

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER CELEBRATION VILLA OF NEWBURGH		STREET ADDRESS, CITY, STATE, ZIP CODE 5311 ROSEBUD LANE, NEWBURGH, , 47630			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE	
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. This visit included the Investigation of Intakes 466089, 468688, 469295, 469572, and 469888. Intake 466089 - State deficiencies related to the allegations are cited at R216 and R241. Intake 468688 - No deficiencies related to the allegations are cited. Intake 469295 - State deficiencies related to the allegations are cited at R246. Intake 469572 - No deficiencies related to the allegations are cited. Intake 469888 - State deficiencies related to the allegations are cited at R52, R241, and R349. Survey dates: July 27, 28, 29,	R 0000	This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions contained in the Statement of Deficiencies. This Plan of Correction is submitted as required by regulation.		

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	and 30, 2026 Facility number: 016891 Residential Census: 69 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on August 10, 2026			
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 a cognitively impaired resident from exiting the facility for 1 of 2 residents reviewed for elopement. (Resident G) The resident left the building on two occasions and was found in the nearby skilled facility 0.2 miles away, residential staff was unaware of	R 0052	The identified resident was assessed for wandering/elopement risk, and the service plan was updated to include appropriate supervision and observation needs. The resident's clinical record was reviewed to ensure appropriate follow-up and monitoring were completed and documented. All residents have the potential to be affected. The DON or designee will review current residents' assessments and service plans to identify residents at risk for wandering or elopement and ensure appropriate supervision, observation, and interventions are in place.	08/26/2026

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Resident G location until notified by the skilled facility. Finding includes: On 7/28/26 at 11:00 A.M., Resident G's clinical record was reviewed. Diagnoses included, but were not limited to, dementia. A pre-admission evaluation, dated 4/8/26, indicated that Resident G was independent in mobility, required observation every eight hours due to cognitive impairment, and required no supervision in the home or in familiar surroundings, but needed attendance in unfamiliar places. Resident G was admitted to the third floor of the assisted living section of the facility on 5/1/26. Admission service plans, dated 4/8/26, included but were not limited to the following care information: BIMS (brief interview for mental status) score - severe impairment The admission service plan lacked care information that addressed required observation due to cognitive impairment or the need for supervision in unfamiliar places. A facility observation note,		Staff will be educated on elopement prevention, monitoring residents at risk for wandering, following service-plan interventions, and accurately documenting required monitoring, follow-up, and the time a resident is unaccounted for. The DON or designee will audit residents identified as having wandering/elopement risk weekly for four weeks, followed by monthly audits for three months, to verify service plans, monitoring, and documentation are complete. Any concerns will be corrected immediately and reviewed through monthly QA for ongoing compliance.	
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	dated 5/2/26 at 11:45 A.M., indicated the facility received a phone call at 8:56 A.M. from a neighboring skilled facility stating that Resident G had walked over and was in their facility. When asked where he was going, Resident G indicated that he was going to the gas station to buy lottery tickets. Family indicated that in his prior living situation, Resident G would walk to the gas station every morning after breakfast. BIMS and Wander Risk assessments were updated. Documentation was lacking as to how long the resident was missing from the residential facility. The clinical record lacked documentation of an updated BIMS or a Wander Risk assessment. The clinical record lacked documentation to indicate the resident's service plan was updated with new care information following the incident. A facility observation note, dated 5/5/26 at 10:15 P.M., indicated Resident G continued to have increased confusion and the inability to locate his room and different areas of the facility. A facility observation note, dated 5/6/26 at 10:15 P.M.,			
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indicated Resident G required assistance getting to the dining room and his room.

A facility observation note, dated 5/8/26 at 9:45 A.M., indicated Resident G attempted to walk outside the doors on the first floor and was redirected to his room.

A facility observation note, dated 5/9/26 at 9:45 P.M., indicated Resident G continued to need frequent checks as he was unable to locate his room, the dining room, and was often seen walking on all floors. He exited his room frequently and indicated he wanted to go outside. He mumbled and rhymed his words. Resident G appeared at the second-floor nurse's station at approximately 9:30 P.M. in his underwear and socks without his cane and allowed staff to escort him back to his room on the third floor. He stated he didn't know where it was.

A facility observation note, dated 5/10/26 at 8:30 P.M., indicated Resident G continued to need assistance going to the dining room and returning to his room and that he was unable to find the elevator. The resident displayed increased levels of confusion and was often heard mumbling to himself as well as making random statements to

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staff, displaying difficulty with two-way conversation.

A 30-day assessment, completed on 5/17/26, indicated that Resident G was independent in mobility, wandered throughout community and occasionally outside, required observation every two hours, exhibited confusion, had non-purposeful wandering, and forgot where his room was.

Resident G's service plan was updated on 5/17/26. Care information included but was not limited to:

Cognitive/Behavioral/Psychosocial - Resident needs observation. Wanders throughout community and occasionally outside

Behaviors - Confusion - Non-purposeful wandering, forgets where room is

A facility observation note, dated 5/17/26 at 5:30 P.M., indicated that Resident G continued to need assistance finding his room upon leaving the dining hall and the front porch where he often sat.

A facility observation note, dated 7/24/26 at 9:15 A.M., indicated that the facility received a call at 6:00 A.M. from a neighboring skilled facility

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stating that Resident G had walked over there and was in their facility. When asked where he was going, Resident G indicated that he was going out to get some air and wasn't sure where he was walking to. The resident was placed on continuous staff monitoring until the family arrived.

Documentation was lacking as to how long the resident was missing from the residential facility.

The clinical record lacked documentation that indicated when family arrived at the facility.

The service plan was updated with the following care information:

Follow Up - Wandering: Check on resident each shift and document observations and interventions after wandering episode, dated 7/24/26 with a stop date of 8/3/26

The clinical record lacked documentation to indicate that Resident G was monitored for increased confusion and wandering during the following times:

Between his admission to the facility on 4/8/26 and 5/5/26 at 10:15 P.M.

Between 5/5/26 at 10:15 P.M.

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and 5/6/26 at 10:15 P.M.

Between 5/6/26 at 10:15 P.M.
and 5/8/26 at 9:45 A.M.

Between 5/8/26 at 9:45 A.M.
and 5/9/26 at 9:45 P.M.

Between 5/9/26 at 9:45 P.M.
and 5/10/26 at 8:30 P.M.

Between 5/10/26 at 8:30 P.M.
and 5/17/26 at 5:30 P.M.

Between 5/17/26 and 6/2/26

Between 6/5/26 and 7/24/26

A Care Provided History record indicated staff were to document a follow up - wandering task three times a day beginning on 7/24/26. The record lacked follow up documentation all three designated times on 7/24/26, 7/25/26, 7/26/26, and 7/27/26.

Observation on 7/29/26 at 12:40 P.M., Resident G was sitting on the front porch without staff supervision. He was not oriented to time.

Interview on 7/29/26 at 1:45 P.M., the Administrator indicated that she was not sure how staff monitored residents for wandering.

Interview on 7/30/26 at 10:25 A.M., the Director of Nursing (DON) indicated that the facility

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	was unaware that Resident G was a wanderer when he was admitted. Staff should have updated the service plan immediately following incident on 5/2/26, but they thought that the wandering could have been due to the unfamiliar environment. On 7/30/26 at 12:45 P.M., the DON provided handwritten Increased Supervision Logs, dated 5/2/26, 5/3/26, 5/4/26, 5/5/26, 7/27/26, 7/28/26, and 7/29/26. The Increased Supervision Logs from 5/2/26 to 5/5/26 for Resident G indicated staff should document the resident's observed activity hourly. The log lacked documentation to indicate staff monitored Resident G from 5/3/26 at 1:30pm to 5/4/26 at 7:00am. The last documented observation was on 5/5/26 at 2:00 P.M. The Increased Supervision Logs from 7/27/26 to 7/29/26 for Resident G indicated staff should document the resident's observed activity every two hours. The log lacked documentation to indicate staff monitored Resident G from 7/27/26 at 10:00 P.M. to 6:00 P.M. and from 7/28/26 at 2:00 P.M. to 7/29/26 at 6:00 A.M. The last documented			
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	observation was on 7/29/26 at 4:00 P.M. At that time, the DON indicated that Resident G received one on one supervision of staff on 7/25/26 and 7/26/26. The clinical record lacked documentation to indicate that staff members provided one on one supervision to Resident G on 7/25/26 and 7/26/26. On 7/30/26 at 8:08 A.M., the Administrator provided a current Missing Resident/Elopement Policy and Procedure, dated 6/29/18, that indicated "An elopement is the unauthorized exit of a resident, who lacks the necessary cognitive skills to maintain individual safety, from the Community without adequate supervision, or staff awareness ... All residents admitted/readmitted to the Community will be assessed by their Health Care Provider or community nurse for cognitive decline with the potential for unsafe exiting from the building ... The Administrator or designee will develop/revise the service plan immediately upon determination that a resident is at risk for elopement. At a minimum, the service plan will be developed/revise as follows: a. Upon admission/readmission b. A change in condition, which			
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	results in the resident being identified as an elopement risk ... If a resident is observed outside staff are to remain with the resident. DO NOT LEAVE RESIDENT UNATTENDED ... If the resident is placed on increased supervision, safety checks are documented in the resident record as scheduled (i.e. every 15 minutes) for the duration of the increased supervision ..." Google maps identified the three minute (0.2 mile) walk from one facility to another, the two facilities had adjoining property, grass, curbs and driveways if leaving from the patio area to the back of the residential building, The frontage area of the residential facility has a driveway leading to the street, the street curves around to lead to the neighboring facility. The street has multiple businesses and traffic from the north and southwest of the residential facility. This citation relates to Intake 469888.			
R 0216	Evaluation - Noncompliance 410 IAC 16.2-5-2(c)(1-4)(d) (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a	R 0216	The identified residents' records will be reviewed and corrected to ensure required weights are obtained and documented and that residents who self-administer medications	08/19/2026

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minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. 2. On 7/27/26 at 1:48 P.M., Resident C's clinical record was reviewed. Resident C's diagnoses included, but were not limited to, dementia. Resident C's most recent service plan included the following care information: Monthly Weights and Vitals Schedule: The first Monday of every 1 month at 12:00 P.M.; Start date 3/18/26 at 7:00 P.M. Resident C's clinical record lacked a weight obtained since 12/2025. 3. On 7/28/26 at 9:00 A.M., Resident D's clinical record was reviewed. Resident D's	have the required assessments and service plans. All residents have the potential to be affected. The DON or designee will review current residents' records to verify required weights, including physician-ordered weights, and self-administration assessments/service plans are complete and current. DON and nursing staff will be educated on requirements for timely weight monitoring, documentation of physician-ordered weights, and assessment and service planning for residents who self-administer medications. The DON or designee will audit weights and self-administration documentation weekly for four weeks, followed by monthly audits for three months. Any concerns will be corrected immediately and reviewed through monthly QA for ongoing compliance.	
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diagnoses included, but were not limited to, diabetes mellitus.

Resident D's most recent service plan, dated 6/2/26, included the following daily treatments and interventions:

Daily Weight - physician order.

Resident D's clinical record lacked daily weights obtained since 6/2/26.

4. On 7/27/26 at 1:54 P.M., Resident B's clinical record was reviewed. Diagnoses included, but were not limited to, Wernicke's encephalopathy.

Resident B was admitted to the facility on 9/30/25 and was discharged from the facility on 5/31/26.

The clinical record lacked a weight recorded semiannually. The last recorded weight was on 10/6/25.

Interview on 7/29/26 at 9:05 A.M., the Assistant Director of Nursing (ADON) indicated that she provided all the information that could be located for Resident B. At that time, she provided weights for Resident B dated 10/2/25 and 10/6/25.

On 7/30/26 at 8:08 A.M., the Administrator provided a current undated Weight Management policy that indicated "A routine

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	cycle will be established in the assistance/service plan for weight monitoring for each resident". This citation relates to Intake 466089. Based on observation, interview, and record review, the facility failed to ensure weights were recorded semi-annually and per physician order for 3 of 10 residents reviewed for weights (Resident B, Resident C, and Resident D) and residents that were self-administering medications were assessed for capability to self-administer medications for 1 of 5 residents reviewed for medication administration (Resident F) Findings include: 1. Observation on 7/27/26 at 2:14 P.M., a bottle of eardrops was observed sitting on Resident F's bedside table. The resident was unsure who the eardrops belonged to. On 7/27/26 at 2:32 P.M., Resident F's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus. The resident was admitted on 6/12/26. The clinical record lacked physician orders for eardrops and to self-administer			
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	medication. The clinical record lacked a service plan for self-administration of medication. The clinical record lacked self-administration of medication evaluation. Interview on 7/29/26 at 9:00 A.M., the Director of Nursing (DON) indicated that medications should not be left at the bedside. Residents needed physician orders and an evaluation in order to administer their own medication. On 7/30/26 at 8:08 A.M., the Administrator provided a current undated Medication Policy that indicated "Residents who elect not to participate in the Medication Management Program are solely responsible for dispensing and administering their own medication, including injectables, and must meet the following requirements: Have written approval from their physician. Participate in an Evaluation for Self-Administration to determine whether the resident can safely manage his/her own medications".			
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5)	R 0217	The nine identified residents' service plans will be reviewed	08/19/2026

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(e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows:

(1) The services offered to the individual resident shall be appropriate to the:

(A) scope;

(B) frequency;

(C) need; and

(D) preference;

of the resident.

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

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

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

(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be

and updated as needed.

Required resident signatures and dates will be obtained.

All residents have the potential to be affected. The DON or designee will review all current residents' service plans to verify they are current, reviewed, and properly signed and dated. Any identified concerns will be corrected.

The DON and appropriate nursing staff will be educated on the requirements for timely review, updating of service plans and obtaining all required signatures and dates.

The DON or designee will audit service plans weekly for four weeks, followed by monthly audits for three months. Findings will be corrected immediately and reviewed during monthly QA to ensure ongoing compliance.

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involved in identification and documentation of the services to be provided.

Based on interview and record review, the facility failed to ensure service plans were signed and updated for 9 of 10 residents reviewed for service plans. (Resident F, Resident L, Resident B, Resident G, Resident K, Resident C, Resident D, Resident 102, and Resident H)

Findings include:

1. On 7/27/26 at 2:32 P.M., Resident F's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus. The resident was admitted to the facility on 6/12/26.

The clinical record lacked a signed service plan.

2. On 7/28/26 at 8:50 A.M., Resident L's clinical record was reviewed. Diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease (COPD). The resident was admitted to the facility on 6/27/25.

The clinical record lacked a signed service plan.

6. On 7/27/26 at 1:48 P.M., Resident C's clinical record was reviewed. Resident C's

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diagnoses included, but were not limited to, dementia.

Resident C's most recent service plan, dated 5/21/26, lacked a signature from the resident or responsible party.

7. On 7/28/26 at 9:00 A.M., Resident D's clinical record was reviewed. Resident D's diagnoses included, but were not limited to, diabetes mellitus.

Resident D's most recent service plan, dated 6/2/26, lacked a signature from the resident or responsible party.

8. On 7/28/26 at 9:45 A.M., Resident 102's clinical record was reviewed. Resident 102's diagnoses included, but were not limited to, type 2 diabetes mellitus.

Resident 102's most recent service plan, dated 5/1/26, lacked a signature from the resident or responsible party.

9. On 7/28/26 at 10:58 A.M., Resident H's clinical record was reviewed. Diagnoses included, but were not limited to, vascular dementia.

Resident H's clinical record lacked a completed or signed service plan.

Interview on 7/28/26 at 10:03 A.M., the Regional Support

Nurse indicated that service plans were emailed to residents and resident representatives who signed them with a digital signature and sent them back. Then they were uploaded to the clinical record. She was aware that service plans were not being signed.

On 7/30/26 at 9:32 A.M., the Administrator provided an undated policy titled Assistance/Service Plan, that indicated "The Resident Assistant and Resident Services Coordinator will visit with the resident and family to develop the plan. All components of the assistance/service plan form must be completed."

3. On 7/28/26 at 11:00 A.M., Resident G's clinical record was reviewed. Diagnoses included, but were not limited to, dementia.

The most current service plan was updated and revised on 5/17/26. It was not signed by the resident or the resident's representative.

4. On 7/28/26 at 10:11 A.M., Resident K's clinical record was reviewed. Diagnoses included, but were not limited to, dementia.

The most current service plan was updated and revised on 5/12/26. It was not signed by

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	the resident or the resident's representative. 5. On 7/27/26 at 1:54 P.M., Resident B's clinical record was reviewed. Diagnoses included, but were not limited to, Wernicke's encephalopathy. The most current service plan was updated and revised on 2/26/26. It was not signed by the resident or the resident's representative.			
R 0241	Health Services - Offense 410 IAC 16.2-5-4(e)(1) (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on interview and record review, the facility failed to ensure medication was administered according to physician orders for 2 of 3 residents reviewed for insulin administration. (Resident P and Resident F)	R 0241	The identified residents' records will be reviewed to determine whether the ordered insulin was administered and ensure the administration is accurately documented. Residents were assessed for any changes in condition. No adverse effects were identified. All residents receiving insulin have the potential to be affected. The DON or designee will review insulin administration records to identify any doses that were administered but not documented and correct any identified concerns. Nursing staff will be re-educated that all insulin administrations must be documented accurately and timely in accordance with the physician's order and facility policy.	08/12/2026

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Findings include: 1. On 7/29/26 at 2:15 P.M., Resident P's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus. Physician orders included, but were not limited to: NovoLog (a rapid-acting insulin) 100 unit per milliliter (mL) Flexpen - Inject five units subcutaneously before meals for diabetes mellitus, dated 7/21/26 The electronic Medication Administration Record (eMAR) for July 2026 was reviewed. NovoLog 100 units/mL was not marked as completed on the following days: 7/27/26 at 11:00 A.M. 7/28/26 at 7:00 A.M. and 11:00 A.M. The clinical record lacked documentation to indicate why NovoLog 100 units/mL was not administered on 7/27/26 and 7/28/26. 2. On 7/29/26 at 2:30 P.M., Resident F's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus. Physician orders included, but		The DON or designee will audit insulin documentation weekly for four weeks, followed by monthly audits for three months. Any concerns will be corrected immediately and reviewed through QA for ongoing compliance.	
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were not limited to:

Humalog (a rapid-acting insulin)
100 units per milliliter (mL) -
Inject six units subcutaneously
before meals for diabetes
mellitus, dated 6/12/26

Lantus SoloStar (a long-acting
insulin) 100 units/mL - Inject 18
units subcutaneously once daily
for diabetes mellitus, dated
6/12/26

The electronic Medication
Administration Record (eMAR)
for July 2026 was reviewed.
Humalog 100 units/mL was not
marked as completed on the
following days:

7/13/26 at 7:00 A.M. and 11:00
A.M.

7/14/26 at 11:00 A.M.

7/15/26 at 7:00 A.M. and 11:00
A.M.

7/20/26 at 11:00 A.M. and 4:00
P.M.

7/21/26 at 11:00 A.M. and 4:00
P.M.

The clinical record lacked
documentation to indicate why
Humalog 100 units/mL was not
administered on 7/13/26,
7/14/26, 7/15/26, 7/20/26, and
7/21/26.

The eMAR for July 2026 was

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reviewed. Lantus SoloStar 100 units/mL was not marked as completed on the following days:

7/13/26

7/15/26

The clinical record lacked documentation to indicate why Lantus SoloStar 100 units/mL was not administered on 7/13/26 and 7/15/26.

Interview on 7/30/26 at 12:45 P.M., the Director of Nursing (DON) indicated that she did not know why the eMAR was blank in July for Resident P and Resident F's insulin administrations. She did not know if it was not given or just was not documented.

On 7/30/26 at 8:08 A.M., the Administrator provided a current undated Policy for Transcription and Compliance with Physician Orders that indicated "Compliance with the physician's order will be documented on the MAR/TAR for the duration of the order.

On 7/30/26 at 8:08 A.M., the Administrator provided a current Resident Medication Administration, dated 11/25/23, that indicated "Medications are to be administered as ordered by the provider."

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	On 7/30/26 at 8:08 A.M., the Administrator provided a current undated Documentation Best Practices policy that indicated "DO ...Document immediately after care ... Document refusals, education provided, and notifications ... DON'T ...Leave blank fields or incomplete documentation". This citation relates to intakes IN00466089 and IN469888.			
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.	R 0246	The identified residents' MARs were reviewed, and the QMA involved was re-educated on obtaining licensed nurse authorization prior to each PRN medication administration. All residents receiving PRN medications have the potential to be affected. The DON or designee will review PRN medication records to verify required nurse authorization is obtained and documented. All QMAs and nurses will be educated on the requirement for licensed nurse authorization prior to each QMA-administered PRN medication and appropriate documentation of authorization. The DON or designee will audit PRN medication administration weekly for four weeks, followed by monthly audits for three	08/12/2026

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	Based on interview and record review, the facility failed to obtain authorization from a licensed nurse prior to a Qualified Medication Aide (QMA) administering as needed (prn) medications for 1 of 5 closed resident records reviewed. (Resident H) Finding includes: On 7/28/26 at 10:58 A.M., Resident H's clinical record was reviewed. Diagnoses included, but were not limited to, anxiety. Physician orders included, but were not limited to: Hydroxyzine (an antianxiety medication) HCl 25 MG (milligrams) tablet Give one tablet three times daily as needed, Indications for use: anxiety; Start Date 1/16/26 Lorazepam (an antianxiety medication) Oral Concentrate 2 MG/ML (milligrams/milliliter) Take 0.25 ML (0.5MG) By mouth every four hours as needed, Indications for use: anxiety/agitation; Start Date 2/16/26 Morphine sulfate (a narcotic pain reliever) 100 MG/5ML Give 0.5ML by mouth every ½ hour as needed for pain or for shortness of breath; Start date 2/22/26		months. Any identified concerns will be corrected immediately and reviewed during monthly QA meetings to determine whether additional monitoring or corrective action is necessary.	
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	The following dates and times recorded in the Electronic Medication Administration Record (EMAR) indicated a QMA administered as needed (PRN) medications without nurse prior authorization: Hydroxyzine 25 MG: 2/1/26 5:24 A.M. 2/1/26 7:23 P.M. 2/2/26 5:16 A.M. 2/3/26 7:33 P.M. 2/3/26 10:29 P.M. 2/7/26 9:52 A.M. 2/7/26 7:31 P.M. 2/8/26 8:21 A.M. 2/8/26 12:17 P.M. 2/9/26 7:35 A.M. 2/9/26 11:45 A.M. 2/10/26 7:40 A.M. 2/14/26 5:10 P.M. 2/15/26 7:48 A.M. 2/15/26 12:32 P.M. 2/15/26 7:18 P.M. 2/20/26 8:32 P.M.			
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Lorazepam 0.5 MG:

2/16/26 9:33 P.M.

2/19/26 7:00 A.M.

2/19/26 8:07 P.M.

2/20/26 2:39 A.M.

2/20/26 5:48 P.M.

2/22/26 4:45 A.M.

2/22/26 7:30 A.M.

2/23/26 5:00 A.M.

2/23/26 7:08 P.M.

2/23/26 8:54 P.M.

2/23/26 10:07 P.M.

2/24/26 2:09 A.M.

Morphine 10 MG:

2/23/26 6:39 P.M.

2/23/26 8:54 P.M.

2/23/26 10:07 P.M.

2/24/26 2:09 A.M.

2/25/26 1:39 A.M.

2/25/26 7:00 A.M.

Interview on 7/30/26 at 9:49 A.M., the Director of Nursing (DON) indicated QMAs should call her after they have given a

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	PRN medication and let her know they gave it, some will call before they give it. On 7/30/26 at 9:32 A.M., the Administrator provided an undated policy titled Medication Policy, that indicated "requirements for PRN medication administration vary according to the resident's cognitive ability and will be given in accordance with physician's orders and licensing requirements" This citation relates to intake 469295.			
R 0247	Health Services - Deficiency 410 IAC 16.2-5-4(e)(7) (7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident. Based on observation, interview, and record review, the facility failed to ensure insulin was administered according to professional standards for 2 of 2 residents observed for insulin administration. (Resident F and Resident P) Findings include:	R 0247	The two identified residents will be assessed for adverse effects. Nurses involved will be re-educated and competency validated on proper insulin pen administration, including priming with two units prior to administration. All residents receiving insulin have the potential to be affected. The DON or designee will review insulin administration practices for all residents receiving insulin and correct any identified concerns. All staff administering insulin will be educated on proper insulin pen administration and facility policy.	08/12/2026

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	1. Observation on 7/27/26 at 11:00 A.M., Licensed Practical Nurse (LPN) 3 prepared and administered Humalog insulin to Resident F. LPN 3 turned the dose selector to six units. She did not prime the pen with two units prior to administration. Physician orders for Resident F included, but were not limited to: Humalog (a rapid-acting insulin) 100 units per milliliter (mL) - Inject six units subcutaneously before meals for diabetes mellitus, dated 6/12/26 2. Observation on 7/27/26 at 11:15 A.M., Licensed Practical Nurse (LPN) 3 prepared and administered NovoLog insulin to Resident P. LPN 3 turned the dose selector to five units. She did not prime the pen with two units prior to administration. Physician orders for Resident P included, but were not limited to: NovoLog (a rapid-acting insulin) 100 unit per milliliter (mL) Flexpen - Inject five units subcutaneously before meals for diabetes mellitus, dated 7/21/26		The DON or designee will conduct weekly insulin administration audits for four weeks, followed by monthly audits for three months. Findings will be corrected immediately and reviewed during monthly QA meetings for ongoing compliance.	
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	Interview on 7/27/26 at 11:30 A.M., LPN 3 indicated she should have primed the insulin pen with two units before giving the ordered dose of insulin to Resident F and Resident P. On 7/29/26 at 11:51 A.M., the Administrator provided a current insert for "Kwik Pen Education" dated July 2023. The insert indicated "... priming your pen means removing the air from the needle and cartridge...if you do not prime before each injection, you may get too much or too little insulin...to prime your pen, turn the dose knob to select 2 units..."			
R 0273	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(f) (f) All food preparation and serving areas (excluding areas in residents' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to ensure items were properly stored and labeled, and staff wore a hair covering in accordance with sanitation standards for 2 of 2 observations of the kitchen. (Kitchen and Activities Director)	R 0273	The kitchen was immediately inspected and the items identified as improperly stored or labeled were corrected. Food and other applicable items were properly stored, covered, and labeled. Staff were immediately reminded that required hair coverings must be worn while working in the kitchen. All residents have the potential to be affected by this deficient practice. The dietary manager conducted a complete inspection of all kitchen food storage areas, including refrigerators, freezers, dry storage, and food preparation areas, to identify	08/14/2026

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Findings include: 1. During an observation on 7/27/26 at 8:40 A.M., the following was observed in the kitchen: In the walk-in refrigerator: Racks of garlic bread- open to air, undated Metal container of shredded cheese- open to air, unlabeled Metal container of sliced tomatoes- open to air, unlabeled Bag of shredded cheese- open, undated Block of sliced cheese- open, undated Bag of cube cheese- open, undated In the reach-in refrigerator: Three cups of strawberries- undated Pitcher of brown liquid- undated, unlabeled Square container brown liquid- undated, unlabeled 2. During an observation on 7/29/26 at 1:02 P.M., the Activities Director was observed in the kitchen wearing a hairnet on the crown of her head; the bottom portion and ends of her	any additional improperly stored or labeled items. No other areas with improperly stored or unlabeled items were identified. All dietary staff practices were also reviewed for compliance with hair-covering requirements. All dietary staff received education on proper sanitation practices, including food storage and labeling requirements and the appropriate use of hair coverings. The Dietary Manager or designee will review these requirements with staff and incorporate them into routine kitchen oversight. New dietary employees will receive this education during orientation. The Dietary Manager or designee will conduct weekly audits for four weeks to verify proper storage and labeling of items and compliance with hair coverings. Audits will then be conducted monthly for three months and thereafter on an ongoing monthly basis to ensure sustained compliance. Any deficiency identified will be corrected immediately, with additional education provided as necessary. Audit results will be reviewed during monthly QA meetings to determine if further monitoring is necessary.	
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	hair were sticking out of the hairnet. Interview on 7/29/26 at 1:03 P.M., the Dietary Manager indicated staff should be dating everything in the kitchen with a received date, open date/preparation date, and expiration date. On 7/30/26 at 9:32 A.M., the Administrator provided an undated policy titled Storage of Refrigerated and Dry Foods, that indicated "All containers must be labeled with the contents and date food item was placed in storage." On 7/30/26 at 9:32 A.M., the Administrator provided an undated policy titled Employee Hygiene, that indicated "Employees must keep hair from contacting exposed food, clean equipment, utensils and linens. Exposed hair must be covered with hairnet, hat, etc."			
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R 0298	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(2) (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. Based on observation, interview, and record review, the facility failed to ensure proper storage of medication for 2 of 4 medication carts and 1 of 1 medication rooms observed. (Third Floor Medication Cart, Second Floor Medication Cart, and First Floor Medication Room) Findings include:	R 0298	The DON or designee immediately conducted an inspection of the identified medication carts and medication room. Loose, unlabeled, and expired medications were removed and disposed of according to facility policy. Refrigerator temperature logs were reviewed and brought current. All residents have the potential to be affected. The DON or designee will conduct a facility-wide inspection of all medication carts, medication rooms, and medication refrigerators to identify and correct any storage, labeling, expiration, or temperature-monitoring concerns. Nursing staff will be re-educated on proper medication storage, labeling, removal of expired medications, and daily refrigerator temperature documentation. Staff will be responsible for completing temperature logs daily and reporting out-of-range temperatures immediately. The DON or designee will conduct weekly audits of all medication carts, medication rooms, and medication refrigerator temperature logs for four weeks, followed by monthly audits for three months. Any	08/14/2026
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1. Observation on 7/27/26 at 9:15 A.M., the following loose pills and unlabeled, expired medication were observed in the Third Floor Medication Cart: 1 unlabeled bottle of nitroglycerin 0.4 milligrams (mg) with an expiration date of 4/2025 1 small white pill with markings "RE22" 1/2 small white pill 2. Observation on 7/27/26 at 9:30 A.M., the following loose pills were observed in the Second Floor Medication Cart: 3 small white oval pills with markings "A10" 1 small round blue pill with markings "B-28" 1 small white oval pill with markings "44" 1 small round light blue pill with markings "BG" 2 small green round pills with markings "ARI" 1 long white oval pill with markings "BP25" Interview on 7/27/26 at 9:30 A.M., Licensed Practical Nurse (LPN) 3 indicated that there shouldn't be any loose pills in		identified concerns will be corrected immediately, and additional education will be provided as needed. Findings will be reviewed during monthly QA meetings to determine whether further monitoring or corrective action is necessary to ensure ongoing compliance.	
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the medication carts. 3. Observation on 7/27/26 at 9:50 A.M., the Director of Nursing (DON) provided a refrigerator temperature log, dated July 2026, for the First Floor Medication Room. Temperatures were missing on the following days: July 1 July 2 July 3 July 4 July 5 July 6 July 7 July 8 July 9 July 19 July 23 July 24 Interview on 7/27/27 at 9:50 A.M., the Director of Nursing (DON) indicated that the log should be filled out every morning and did not know why the logs were not filled out. Interview on 7/30/26 at 9:15 A.M., the DON indicated that			
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	there should not be any expired medications or loose pills in the medication carts. On 7/30/26 at 11:51 A.M., the Administrator provided a current, undated Medication Refrigerator Temperature Monitoring policy that indicated "... medication refrigerator temperatures shall be checked and documented once each day that the community is in operation..." On 7/30/26 at 12:30 P.M., the Administrator provided a current, undated "Medication Storage" policy. The policy indicated "...Medications will be stored in medication storage carts and will be organized by resident name".			
R 0299	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(c)(3) (3) The medication review, recommendations, and notification of the physician, if necessary, shall be documented in accordance with the facility ' s policy. 2. On 7/28/26 at 10:11 A.M., Resident K's clinical record was reviewed. Diagnoses included, but were not limited to, anxiety.	R 0299	The DON or designee will review the pharmacy recommendations for the identified residents and ensure physician notifications and responses are obtained and documented in a timely manner. All residents have the potential to be affected. The DON or designee will review all current residents' pharmacy recommendations to verify that each recommendation has been reviewed, forwarded to the physician as applicable, and that the physician's response is	08/25/2026

Physician orders included, but were not limited to: hydroxyzine (an antianxiety medication) 25 milligram (mg) tablet - Take one table by mouth three times daily (TID) for anxiety, dated 4/8/26 A pharmacy review, dated 4/23/26, indicated "Hydroxyzine is not recommended for use as an anxiolytic drug due to the potential for anticholinergic side effects (e.g. confusion, urinary retention, falls, etc.) *Please note, she has experienced a couple falls since admission.* Recommend reducing the dose of hydroxyzine from 25mg TID to 10mg TID. If the medication is continued as written, please write a brief statement explaining the rationale, and that the risk vs. benefit has been considered". The physician had not signed the pharmacy review. The clinical record lacked documentation to indicate the physician reviewed and addressed the recommendation to decrease Resident K's hydroxyzine. 3. On 7/27/26 at 1:54 P.M., Resident B's clinical record was reviewed. Diagnoses included, but were not limited to, dementia. Physician orders included, but	documented. Nursing staff will be educated on the required process and timely follow-up of pharmacy recommendations, including documentation of physician notification and response. The DON or designee will audit pharmacy recommendations weekly for four weeks, then monthly for three months, to ensure timely review, physician notification, response, and documentation. Any identified concerns will be corrected promptly. Findings will be addressed during monthly QA meetings to determine if further monitoring is necessary	
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	were not limited to: donepezil 5 milligrams (mg) tablet - Take one tablet by mouth once daily for amnesia, dated 10/8/25 A pharmacy review, dated 4/23/26, indicated "Resident B is receiving donepezil 5 mg daily for Dementia. Donepezil is started at 5mg to minimize GI (gastro-intestinal) side effects, but maximal efficacy has been shown at 10 mg daily. If tolerated, dose should be increased from 5 mg to 10 mg at bedtime after 4 to 6 weeks of therapy. Please consider increasing donepezil to 10 mg at bedtime". The physician had not signed the pharmacy review. The clinical record lacked documentation to indicate the physician reviewed and addressed the recommendation to increase Resident B's donepezil. Interview on 7/30/36 at 9:43 A.M., the Director of Nursing (DON) indicated that pharmacy reviews were faxed to the resident's provider, the provider faxed the signed pharmacy review back with the response. If the facility did not receive the providers response, they refaxed the review to the provider. The pharmacy reviews were scanned and uploaded into the resident's clinical record			
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once the pharmacy reviews had been responded to. She indicated that providers did not respond a couple of times in April and one in June.

Interview on 7/30/26 at 10:37 A.M., the Regional Support Nurse indicated that the facility followed state rules in regards to pharmacy review requirements and guidelines.

Based on interview and record review, the facility failed to ensure pharmacist medication recommendations were reviewed, notification was sent to the physician, and physician response to the pharmacy recommendations was made, in a timely manner for 3 of 10 residents reviewed for unsigned drug regimen reviews. (Resident C, Resident K, and Resident B)

Findings include:

1. On 7/27/26 at 1:48 P.M., Resident C's clinical record was reviewed. Resident C's diagnoses included, but were not limited to, dementia.

Physician orders included, but were not limited to:

Alprazolam tablet 0.5MG (milligrams) by mouth take one tablet by mouth three times daily

Quetiapine tablet 25MG by mouth take one tablet by mouth

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once a day

A Pharmacist Recommendation to Provider, dated 4/23/26, indicated "Low doses of quetiapine would be expected to have a small effect on dopamine given the normal therapeutic dosing ranges, but may increase adverse effects.

Please note she has sustained a recent fall and also receives alprazolam 0.5mg tid (three times a day) which can contribute to falls as well.

Please evaluate current dose of quetiapine and if it could be discontinued. If quetiapine is to continue as ordered, please provide rationale as well as the risk/benefits of continuing therapy. If continued, please provide appropriate indication for use and complete an AIMS assessment." The pharmacist recommendation was not addressed by the provider as accepted or denied with rationale.

A Pharmacist Recommendation to Provider, dated 6/18/26, stated "Low doses of quetiapine have a high affinity for histamine H1 receptors, causing sedative effects, would be expected to have a small effect on dopamine given the normal therapeutic dosing ranges. Please evaluate current dose of quetiapine and consider discontinuing. If quetiapine is to continue as

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	ordered, please provide rationale as well as the risk/benefits of continuing therapy." The pharmacist recommendation was not addressed by the provider as accepted or denied with rationale.			
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. 5. On 7/28/26 at 8:50 A.M., Resident L's clinical record was reviewed. Diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease (COPD). The resident was admitted to the facility on 6/27/25. The clinical record lacked documentation to indicate pharmacy reviews had been completed every 60 days.	R 0349	The DON or designee will review the clinical records of the eight residents identified to ensure pharmacy reviews, insulin administration documentation, and medication administration times are complete and accurate. Any identified omissions or discrepancies will be corrected. All residents have the potential to be affected. The DON or designee will conduct a facility-wide audit of current residents' clinical records to verify that required documentation, including pharmacy reviews and medication administration records is complete, accurate, and readily accessible including verification that the individual administering the insulin documents the administration. Any identified omissions or inaccuracies will be corrected. Nursing staff will be re-educated on clinical-record documentation requirements, including that the individual administering insulin	08/14/2026

	6. On 7/28/26 at 1:47 P.M., Resident S's clinical record was reviewed. Diagnoses included, but were not limited to, Parkinson's disease. The resident was admitted to the facility on 11/27/24. The clinical record lacked documentation to indicate pharmacy reviews had been completed every 60 days. Interview on 7/28/26 at 10:07 A.M., the Director of Nursing (DON) indicated that she was unable to find the former DON's binder that contained all the pharmacy reviews. At that time, she provided a file folder with pharmacy reviews from June in it and indicated that was all she had. Interview on 7/29/26 at 1:45 P.M., the Administrator indicated she would need to call the pharmacy to get the pharmacy reviews that were completed in the past year because the facility did not have any record of them. 7. On 7/29/26 at 2:15 P.M., Resident P's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus. Physician orders included, but were not limited to: NovoLog (a rapid-acting insulin)		must document the administration under their own name/initial, and that the correct administration time must be recorded. Staff will also be educated to ensure required pharmacy reviews are maintained in the residents' clinical record. The DON or designee will audit MARs weekly for four weeks, then monthly for three months, to verify compliance. Any identified concerns will be corrected immediately and additional education provided as needed. Audit results will be reviewed during monthly QA meetings to ensure sustained compliance.	
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100 unit per milliliter (mL)
Flexpen - Inject five units
subcutaneously before meals
for diabetes mellitus, dated
7/21/26

The electronic Medication
Administration Record (eMAR)
for July 2026 was reviewed.
NovoLog 100 units/mL was
marked as administered by a
Qualified Medication Aide
(QMA) without insulin
certification on the following
days:

7/22/26 at 9:26 A.M. (given by
QMA 2)

8. On 7/29/26 at 2:30 P.M.,
Resident F's clinical record was
reviewed. Diagnoses included,
but were not limited to, diabetes
mellitus.

Physician orders included, but
were not limited to:

Humalog (a rapid-acting insulin)
100 units per milliliter (mL) -
Inject six units subcutaneously
before meals for diabetes
mellitus, dated 6/12/26

Lantus SoloStar (a long-acting
insulin) 100 units/mL - Inject 18
units subcutaneously once daily
for diabetes mellitus, dated
6/12/26

The electronic Medication
Administration Record (eMAR)
for July 2026 was reviewed.

Humalog 100 units/mL was marked as administered by a Qualified Medication Aide (QMA) without insulin certification on the following days:

7/19/26 at 8:56 A.M. (given by QMA 7)

7/19/26 at 1:25 P.M. (given by QMA 7)

7/19/26 at 5:45 P.M. (given by QMA 7)

The eMAR for July 2026 was reviewed. Lantus SoloStar 100 units/mL was marked as administered by a QMA without insulin certification on the following days:

7/19/26 (given by QMA 7)

7/21/26 (given by QMA 2)

7/28/26 (given by QMA 2)

Interview on 7/30/26 at 12:45 P.M., the Director of Nursing (DON) indicated that the QMAs did not administer insulin on those days, but the nurse who administered the insulin did not sign out of the QMA's account before documenting that the insulin had been given.

9. During a record review on 7/27/26 at 2:29 P.M., Resident C's Electronic Medication Administration Record (EMAR)

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indicated Resident C received alprazolam tablet 0.5MG (milligrams) on 7/27/26 at 2:58 P.M.

Interview on 7/27/26 at 2:36 P.M., the Dementia Care Director indicated all notes and medication administration in the Electronic Health Records System recorded an hour ahead of time in a different time zone.

Interview on 7/27/26 at 2:39 P.M., Qualified Medication Aide (QMA) 2 indicated the orders in the clinical record were entered for the correct time, and medications were administered at the correct time, but the charting system documented an hour in advance.

On 7/30/26 at 8:08 A.M., the Administrator provided a current undated Documentation Best Practices policy that indicated "DON'T...chart before care is provided ... Leave refusals undocumented ... Leave blank fields or incomplete documentation".

This citation relates to Intake 469888.

3. On 7/27/26 at 1:48 P.M., Resident C's clinical record was reviewed. Resident C's diagnoses included, but were not limited to, dementia.

Resident C lacked pharmacy

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reviews or recommendations in the clinical record within the last year.

4. On 7/28/26 at 9:00 A.M., Resident D's clinical record was reviewed. Resident D's diagnoses included, but were not limited to, diabetes mellitus.

Resident D lacked pharmacy reviews or recommendations in the clinical record within the last year.

Based on observation, interview, and record review, the facility failed to ensure documentation was complete, accurate, and readily accessible for 8 of 10 clinical records reviewed. Pharmacy reviews were not in the clinical record, insulin administration was not documented by the nurse who gave the insulin, and medication administration was documented in the wrong time zone. (Resident B, Resident C, Resident D, Resident F, Resident K, Resident L, Resident P, Resident S, and Electronic Health Record System)

Findings include:

1. On 7/27/26 at 1:54 P.M., Resident B's clinical record was reviewed. Diagnoses included, but were not limited to, Wernicke's encephalopathy.

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	Resident B was admitted to the facility on 9/30/25 and discharged on 5/31/26. The clinical record lacked documentation to indicate pharmacy reviews had been completed every 60 days. 2. On 7/28/26 at 10:11 A.M., Resident P's clinical record was reviewed. Diagnoses included, but were not limited to, dementia. Resident P was admitted to the facility on 4/3/26 and discharged on 7/8/26. The clinical record lacked documentation to indicate pharmacy reviews had been completed every 60 days.			
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R 0407	Infection Control - Noncompliance 410 IAC 16.2-5-12(b)(1-4) (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on observation, interview, and record review, the facility failed to ensure infection control practices were implemented during observations of 2 of 2 insulin administrations. (Resident F and Resident P) Findings include: 1. Observation on 7/27/26 at 11:00 A.M., Licensed Practical Nurse (LPN) 3 prepared and administered Humalog insulin to Resident F. She did not clean the stopper of the insulin pen with alcohol prior to placing the needle on the pen.	R 0407	The nurse involved was re-educated immediately on proper insulin administration procedures and infection control practices, including disinfecting the insulin pen stopper with alcohol and allowing it to dry prior to attaching the needle. The nurse will also be re-educated on completing all required documentation accurately and timely for insulin administration. The affected residents' records will be reviewed to ensure insulin administration and required documentation are complete. All residents have the potential to be affected by this deficient practice. The DON or designee will conduct an audit of all residents receiving insulin to ensure insulin pens are being handled according to infection control practices and that insulin administration is properly documented. Any identified concerns will be corrected immediately. All nurses and certified QMAs who administer insulin will receive education on infection control requirements for insulin administration, including proper disinfection of insulin pen stoppers prior to needle placement and administration, and the required documentation	08/14/2026
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	Physician orders for Resident F included, but were not limited to: Humalog (a rapid-acting insulin) 100 units per milliliter (mL) - Inject six units subcutaneously before meals for diabetes mellitus, dated 6/12/26 2. Observation on 7/27/26 at 11:15 A.M., Licensed Practical Nurse (LPN) 3 prepared and administered NovoLog insulin to Resident P. She did not clean the stopper of the insulin pen with alcohol prior to placing the needle on the pen. Physician orders for Resident P included, but were not limited to: NovoLog (a rapid-acting insulin) 100 unit per milliliter (mL) Flexpen - Inject five units subcutaneously before meals for diabetes mellitus, dated 7/21/26 Interview on 7/27/26 at 11:30 A.M., LPN 3 indicated that she forgot to clean the stopper on the insulin pen prior to attaching the needle. On 7/29/26 at 11:51 A.M., the Administrator provided a current insert for "Kwik Pen Education" dated July 2023. The insert indicated "Wipe the Rubber Seal with an alcohol swab".		for insulin administration. Competency validation will be completed as appropriate. The DON/designee will conduct weekly observations of insulin administration for four weeks, followed by monthly audits for three months. Audits will include observation of proper infection control practices and review of documentation for completeness and accuracy. Any identified deficiency will be immediately corrected, and additional education or competency validation will be provided as needed. Audit results will be reviewed during monthly QA meetings to determine if further monitoring is necessary until sustained compliance is demonstrated.	
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R 0410	Infection Control - Noncompliance 410 IAC 16.2-5-12(e)(f)(g) (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on interview and record review, the facility failed to ensure Tuberculosis (TB) testing was completed prior to or on admission, or annually for 3 of 10 resident records reviewed. (Resident C, Resident D, and Resident H) Findings include:	R 0410	For the three residents identified with incomplete or missing TB documentation, the facility will obtain and document the required TB testing or TB screening/risk assessment, as applicable, and ensure the results are maintained in the residents' clinical records. The Director of Nursing or designee will review each affected resident's record and follow up with the physician as necessary. All residents have the potential to be affected by this deficient practice. The DON or designee will conduct a review of all current residents' clinical records to verify that required TB testing, TB screening, and/or TB risk assessments were completed prior to or upon admission and annually thereafter, as applicable. Any missing, incomplete, or outdated documentation will be identified and corrected. Physician notification will be completed and documented when required. The facility will implement a TB compliance tracking system identifying admission and required testing/screening due dates. The DON or designee will monitor the TB log and verify timely completion and documentation of required TB testing, screening, and/or risk assessments and verify required	08/28/2026
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1. On 7/27/26 at 1:48 P.M., Resident C's clinical record was reviewed. Resident C's diagnoses included, but were not limited to, dementia. Resident C's clinical record lacked a tuberculin skin test or tuberculosis risk assessment completed within the last year. 2. On 7/28/26 at 9:00 A.M., Resident D's clinical record was reviewed. Resident D's diagnoses included, but were not limited to, diabetes mellitus. Resident D's clinical record lacked a tuberculin skin test completed prior to, on, or since admission. 3. On 7/28/26 at 10:58 A.M., Resident H's clinical record was reviewed. Diagnoses included, but were not limited to, vascular dementia. Resident H's clinical record lacked a tuberculin skin test completed prior to, on, or after admission. Interview on 7/30/26 at 9:48 A.M., the Director of Nursing (DON) indicated the facility did not have TB tests for the residents requested. On 7/30/26 at 9:32 A.M., the Administrator provided an undated policy titled Testing, that indicated "All residents will	TB documentation prior to or upon admission. Nursing staff will be educated on TB requirements and documentation standards. The Director of Nursing or designee will audit all resident records weekly for three months, then monthly indefinitely to ensure compliance. Any identified deficiency will be corrected immediately and additional education provided as needed. Audit results will be reviewed during monthly QA meetings to ensure sustained compliance.
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FORM APPROVED

OMB NO. 0938-0391

	be given a 2-step Mantoux (tuberculin) test per guidelines within 3 days of entering the residence".			
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATUREMichelle Weber	TITLEExecutive Director	(X6) DATE08/21/2026
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