

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/09/2026	
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 Post Survey Revisit (PSR) to the State Residential Licensure Survey and the Investigation of Intakes IN00466089, IN00469295, and IN00469888 completed on July 30, 2026. Intake IN00466089 - Not corrected. Intake IN00469295 - Corrected. Intake IN00469888 - Not corrected. Survey dates: September 9, 2026 Facility number: 016891 Residential Census: 64 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on September 15, 2026.	R 0000					

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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 interview and record review, the facility failed to prevent a cognitively impaired resident from exiting the facility for 1 of 1 residents reviewed for elopement. (Resident G) Finding includes: On 9/9/26 at 9:33 A.M., Resident G's clinical record was reviewed. Diagnoses included, but were not limited to, dementia.	R 0052	R052 Elopement/Wandering Corrective Action for the Resident Identified The resident identified in the deficient practice was immediately reassessed by the DON/Designee for wandering, exit seeking and elopement risk. The residents' current behaviors, cognitive status, history of wandering/exit seeking, and supervision needs were reviewed. The residents' service plan/clinical record was revised to include the supervision and monitoring necessary to maintain the residents' safety. Direct care staff were educated regarding the residents' current elopement risk, supervision requirements and the required documentation. Identification and Correction for other residents potentially affected: All residents have the potential to be affected by the deficient practice. Systemic Changes: For competency training, the Maintenance Director conducted an elopement drill with education.	10/07/2026
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	A level of care assessment, dated 8/14/26, indicated that Resident G was independent in mobility, exhibited confusion, non-purposeful wandering, forgot where his room was, and required supervision every two hours due to a history of wandering and elopement. A current service plan, dated 8/14/26, included, but were not limited to, the following care information: BIMS (brief interview for mental status) score - severe impairment Wandering/Elopement - Supervision - Provide supervision and redirection to avoid and prevent wandering episodes. Increased Supervision - Monitor resident's location every two hours daily at 12:00 P.M., 2:00 P.M., 4:00 P.M., 6:00 P.M., 8:00 P.M., 10:00 P.M., 12:00 A.M., 2:00 A.M., 4:00 A.M., 6:00 A.M., 8:00 A.M., 10:00 A.M., As Needed Cognitive/Behavioral/Psychosocial - Supervision - Resident requires supervision every two hours due to history of wandering/elopement An increased monitoring log, dated 8/27/26 through 9/9/26, was reviewed. The log lacked		The DON/Designee will review the residents clinical record to verify that the interventions are being implemented consistently and that monitoring is documented as required. Monitoring: The DON/Designee will complete an initial audit of AL residents, thereafter, DON/Designee will review all AL residents weekly for 12 weeks, and monthly thereafter. Any identified areas will be placed on the QA log and reviewed monthly by the QA committee thereafter.	
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documentation to indicate staff monitored Resident G on the following days:

8/28/26 4:00 P.M. - 12:00 A.M.

8/30/26 8:00 A.M. - 4:00 P.M.

8/31/26 4:00 P.M. - 12:00 A.M.

9/2/26 4:00 P.M. - 12:00 A.M.

9/4/26 10:00 P.M. - 12:00 A.M.

9/7/26 6:00 A.M. - 12:00 A.M.

A staff observation note, dated 8/28/26 at 11:30 P.M., indicated that "Resident took the exit door by his apartment on the 3rd floor down the stairs and out of the activity room doors on the first floor. QMA (Qualified Medication Aide) walked past and noticed the door was propped open and resident was sitting outside on the porch. QMA directed resident back inside facility and up the elevator and back up to his apartment".

Interview on 9/9/26 at 12:43 P.M., the Administrator indicated that Resident G had a staff caregiver assigned to him during awake hours, but not at night. She indicated staff were supposed to be checking on him every two hours and documenting it on the increased monitoring log.

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	On 9/9/26 at 2:28 P.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 ... 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" This deficiency was cited on 7/30/26. The facility failed to implement a systemic plan of correction to prevent recurrence.			
R 0216	Evaluation - Noncompliance 410 IAC 16.2-5-2(c)(1-4)(d) (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on	R 0216	Tag 216 was corrected on Post Survey Revisit.	10/07/2026

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	admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility.			
R 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	R 0217	Tag was corrected on Post Survey Revisit	10/07/2026

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	shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.			
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 2 residents reviewed for insulin	R 0241	R241 1. Corrective Action for Residents Identified: The facility conducted a review of the medication administration record, and related clinical documentation for the residents identified in the deficiency to ensure the accuracy of documentation and administration. Residents were assessed for any changes in condition, and no adverse effects were noted. 1. Identification of other residents potentially affected:	10/07/2026

administration. (Resident P and Resident F) Findings include: 1. On 9/9/26 at 10:30 A.M., Resident P's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus, hypertension, and mild cognitive impairment. 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 aspirin (a blood thinner) 81 milligrams (mg) - Take one tablet by mouth twice daily donepezil (a medication used to treat memory loss) 10 mg - Take one tablet by mouth at bedtime The electronic Medication Administration Record (eMAR) for 8/26/26 through 9/8/26 was reviewed. NovoLog 100 units/mL was not marked as completed on the following days: 8/31/26 at 7:00 A.M. and 11:00 A.M. The electronic Medication Administration Record (eMAR)		The facility recognizes that all residents receiving medications have the potential to be affected by incomplete medication administration documentation or failure to document the clinical reason a medication was not administered. 1. Systemic Changes: Nursing staff were re-educated on a medication omission, that it must not be left blank space on the medication administration record without the reason clearly documented in the record. 1. Monitoring: Starting 9/10/26, the DON/Designee are completing daily audits of the medication record for 4 weeks, followed by weekly audits for 4 weeks, and ongoing monthly thereafter. Any identified areas will be reviewed by the QA committee monthly. Routine MAR reviews will continue.	
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for 8/26/26 through 9/8/26 was reviewed. Aspirin 81 mg was not marked as completed on the following days:

9/3/26 at 8:00 P.M.

9/4/26 at 8:00 P.M.

9/6/26 at 8:00 P.M.

The electronic Medication Administration Record (eMAR) for 8/26/26 through 9/8/26 was reviewed. Donepezil 10 mg was not marked as completed on the following days:

9/3/26 at 8:00 P.M.

9/4/26 at 8:00 P.M.

9/6/26 at 8:00 P.M.

The clinical record lacked documentation to indicate why the medication was not administered.

2. On 9/9/26 at 10:11 A.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:

NovoLog (a rapid-acting insulin) 100 unit per milliliter (mL)
Flexpen - Inject six units subcutaneously three times a day before meals for diabetes

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mellitus

midodrine (medication used to treat low blood pressure upon standing up) 5 milligrams (mg) - Give one tablet by mouth three times daily for hypotension

The electronic Medication Administration Record (eMAR) for 8/26/26 through 9/8/26 was reviewed. NovoLog 100 units/mL was not marked as completed on the following days:

8/31/26 at 11:00 A.M.

9/6/26 at 11:00 A.M.

The electronic Medication Administration Record (eMAR) for 8/26/26 through 9/8/26 was reviewed. Midodrine 5 mg was not marked as completed on the following days:

8/29/26 at 2:00 P.M.

The clinical record lacked documentation to indicate why the medications were not administered.

On 9/9/26 at 10:55 A.M., the plan of correction (POC) audit binder was reviewed. The binder lacked completed audits related to medication administration and documentation of the administration.

Interview on 9/9/26 at 12:48 P.M., the Director of Nursing (DON) indicated that she did not know why the eMAR was blank for Resident P and Resident F's medication administrations. Nursing staff were supposed to check for holes in the eMAR at the end of their shifts. If a medication was given and not documented, they were supposed to correct it. If a medication was not given, they were supposed to let her know. She had not started auditing residents' MARs for medication administration and documentation.

On 9/9/26 at 2:28 P.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 9/9/26 at 2:28 P.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."

This deficiency was cited on 7/30/26. The facility failed to implement a systemic plan of correction to prevent recurrence.

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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	Tag was corrected on Post Survey Revisit	10/07/2026
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.	R 0247	Tag was corrected on Post Survey Revisit	10/07/2026
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	R 0273	R273 Corrective Action: Upon identification of continued noncompliance during the revisit, the facility immediately initiated a re-evaluation of kitchen food storage, labeling	10/07/2026

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standards, including 410 IAC 7-24. Based on observation, record review, and interview, the facility failed to ensure that food containers were appropriately labeled with open and expiration dates and boxes were off the floor during 1 of 1 kitchen observations. (Kitchen) Finding includes: Observation on 9/10/26 at 9:00 A.M., the following was observed during the kitchen tour: Reach-in refrigerator: 2 bottles of white liquid with no label, preparation date, or use by date 1 bottle of orange colored liquid with no label, preparation date, or use by date 1 bottle of brown colored liquid with no label, preparation date, or use by date 1 bottle of yellow colored liquid with no label, preparation date or use by date 1 bottle of clear and brown liquids with no label, preparation date or use by date 1 container of white rice with no label or open date	and sanitation practices. The Dietary Manager immediately inspected all food storage, refrigeration, freezer, dry storage, and food preparation areas. Any item identified as improperly stored, uncovered, unlabeled, expired, or otherwise not meeting applicable requirements was immediately corrected or discarded as appropriate. Identification of Others Potentially Affected: All residents have the potential to be affected by deficient dietary practices. Systemic Changes: All Dietary staff were re-educated on food storage/labeling and sanitation. The Dietary Manager/Designee will complete a daily kitchen compliance check for food storage, labeling, and covering of food. Any deficiency identified during an audit will be corrected immediately with the corrective action documented. The Dietary Manager will review compliance with dietary staff during routine shift oversight and will address any repeated noncompliance through	
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1 bottle of salsa with no open date

1 container of prune juice with no open date

Sitting on a shelf above the preparation area:

3 open containers of cereal with no label or open date

Dry storage:

1 container of biscuits with no use by date

3 boxes sitting on the floor

1 roll of tortillas with no open date

1 bag of rice cereal with no open date

In the reach-in freezer:

1 container of tuna salad with a prep date of 8/20/26

1 large bowl of fruit salad with a prep date of 9/3/26

3 boxes sitting on the floor

Interview on 9/9/26 at 9:05 A.M., Kitchen Aide 6 indicated that all containers needed to be labeled and dated.

Interview on 9/9/26 at 9:15 A.M., Cook 9 indicated that the wrong date was probably placed on the tuna salad, but she

additional education and/or employee counseling.

Monitoring:

The Administrator and/or Designated leadership will complete a daily audit to ensure compliance with food storage, labeling, and sanitation for 4 weeks. Bi-weekly audits will be conducted for the next 6 weeks, and monthly thereafter. Any identified areas of concern will be corrected immediately, placed on the QA log.

All audits will be reviewed by the QA committee, and any identified areas will be placed on the QA log and reviewed monthly by thereafter.

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	would throw it away and there should be no boxes on the floor. On 9/9/23 at 2:28 P.M., the Administrator provided a current, non-dated policy "Storage of Refrigerated and Dry Foods." The policy indicated " all containers must be labeled with the contents and date food item was placed in storage..." This deficiency was cited on 7/30/26. The facility failed to implement a systemic plan of correction to prevent recurrence.			
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	R 0298	R298 Corrective Action for the Specific Findings: Immediately upon identification during the revisit survey, the expired medication and loose pills were removed from the medication cart and disposed of in accordance with facility policy and applicable medication-disposal requirements. Staff re-education was initiated. Identification of Other Residents Potentially Affected: All residents whose medications are stored or administered by the facility have the potential to be affected by this deficient practice. Systemic Changes: 9/10/26-the DON/Designee	10/07/2026

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drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. Based on observation, record review, and interview, the facility failed to ensure proper storage of medication in 1 of 2 medication carts observed. (Second Floor Medication Cart) Finding includes: Observation on 9/9/26 at 9:45 A.M., the Second Floor Medication Cart was observed to have the following loose pills and expired medication: 1 bottle of nitroglycerin had an expiration date of 7/2026 2 small round blue pills with markings HH208 1 small round white pill with markings Z541 Interview on 9/9/26 at 9:50 A.M. Qualified Medication Aide (QMA) 4 indicated that the loose pills should not be there and that she would have to call and replace the expired nitroglycerin. On 9/9/26 at 2:28 P.M., the Administrator provided a current, non-dated policy "Medication Policy." The policy		completed a 100% inspection of all medication carts and medication-storage areas within the community. Any concerns identified were corrected immediately. 9/10/26- DON/Designee re-educated all licensed nurses and Qualified Medication Aides who store, handle, or administer medications. Monitoring: The DON/Designee will audit 100% of medication carts and medication-storage areas: Twice weekly for 4 weeks; Weekly for 8 weeks; and monthly thereafter. All logs and audits will be reviewed by the QA committee, and any identified areas will be placed on the QA log and reviewed monthly thereafter.	
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	indicated"...Our community complies with all state licensing and environmental regulations in regards to the destruction and disposal of discontinued or expired medications..." This deficiency was cited on 7/30/26. The facility failed to implement a systemic plan of correction to prevent recurrence.			
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.	R 0299	Tag was corrected on Post survey revisit.	10/07/2026
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.	R 0349	Tag was corrected on Post Survey Revisit	10/07/2026

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	(4) Systematically organized.			
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.	R 0407	Tag was corrected on post survey revisit.	10/07/2026
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	R 0410	R410 Corrective Action: Immediately following identification of continued noncompliance during the revisit survey, the DON/Designee reviewed the clinical records of 100% of residents in the community. Any resident who does not have documentation of an acceptable initial TB test on file will receive an	10/07/2026

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 for 1 of 2 residents reviewed for TB testing. (Resident D)

Finding includes:

On 9/9/26 at 9:09 A.M., Resident D's clinical record was reviewed. Resident D's diagnosis included, but was not limited to, diabetes mellitus.

Resident D's clinical record lacked a tuberculin skin test completed prior to, on, or since admission.

Interferon Gamma Release Assay(IGRA) blood test. Results will be obtained, reviewed by the DON/Designee, and maintained in the residents' clinical record.

Identification and Correction of Other Residents Potentially Affected:

All residents have the potential to be affected by this deficient practice.

Systemic Changes to Prevent Recurrence:

100% audit of all current resident clinical records has been completed for verification of an appropriate initial TB test and that supporting documentation is in the clinical record.

Any current resident for whom an acceptable initial TB test cannot be verified will receive and IGRA blood test.

Effective immediately, the facility will ensure verification of TB compliance before a new resident is permitted to move into the community.

Monitoring:

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FORM APPROVED

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OMB NO. 0938-0391

During an interview on 9/9/26 at 12:45 P.M., the Administrator indicated Resident D had not received a TB skin test but was given a risk assessment questionnaire on 8/17/26.

On 9/9/26 at 2:28 P.M., the Administrator provided an undated policy titled Mantoux Testing Policy, that indicated "All assisted living residents will have a two-step mantoux within three days of admission unless one was completed within 3 months of admission to the residence. All staff and residents will be retested per state and county guidelines, annually."

This deficiency was cited on 7/30/26. The facility failed to implement a systemic plan of correction to prevent recurrence.

Starting 9/10/26, the DON/Designee will audit 100% of new admissions weekly for 4 weeks. Audits will be completed monthly for an additional 5 months.

The QA Committee will review the audits and any identified areas will be placed on the

QA log and reviewed monthly by the QA committee thereafter.

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) DATE10/02/2026