STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAPTERS LIVING OF SOUTH BEND	955 HICKORY ROAD, SOUTH BEND, , 46615

(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 466065. Intake 466065 - State deficiencies related to the allegations are cited at R0027, R0042, R0217, R0246 and R0297. Survey date: November 25 & 26, 2025. Facility number: 016149 Residential Census: 15 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review completed on 12/02/2025	R 0000		
R 0027	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(b) (b) Residents have the right to a dignified existence, self-determination, and	R 0027	1. What corrective action(s) will be accomplished for those residents found to have been affected by	12/08/2025

	communication with and access to persons and services inside and outside the facility. Residents have the right to exercise their rights as a resident of the facility and as a citizen or resident of the United States. Based on record review and interviews, the facility failed to follow a resident's preference for photographs being used on a social media platform for 1 of 4 residents reviewed for self-determination. (Resident B) Finding includes: A review of Resident B's Admission Agreement was completed, on 11/26/2025 at 9:02 A.M. A form titled, "Activity Release Form", indicated Resident B's responsible party had not given consent for Resident B's photo to appear in photographs, quotes or mentions in the facility's media and marketing sources which included social media and marketing sources. The facility's Facebook page showed Resident B in numerous photographs, including, but not limited to: -11/25/2025 Resident B playing Bingo. -11/22/2025 Resident B participating in a bowling activity.		the deficient practice? Resident POA is aware of the deficient, POA stated consent form is signed. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken? Executive Director did an audit on resident files. All files have signed consent forms for photo’s of residents. 3. What measures will be put into place or what system changes the facility will make to ensure that the deficient practice does not recur? On admission, resident or POA will be given the Photo consent form. They will be given the chance to accept or deny photo’s. 4. How the correction action(s) will be monitored to ensure the deficient practice will not recur- what quality assurance program will	

	-11/20/2025 Resident B participating in the facility's monthly birthday party. -11/18/2025 Resident B playing Bingo. -11/15/2025 Resident B had his name listed and photographs posted for his birthday. -11/14/2025 Resident B playing Bingo. -11/13/2025 Resident B playing Tetris. During an interview, on 11/26/2025 11:01 A.M. the Activity Director indicated most families had expressed verbally or in writing their consent to have photographs published and there was no one in the facility who had not wanted photographed. She indicated the residents' consents for photographs should have been located in the residents' personal files or medical charts. During an interview, on 11/26/2025 at 11:30 A.M., Resident B indicated he was aware of the social media platform Facebook and he did not have a Facebook account. He indicated he did not want his photographs posted on Facebook or other social media platforms for the facility. A Policy was provided by the Executive Director, on		be put into place? Photo consent forms will be monitored for 1x a month for 6 months, thereafter every 6 months to ensure policy is being implemented. 5. By what date will the systemic changes be completed? 12/1/25 all residents have singed Photo consent forms.	

	11/26/2025 at 11:53 A.M. The policy titled, "Video and Photography", indicated, " ... Policy: It is the policy of [Name of AL], consistent with its respect for resident privacy and confidentiality, to provide clear and concise guidelines to obtain consent to photograph, video or audio record ["film"] residents and/or staff ...Procedure: All photographs and/or video taping of residents and/or staff are not permitted without expressed consent. A signed consent form is to be kept in the resident or staff records ...." This citation relates to Intake 466065 Based on record review and interviews, the facility failed to follow a resident's preference for photographs being used on a social media platform for 1 of 4 residents reviewed for self-determination. (Resident B) Finding includes: A review of Resident B's Admission Agreement was completed, on 11/26/2025 at 9:02 A.M. A form titled, "Activity Release Form", indicated Resident B's responsible party had not given consent for Resident B's photo to appear in photographs, quotes or mentions in the facility's media and marketing sources which included social media and			

	marketing sources. The facility's Facebook page showed Resident B in numerous photographs, including, but not limited to: -11/25/2025 Resident B playing Bingo. -11/22/2025 Resident B participating in a bowling activity. -11/20/2025 Resident B participating in the facility's monthly birthday party. -11/18/2025 Resident B playing Bingo. -11/15/2025 Resident B had his name listed and photographs posted for his birthday. -11/14/2025 Resident B playing Bingo. -11/13/2025 Resident B playing Tetris.			

	During an interview, on 11/26/2025 11:01 A.M. the Activity Director indicated most families had expressed verbally or in writing their consent to have photographs published and there was no one in the facility who had not wanted photographed. She indicated the residents' consents for photographs should have been located in the residents' personal files or medical charts. During an interview, on 11/26/2025 at 11:30 A.M., Resident B indicated he was aware of the social media platform Facebook and he did not have a Facebook account. He indicated he did not want his photographs posted on Facebook or other social media platforms for the facility. A Policy was provided by the Executive Director, on 11/26/2025 at 11:53 A.M. The policy titled, "Video and Photography", indicated, " ... Policy: It is the policy of [Name of AL], consistent with its respect for resident privacy and confidentiality, to provide clear and concise guidelines to obtain consent to photograph, video or audio record ["film"] residents and/or staff ...Procedure: All photographs and/or video taping of residents and/or staff are not permitted without expressed consent. A signed consent form is to be kept in the resident or			

	staff records ...." This citation relates to Intake 466065			
R 0042	Residents' Rights - Noncompliance 410 IAC 16.2-5-1.2(p) (p) Residents have the right to the examination of the results of the most recent annual survey of the facility conducted by the state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. Based on observation, record review and interview, the facility failed to provide and make available the results and plan of correction for the recent State survey. This practice had the potential to affect 15 of 15 residents. Finding includes: During an observation on 11/25/2025 at 10:32 A.M., a framed notice was posted in the common area. The notice indicated, "State survey binder available upon request". On 11/26/2025 at 9:12 A.M., the state survey binder was requested. A binder titled, "Indiana State Surveys", was provided. The binder had a letter, dated 7/23/2025, from the Indiana Department of Health. The letter indicated compliance	R 0042	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. All residents are aware of the location of the state binder, along with POA's. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken. All 15 residents were affected by deficient . Executive Director was educated on the importance of updating binder and having it available anytime. 3. What measures will be put into place or what system changes the facility will make to ensure that the deficient practice does not recur? The state binder will be audited by different members of	12/08/2025

	from a Post Survey Revisit that had been completed for the Recertification and State Licensure Survey and complaints conducted on 7/1/2025 and 7/2/2025. The binder did not have the deficiencies nor the plan of correction from the survey conducted on 7/1/2025 and 7/2/2025. During an interview, on 11/26/2025 at 12:40 P.M., the Executive Director indicated the State survey results and plan of correction should have been available in the State survey binder. A policy was requested for the availability of the State survey results on 11/26/2025 at 11:16 A.M. At 12:43 P.M., the Executive Director indicated a policy was not available and the facility followed the State regulations for the availability of the State survey results. This citation relates to Intake 466065 Based on observation, record review and interview, the facility failed to provide and make available the results and plan of correction for the recent State survey. This practice had the potential to affect 15 of 15 residents. Finding includes:		management. 4. How the correction action(s) will be monitored to ensure the deficient practice will not recur- what quality assurance program will be put into place? The state binder will be monitored 1x a month for 6 months. The state binder will be updated as needed, after every survey and complaint investigation. 5. By what date will the systemic changes be completed? The state binder has been updated on 11/25/25	

	During an observation on 11/25/2025 at 10:32 A.M., a framed notice was posted in the common area. The notice indicated, "State survey binder available upon request". On 11/26/2025 at 9:12 A.M., the state survey binder was requested. A binder titled, "Indiana State Surveys", was provided. The binder had a letter, dated 7/23/2025, from the Indiana Department of Health. The letter indicated compliance from a Post Survey Revisit that had been completed for the Recertification and State Licensure Survey and complaints conducted on 7/1/2025 and 7/2/2025. The binder did not have the deficiencies nor the plan of correction from the survey conducted on 7/1/2025 and 7/2/2025. During an interview, on 11/26/2025 at 12:40 P.M., the Executive Director indicated the State survey results and plan of correction should have been available in the State survey binder. A policy was requested for the availability of the State survey results on 11/26/2025 at 11:16 A.M. At 12:43 P.M., the Executive Director indicated a policy was not available and the facility followed the State regulations for the availability of			

	the State survey results. This citation relates to Intake 466065			
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 (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	R 0217	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. All care plans are updated. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken. No potential threat to other residents 3. What measures will be put into place or what system changes the facility will make to ensure that the deficient practice does not recur? All care plans will be completed by Health and Wellness nurse before admission, 7-14 days after admission, 30 days after admission and every 6 months after. However, care plans will be updated when needed	12/08/2025

	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. Based on record review and interview, the facility failed to develop service plans for 2 of 4 residents reviewed for service plans. (Resident D & E) Findings include: 1. A record review for Resident D was completed, on 11/25/2025 at 1:40 P.M. Diagnoses included, but were not limited to: glioblastoma, history of falls and hypertension. A Personal Service Assessment was completed on 11/7/2025. The assessment indicated Resident D required assistance with escorts and mobility, dressing, showering and service arrangements. A Service Plan could not be located for Resident D in the electronic or paper medical record. During an interview, on 11/26/2025 at 10:43 A.M., the Director of Health and Wellness		due to change of condition. Health and Wellness director was reeducated on Assessments and the importance of them being updated as such. 4. How the correction action(s) will be monitored to ensure the deficient practice will not recur- what quality assurance program will be put into place? Care plans will be audit 1x a month for 6 months and upon admission's or change in condition. We will discontinue auditing after the 6 months to ensure policy is being followed. 5. By what date will the systemic changes be completed? All care plans have been reviewed and changes were completed on 12/5/25.	

reviewed Resident D's medical record and indicated the resident assessment had been completed, but a service plan had not been completed. She indicated a service plan should have been completed at 30 days and with any change of condition.

2. A record review for Resident E was completed on 11/25/2025 at 1:52 P.M. Diagnoses included, but were not limited to: Alzheimer's disease, anxiety disorder and atrial flutter.

A Personal Service Assessment was completed on 11/7/2025. The assessment indicated Resident E required assistance with showering, escort and mobility, pet care and service arrangements.

A Service Plan could not be located for Resident E in the electronic or paper medical record.

A Hospice Plan of Care, dated 11/18/2025, was available but did not address any daily assistance needs.

During an interview, on 11/26/2025 at 10:43 A.M., the Director of Health and Wellness reviewed Resident E's medical record. She indicated the only service plan available was dated 7/23/2024 and should have been updated with the change of services to include the need

for hospice services. She indicated a service plan should have been completed at 30 days and with any change of condition.

A policy was provided by the Executive Director, on 11/26/2025 at 12:43 P.M. The policy titled, "Service/Care Plans", indicated, " ...All residents receiving assisted living services should have a service/care plan in place. Service/care plans are based on the outcomes of initial and subsequent assessments, reassessments, monitoring, and individual reviews of the resident's needs and preferences ...."

This citation relates to Intake 466065

Based on record review and interview, the facility failed to develop service plans for 2 of 4 residents reviewed for service plans. (Resident D & E)

Findings include:

1. A record review for Resident D was completed, on 11/25/2025 at 1:40 P.M. Diagnoses included, but were not limited to: glioblastoma, history of falls and hypertension.

A Personal Service Assessment was completed on 11/7/2025. The assessment indicated Resident D required assistance

with escorts and mobility, dressing, showering and service arrangements.

A Service Plan could not be located for Resident D in the electronic or paper medical record.

During an interview, on 11/26/2025 at 10:43 A.M., the Director of Health and Wellness reviewed Resident D's medical record and indicated the resident assessment had been completed, but a service plan had not been completed. She indicated a service plan should have been completed at 30 days and with any change of condition.

2. A record review for Resident E was completed on 11/25/2025 at 1:52 P.M. Diagnoses included, but were not limited to: Alzheimer's disease, anxiety disorder and atrial flutter.

A Personal Service Assessment was completed on 11/7/2025. The assessment indicated Resident E required assistance with showering, escort and mobility, pet care and service arrangements.

A Service Plan could not be located for Resident E in the electronic or paper medical record.

A Hospice Plan of Care, dated 11/18/2025, was available but

	did not address any daily assistance needs. During an interview, on 11/26/2025 at 10:43 A.M., the Director of Health and Wellness reviewed Resident E's medical record. She indicated the only service plan available was dated 7/23/2024 and should have been updated with the change of services to include the need for hospice services. She indicated a service plan should have been completed at 30 days and with any change of condition. A policy was provided by the Executive Director, on 11/26/2025 at 12:43 P.M. The policy titled, "Service/Care Plans", indicated, " ...All residents receiving assisted living services should have a service/care plan in place. Service/care plans are based on the outcomes of initial and subsequent assessments, reassessments, monitoring, and individual reviews of the resident's needs and preferences ...." This citation relates to Intake 466065			

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 obtain permission prior to administration from a licensed nurse to provide as needed (PRN) medications to residents for 2 of 4 residents reviewed for PRN medications. (Residents C & F) Findings include: 1.A record review for Resident C was completed on 11/25/2025 at 11:14 A.M. Diagnoses included, but were not limited to: unspecified dementia, aphasia and persistent mood disorder. A Physician's Order, dated 8/5/2025, indicated alprazolam (an antianxiety medication) 0.25 milligrams every six hours as needed for restlessness or anxiety.	R 0246	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. All staff were re-educated on getting permission to give a PRN medication. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken. No potential threat to other residents 3. What measures will be put into place or what system changes the facility will make to ensure that the deficient practice does not recur? Executive Director held an in-service with all Qma's and Health and Wellness director, about the importance of communicating with the nurse and Doctor. We will hold in-service every month for 6 months on communicating with Nurse and Doctor. No PRN's will be given prior to getting permission.	12/08/2025

	The Medication Administration Record (MAR), dated November 2025, indicated the following doses of alprazolam were administered without any documentation of prior approval from a licensed nurse. -11/16/2025 at 2:20 A.M. Alprazolam administered for restlessness by QMA 3 with no documentation of licensed nurse approval. -11/20/2025 at 2:30 A.M. Alprazolam administered for restlessness by QMA 3 with no documentation of licensed nurse approval. -11/22/2025 at 5:12 A.M. Alprazolam administered for bad anxiety and crying frantically by QMA 4 with no documentation of licensed nurse approval. -11/22/2025 at 12:17 P.M. Alprazolam administered for anxiousness and hard to redirect by QMA 2 with no documentation of licensed nurse approval. -11/22/2025 at 6:00 P.M. Alprazolam administered for restlessness by QMA 3 with no documentation of licensed nurse approval. A Physician's Order, dated 10/21/2025, included hydrocodone/APAP (a narcotic pain medication) 5-325 milligrams every six hours as		4. How the correction action(s) will be monitored to ensure the deficient practice will not recur- what quality assurance program will be put into place? Health and Wellness or Designee will audit PRN book and charting in Alis to ensure policy is being followed. Audits will happen everyday for 4 weeks, 1x a month for 4 months and randomly for 6 months to ensure policy is consistently followed. 5. By what date will the systemic changes be completed? 11/28/25 changes were completed.	

needed for pain.

The Medication Administration Record (MAR), dated November 2025, indicated the following doses of hydrocodone/APAP were administered without any documentation of prior approval from a licensed nurse.

-11/12/2025 at 6:01 A.M. Hydrocodone/APAP administered for complaints of excruciating pain in groin area by QMA 3 with no documentation of licensed nurse approval .

-11/14/2025 at 3:00 P.M. Hydrocodone/APAP administered for complaints of groin area pain by QMA 3 with no documentation of licensed nurse approval.

-11/14/2025 at 10:05 P.M. Hydrocodone/APAP administered for complaints of leg and groin pain by QMA 3 with no documentation of licensed nurse approval.

-11/16/2025 at 12:30 A.M. Hydrocodone/APAP administered for complaints of leg and side area pain by QMA 3 with no documentation of licensed nurse approval.

-11/18/2025 at 3:30 P.M. Hydrocodone/APAP administered with executive director approval for pain by QMA 3 with no documentation

of licensed nurse approval.

-11/18/2025 at 10:00 P.M. Hydrocodone/APAP administered for complaints of right hand/finger pain by QMA 3 with no documentation of licensed nurse approval.

-11/19/2025 at 10:01 P.M. Hydrocodone/APAP administered for complaints of right-hand pain by QMA 3 with no documentation of licensed nurse approval.

-11/22/2025 at 3:00 P.M. Hydrocodone/APAP administered for complaints of severe pain in legs back and groin by QMA 3 with no documentation of licensed nurse approval.

-11/22/2025 at 9:45 P.M. Hydrocodone/APAP administered for complaints of legs and groin pain by QMA 3 with no documentation of licensed nurse approval.

2. A record review for Resident F was completed on 11/25/2025 at 2:18 P.M. Diagnoses included, but were not limited to: Alzheimer's disease, anxiety disorder and dementia with agitation.

A Physician's Order, dated 11/1/2025, included haloperidol concentrate (an antipsychotic medication) 2 milligrams per milliliter (mg/ml) take one

	milliliter every hour as needed for agitation. The Medication Administration Record (MAR), dated November 2025, indicated the following doses of haloperidol concentrate were administered without any documentation of prior approval from a licensed nurse. -11/14/2025 8:06 P.M. Haloperidol concentrate was administered for aggressiveness with staff and other residents by QMA 3. -11/16/2025 at 10:00 P.M. Haloperidol concentrate was administered for aggressiveness, no documentation of licensed nurse approval by QMA 3. During an interview, on 11/26/2025 at 10:03 A.M., QMA 6 indicated prior approval was needed from a licensed nurse for an as needed (PRN) medication to be administered. She indicated the approval was to be documented in the Medication Administration Record or in a progress note. During an interview, on 11/26/2025 at 10:49 A.M., the Director of Health and Wellness indicated all non-licensed nursing staff needed to call the licensed nurse prior to the administration of an as needed (PRN) medication and			

document the approval.

A policy was provided by the Executive Director, on 11/26/2025 at 12:43 P.M. The policy titled, "PRN Medications", indicated, " ...Only properly trained staff of the Community may provide PRN medication administration. Staff must be trained, with documentation on file. PRN medications must be administered according to the prescriber's orders ...."

This citation relates to Intake 466065

Based on record review and interview, the facility failed to obtain permission prior to administration from a licensed nurse to provide as needed (PRN) medications to residents for 2 of 4 residents reviewed for PRN medications. (Residents C & F)

Findings include:

1.A record review for Resident C was completed on 11/25/2025 at 11:14 A.M. Diagnoses included, but were not limited to: unspecified dementia, aphasia and persistent mood disorder.

A Physician's Order, dated 8/5/2025, indicated alprazolam (an antianxiety medication) 0.25 milligrams every six hours as needed for restlessness or anxiety.

	The Medication Administration Record (MAR), dated November 2025, indicated the following doses of alprazolam were administered without any documentation of prior approval from a licensed nurse. -11/16/2025 at 2:20 A.M. Alprazolam administered for restlessness by QMA 3 with no documentation of licensed nurse approval. -11/20/2025 at 2:30 A.M. Alprazolam administered for restlessness by QMA 3 with no documentation of licensed nurse approval. -11/22/2025 at 5:12 A.M. Alprazolam administered for bad anxiety and crying frantically by QMA 4 with no documentation of licensed nurse approval. -11/22/2025 at 12:17 P.M. Alprazolam administered for anxiousness and hard to redirect by QMA 2 with no documentation of licensed nurse approval. -11/22/2025 at 6:00 P.M. Alprazolam administered for restlessness by QMA 3 with no documentation of licensed nurse approval. A Physician's Order, dated 10/21/2025, included hydrocodone/APAP (a narcotic pain medication) 5-325 milligrams every six hours as			

needed for pain.

The Medication Administration Record (MAR), dated November 2025, indicated the following doses of hydrocodone/APAP were administered without any documentation of prior approval from a licensed nurse.

-11/12/2025 at 6:01 A.M. Hydrocodone/APAP administered for complaints of excruciating pain in groin area by QMA 3 with no documentation of licensed nurse approval .

-11/14/2025 at 3:00 P.M. Hydrocodone/APAP administered for complaints of groin area pain by QMA 3 with no documentation of licensed nurse approval.

-11/14/2025 at 10:05 P.M. Hydrocodone/APAP administered for complaints of leg and groin pain by QMA 3 with no documentation of licensed nurse approval.

-11/16/2025 at 12:30 A.M. Hydrocodone/APAP administered for complaints of leg and side area pain by QMA 3 with no documentation of licensed nurse approval.

-11/18/2025 at 3:30 P.M. Hydrocodone/APAP administered with executive director approval for pain by QMA 3 with no documentation

of licensed nurse approval.

-11/18/2025 at 10:00 P.M. Hydrocodone/APAP administered for complaints of right hand/finger pain by QMA 3 with no documentation of licensed nurse approval.

-11/19/2025 at 10:01 P.M. Hydrocodone/APAP administered for complaints of right-hand pain by QMA 3 with no documentation of licensed nurse approval.

-11/22/2025 at 3:00 P.M. Hydrocodone/APAP administered for complaints of severe pain in legs back and groin by QMA 3 with no documentation of licensed nurse approval.

-11/22/2025 at 9:45 P.M. Hydrocodone/APAP administered for complaints of legs and groin pain by QMA 3 with no documentation of licensed nurse approval.

2. A record review for Resident F was completed on 11/25/2025 at 2:18 P.M. Diagnoses included, but were not limited to: Alzheimer's disease, anxiety disorder and dementia with agitation.

A Physician's Order, dated 11/1/2025, included haloperidol concentrate (an antipsychotic medication) 2 milligrams per milliliter (mg/ml) take one

	milliliter every hour as needed for agitation. The Medication Administration Record (MAR), dated November 2025, indicated the following doses of haloperidol concentrate were administered without any documentation of prior approval from a licensed nurse. -11/14/2025 8:06 P.M. Haloperidol concentrate was administered for aggressiveness with staff and other residents by QMA 3. -11/16/2025 at 10:00 P.M. Haloperidol concentrate was administered for aggressiveness, no documentation of licensed nurse approval by QMA 3. During an interview, on 11/26/2025 at 10:03 A.M., QMA 6 indicated prior approval was needed from a licensed nurse for an as needed (PRN) medication to be administered. She indicated the approval was to be documented in the Medication Administration Record or in a progress note. During an interview, on 11/26/2025 at 10:49 A.M., the Director of Health and Wellness indicated all non-licensed nursing staff needed to call the licensed nurse prior to the administration of an as needed (PRN) medication and			

	document the approval. A policy was provided by the Executive Director, on 11/26/2025 at 12:43 P.M. The policy titled, "PRN Medications", indicated, " ...Only properly trained staff of the Community may provide PRN medication administration. Staff must be trained, with documentation on file. PRN medications must be administered according to the prescriber's orders ...." This citation relates to Intake 466065			
R 0297	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(c)(1) (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on record review and interview, the facility failed to account for narcotic medication cards and bottles for 2 of 2 medication carts. (North & South House)	R 0297	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. No residents were affected by deficient practice. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken. No potential threat to other residents 3. What measures will be put into place or what	12/08/2025

Finding includes:

A record review for the narcotic counts was completed, on 11/26/2025 at 9:57 A.M., for the North House. The narcotic count binder had a form titled, "Controlled Medication Count", dated November 2025. The form, which counted the number of narcotic medication cards and pill bottles, had four entries completed. On 11/1/2025 for the first shift count with the "on" shift initialed, 11/25/2025 with the first shift "on" shift initialed, the second shift count with the "off" shift initialed and the third shift count with the "on" and "off" shift initialed. QMA 2 placed an entry and initials during the record review for 11/26/2025 first shift "on" shift.

A record review for the narcotic counts was completed, on 11/26/2025 at 10:11 A.M., for the South House. The narcotic count binder had a form titled, "Controlled Medication Count", dated November 2025. The form, which counted the number of narcotic medication cards and pill bottles, had two entries completed, on 11/25/2025 for the first shift count with the "on" shift initialed and the second shift count with the "off" shift initialed.

During an interview, on 11/26/2025 at 10:03 A.M., QMA 2 indicated narcotic counts for

system changes the facility will make to ensure that the deficient practice does not recur?

Each unit has a revamped sign off sheet. Upon the beginning of shift and end of shifts, nursing staff will count each narc on both units. Hand off will not happen without count being done.

4. How the correction action(s) will be monitored to ensure the deficient practice will not recur- what quality assurance program will be put into place?

   Executive Director will audit narc books for 2x a week for 4 weeks, 1x a week for 4 months and randomly to ensure policy’s being followed.

5. By what date will the systemic changes be completed?

11/26/25 changes were completed.

the medication cards and pill bottles should have been completed at the beginning and end of every shift.

A policy was provided by the Executive Director, on 11/26/2025 at 12:45 P.M. The policy titled, "Narcotic Log", indicated, " ...6. The accuracy of the count will be documented by the initials of the personnel on the narcotic count sheet, along with the date and time count is performed. The RN [Registered Nurse] Supervisor will verify the documentation in the Narcotic Logbook including counts records regularly ...."

This citation relates to Intake 466065

Based on record review and interview, the facility failed to account for narcotic medication cards and bottles for 2 of 2 medication carts. (North & South House)

Finding includes:

A record review for the narcotic counts was completed, on 11/26/2025 at 9:57 A.M., for the North House. The narcotic count binder had a form titled, "Controlled Medication Count", dated November 2025. The form, which counted the number of narcotic medication cards and pill bottles, had four entries completed. On 11/1/2025 for the first shift count with the "on" shift

initialed, 11/25/2025 with the first shift "on" shift initialed, the second shift count with the "off" shift initialed and the third shift count with the "on" and "off" shift initialed. QMA 2 placed an entry and initials during the record review for 11/26/2025 first shift "on" shift.

A record review for the narcotic counts was completed, on 11/26/2025 at 10:11 A.M., for the South House. The narcotic count binder had a form titled, "Controlled Medication Count", dated November 2025. The form, which counted the number of narcotic medication cards and pill bottles, had two entries completed, on 11/25/2025 for the first shift count with the "on" shift initialed and the second shift count with the "off" shift initialed.

During an interview, on 11/26/2025 at 10:03 A.M., QMA 2 indicated narcotic counts for the medication cards and pill bottles should have been completed at the beginning and end of every shift.

A policy was provided by the Executive Director, on 11/26/2025 at 12:45 P.M. The policy titled, "Narcotic Log", indicated, " ...6. The accuracy of the count will be documented by the initials of the personnel on the narcotic count sheet, along with the date and time count is

	performed. The RN [Registered Nurse] Supervisor will verify the documentation in the Narcotic Logbook including counts records regularly ...." This citation relates to Intake 466065			

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 SIGNATUREJasmine Wynne	TITLEExecutive Director	(X6) DATE01/07/2026