on the evening of 10-17-25, approximately one mile from the facility. She indicated the resident was out of the building more than one hour and was returned to the building by the daughter/POA. The RDO indicated the resident followed Licensed Practical Nurse (LPN) 6, out of the building from the memory care unit and the nurse apparently did not notice the resident following her out of the building. In an interview on 10-23-25 at			

	12:10 p.m., with the daughter/POA, she indicated she received a call on 10-17-25 around 6:30 p.m., from her father's cell phone. She indicated "a good Samaritan," noticed her father seemed lost and stopped to help him. She indicated her father was at a traffic circle, not far from the facility. She indicated the man who found her father said that her father was unable to tell him his name, where he lived or who to call for family. "So they were just calling names on dad's cell phone and thankfully, my name and number were near the top of the phone list." She recalled by the time she received this call, the man had already called 911. She added by the time she arrived on the scene, emergency medical staff (EMS) was already on site. She clarified her father was not taken to the hospital or police department from the location in which he was found and remained on site where he was located by the community member until she returned him back to the facility. She additionally clarified her father had walked to that location and did not have a walker or wheelchair with him, and that he can, in fact, walk, just does so very slowly. She indicated the facility told her the resident was able "to piggyback on a nurse who walked out the door and the door apparently did not latch			

	properly after the nurse went out the door." The daughter/POA recalled the weather the evening of 10-17-25, "was nice, a little cool and was around dusk time." She indicated she was not aware of any issues with Resident C exit-seeking while at home, prior to admission to the nursing facility. During an interview with LPN 6 on 10-23-25 at 2:56 p.m., she recalled on the evening of 10-17-25, she was the only nurse in the building for the facility. She indicated somewhere around 5:00 p.m. to 5:30 p.m., she needed to go over to the other portion of the facility. "Before I left the [MCU] floor, I remember seeing the resident down the hall, I would guess about where the med room is located. He was just standing in the hall, not using any equipment. He was able to walk pretty good in my opinion. He was just standing in the hall, not really doing anything. I used my badge to get the door open/unlocked and went to the [other portion of the facility]. From what I have been told since, apparently that door does not shut completely." LPN 6 indicated she recalled seeing the resident having dinner with his daughter on the unit around 4:00 p.m. She recalled being called/paged "to the front desk somewhere between 6:00 p.m.-7:00 p.m., but not sure of			

	the exact time." She indicated the receptionist told her she had received a call from the local police department "that they had a resident of ours and that he was there with his daughter." LPN 6 indicated the daughter was who returned him to the facility sometime between 7:00 p.m. and 8:00 p.m. LPN 6 indicated upon his return to the facility, she did conduct a "head to toe assessment and found a few scratches, but they looked like they were not necessarily new ones and I did chart all of this." LPN 6 recalled she and the daughter helped Resident C get ready for bed and the resident did not make any comments at all about being gone or how he was feeling at the time. LPN 6 indicated she initiated the one on one (1:1) monitoring and the every 15 minute checks for his safety at that point. "I worked a double that night and was with him until 7am, the next morning. He slept the whole night." During the in-person interview with LPN 6, she conducted a re-enactment of the elopement of Resident C, at the location of the MCU's west door. She utilized her key fob to unlock the door from the MCU to the vestibule. The secured door unlocked and an audible alarm was heard until the door closed and locked. LPN 6 indicated the second door, in the vestibule,			

goes to an unsecured area of the property and was able to be accessed when door handle bar was pushed. Another door in the vestibule, exits into the other portion of the building and this was the door she indicated which she used on the evening of 10-17-25. This door was secured from the exterior, but not secured/was unlocked from the vestibule to the outside.

On 10-23-25 at 12:54 p.m., the RDO provided copies of the facility's camera footage of the MCU west exit door from 10-17-25 around 5:20 p.m. Upon reviewing the camera footage, the following was observed from 10-17-25:

-5:20:34 p.m. - LPN 6 was observed to approach the MCU's west exit door. In the background, Resident C was observed standing in the hallway with a rollator near him.

-5:20:38 p.m. - LPN 6 was observed to use her key fob to unlock the door to the vestibule. LPN 6 was observed to look behind her immediately prior to opening.

-5:20:40 p.m. - LPN 6 was observed to exit the MCU via this door. LPN 6 was not observed to look behind her after exiting door.

-5:20:42 p.m. - The west exit door was observed to shut

behind LPN 6. LPN 6 was observed to turn to her right after entry into the vestibule and then moved out of the camera's view. Resident C was observed to walk towards the west exit door.

-5:20:44 p.m. - Resident C was observed to place his hands on the door's bar handle and push on it, causing it to open.

-5:20:49 p.m. - Resident C was observed to open the door wide enough to exit through the door and both feet were visible and into the vestibule.

-5:20:52 p.m. - Resident C was observed to turn around and face the door he exited, as he closed the door.

-5:21:00 p.m. - Resident C was observed to no longer be in the camera footage as he walked towards the second door in the vestibule, leading to the outside.

-5:21:55 p.m. - LPN 6 was observed to return to the MCU, utilizing the same west exit door. LPN 6 was then observed to locate the rollator, near the location of where Resident C initially was located at 5:20:34 p.m., and moved it down the hall and out of the camera view.

-Total time elapsed from the time the resident was observed from down the hallway near the MCU's west exit door to leaving

	facility was 26 seconds. In an observation on 10-23-25 at 4:00 p.m., a mileage calculation was conducted for the distance Resident C traveled from the parking lot near the MCU's west door to the traffic circle at the intersection of where Resident C was found by a community member. From the parking lot to the stop sign at Blue Road, immediately north and west of the facility, was measured at 0.3 miles. This area had easily accessible sidewalks and/or walking paths on both sides of the street on Blue Road. The remaining 0.5 miles of roadway, located on New Road, did not have sidewalks or walking paths on either side of the road and the roadway has substantial traffic. On 10-24-25 at 9:30 a.m., an observation of the MCU's west door was conducted with the RDO to verify its functioning. The RDO was observed to utilize her key fob to gain access from the unsecured portion of the building to the vestibule of the west door. After entering the MCU at this location, the door was verified to be securely closed and locked by pushing on the bar handle and it did not unlock. In an interview on 10-24-25 at 11:33 a.m., with the RDO, she indicated the facility's contracted			

	door security company did come into the facility on 10-20-25 to verify the MCU's west door was functioning correctly with no concerns. She provided documentation at that time that the facility had obtained a written quote for the installation of a "wander protection" system to assist in monitoring of residents who have a past or current history of exit-seeking or elopement. She indicated this system was expected to arrive within the next few weeks. She indicated the facility has not experienced any other elopements from the facility since 7-4-25. On 10-23-25 at 12:20 p.m., the RDO provided a copy of a policy, dated 7-10-25, and entitled "Elopement Policy." This policy indicated, "The purpose of this policy is to establish guidelines for preventing, managing, and responding to elopement incidents involving residents. Residents in Assisted Living may be at risk for elopement due to cognitive or physical impairments. Vita is committed to identifying at-risk residents, implementing preventative measures, and ensuring an immediate and coordinating response to elopement incidents. Definition: Elopement: The act of a resident leaving the premises unsupervised or unnoticed posing a risk to their			

	safety...Resident Assessment: All Residents will be assessed for elopement risk upon admission and during regular care plan reviews. The assessment includes: Cognitive impairments (e.g., dementia, Alzheimer's); Behavioral history (e.g., past elopement attempts); Physical ability to exit the premises unsupervised; Documentation of risk assessments and individualized care plans for at risk residents will be maintained in the resident's record. Staff Training: Staff will receive training upon hire and annually on: Recognizing elopement risks; Protocols for monitoring, preventing, and responding to elopement systems...Prevention Measures: Exit doors will be equipped with alarms, locks or keypads as allowed by state regulations. Security cameras will monitor entry and exit points..." This Residential tag relates to Intakes IN00465540 and IN00465661. Based on observation, interview, and record review, the facility failed to prevent the neglect of Resident C, due to lack of appropriate supervision when a resident followed a staff member out of a secured door of the memory care unit (MCU) which allowed him to exit the building and later be found by a			

	member of the community 0.8 miles from the facility. The facility staff were unaware of Resident C being missing for over one hour. This lack of appropriate supervision had the potential to place this resident at risk of injury, exposure or death. (Resident C) Findings include: The clinical record of Resident C was reviewed on 10-22-25 at 12:40 p.m. His diagnoses included, but were not limited to vascular dementia, mild cognitive impairment, mononeuropathy of the lower extremities and legally blind. It indicated he was admitted to the facility on 10-13-25. It indicated his SLUMS (Saint Louis University Mental Status) score, dated 10-15-25, was indicative of mild cognitive impairment. It indicated he was a moderate risk for elopement. It indicated he was ambulatory without balance issues but did use a wheelchair. It indicated he was a moderate fall risk with a history of one to two falls in the last year. His initial/ pre-admission, individualized service plan, dated 10-15-25, indicated he was admitted to the facility's secured memory care unit, would be monitored for elopement, would be redirected and reminded of surroundings as needed to keep the resident safe and happy, required			

assistance as needed to decrease his anxiety and agitation to promote his quality of life, required stand-by assistance for transfers with standing as needed and indicated he was legally blind in the left eye.

The facility submitted an initial report of an unusual occurrence to the Indiana Department of Health's (IDOH) Long Term Care Division on 10-17-25 at 7:42 p.m., which indicated Resident C had eloped (left the nursing facility without the nursing staff's permission or knowledge, usually related to a resident's impaired cognition which can place the resident at risk of injury, exposure or death) from the facility's secured MCU earlier the same evening as he "followed [an] employee out of side door." It did not indicate the particular circumstances of the elopement. However, it did indicate he did not have any injuries and the resident's POA (power of attorney), medical provider and the police and fire department were notified of the event.

In an interview on 10-22-25 at 2:24 p.m., with the Regional Director of Operations (RDO), she indicated Resident C was found on the evening of 10-17-25, approximately one mile from the facility. She indicated the resident was out of

	the building more than one hour and was returned to the building by the daughter/POA. The RDO indicated the resident followed Licensed Practical Nurse (LPN) 6, out of the building from the memory care unit and the nurse apparently did not notice the resident following her out of the building. In an interview on 10-23-25 at 12:10 p.m., with the daughter/POA, she indicated she received a call on 10-17-25 around 6:30 p.m., from her father's cell phone. She indicated "a good Samaritan," noticed her father seemed lost and stopped to help him. She indicated her father was at a traffic circle, not far from the facility. She indicated the man who found her father said that her father was unable to tell him his name, where he lived or who to call for family. "So they were just calling names on dad's cell phone and thankfully, my name and number were near the top of the phone list." She recalled by the time she received this call, the man had already called 911. She added by the time she arrived on the scene, emergency medical staff (EMS) was already on site. She clarified her father was not taken to the hospital or police department from the location in which he was found and remained on site where he was located by the community			

	member until she returned him back to the facility. She additionally clarified her father had walked to that location and did not have a walker or wheelchair with him, and that he can, in fact, walk, just does so very slowly. She indicated the facility told her the resident was able "to piggyback on a nurse who walked out the door and the door apparently did not latch properly after the nurse went out the door." The daughter/POA recalled the weather the evening of 10-17-25, "was nice, a little cool and was around dusk time." She indicated she was not aware of any issues with Resident C exit-seeking while at home, prior to admission to the nursing facility. During an interview with LPN 6 on 10-23-25 at 2:56 p.m., she recalled on the evening of 10-17-25, she was the only nurse in the building for the facility. She indicated somewhere around 5:00 p.m. to 5:30 p.m., she needed to go over to the other portion of the facility. "Before I left the [MCU] floor, I remember seeing the resident down the hall, I would guess about where the med room is located. He was just standing in the hall, not using any equipment. He was able to walk pretty good in my opinion. He was just standing in the hall, not really doing anything. I used my badge to get the door			

	open/unlocked and went to the [other portion of the facility]. From what I have been told since, apparently that door does not shut completely." LPN 6 indicated she recalled seeing the resident having dinner with his daughter on the unit around 4:00 p.m. She recalled being called/paged "to the front desk somewhere between 6:00 p.m.-7:00 p.m., but not sure of the exact time." She indicated the receptionist told her she had received a call from the local police department "that they had a resident of ours and that he was there with his daughter." LPN 6 indicated the daughter was who returned him to the facility sometime between 7:00 p.m. and 8:00 p.m. LPN 6 indicated upon his return to the facility, she did conduct a "head to toe assessment and found a few scratches, but they looked like they were not necessarily new ones and I did chart all of this." LPN 6 recalled she and the daughter helped Resident C get ready for bed and the resident did not make any comments at all about being gone or how he was feeling at the time. LPN 6 indicated she initiated the one on one (1:1) monitoring and the every 15 minute checks for his safety at that point. "I worked a double that night and was with him until 7am, the next morning. He slept the whole night."			

	During the in-person interview with LPN 6, she conducted a re-enactment of the elopement of Resident C, at the location of the MCU's west door. She utilized her key fob to unlock the door from the MCU to the vestibule. The secured door unlocked and an audible alarm was heard until the door closed and locked. LPN 6 indicated the second door, in the vestibule, goes to an unsecured area of the property and was able to be accessed when door handle bar was pushed. Another door in the vestibule, exits into the other portion of the building and this was the door she indicated which she used on the evening of 10-17-25. This door was secured from the exterior, but not secured/was unlocked from the vestibule to the outside. On 10-23-25 at 12:54 p.m., the RDO provided copies of the facility's camera footage of the MCU west exit door from 10-17-25 around 5:20 p.m. Upon reviewing the camera footage, the following was observed from 10-17-25: -5:20:34 p.m. - LPN 6 was observed to approach the MCU's west exit door. In the background, Resident C was observed standing in the hallway with a rollator near him. -5:20:38 p.m. - LPN 6 was observed to use her key fob to			

unlock the door to the vestibule. LPN 6 was observed to look behind her immediately prior to opening.

-5:20:40 p.m. - LPN 6 was observed to exit the MCU via this door. LPN 6 was not observed to look behind her after exiting door.

-5:20:42 p.m. - The west exit door was observed to shut behind LPN 6. LPN 6 was observed to turn to her right after entry into the vestibule and then moved out of the camera's view. Resident C was observed to walk towards the west exit door.

-5:20:44 p.m. - Resident C was observed to place his hands on the door's bar handle and push on it, causing it to open.

-5:20:49 p.m. - Resident C was observed to open the door wide enough to exit through the door and both feet were visible and into the vestibule.

-5:20:52 p.m. - Resident C was observed to turn around and face the door he exited, as he closed the door.

-5:21:00 p.m. - Resident C was observed to no longer be in the camera footage as he walked towards the second door in the vestibule, leading to the outside.

-5:21:55 p.m. - LPN 6 was

	observed to return to the MCU, utilizing the same west exit door. LPN 6 was then observed to locate the rollator, near the location of where Resident C initially was located at 5:20:34 p.m., and moved it down the hall and out of the camera view. -Total time elapsed from the time the resident was observed from down the hallway near the MCU's west exit door to leaving facility was 26 seconds. In an observation on 10-23-25 at 4:00 p.m., a mileage calculation was conducted for the distance Resident C traveled from the parking lot near the MCU's west door to the traffic circle at the intersection of where Resident C was found by a community member. From the parking lot to the stop sign at Blue Road, immediately north and west of the facility, was measured at 0.3 miles. This area had easily accessible sidewalks and/or walking paths on both sides of the street on Blue Road. The remaining 0.5 miles of roadway, located on New Road, did not have sidewalks or walking paths on either side of the road and the roadway has substantial traffic. On 10-24-25 at 9:30 a.m., an observation of the MCU's west door was conducted with the RDO to verify its functioning. The RDO was observed to			

	utilize her key fob to gain access from the unsecured portion of the building to the vestibule of the west door. After entering the MCU at this location, the door was verified to be securely closed and locked by pushing on the bar handle and it did not unlock. In an interview on 10-24-25 at 11:33 a.m., with the RDO, she indicated the facility's contracted door security company did come into the facility on 10-20-25 to verify the MCU's west door was functioning correctly with no concerns. She provided documentation at that time that the facility had obtained a written quote for the installation of a "wander protection" system to assist in monitoring of residents who have a past or current history of exit-seeking or elopement. She indicated this system was expected to arrive within the next few weeks. She indicated the facility has not experienced any other elopements from the facility since 7-4-25. On 10-23-25 at 12:20 p.m., the RDO provided a copy of a policy, dated 7-10-25, and entitled "Elopement Policy." This policy indicated, "The purpose of this policy is to establish guidelines for preventing, managing, and responding to elopement incidents involving residents. Residents in Assisted			

	Living may be at risk for elopement due to cognitive or physical impairments. Vita is committed to identifying at-risk residents, implementing preventative measures, and ensuring an immediate and coordinating response to elopement incidents. Definition: Elopement: The act of a resident leaving the premises unsupervised or unnoticed posing a risk to their safety...Resident Assessment: All Residents will be assessed for elopement risk upon admission and during regular care plan reviews. The assessment includes: Cognitive impairments (e.g., dementia, Alzheimer's); Behavioral history (e.g., past elopement attempts); Physical ability to exit the premises unsupervised; Documentation of risk assessments and individualized care plans for at risk residents will be maintained in the resident's record. Staff Training: Staff will receive training upon hire and annually on: Recognizing elopement risks; Protocols for monitoring, preventing, and responding to elopement systems...Prevention Measures: Exit doors will be equipped with alarms, locks or keypads as allowed by state regulations. Security cameras will monitor entry and exit points..." This Residential tag relates to			

	Intakes IN00465540 and IN00465661.			
R 0091	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(h)(1-4) (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request. Based on interview and record review, the facility failed to develop and implement a policy regarding safe administration of medication by a family while a resident was still admitted to the facility for 1 of 3 residents reviewed for safe medication administration. (Resident B) Findings include: The clinical record for Resident B was reviewed on 10/22/2025 at 12:45 p.m. The medical diagnoses included senile degeneration of the brain and	R 0091	All Residents Potentially Affected. On 10/20/2025, the DON/RCC and Executive Director reviewed Resident's medication orders, MAR, and the circumstances of family involvement in medication administration. Remaining medications were reconciled and handled per facility/hospice policy with storage/return/destruction documented. On 10/20/2025, the DON/RCC audited all current residents to identify anyone with family involvement in administering medications. Effective 10/20/2025, Vita paused all family/legal representative administration of medications for all residents. For any residents previously affected, orders, MARs, and service plans were updated to show that only facility staff and/or hospice staff now administer medications. Vita has paused	11/24/2025

	depression. The individual service plan for Resident B, revised on 10/16/2025, indicated " ...POA [power of attorney] taking over administration of medication..." No documentation in the clinical record, on 10/16/2025, indicated Family Member 17 was assessed or educated for safe administration of medications. During an interview on 10/22/2025 at 2:45 p.m., Qualified Medication Aide (QMA) 3 indicated she was working on 10/16/2025. Around 6:00 p.m., Family Member 17 came up to the nurses' station and stated Administrator had given permission for Family Member 17 to administer comfort medications to Resident B. Family Member 17 put her phone in QMA 3's face to show a text message. QMA 3 said she would need to verify with the Director of Nursing (DON) and went to the DON's office. The DON verified with the Administrator that the Administrator had given permission for Family Member 17 to administer comfort medications via phone. The DON and QMA 3 went back to the unit, signed out all controlled substances. The DON took the controlled substance logs and medications to Resident B's room. Family Member 17		family administration and will not allow it again until a safe, compliant process is in place. Vita currently developing a written policy, “Medication Administration by Family/Legal Representatives While Resident Is Admitted,” that addresses: • When/if family administration is permitted. • Required provider orders specifying which medications can be administered by family. • Nursing assessment and approval of family ability to administer safely. • Storage, accountability (including controlled substances), and documentation requirements. • Criteria and process to discontinue family administration if safety concerns arise. The DON/Designee to audit weekly for 4 weeks, then monthly for 3 months to confirm: • No medications are being administered by family/legal representatives outside of the approved policy. • MARs show medications are administered by facility and/or hospice staff only. - Any	

	refused control of all controlled substances except for three tablets of Ativan, one full 30 milliliter (mL) bottle of morphine, and one opened bottle of morphine with 8 mL remaining. QMA 3 watched the DON sign the sheets over to Family Member 17 but then left the room to go secure the controlled substances Family Member 17 had refused. During an interview on 10/23/2025 at 12:40 p.m., the DON indicated, on 10/16/2025, QMA 3 came to her office stating that Family Member 17 wanted to administer medication to Resident B. The DON then called the Administrator to verify this, and recalled the Administrator said, " ...if you're okay with it ..." Family Member 17 was a former employee of the corporation and a practicing nurse, so the DON stated she felt comfortable allowing the administration of medication. The DON then went to the unit with QMA 3, signed out the controlled substances and took the logs to Resident B's room. The DON verified no copies of the original sheets were retained by the facility. When the DON was signing over medications to Family Member 17, Family Member 17 refused some medication. The refused medications were given back to QMA 3 to secure. The DON verified she did not assess		noncompliance will be corrected immediately with staff re-education and discontinuation of any family administration. - Audit results will be reviewed at least monthly for 3 months, or longer if needed. In-service for all clinical employees on safe medication administration and family/legal representative involvement on 11/19/25.	

Family Member 17 for safe medication administration or provide education to current physician's order of morphine or Ativan to Family Members under the pretense that Family Member 17 was an actively practicing nurse.

During an interview on 10/23/2025 at 1:08 p.m., the Administrator indicated the facility did not have a policy regarding safe administration of medication completed by family members while residents were residing in the facility and did not have any other circumstances of family members administering medications while residents were in the facility. The Administrator stated the facility will be developing policies and procedures for future circumstances.

This citation relates to Intake IN00465531.

Based on interview and record review, the facility failed to develop and implement a policy regarding safe administration of medication by a family while a resident was still admitted to the facility for 1 of 3 residents reviewed for safe medication administration. (Resident B)

Findings include:

The clinical record for Resident B was reviewed on 10/22/2025

	at 12:45 p.m. The medical diagnoses included senile degeneration of the brain and depression. The individual service plan for Resident B, revised on 10/16/2025, indicated " ...POA [power of attorney] taking over administration of medication..." No documentation in the clinical record, on 10/16/2025, indicated Family Member 17 was assessed or educated for safe administration of medications. During an interview on 10/22/2025 at 2:45 p.m., Qualified Medication Aide (QMA) 3 indicated she was working on 10/16/2025. Around 6:00 p.m., Family Member 17 came up to the nurses' station and stated Administrator had given permission for Family Member 17 to administer comfort medications to Resident B. Family Member 17 put her phone in QMA 3's face to show a text message. QMA 3 said she would need to verify with the Director of Nursing (DON) and went to the DON's office. The DON verified with the Administrator that the Administrator had given permission for Family Member 17 to administer comfort medications via phone. The DON and QMA 3 went back to the unit, signed out all controlled substances. The DON took the			

	controlled substance logs and medications to Resident B's room. Family Member 17 refused control of all controlled substances except for three tablets of Ativan, one full 30 milliliter (mL) bottle of morphine, and one opened bottle of morphine with 8 mL remaining. QMA 3 watched the DON sign the sheets over to Family Member 17 but then left the room to go secure the controlled substances Family Member 17 had refused. During an interview on 10/23/2025 at 12:40 p.m., the DON indicated, on 10/16/2025, QMA 3 came to her office stating that Family Member 17 wanted to administer medication to Resident B. The DON then called the Administrator to verify this, and recalled the Administrator said, " ...if you're okay with it ..." Family Member 17 was a former employee of the corporation and a practicing nurse, so the DON stated she felt comfortable allowing the administration of medication. The DON then went to the unit with QMA 3, signed out the controlled substances and took the logs to Resident B's room. The DON verified no copies of the original sheets were retained by the facility. When the DON was signing over medications to Family Member 17, Family Member 17 refused some medication. The refused			

	medications were given back to QMA 3 to secure. The DON verified she did not assess Family Member 17 for safe medication administration or provide education to current physician's order of morphine or Ativan to Family Members under the pretense that Family Member 17 was an actively practicing nurse. During an interview on 10/23/2025 at 1:08 p.m., the Administrator indicated the facility did not have a policy regarding safe administration of medication completed by family members while residents were residing in the facility and did not have any other circumstances of family members administering medications while residents were in the facility. The Administrator stated the facility will be developing policies and procedures for future circumstances. This citation relates to Intake IN00465531.			
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	R 0241	All Residents potentially affected. On 10/20/2025, the DON/RCC and RDO reviewed the clinical record for Resident.	11/24/2025

	premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on interview and record review, the facility failed to ensure safe administration of medications by a family member by not assessing or providing education to a family member requesting to administer medications, developing and implementing policies regarding family administration of medications to a resident residing in a facility (Cross reference R0091), and not ensuring medication records were complete and accurate (Cross reference R0349) for 1 of 3 residents reviewed for medication administration. (Resident B) Findings include: The clinical record for Resident B was reviewed on 10/22/2025 at 12:45 p.m. The medical diagnoses included senile degeneration of the brain and depression. The individual service plan for Resident B, revised on 10/16/2025, indicated " ...POA taking over administration of medication..." No documentation on the		On 10/20/2025, the DON/RCC audited all current residents to identify any with prior or current family involvement in medication administration. - For any such residents, charts were reviewed to determine whether education of family/legal representatives on safe medication administration was documented. family administration has been paused for all residents as of 10/22/2025, no residents currently rely on family-administered medications, and all medications are administered by facility. By 11/24/25, Vita will create a Family Medication Education & Acknowledgement Form to be used any time family/legal representatives are involved in medication administration under the new policy. The form will document: • Medications reviewed and key teaching points (name, dose, route, timing, indication, side effects, when to hold, when to call). • Nurse providing education. • Signature of family/legal representative acknowledging understanding. - Admission and care-conference processes will be updated so that: • Medication management options	

	medical record on 10/16/2025 indicated Family Member 17 was assessed or educated for safe administration of medications. A progress note narrated by the Administrator, dated 10/16/2025 at 5:30 p.m., indicated the Administrator received a text message request to administer comfort medications at beside. " ...Writer spoke to DON [Director of Nursing] and discussed comfort medications be signed out and medication administration to be completed by [Family Member 17]. MAR [Medication Administration Record] to be given to POA [power of attorney] for sign out purposes ..." A progress note narrated by the DON, on 10/16/2025 at 5:55 p.m., indicated " ...Writer approached by [QMA 3] with [Family Member 17's] request to be given [Resident B's] medications so that she [Family Member 17] ..." The DON goes on to indicate she verified with the Administrator and signed over, " ...morphine sulfate bottle 8 mL [milliliters], bottle of 30mL and 3 lorazepam tabs ..." A progress note, dated 10/16/2025 at 7:16 p.m., narrated by Qualified Medication Aide (QMA) 3 indicated " ...Resident family member alerted staff at 6:54 that resident		and the facility's policy on family involvement with medications are reviewed with residents/families. • Education and discussions are documented in the record. After the policy and form are finalized, licensed nurses and key staff will be educated on: • When and how to provide and document family education. • The requirement to complete the Family Medication Education & Acknowledgement Form whenever family administration is allowed under policy. The DON or designee will audit weekly for 4 weeks, then monthly for 3 months: • Any future cases in which family medication administration is considered or approved, to confirm that education is documented and the Family Medication Education & Acknowledgement Form is completed.	

	had just passed away. Staff went to see resident and console family. Hospice notified, memory care director, director of nursing notified ..." During an interview on 10/22/2025 at 2:45 p.m., QMA 3 indicated she was working on 10/16/2025. Around 6:00 p.m., QMA 3 took the controlled substance logs and medications to Resident B's room under the pretense of Family Member 17 administering comfort medications. Family Member 17 refused control of all controlled substances except for three tablets of Ativan, one full 30 mL bottle of morphine, and one opened bottle of morphine with 8 mL remaining. QMA 3 watched the DON sign the sheets over to Family Member 17, but then left the room to go secure the controlled substances Family Member 17 had refused. The DON remained in the room at this time. QMA 3 verified she did not notify Hospice 16 or Resident B's primarily care provider of the family requesting to administer medications. QMA 3 recalled being notified Resident B had passed away around 6:50-7:00 p.m. on 10/16/2025. QMA 3 went to the room at that time to verify with Certified Nurse Aide (CNA) 4 and CNA 2. While in the room, QMA 3 did not see the medications, but the controlled substance sheets		• Admission and care-conference records to verify that medication management and the facility's policy on family involvement are discussed and documented. - Any missing or incomplete documentation of education will be corrected immediately and staff re-educated. - Audit results will be reviewed monthly for 3 months, or longer if needed	

	were on the table. QMA 3 left the room and a few minutes later, CNA 2 and CNA 4 approached QMA 3 with a bag of trash retrieved from Resident B's room. QMA 3, CNA 2, and CNA 4 opened the trash bag at the nurses' station. In the bag of trash were "4 or 5 plastic water cups, a used morphine syringe, an empty bottle of morphine, and a torn up box. There was some clear liquid in the bottom of the bag, but that was water." QMA 3 further stated the liquid at the bottom of the bag had no smell, did not have a tint to it, and was not "sticky". Immediately QMA 3 "knew something was wrong", and called leadership at the facility. During the "3 minutes we were out of the room", Family Member 17 left the facility and locked the resident's room with the deceased resident inside. QMA 3 was instructed to call hospice to verify Family Member 17 had actually notified hospice of Resident B's passing. When Hospice Nurse arrived on site, QMA 3 was sitting outside of the room with CNA 2 and CNA 4. Hospice Nurse asked where the medications were and QMA 3 disclosed about the bag in the nurses' station, but QMA 3 did not have any actual medications. Hospice Nurse, QMA 3, CNA 2 and CNA 4 then entered Resident B's room to attempt to locate medications. No medication was found and			

	QMA 3 overheard conversations between the Hospice Nurse, Family Member 17, and members of leadership from hospice and the facility. During an interview on 10/23/2025 at 11:15 a.m., CNA 4 indicated she worked with Resident B on the evening of 10/16/2025. CNA 4 stated she had never seen Family Member 17 prior to this date, but around 5:45-6:00 p.m. on 10/16/2025, Family Member 17 came to the nurses' station and stated Family Member 17 was going to be taking over medication administration for Resident B. CNA 4 recalls " ... she [Family Member 17] put her phone in my face and then in [QMA 3's] face, showing us a message...[QMA 3] said she [QMA 3] would have to check with [DON] ..." CNA 4 recalled QMA 3 went to check with the DON and CNA 4 walked with Family Member 17 back to Resident B's room, making small talk. It was just a few minutes later that QMA 3 and the DON came back on the unit and CNA 4 saw them sign out medicine then take them to Resident B's room. Around 6:10 p.m., the door to Resident B's room was closed, but QMA 3 instructed CNA 4 the family had requested some privacy. CNA 4 went to break at 6:20 p.m. and returned at 6:50 p.m. CNA 4 was walking back into the			

	building when Family Member 17 told her Resident B had passed away, so CNA 4 immediately went to the room. CNA 4 stated that Family Member 17 was " ... refusing to talk to the nurses after she [Family Member 17] got the medications, so I beat [QMA 3] to the room..." CNA 4 verified Resident B was cold to the touch, the papers that CNA 4 believed to be the controlled substance logs were on the table, but CNA 4 did not recall seeing any medications in the room. CNA 4 had to leave the room for a moment while CNA 2 and QMA 3 were in the room because another resident was having behaviors. CNA 4 returned to the room. When CNA 4 was walking in, CNA 4 stepped on a "sealed morphine syringe", which was "weird" to CNA 4. CNA 2 was present with CNA 4 at this time. Family Member 17 disclosed " ...[Family Member 18] had thrown the medications into the trash can." CNA 4 said this was "weird because we didn't ask about the meds. She just said it out of nowhere, so I told [Family Member 17] that we needed to take the trash out so another resident didn't get into it ..." CNA 4 and CNA 2 took the trash bag to the QMA at the nurses' station. CNA 4 verified there were "a few plastic cups, like the ones the nurses use for medications in there, a			

	morphine syringe that had blue residual all the way up the tube, an empty bottle of morphine, and a torn-up morphine box ..." CNA 4 stated, " ...there was water in the bottom of the bag. It didn't have any color at all to it, didn't smell, wasn't sticky ..." Per CNA 4's recall, QMA 3 said " ...we are missing meds ..." CNA 4 and QMA 3 go to ask Family Member 17 about medications and check the room, but when they got to the room, Resident B's door was shut and locked with Family Member 17 gone from the facility. Attempts to contact Family Member 17 during the investigation were unsuccessful. During an interview on 10/23/2025 at 11:30 a.m., the Hospice Administrator indicated the Hospice Nurse made a visit after the passing of Resident B. The Hospice Administrator indicated she had a statement from the Hospice Nurse which she would provide. The Hospice Administrator was the leadership on call when she received a call from the Hospice Nurse, indicating there were medications not accounted for at the facility. The Hospice Administrator instructed the Hospice Nurse to call the authorities. The Hospice Administrator indicated Hospice was not aware of Family			

	Member 17's request to administer Resident B's medications, nor did hospice provide the physician's order or education for the family to administer medications. Hospice did not have a policy regarding this but would defer to the facility's policy. Hospice notified the local police department to the situation the evening of 10/16/2025. The Hospice Administrator had been in correspondence with the facility Administrator on 10/16/2025, provided requested records to the coroner on 10/17/2025, and had additional communication with the facility Administrator, on 10/20/2025, when facility requested copies of the controlled substance logs. Family Member 17 had sent pictures of the controlled substance logs to hospice, and hospice had provided these pictures to the facility. A statement from the Hospice Nurse was provided on 10/23/2025 at 1:30 p.m. The statement indicated that Family Member 17 notified hospice of Resident B's passing on 10/16/2025 at 6:49 p.m. The Hospice Nurse spoke with Family Member 17, on 10/16/2025 at 7:17 p.m., via telephone. During this conversation, Family Member 17 " ... stated she would need to leave prior to writer's arrival ..." and " ...she [Family Member 17]			

	would leave morphine and lorazepam under the patient's [Resident B] pillow ..." Hospice Nurse stated leaving medication under the resident's pillow was not Hospice Company's policy and that she would need to wait or leave the medications with the facility QMA. Family Member 17 decline waiting. When the Hospice Nurse arrived, there were four staff members sitting outside of the door. Staff disclosed Resident B's family locked Resident B's door and left without talking to staff. QMA 3 disclosed concern about comfort medications given to Family Member 17, including three tablets of lorazepam, a 30 mL bottle of morphine concentrate (20 mg/ml), and a partially used bottle of morphine concentrate (20 mg/ml). QMA 3 reported to the Hospice Nurse that facility management had given Family Member 17 authorization to administer comfort medications to Resident B. Hospice Nurse notified hospice's leadership and was instructed to contact the local police department. During an interview on 10/23/2025 at 12:40 p.m., the DON indicated, on 10/16/2025, QMA 3 came to her office stating that Family Member 17 wanted to administer medication to Resident B. The DON then called the Administrator to verify this, and recalled the			

	Administrator said, " ...if you're okay with it ..." Family Member 17 was a former employee of the corporation and a practicing nurse, so the DON stated she felt comfortable allowing the administration of medication. The DON then went to the unit with QMA 3, signed out the controlled substances and took the logs to Resident B's room. The DON verified no copies of the original sheets were retained by the facility. When the DON was signing over medications to Family Member 17, Family Member 17 refused some medication. The refused medications were given back to QMA 3 to be secured. The DON verified she did not assess Family Member 17 for safe medication administration or provide education to current physician's order of morphine or Ativan to Family Members under the pretense that Family Member 17 was an actively practicing nurse. The DON verified she did not notify hospice of the request from Resident B's family to administer medications, nor did the DON obtain a physician's order for Resident B's family to administer medications. During an interview on 10/23/2025 at 1:08 p.m., the Administrator indicated, on the evening of 10/16/2025, the Administrator was made aware of Family Member 17's request			

	to administer medications to Resident B via text message. The Administrator had given permission for this via text message, and the Administrator was about to correspond with the DON, but the DON called the Administrator to verify. The Administrator indicated the facility did not have a procedure for this at the time, but if the DON was okay with it then it was fine. The Administrator verified she did provide education to Family Member 17, but she felt okay with it because Family Member 17 was a former employee and an actively practicing nurse. The Administrator was made aware of issues with the controlled substances after Resident B's passing, on the evening of 10/16/2025, and launched an investigation at that time. The Administrator corresponded with Family Member 17, the Hospice Administrator, the Hospice Nurse, and the local police department, the night of 10/16/2025, regarding Resident B's controlled substances. The Administrator verified the facility did not have a policy regarding safe administration of medication completed by family members while residents were residing in the facility and did not have any other circumstances of family members administering medications while residents were in the facility. The			

	Administrator stated the facility will be developing policies and procedures for future circumstances. This citation relates to Intake IN00465531. Based on interview and record review, the facility failed to ensure safe administration of medications by a family member by not assessing or providing education to a family member requesting to administer medications, developing and implementing policies regarding family administration of medications to a resident residing in a facility (Cross reference R0091), and not ensuring medication records were complete and accurate (Cross reference R0349) for 1 of 3 residents reviewed for medication administration. (Resident B) Findings include: The clinical record for Resident B was reviewed on 10/22/2025 at 12:45 p.m. The medical diagnoses included senile degeneration of the brain and depression. The individual service plan for Resident B, revised on 10/16/2025, indicated " ...POA taking over administration of medication..."			

	No documentation on the medical record on 10/16/2025 indicated Family Member 17 was assessed or educated for safe administration of medications. A progress note narrated by the Administrator, dated 10/16/2025 at 5:30 p.m., indicated the Administrator received a text message request to administer comfort medications at beside. " ...Writer spoke to DON [Director of Nursing] and discussed comfort medications be signed out and medication administration to be completed by [Family Member 17]. MAR [Medication Administration Record] to be given to POA [power of attorney] for sign out purposes ..." A progress note narrated by the DON, on 10/16/2025 at 5:55 p.m., indicated " ...Writer approached by [QMA 3] with [Family Member 17's] request to be given [Resident B's] medications so that she [Family Member 17] ..." The DON goes on to indicate she verified with the Administrator and signed over, " ...morphine sulfate bottle 8 mL [milliliters], bottle of 30mL and 3 lorazepam tabs ..." A progress note, dated 10/16/2025 at 7:16 p.m., narrated by Qualified Medication Aide (QMA) 3 indicated " ...Resident family member			

	alerted staff at 6:54 that resident had just passed away. Staff went to see resident and console family. Hospice notified, memory care director, director of nursing notified ..." During an interview on 10/22/2025 at 2:45 p.m., QMA 3 indicated she was working on 10/16/2025. Around 6:00 p.m., QMA 3 took the controlled substance logs and medications to Resident B's room under the pretense of Family Member 17 administering comfort medications. Family Member 17 refused control of all controlled substances except for three tablets of Ativan, one full 30 mL bottle of morphine, and one opened bottle of morphine with 8 mL remaining. QMA 3 watched the DON sign the sheets over to Family Member 17, but then left the room to go secure the controlled substances Family Member 17 had refused. The DON remained in the room at this time. QMA 3 verified she did not notify Hospice 16 or Resident B's primarily care provider of the family requesting to administer medications. QMA 3 recalled being notified Resident B had passed away around 6:50-7:00 p.m. on 10/16/2025. QMA 3 went to the room at that time to verify with Certified Nurse Aide (CNA) 4 and CNA 2. While in the room, QMA 3 did not see the medications, but the			

	controlled substance sheets were on the table. QMA 3 left the room and a few minutes later, CNA 2 and CNA 4 approached QMA 3 with a bag of trash retrieved from Resident B's room. QMA 3, CNA 2, and CNA 4 opened the trash bag at the nurses' station. In the bag of trash were "4 or 5 plastic water cups, a used morphine syringe, an empty bottle of morphine, and a torn up box. There was some clear liquid in the bottom of the bag, but that was water." QMA 3 further stated the liquid at the bottom of the bag had no smell, did not have a tint to it, and was not "sticky". Immediately QMA 3 "knew something was wrong", and called leadership at the facility. During the "3 minutes we were out of the room", Family Member 17 left the facility and locked the resident's room with the deceased resident inside. QMA 3 was instructed to call hospice to verify Family Member 17 had actually notified hospice of Resident B's passing. When Hospice Nurse arrived on site, QMA 3 was sitting outside of the room with CNA 2 and CNA 4. Hospice Nurse asked where the medications were and QMA 3 disclosed about the bag in the nurses' station, but QMA 3 did not have any actual medications. Hospice Nurse, QMA 3, CNA 2 and CNA 4 then entered Resident B's room to attempt to locate medications.			

	No medication was found and QMA 3 overheard conversations between the Hospice Nurse, Family Member 17, and members of leadership from hospice and the facility. During an interview on 10/23/2025 at 11:15 a.m., CNA 4 indicated she worked with Resident B on the evening of 10/16/2025. CNA 4 stated she had never seen Family Member 17 prior to this date, but around 5:45-6:00 p.m. on 10/16/2025, Family Member 17 came to the nurses' station and stated Family Member 17 was going to be taking over medication administration for Resident B. CNA 4 recalls " ... she [Family Member 17] put her phone in my face and then in [QMA 3's] face, showing us a message...[QMA 3] said she [QMA 3] would have to check with [DON] ..." CNA 4 recalled QMA 3 went to check with the DON and CNA 4 walked with Family Member 17 back to Resident B's room, making small talk. It was just a few minutes later that QMA 3 and the DON came back on the unit and CNA 4 saw them sign out medicine then take them to Resident B's room. Around 6:10 p.m., the door to Resident B's room was closed, but QMA 3 instructed CNA 4 the family had requested some privacy. CNA 4 went to break at 6:20 p.m. and returned at 6:50 p.m. CNA 4			

	was walking back into the building when Family Member 17 told her Resident B had passed away, so CNA 4 immediately went to the room. CNA 4 stated that Family Member 17 was " ... refusing to talk to the nurses after she [Family Member 17] got the medications, so I beat [QMA 3] to the room..." CNA 4 verified Resident B was cold to the touch, the papers that CNA 4 believed to be the controlled substance logs were on the table, but CNA 4 did not recall seeing any medications in the room. CNA 4 had to leave the room for a moment while CNA 2 and QMA 3 were in the room because another resident was having behaviors. CNA 4 returned to the room. When CNA 4 was walking in, CNA 4 stepped on a "sealed morphine syringe", which was "weird" to CNA 4. CNA 2 was present with CNA 4 at this time. Family Member 17 disclosed " ...[Family Member 18] had thrown the medications into the trash can." CNA 4 said this was "weird because we didn't ask about the meds. She just said it out of nowhere, so I told [Family Member 17] that we needed to take the trash out so another resident didn't get into it ..." CNA 4 and CNA 2 took the trash bag to the QMA at the nurses' station. CNA 4 verified there were "a few plastic cups, like the ones the nurses use for			

	medications in there, a morphine syringe that had blue residual all the way up the tube, an empty bottle of morphine, and a torn-up morphine box ..." CNA 4 stated, " ...there was water in the bottom of the bag. It didn't have any color at all to it, didn't smell, wasn't sticky ..." Per CNA 4's recall, QMA 3 said " ...we are missing meds ..." CNA 4 and QMA 3 go to ask Family Member 17 about medications and check the room, but when they got to the room, Resident B's door was shut and locked with Family Member 17 gone from the facility. Attempts to contact Family Member 17 during the investigation were unsuccessful. During an interview on 10/23/2025 at 11:30 a.m., the Hospice Administrator indicated the Hospice Nurse made a visit after the passing of Resident B. The Hospice Administrator indicated she had a statement from the Hospice Nurse which she would provide. The Hospice Administrator was the leadership on call when she received a call from the Hospice Nurse, indicating there were medications not accounted for at the facility. The Hospice Administrator instructed the Hospice Nurse to call the authorities. The Hospice Administrator indicated Hospice			

	was not aware of Family Member 17's request to administer Resident B's medications, nor did hospice provide the physician's order or education for the family to administer medications. Hospice did not have a policy regarding this but would defer to the facility's policy. Hospice notified the local police department to the situation the evening of 10/16/2025. The Hospice Administrator had been in correspondence with the facility Administrator on 10/16/2025, provided requested records to the coroner on 10/17/2025, and had additional communication with the facility Administrator, on 10/20/2025, when facility requested copies of the controlled substance logs. Family Member 17 had sent pictures of the controlled substance logs to hospice, and hospice had provided these pictures to the facility. A statement from the Hospice Nurse was provided on 10/23/2025 at 1:30 p.m. The statement indicated that Family Member 17 notified hospice of Resident B's passing on 10/16/2025 at 6:49 p.m. The Hospice Nurse spoke with Family Member 17, on 10/16/2025 at 7:17 p.m., via telephone. During this conversation, Family Member 17 " ... stated she would need to leave prior to writer's arrival ..."			

	and " ...she [Family Member 17] would leave morphine and lorazepam under the patient's [Resident B] pillow ..." Hospice Nurse stated leaving medication under the resident's pillow was not Hospice Company's policy and that she would need to wait or leave the medications with the facility QMA. Family Member 17 decline waiting. When the Hospice Nurse arrived, there were four staff members sitting outside of the door. Staff disclosed Resident B's family locked Resident B's door and left without talking to staff. QMA 3 disclosed concern about comfort medications given to Family Member 17, including three tablets of lorazepam, a 30 mL bottle of morphine concentrate (20 mg/ml), and a partially used bottle of morphine concentrate (20 mg/ml). QMA 3 reported to the Hospice Nurse that facility management had given Family Member 17 authorization to administer comfort medications to Resident B. Hospice Nurse notified hospice's leadership and was instructed to contact the local police department. During an interview on 10/23/2025 at 12:40 p.m., the DON indicated, on 10/16/2025, QMA 3 came to her office stating that Family Member 17 wanted to administer medication to Resident B. The DON then called the Administrator to verify			

	this, and recalled the Administrator said, " ...if you're okay with it ..." Family Member 17 was a former employee of the corporation and a practicing nurse, so the DON stated she felt comfortable allowing the administration of medication. The DON then went to the unit with QMA 3, signed out the controlled substances and took the logs to Resident B's room. The DON verified no copies of the original sheets were retained by the facility. When the DON was signing over medications to Family Member 17, Family Member 17 refused some medication. The refused medications were given back to QMA 3 to be secured. The DON verified she did not assess Family Member 17 for safe medication administration or provide education to current physician's order of morphine or Ativan to Family Members under the pretense that Family Member 17 was an actively practicing nurse. The DON verified she did not notify hospice of the request from Resident B's family to administer medications, nor did the DON obtain a physician's order for Resident B's family to administer medications. During an interview on 10/23/2025 at 1:08 p.m., the Administrator indicated, on the evening of 10/16/2025, the Administrator was made aware			

	of Family Member 17's request to administer medications to Resident B via text message. The Administrator had given permission for this via text message, and the Administrator was about to correspond with the DON, but the DON called the Administrator to verify. The Administrator indicated the facility did not have a procedure for this at the time, but if the DON was okay with it then it was fine. The Administrator verified she did provide education to Family Member 17, but she felt okay with it because Family Member 17 was a former employee and an actively practicing nurse. The Administrator was made aware of issues with the controlled substances after Resident B's passing, on the evening of 10/16/2025, and launched an investigation at that time. The Administrator corresponded with Family Member 17, the Hospice Administrator, the Hospice Nurse, and the local police department, the night of 10/16/2025, regarding Resident B's controlled substances. The Administrator verified the facility did not have a policy regarding safe administration of medication completed by family members while residents were residing in the facility and did not have any other circumstances of family members administering medications while residents			

	were in the facility. The Administrator stated the facility will be developing policies and procedures for future circumstances. This citation relates to Intake IN00465531.			
R 0349	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(a)(1-4) (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on interview and record review, the facility failed to ensure complete and accurate documentation of controlled substance control logs for 1 of 3 records reviewed. (Resident B) Findings include:	R 0349	All Residents potentially affected. DON or designee will audit all residents with controlled substance orders to verify a current controlled substance control log is in place for each medication. Logs for the previous 30 days will be reviewed for missing or incomplete entries. Any issues were clarified, corrected, and documented. By 11/24/25 a “Controlled Substances – Storage, Administration, and Documentation” policy will be developed and implemented to require: • Original controlled substance logs are maintained onsite and not removed from the facility. • Each dose or waste is documented immediately with date, time, dose, remaining count, and signatures. • Required shift counts are completed and signed per policy. - A standardized controlled substance log form and a designated binder/storage area in	11/24/2025

	The clinical record for Resident B was reviewed on 10/22/2025 at 12:45 p.m. The medical diagnoses included senile degeneration of the brain and depression. Review of the clinical record indicated three controlled substance logs were not part of the clinical record for Resident B. During an interview on 10/23/2025 at 2:24 p.m., the Regional Director of Operations (RDO) indicated the three controlled substance sheets not within the medical record were given to Family Member 17 to record beside administration of comfort medication. Upon the time of Resident B's passing, a family member removed the controlled substance sheets from the facility. The RDO confirmed the facility did not retain a copy of the record prior to releasing them to Family Member 17, but they had received photos of the controlled substance sheets during an investigation. On 10/23/2025 at 2:25 p.m., the RDO provided photos of the three controlled substance sheets in question. The first sheet was for three tablets of Ativan, with the final line being dated, 10/16/2025, at a quantity of 3 being signed over to Family Member 17 by the Director of		the medication room were implemented for all current logs. On 11/19/25, the DON will provide inservice education to all licensed nursing staff, the RDO will in-service DON and RCC on the policy, documentation expectations, and onsite maintenance of original logs. The DON or designee will audit controlled substance logs weekly for 4 weeks, then monthly for 3 months to confirm: • Entries are complete and accurate. • Counts match on-hand amounts when checked. • Original logs are present onsite in the designated location. Any problems will be corrected immediately with staff re-education as needed. Audit findings will be reviewed at least monthly for 3 months, or longer if needed	

Nursing (DON) without a time documented for this exchange. The second sheet was for morphine, with the final line being dated, 10/16/2025, at a quantity of 7 milliliters (mL) being signed over to Family Member 17 by the DON without a time documented for this exchange. A handwritten note under this line says, "I gave 0.5 ml x 2's" without a date, time, or signature. The third sheet was for morphine, with the final line being dated, 10/16/2025, at a quantity of 30 milliliters being signed over to Family Member 17 by the DON without a time documented for this exchange.

A policy entitled "Medication Administration Policy" was provided by the RDO on 10/24/2025 at 11:33 a.m. The policy indicated, " ... Controlled substance must be properly signed out, tracked and stored securely ..."

This citation relates to Intake IN00465531.

Based on interview and record review, the facility failed to ensure complete and accurate documentation of controlled substance control logs for 1 of 3 records reviewed. (Resident B)

Findings include:

The clinical record for Resident B was reviewed on 10/22/2025 at 12:45 p.m. The medical

diagnoses included senile degeneration of the brain and depression.

Review of the clinical record indicated three controlled substance logs were not part of the clinical record for Resident B.

During an interview on 10/23/2025 at 2:24 p.m., the Regional Director of Operations (RDO) indicated the three controlled substance sheets not within the medical record were given to Family Member 17 to record beside administration of comfort medication. Upon the time of Resident B's passing, a family member removed the controlled substance sheets from the facility. The RDO confirmed the facility did not retain a copy of the record prior to releasing them to Family Member 17, but they had received photos of the controlled substance sheets during an investigation.

On 10/23/2025 at 2:25 p.m., the RDO provided photos of the three controlled substance sheets in question. The first sheet was for three tablets of Ativan, with the final line being dated, 10/16/2025, at a quantity of 3 being signed over to Family Member 17 by the Director of Nursing (DON) without a time documented for this exchange. The second sheet was for

	morphine, with the final line being dated, 10/16/2025, at a quantity of 7 milliliters (mL) being signed over to Family Member 17 by the DON without a time documented for this exchange. A handwritten note under this line says, "I gave 0.5 ml x 2's" without a date, time, or signature. The third sheet was for morphine, with the final line being dated, 10/16/2025, at a quantity of 30 milliliters being signed over to Family Member 17 by the DON without a time documented for this exchange. A policy entitled "Medication Administration Policy" was provided by the RDO on 10/24/2025 at 11:33 a.m. The policy indicated, " ... Controlled substance must be properly signed out, tracked and stored securely ..." This citation relates to Intake IN00465531.			

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 SIGNATUREAllison Catron	TITLERDCS	(X6) DATE11/14/2025