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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CELEBRATION VILLA OF NEWBURGH	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 the Investigation of Intake IN00464374, IN00464964, IN00464982, IN00465035, and IN00465036. Intake IN00464374 - State deficiencies related to the allegations are cited at R0243 and R0245. Intake IN00464964 - No deficiencies cited related to the allegations. Intake IN00464982 - State deficiencies related to the allegations are cited at R0117, R0144, and R0241. Intake IN00465035 - State deficiencies related to the allegations are cited at R0117. Intake IN00465036 - No deficiencies cited related to the allegations. Survey date: October 8, 9, and 10, 2025	R 0000	This plan of correction is not to be construed as an admission of, or agreement with the findings and conclusions in the statement of deficiencies. This Plan of Correction is being submitted as required by regulation.	

	Facility number: 016891 Residential Census: 69 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on October 16, 2025.			
R 0006	Scope of Residential Care - Deficiency 410 IAC 16.2-5-0.5(f)(1-5) (f) The resident must be discharged if the resident: (1) is a danger to the resident or others; (2) requires twenty-four (24) hour per day comprehensive nursing care or comprehensive nursing oversight; (3) requires less than twenty-four (24) hour per day comprehensive nursing care, comprehensive nursing oversight, or rehabilitative therapies and has not entered into a contract with an appropriately licensed provider of the resident ' s choice to provide those services; (4) is not medically stable; or (5) meets at least two (2) of the following three (3) criteria unless the resident is medically stable and the health facility can meet the resident ' s needs: (A) Requires total assistance with eating.	R 0006	The ADON reassessed the resident and confirmed that the resident required higher level of care needs that could not be met within the facility. The physician and responsible party were notified, and discharge planning was initiated with full documentation as required. All current resident service plans and assessments will be reviewed by the DON to ensure that residents' care needs remain within the facilities acuity guidelines and state regulations. No additional residents have been identified as requiring higher level of care.	11/10/2025

	(B) Requires total assistance with toileting. (C) Requires total assistance with transferring. Based on observation, interview, and record review, the facility failed to discharge a resident who had been determined to require a level of care beyond the scope of services the facility could provide. A resident remained in the facility and had not received a discharge notice and required total assistance with toileting and transferring. (Resident F) Finding includes: On 10/9/25 at 9:20 A.M., Resident F's clinical record was reviewed. Diagnoses included, but were not limited to, Alzheimer's dementia, Parkinson's disease, and spinal dementia. The most recent service plan report, dated 7/3/25, indicated Resident F required the assistance of 1 person for bathing, toileting, and transferring. Resident F was evaluated by physical therapy on 8/26/25 and the notes indicated, "Remaining Impairments: Patient demonstrates decreased strength, decreased balance, decreased activity tolerance and		The admission and discharge policy was reviewed with ED and DON to ensure timely discharge of any resident who exceeds the facility's acuity guidelines and state regulations. DON and/or designee will review all new admissions and reassessments per schedule and as necessary to ensure residents meet the facility’s acuity guidelines and state regulations. DON or designee will review all resident assessments quarterly, with any change in condition, and as necessary, and review service plan updates to verify that residents remain within the company acuity guidelines and state regulations. Any resident identified as requiring total assistance or skilled nursing care will be reviewed for discharge as appropriate. The QA committee will review all discharge related documentation monthly indefinitely to ensure compliance with state regulations and facility	

	decreased safety which limit functional mobility and increase fall risk ...Chair/bed-to-chair transfer = Substantial/maximal assistance. Toilet transfer = Substantial/maximal assistance. During an observation of care on 10/10/25 at 9:16 A.M., Qualified Medication Aide (QMA) 3 and QMA 5 provided total care to transfer Resident F from the motorized scooter to the shower. QMA 3 and QMA 5 both had to assist Resident F to stand, pivot, and sit down in the shower. Resident F indicated she was unable to stand on her own. QMA 5 had to remove all articles of clothing from Resident F as she was unable to remove them. During an interview on 10/9/25 at 1:21 P.M., the Assistant Director of Nursing (ADON) indicated Resident F is an extensive assist of 1 to 2 persons for transferring, toileting, and showers. During an interview on 10/10/25 at 9:42 A.M., Physical Therapy Assistant (PTA) 7 indicated Resident F was not an easy transfer as she needed a lot of assistance and had difficulty moving her feet. During an observation on 10/10/25 at 10:08 A.M., Resident F used her motorized wheelchair in her room and ran		acuity guidelines. Compliance will be verified during internal audits and state readiness reviews.	

into the bathroom door and smashed her left foot. At that time, Resident F indicated she fully relied on staff assistance to transfer and toilet.

On 10/10/25 at 9:15 A.M., Regional Support 11 provided Resident F's current Resident Policies and Agreement, dated 11/27/24, that indicated, " ...It is the policy of the Community not to accept for admission or retain ...(2) persons who routinely require a two- person assist to transfer ..."

Based on observation, interview, and record review, the facility failed to discharge a resident who had been determined to require a level of care beyond the scope of services the facility could provide. A resident remained in the facility and had not received a discharge notice and required total assistance with toileting and transferring. (Resident F)

Finding includes:

On 10/9/25 at 9:20 A.M., Resident F's clinical record was reviewed. Diagnoses included, but were not limited to, Alzheimer's dementia, Parkinson's disease, and spinal dementia.

The most recent service plan report, dated 7/3/25, indicated Resident F required the assistance of 1 person for

	bathing, toileting, and transferring. Resident F was evaluated by physical therapy on 8/26/25 and the notes indicated, "Remaining Impairments: Patient demonstrates decreased strength, decreased balance, decreased activity tolerance and decreased safety which limit functional mobility and increase fall risk ...Chair/bed-to-chair transfer = Substantial/maximal assistance. Toilet transfer = Substantial/maximal assistance. During an observation of care on 10/10/25 at 9:16 A.M., Qualified Medication Aide (QMA) 3 and QMA 5 provided total care to transfer Resident F from the motorized scooter to the shower. QMA 3 and QMA 5 both had to assist Resident F to stand, pivot, and sit down in the shower. Resident F indicated she was unable to stand on her own. QMA 5 had to remove all articles of clothing from Resident F as she was unable to remove them. During an interview on 10/9/25 at 1:21 P.M., the Assistant Director of Nursing (ADON) indicated Resident F is an extensive assist of 1 to 2 persons for transferring, toileting, and showers. During an interview on 10/10/25 at 9:42 A.M., Physical Therapy			

	Assistant (PTA) 7 indicated Resident F was not an easy transfer as she needed a lot of assistance and had difficulty moving her feet. During an observation on 10/10/25 at 10:08 A.M., Resident F used her motorized wheelchair in her room and ran into the bathroom door and smashed her left foot. At that time, Resident F indicated she fully relied on staff assistance to transfer and toilet. On 10/10/25 at 9:15 A.M., Regional Support 11 provided Resident F's current Resident Policies and Agreement, dated 11/27/24, that indicated, " ...It is the policy of the Community not to accept for admission or retain ...(2) persons who routinely require a two- person assist to transfer ..."			
R 0117	Personnel - Deficiency 410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff	R 0117	This schedule was immediately revised to ensure that the appropriate nursing staff were present in the facility on all shifts. Staff were reassigned as needed to provide continuous coverage and meet staffing requirements. All current staffing schedules were reviewed to ensure compliance	11/10/2025

	person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on observation, interview, and record review, the facility failed to have sufficient daily nursing staff in the facility for 4 of 5 months reviewed for staffing. There was not a licensed nurse or Qualified Medication Aide (QMA) in the building at all times when the daily facility census was 50 or more residents. Finding includes: On 10/8/25 at 4:11 A.M., Certified Nurse Aide (CNA) 20 indicated first shift was from 6:00 A.M. until 2:00 P.M. Second shift was 2:00 until 10:00 P.M. Third shift was 10:00 P.M. until 6:00 A.M. She indicated she had worked without nursing staff on third		with state requirements. No additional staffing gaps were identified. The DON or designee will monitor daily schedules to ensure a licensed nurse, QMA and all appropriate nursing staff are on duty during all shifts. The DON or designee will review staffing schedules weekly for four weeks, then monthly for three months to ensure ongoing compliance. Results will be reviewed in monthly QA meetings to determine if continued monitoring is necessary.	

shift several times and had to tell residents that she was unable to give them medications they had requested. She was also working when a resident fell a couple weeks ago and she had to call Emergency Medical Services (EMS) because there wasn't a nurse in the facility to assess the resident.

On 10/10/25 at 10:35 A.M., nursing staff schedules as worked were provided by Regional Support 13. The following dates and shifts lacked a Certified QMA or licensed nurse in the facility when the facility census was 50 or more residents:

6/1/25-1st and 3rd

6/27/25-3rd

7/2/25-3rd

7/4/25 - 1st and 3rd

7/7/25-3rd

7/9/25-3rd

7/11/25-3rd

7/13/25-3rd

7/14/25-1st

8/1/25-3rd

8/2/25-2nd and 3rd

8/3/25-3rd

	8/4/25-3rd 8/5/25-3rd 8/7/25-3rd 8/9/25-3rd 8/11/25-3rd 8/12/25-3rd 8/13/25-3rd 8/14/25-3rd 8/18/25-2nd 8/20/25-1st 8/21/25-1st and 2nd 8/23/25-3rd 8/24/25-3rd 9/1/25-2nd 9/3/25-1st 9/4/25-2nd 9/8/25-2nd 9/10/25-1st 9/12/25-3rd 9/13/25-3rd 9/14/25-3rd 9/19/25-3rd 9/20/25-3rd			

	9/21/25-3rd 9/22/25-2nd During an interview on 10/10/25 at 11:39 A.M., Regional Support 13 indicated at that time, they should have nursing on each shift and they may have more documentation of agency workers, the Director of Nursing, or Assistant Director of Nursing being in the building on those dates but it was not made available during the survey period. She indicated they did not have a staffing policy, but they would follow state regulations. This citation relates to Intakes IN00465035 and IN00464982. Based on observation, interview, and record review, the facility failed to have sufficient daily nursing staff in the facility for 4 of 5 months reviewed for staffing. There was not a licensed nurse or Qualified Medication Aide (QMA) in the building at all times when the daily facility census was 50 or more residents. Finding includes: On 10/8/25 at 4:11 A.M., Certified Nurse Aide (CNA) 20 indicated first shift was from 6:00 A.M. until 2:00 P.M. Second shift was 2:00 until 10:00 P.M. Third shift was 10:00 P.M. until 6:00 A.M. She			

	indicated she had worked without nursing staff on third shift several times and had to tell residents that she was unable to give them medications they had requested. She was also working when a resident fell a couple weeks ago and she had to call Emergency Medical Services (EMS) because there wasn't a nurse in the facility to assess the resident. On 10/10/25 at 10:35 A.M., nursing staff schedules as worked were provided by Regional Support 13. The following dates and shifts lacked a Certified QMA or licensed nurse in the facility when the facility census was 50 or more residents: 6/1/25-1st and 3rd 6/27/25-3rd 7/2/25-3rd 7/4/25 - 1st and 3rd 7/7/25-3rd 7/9/25-3rd 7/11/25-3rd 7/13/25-3rd 7/14/25-1st 8/1/25-3rd			

	8/2/25-2nd and 3rd 8/3/25-3rd 8/4/25-3rd 8/5/25-3rd 8/7/25-3rd 8/9/25-3rd 8/11/25-3rd 8/12/25-3rd 8/13/25-3rd 8/14/25-3rd 8/18/25-2nd 8/20/25-1st 8/21/25-1st and 2nd 8/23/25-3rd 8/24/25-3rd 9/1/25-2nd 9/3/25-1st 9/4/25-2nd 9/8/25-2nd 9/10/25-1st 9/12/25-3rd 9/13/25-3rd 9/14/25-3rd			

	9/19/25-3rd 9/20/25-3rd 9/21/25-3rd 9/22/25-2nd During an interview on 10/10/25 at 11:39 A.M., Regional Support 13 indicated at that time, they should have nursing on each shift and they may have more documentation of agency workers, the Director of Nursing, or Assistant Director of Nursing being in the building on those dates but it was not made available during the survey period. She indicated they did not have a staffing policy, but they would follow state regulations. This citation relates to Intakes IN00465035 and IN00464982.			
R 0144	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(a) (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation and interview, the facility failed to ensure a cleanly environment free of hazards and pests for 3 of 3 floors observed for	R 0144	All affected areas were immediately cleaned and sanitized, the raised and stained carpet sections were repaired or replaced, and pest control services were contacted for treatment and follow up inspection to ensure the environment is safe and sanitary. A full inspection of all resident	11/10/2025

	environment. Carpet was raised and uneven, carpet was stained, and dead bugs were observed on floor. (First Floor, Second Floor, Third Floor) Findings include: On 10/8/25 at 4:31 A.M., two dead bugs were observed on floor by the bookshelves on the Second Floor. On 10/9/25 at 12:35 P.M., on the Second Floor, a dead bug was observed on the floor outside the elevator and one was in the hallway near Room 210. On 10/8/25 at 4:36 A.M., an observation of the third floor included stains on the carpet just outside elevator entrance, in the middle lobby area, near Room 310, and Room 316. Down the hallway of Room 310 and in the middle lobby area, the carpet had several areas where it was raised and uneven. There was a loud buzzing at the end of the hallway by Room 310. On 10/9/25 at 12:37 P.M., the same was observed. On 10/8/25 at 4:40 A.M., the First Floor stairwell landing had dead bugs, debris, and dirt scattered throughout the floor.		common areas was completed to identify and correct any additional hazards for cleanliness concerns. No further issues were identified. The housekeeping and maintenance staff were re-educated on cleaning standards and safety expectations. The maintenance director or designee will oversee compliance with cleaning and maintenance schedules. The director of maintenance or designee will conduct weekly environmental rounds for four weeks, then monthly for three months. Any findings will be addressed immediately and reviewed during QA meetings to ensure continued compliance.	

	On 10/9/25 at 12:59 P.M., the same was observed. During an interview on 10/10/25 at 10:01 A.M., the Maintenance Director indicated staff should be using TELS (computer based program) to put in work orders that need to be addressed. Since he started at the facility 7/9/25, there had not been a pest problem that he was aware of. He indicated he would be responsible for cleaning and fixing the carpet and they have had plans to remodel the third floor since he's been here and that's why it's not been taken care of. He indicated he would provide documentation of the plans, but this was not made available during the survey period. On 10/10/25 at 9:43 A.M. a current non dated Assisted Living Guideline Policy, was provided by Regional Support 11 and indicated, " ... The residence will be kept clean and well-maintained. This will be accomplished through a regular cleaning schedule, a preventive maintenance program, and repair or enhancement of existing structures, systems, and fixtures ... " This citation relates to Intake IN00464982. Based on observation and interview, the facility failed to			

	ensure a cleanly environment free of hazards and pests for 3 of 3 floors observed for environment. Carpet was raised and uneven, carpet was stained, and dead bugs were observed on floor. (First Floor, Second Floor, Third Floor) Findings include: On 10/8/25 at 4:31 A.M., two dead bugs were observed on floor by the bookshelves on the Second Floor. On 10/9/25 at 12:35 P.M., on the Second Floor, a dead bug was observed on the floor outside the elevator and one was in the hallway near Room 210. On 10/8/25 at 4:36 A.M., an observation of the third floor included stains on the carpet just outside elevator entrance, in the middle lobby area, near Room 310, and Room 316. Down the hallway of Room 310 and in the middle lobby area, the carpet had several areas where it was raised and uneven. There was a loud buzzing at the end of the hallway by Room 310. On 10/9/25 at 12:37 P.M., the same was observed.			

	On 10/8/25 at 4:40 A.M., the First Floor stairwell landing had dead bugs, debris, and dirt scattered throughout the floor. On 10/9/25 at 12:59 P.M., the same was observed. During an interview on 10/10/25 at 10:01 A.M., the Maintenance Director indicated staff should be using TELS (computer based program) to put in work orders that need to be addressed. Since he started at the facility 7/9/25, there had not been a pest problem that he was aware of. He indicated he would be responsible for cleaning and fixing the carpet and they have had plans to remodel the third floor since he's been here and that's why it's not been taken care of. He indicated he would provide documentation of the plans, but this was not made available during the survey period. On 10/10/25 at 9:43 A.M. a current non dated Assisted Living Guideline Policy, was provided by Regional Support 11 and indicated, " ... The residence will be kept clean and well-maintained. This will be accomplished through a regular cleaning schedule, a preventive maintenance program, and repair or enhancement of existing structures, systems, and fixtures ... "			

	This citation relates to Intake IN00464982.			
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. 3. On 10/8/25 at 5:17 A.M., Resident C's clinical record was reviewed. Current diagnosis included, but was not limited to, hypertension. Current Physician's Orders included, but were not limited to: Metronidazol gel 0.75%, insert 5gm (grams) vaginally at bedtime for 5 days, start date 9/29/25 Ofloxacin 0.3%, instill 1 drop in the right eye four times a day, start date 9/26/25 prednisolone 1%, instill 1 drop in the right eye four times a day, start date 9/26/25 Resident C's Medication	R 0241	The residents identified were assessed for any adverse effects. The medication errors were immediately corrected. The residents' physicians were notified, and orders were verified. No negative outcomes were identified. An audit of all current residents' medication administration records was conducted to verify medications are available and administered per physician orders. Any discrepancies were corrected immediately. No additional issues were identified. No other residents were affected. All nurses and QMAs were re-educated on medication administration procedures and the facilities policy requiring medications be administered exactly as ordered. The DON or designee will audit medication administration records weekly for four weeks, then monthly for three months to ensure medications	11/10/2025

	Administration Record (MAR) from August 2025 through October 2025 indicated the following medications were not administered: Metronidazol was marked NA on 9/29/25, 9/30/25, and 10/1/25 at 8:00 p.m. Ofloxacin 0.3% was marked NA on the following dates: 9/26/25-- 4:00 p.m., 8:00 p.m. 9/27/25-- 4:00 p.m., 8:00 p.m. 9/28/25-- 8:00 a.m., 4:00 p.m. 9/29/25-- 8:00 a.m., 12:00 p.m. prednisolone was marked NA on the following dates and times: 9/27/25 at 3:00 p.m., 7:00 p.m. 9/28/25 at 6:30 a.m., 10:30 a.m., 3:00 p.m., 7:00 p.m. 9/29/25 at 6:30 a.m., 10:30 a.m. Resident C's clinical record lacked documentation related to why medications were not available and notification to the physician related to the missed doses. On 10/8/25 at 1:35 P.M., the Assistant Director of Nursing (ADON) indicated many times, staff did not look everywhere in the medication cart when		are given as ordered and properly documented. Results will be reviewed during monthly QA meetings to determine if continued monitoring is necessary.	

	administering medications. She indicated some medications could be located in different drawers, but because staff did not look, they have been marked "NA" on the MAR. She indicated the MAR should not have had blank spaces as there were reason codes, or staff could have left a note. At that time, she also indicated on 9/17/25 Resident H's MAR for Trolamine Salicylate should have been marked "NA" instead of "SL". On 10/10/25 at 10:37 A.M., the Administrator provided a current Resident Medication Administration policy, dated 2/2019, that indicated "To ensure that medications are administered to residents in accordance to prescribed schedule ... Medication is to be administered as ordered by the Provider ... If medication is not available, the qualified staff will notify the Licensed Nurse ... The Licensed nurse will notify the Pharmacy for medication order ... If a dose of medication is missed related to no supply and/or unavailable in the Emergency Drug Kit (EDK) the Licensed Nurse will notify the Provider and Family, when acceptable, of reason related to the missed dose. The Licensed Nurse will then document conversations in the clinical record"			

This citation relates to Complaint IN00464982.

Based on interview and record review, the facility failed to ensure medications were administered as ordered by a physician for 3 of 3 residents reviewed for medication administration and failed to follow their facility policy. (Resident C, Resident G, Resident H)

Findings include:

1. On 10/8/25 at 7:40 A.M., Resident G's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus, hypertension, hyperlipidemia, and chronic obstructive pulmonary disease (COPD).

Current physician orders included, but were not limited to:

Latanoprost Solution 0.005%, 1 drop in both eyes every evening, dated 7/29/25.

Jardiance 25mg (milligram) daily, dated 7/17/25.

Metformin 500mg extended release, 2 tablets daily, dated 7/16/25.

Aspirin 81mg daily, dated 7/17/25.

	Chlorthalid 25mg, 1/2 tablet daily, dated 7/17/25. Diltiazem 120mg extended release daily, dated 7/17/25. Fluticasone-Salmeterol 250/50, inhale 1 puff twice daily, dated 7/15/25. Rosuvastatin 40mg, 1/2 tablet daily, dated 7/16/25. FreeStyle Libre 3 reader device (continuous glucose system receiver), inject 1 subcutaneously in the morning every Tuesday and Friday, dated 7/15/25. Rocklatan, instill 1 drop in both eyes at bedtime, dated 8/28/25. Vitamin D3 25mcg (microgram) daily, dated 7/17/25. Resident G's Medication Administration Record (MAR) from August 2025 through October 2025 indicated the following medications were not administered: Latanoprost Solution 0.005%: 8/17/25 marked "NA" (medication not available) Chlorthalid 25mg: 8/12/25 marked "NA" 10/4/25 marked blank			

	Diltiazem 120mg: 8/25/25 marked "NA" 9/10/25 marked "NA" 10/4/25 marked blank Fluticasone-Salmeterol 250/50: 8/2/25 marked "NA" for one of two doses that day Rosuvastatin 40mg: 8/15/25 marked "NA" 8/23/25 marked "NA" Rocklatan: 9/6/25 marked "NA" 9/7/25 marked "NA" 8/23/25 marked "NA" Aspirin 81mg: 9/2/25 marked "NA" 9/5/25 marked "NA" 10/4/25 marked blank FreeStyle Libre 3 reader device: 9/9/25 marked "NA" 9/12/25 marked "NA" 9/26/25 marked "NA" Jardiance 25mg:			

	10/4/25 marked blank Metformin 500mg: 10/4/25 marked blank Vitamin D3 25mcg: 10/4/25 marked blank Resident G's clinical record lacked documentation related to why medications were not available and notification to the physician related to the missed doses. 2. On 10/9/25 at 12:23 P.M., Resident H's clinical record was reviewed. Diagnosis included, but were not limited to, gastro-esophageal reflux disease (GERD), Current physician orders included, but were not limited to: Famotidine 20mg twice daily, dated 7/9/25. Trolamine Salicylate twice daily, dated 7/10/25. Melatonin 3mg at bedtime, dated 7/9/25. Timolol mal solution 0.5% instill 1 drop in both eyes every morning, dated 7/12/25. Lorazepam 0.5mg every 6 hours as needed, dated 7/9/25. Resident H's MAR from August			

	2025 through October 2025 indicated the following medications that were not administered: Famotidine: 8/26/25 marked blank for one of the two daily doses. Trolamine Salicylate: 8/14/25 marked "NA" for one of the two daily doses. 8/15/25 marked "NA" for one of the two daily doses. 8/16/25 marked "NA" for one of the two daily doses. 8/17/25 marked "NA" for one of the two daily doses. 8/20/25 marked "NA" for one of the two daily doses. 8/26/25 marked blank for one of the two daily doses. 8/27/25 marked "NA" for both of the two daily doses. 9/17/25 marked "SL" (sleeping) for one of the two daily doses, and marked blank for the other dose. 9/19/25 marked "NA" Melatonin 3mg: 8/26/25 marked blank			

	9/17/25 marked blank Timolol mal solution 0.5%: 8/7/25 marked "NA" Lorazepam 0.5mg: 9/24/25 marked "NA" Resident H's clinical record lacked documentation related to why medications were not available and notification to the physician related to the missed doses. 3. On 10/8/25 at 5:17 A.M., Resident C's clinical record was reviewed. Current diagnosis included, but was not limited to, hypertension. Current Physician's Orders included, but were not limited to: Metronidazol gel 0.75%, insert 5gm (grams) vaginally at bedtime for 5 days, start date 9/29/25 Ofloxacin 0.3%, instill 1 drop in the right eye four times a day, start date 9/26/25 prednisolone 1%, instill 1 drop in the right eye four times a day, start date 9/26/25 Resident C's Medication Administration Record (MAR) from August 2025 through October 2025 indicated the following medications were not			

	administered: Metronidazol was marked NA on 9/29/25, 9/30/25, and 10/1/25 at 8:00 p.m. Ofloxacin 0.3% was marked NA on the following dates: 9/26/25-- 4:00 p.m., 8:00 p.m. 9/27/25-- 4:00 p.m., 8:00 p.m. 9/28/25-- 8:00 a.m., 4:00 p.m. 9/29/25-- 8:00 a.m., 12:00 p.m. prednisolone was marked NA on the following dates and times: 9/27/25 at 3:00 p.m., 7:00 p.m. 9/28/25 at 6:30 a.m., 10:30 a.m., 3:00 p.m., 7:00 p.m. 9/29/25 at 6:30 a.m., 10:30 a.m. Resident C's clinical record lacked documentation related to why medications were not available and notification to the physician related to the missed doses. On 10/8/25 at 1:35 P.M., the Assistant Director of Nursing (ADON) indicated many times, staff did not look everywhere in the medication cart when administering medications. She indicated some medications could be located in different drawers, but because staff did			

	not look, they have been marked "NA" on the MAR. She indicated the MAR should not have had blank spaces as there were reason codes, or staff could have left a note. At that time, she also indicated on 9/17/25 Resident H's MAR for Trolamine Salicylate should have been marked "NA" instead of "SL". On 10/10/25 at 10:37 A.M., the Administrator provided a current Resident Medication Administration policy, dated 2/2019, that indicated "To ensure that medications are administered to residents in accordance to prescribed schedule ... Medication is to be administered as ordered by the Provider ... If medication is not available, the qualified staff will notify the Licensed Nurse ... The Licensed nurse will notify the Pharmacy for medication order ... If a dose of medication is missed related to no supply and/or unavailable in the Emergency Drug Kit (EDK) the Licensed Nurse will notify the Provider and Family, when acceptable, of reason related to the missed dose. The Licensed Nurse will then document conversations in the clinical record" This citation relates to Complaint IN00464982. Based on interview and record			

	review, the facility failed to ensure medications were administered as ordered by a physician for 3 of 3 residents reviewed for medication administration and failed to follow their facility policy. (Resident C, Resident G, Resident H) Findings include: 1. On 10/8/25 at 7:40 A.M., Resident G's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus, hypertension, hyperlipidemia, and chronic obstructive pulmonary disease (COPD). Current physician orders included, but were not limited to: Latanoprost Solution 0.005%, 1 drop in both eyes every evening, dated 7/29/25. Jardiance 25mg (milligram) daily, dated 7/17/25. Metformin 500mg extended release, 2 tablets daily, dated 7/16/25. Aspirin 81mg daily, dated 7/17/25. Chlorthalid 25mg, 1/2 tablet daily, dated 7/17/25. Diltiazem 120mg extended release daily, dated 7/17/25.			

	Fluticasone-Salmeterol 250/50, inhale 1 puff twice daily, dated 7/15/25. Rosuvastatin 40mg, 1/2 tablet daily, dated 7/16/25. FreeStyle Libre 3 reader device (continuous glucose system receiver), inject 1 subcutaneously in the morning every Tuesday and Friday, dated 7/15/25. Rocklatan, instill 1 drop in both eyes at bedtime, dated 8/28/25. Vitamin D3 25mcg (microgram) daily, dated 7/17/25. Resident G's Medication Administration Record (MAR) from August 2025 through October 2025 indicated the following medications were not administered: Latanoprost Solution 0.005%: 8/17/25 marked "NA" (medication not available) Chlorthalid 25mg: 8/12/25 marked "NA" 10/4/25 marked blank Diltiazem 120mg: 8/25/25 marked "NA" 9/10/25 marked "NA"			

	10/4/25 marked blank Fluticasone-Salmeterol 250/50: 8/2/25 marked "NA" for one of two doses that day Rosuvastatin 40mg: 8/15/25 marked "NA" 8/23/25 marked "NA" Rocklatan: 9/6/25 marked "NA" 9/7/25 marked "NA" 8/23/25 marked "NA" Aspirin 81mg: 9/2/25 marked "NA" 9/5/25 marked "NA" 10/4/25 marked blank FreeStyle Libre 3 reader device: 9/9/25 marked "NA" 9/12/25 marked "NA" 9/26/25 marked "NA" Jardiance 25mg: 10/4/25 marked blank Metformin 500mg: 10/4/25 marked blank			

	Vitamin D3 25mcg: 10/4/25 marked blank Resident G's clinical record lacked documentation related to why medications were not available and notification to the physician related to the missed doses. 2. On 10/9/25 at 12:23 P.M., Resident H's clinical record was reviewed. Diagnosis included, but were not limited to, gastro-esophageal reflux disease (GERD), Current physician orders included, but were not limited to: Famotidine 20mg twice daily, dated 7/9/25. Trolamine Salicylate twice daily, dated 7/10/25. Melatonin 3mg at bedtime, dated 7/9/25. Timolol mal solution 0.5% instill 1 drop in both eyes every morning, dated 7/12/25. Lorazepam 0.5mg every 6 hours as needed, dated 7/9/25. Resident H's MAR from August 2025 through October 2025 indicated the following medications that were not administered:			

	Famotidine: 8/26/25 marked blank for one of the two daily doses. Trolamine Salicylate: 8/14/25 marked "NA" for one of the two daily doses. 8/15/25 marked "NA" for one of the two daily doses. 8/16/25 marked "NA" for one of the two daily doses. 8/17/25 marked "NA" for one of the two daily doses. 8/20/25 marked "NA" for one of the two daily doses. 8/26/25 marked blank for one of the two daily doses. 8/27/25 marked "NA" for both of the two daily doses. 9/17/25 marked "SL" (sleeping) for one of the two daily doses, and marked blank for the other dose. 9/19/25 marked "NA" Melatonin 3mg: 8/26/25 marked blank 9/17/25 marked blank Timolol mal solution 0.5%: 8/7/25 marked "NA"			

Lorazepam 0.5mg:

9/24/25 marked "NA"

Resident H's clinical record lacked documentation related to why medications were not available and notification to the physician related to the missed doses.

3. On 10/8/25 at 5:17 A.M., Resident C's clinical record was reviewed. Current diagnosis included, but was not limited to, hypertension.

Current Physician's Orders included, but were not limited to:

Metronidazol gel 0.75%, insert 5gm (grams) vaginally at bedtime for 5 days, start date 9/29/25

Ofloxacin 0.3%, instill 1 drop in the right eye four times a day, start date 9/26/25

prednisolone 1%, instill 1 drop in the right eye four times a day, start date 9/26/25

Resident C's Medication Administration Record (MAR) from August 2025 through October 2025 indicated the following medications were not administered:

Metronidazol was marked NA on 9/29/25, 9/30/25, and 10/1/25 at 8:00 p.m.

	Ofloxacin 0.3% was marked NA on the following dates: 9/26/25-- 4:00 p.m., 8:00 p.m. 9/27/25-- 4:00 p.m., 8:00 p.m. 9/28/25-- 8:00 a.m., 4:00 p.m. 9/29/25-- 8:00 a.m., 12:00 p.m. prednisolone was marked NA on the following dates and times: 9/27/25 at 3:00 p.m., 7:00 p.m. 9/28/25 at 6:30 a.m., 10:30 a.m., 3:00 p.m., 7:00 p.m. 9/29/25 at 6:30 a.m., 10:30 a.m. Resident C's clinical record lacked documentation related to why medications were not available and notification to the physician related to the missed doses. On 10/8/25 at 1:35 P.M., the Assistant Director of Nursing (ADON) indicated many times, staff did not look everywhere in the medication cart when administering medications. She indicated some medications could be located in different drawers, but because staff did not look, they have been marked "NA" on the MAR. She indicated the MAR should not have had blank spaces as there were reason codes, or staff could have left a note. At that			

	time, she also indicated on 9/17/25 Resident H's MAR for Trolamine Salicylate should have been marked "NA" instead of "SL". On 10/10/25 at 10:37 A.M., the Administrator provided a current Resident Medication Administration policy, dated 2/2019, that indicated "To ensure that medications are administered to residents in accordance to prescribed schedule ... Medication is to be administered as ordered by the Provider ... If medication is not available, the qualified staff will notify the Licensed Nurse ... The Licensed nurse will notify the Pharmacy for medication order ... If a dose of medication is missed related to no supply and/or unavailable in the Emergency Drug Kit (EDK) the Licensed Nurse will notify the Provider and Family, when acceptable, of reason related to the missed dose. The Licensed Nurse will then document conversations in the clinical record" This citation relates to Complaint IN00464982. Based on interview and record review, the facility failed to ensure medications were administered as ordered by a physician for 3 of 3 residents reviewed for medication administration and failed to			

	follow their facility policy. (Resident C, Resident G, Resident H) Findings include: 1. On 10/8/25 at 7:40 A.M., Resident G's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus, hypertension, hyperlipidemia, and chronic obstructive pulmonary disease (COPD). Current physician orders included, but were not limited to: Latanoprost Solution 0.005%, 1 drop in both eyes every evening, dated 7/29/25. Jardiance 25mg (milligram) daily, dated 7/17/25. Metformin 500mg extended release, 2 tablets daily, dated 7/16/25. Aspirin 81mg daily, dated 7/17/25. Chlorthalid 25mg, 1/2 tablet daily, dated 7/17/25. Diltiazem 120mg extended release daily, dated 7/17/25. Fluticasone-Salmeterol 250/50, inhale 1 puff twice daily, dated 7/15/25.			

Rosuvastatin 40mg, 1/2 tablet daily, dated 7/16/25.

FreeStyle Libre 3 reader device (continuous glucose system receiver), inject 1 subcutaneously in the morning every Tuesday and Friday, dated 7/15/25.

Rocklatan, instill 1 drop in both eyes at bedtime, dated 8/28/25.

Vitamin D3 25mcg (microgram) daily, dated 7/17/25.

Resident G's Medication Administration Record (MAR) from August 2025 through October 2025 indicated the following medications were not administered:

Latanoprost Solution 0.005%:

8/17/25 marked "NA" (medication not available)

Chlorthalid 25mg:

8/12/25 marked "NA"

10/4/25 marked blank

Diltiazem 120mg:

8/25/25 marked "NA"

9/10/25 marked "NA"

10/4/25 marked blank

Fluticasone-Salmeterol 250/50:

8/2/25 marked "NA" for one of

two doses that day

Rosuvastatin 40mg:

8/15/25 marked "NA"

8/23/25 marked "NA"

Rocklatan:

9/6/25 marked "NA"

9/7/25 marked "NA"

8/23/25 marked "NA"

Aspirin 81mg:

9/2/25 marked "NA"

9/5/25 marked "NA"

10/4/25 marked blank

FreeStyle Libre 3 reader device:

9/9/25 marked "NA"

9/12/25 marked "NA"

9/26/25 marked "NA"

Jardiance 25mg:

10/4/25 marked blank

Metformin 500mg:

10/4/25 marked blank

Vitamin D3 25mcg:

10/4/25 marked blank

Resident G's clinical record lacked documentation related to

	why medications were not available and notification to the physician related to the missed doses. 2. On 10/9/25 at 12:23 P.M., Resident H's clinical record was reviewed. Diagnosis included, but were not limited to, gastro-esophageal reflux disease (GERD), Current physician orders included, but were not limited to: Famotidine 20mg twice daily, dated 7/9/25. Trolamine Salicylate twice daily, dated 7/10/25. Melatonin 3mg at bedtime, dated 7/9/25. Timolol mal solution 0.5% instill 1 drop in both eyes every morning, dated 7/12/25. Lorazepam 0.5mg every 6 hours as needed, dated 7/9/25. Resident H's MAR from August 2025 through October 2025 indicated the following medications that were not administered: Famotidine: 8/26/25 marked blank for one of the two daily doses. Trolamine Salicylate:			

	8/14/25 marked "NA" for one of the two daily doses. 8/15/25 marked "NA" for one of the two daily doses. 8/16/25 marked "NA" for one of the two daily doses. 8/17/25 marked "NA" for one of the two daily doses. 8/20/25 marked "NA" for one of the two daily doses. 8/26/25 marked blank for one of the two daily doses. 8/27/25 marked "NA" for both of the two daily doses. 9/17/25 marked "SL" (sleeping) for one of the two daily doses, and marked blank for the other dose. 9/19/25 marked "NA" Melatonin 3mg: 8/26/25 marked blank 9/17/25 marked blank Timolol mal solution 0.5%: 8/7/25 marked "NA" Lorazepam 0.5mg: 9/24/25 marked "NA" Resident H's clinical record lacked documentation related to why medications were not			

available and notification to the physician related to the missed doses.

3. On 10/8/25 at 5:17 A.M., Resident C's clinical record was reviewed. Current diagnosis included, but was not limited to, hypertension.

Current Physician's Orders included, but were not limited to:

Metronidazol gel 0.75%, insert 5gm (grams) vaginally at bedtime for 5 days, start date 9/29/25

Ofloxacin 0.3%, instill 1 drop in the right eye four times a day, start date 9/26/25

prednisolone 1%, instill 1 drop in the right eye four times a day, start date 9/26/25

Resident C's Medication Administration Record (MAR) from August 2025 through October 2025 indicated the following medications were not administered:

Metronidazol was marked NA on 9/29/25, 9/30/25, and 10/1/25 at 8:00 p.m.

Ofloxacin 0.3% was marked NA on the following dates:

9/26/25-- 4:00 p.m., 8:00 p.m.

9/27/25-- 4:00 p.m., 8:00 p.m.

	9/28/25-- 8:00 a.m., 4:00 p.m. 9/29/25-- 8:00 a.m., 12:00 p.m. prednisolone was marked NA on the following dates and times: 9/27/25 at 3:00 p.m., 7:00 p.m. 9/28/25 at 6:30 a.m., 10:30 a.m., 3:00 p.m., 7:00 p.m. 9/29/25 at 6:30 a.m., 10:30 a.m. Resident C's clinical record lacked documentation related to why medications were not available and notification to the physician related to the missed doses. On 10/8/25 at 1:35 P.M., the Assistant Director of Nursing (ADON) indicated many times, staff did not look everywhere in the medication cart when administering medications. She indicated some medications could be located in different drawers, but because staff did not look, they have been marked "NA" on the MAR. She indicated the MAR should not have had blank spaces as there were reason codes, or staff could have left a note. At that time, she also indicated on 9/17/25 Resident H's MAR for Trolamine Salicylate should have been marked "NA" instead of "SL". On 10/10/25 at 10:37 A.M., the			

	Administrator provided a current Resident Medication Administration policy, dated 2/2019, that indicated "To ensure that medications are administered to residents in accordance to prescribed schedule ... Medication is to be administered as ordered by the Provider ... If medication is not available, the qualified staff will notify the Licensed Nurse ... The Licensed nurse will notify the Pharmacy for medication order ... If a dose of medication is missed related to no supply and/or unavailable in the Emergency Drug Kit (EDK) the Licensed Nurse will notify the Provider and Family, when acceptable, of reason related to the missed dose. The Licensed Nurse will then document conversations in the clinical record" This citation relates to Complaint IN00464982. Based on interview and record review, the facility failed to ensure medications were administered as ordered by a physician for 3 of 3 residents reviewed for medication administration and failed to follow their facility policy. (Resident C, Resident G, Resident H) Findings include: 1. On 10/8/25 at 7:40 A.M.,			

	Resident G's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus, hypertension, hyperlipidemia, and chronic obstructive pulmonary disease (COPD). Current physician orders included, but were not limited to: Latanoprost Solution 0.005%, 1 drop in both eyes every evening, dated 7/29/25. Jardiance 25mg (milligram) daily, dated 7/17/25. Metformin 500mg extended release, 2 tablets daily, dated 7/16/25. Aspirin 81mg daily, dated 7/17/25. Chlorthalid 25mg, 1/2 tablet daily, dated 7/17/25. Diltiazem 120mg extended release daily, dated 7/17/25. Fluticasone-Salmeterol 250/50, inhale 1 puff twice daily, dated 7/15/25. Rosuvastatin 40mg, 1/2 tablet daily, dated 7/16/25.			

	FreeStyle Libre 3 reader device (continuous glucose system receiver), inject 1 subcutaneously in the morning every Tuesday and Friday, dated 7/15/25. Rocklatan, instill 1 drop in both eyes at bedtime, dated 8/28/25. Vitamin D3 25mcg (microgram) daily, dated 7/17/25. Resident G's Medication Administration Record (MAR) from August 2025 through October 2025 indicated the following medications were not administered: Latanoprost Solution 0.005%: 8/17/25 marked "NA" (medication not available) Chlorthalid 25mg: 8/12/25 marked "NA" 10/4/25 marked blank Diltiazem 120mg: 8/25/25 marked "NA" 9/10/25 marked "NA" 10/4/25 marked blank Fluticasone-Salmeterol 250/50: 8/2/25 marked "NA" for one of two doses that day			

	Rosuvastatin 40mg: 8/15/25 marked "NA" 8/23/25 marked "NA" Rocklatan: 9/6/25 marked "NA" 9/7/25 marked "NA" 8/23/25 marked "NA" Aspirin 81mg: 9/2/25 marked "NA" 9/5/25 marked "NA" 10/4/25 marked blank FreeStyle Libre 3 reader device: 9/9/25 marked "NA" 9/12/25 marked "NA" 9/26/25 marked "NA" Jardiance 25mg: 10/4/25 marked blank Metformin 500mg: 10/4/25 marked blank Vitamin D3 25mcg: 10/4/25 marked blank Resident G's clinical record lacked documentation related to why medications were not			

	available and notification to the physician related to the missed doses. 2. On 10/9/25 at 12:23 P.M., Resident H's clinical record was reviewed. Diagnosis included, but were not limited to, gastro-esophageal reflux disease (GERD), Current physician orders included, but were not limited to: Famotidine 20mg twice daily, dated 7/9/25. Trolamine Salicylate twice daily, dated 7/10/25. Melatonin 3mg at bedtime, dated 7/9/25. Timolol mal solution 0.5% instill 1 drop in both eyes every morning, dated 7/12/25. Lorazepam 0.5mg every 6 hours as needed, dated 7/9/25. Resident H's MAR from August 2025 through October 2025 indicated the following medications that were not administered: Famotidine: 8/26/25 marked blank for one of the two daily doses. Trolamine Salicylate: 8/14/25 marked "NA" for one of			

	the two daily doses. 8/15/25 marked "NA" for one of the two daily doses. 8/16/25 marked "NA" for one of the two daily doses. 8/17/25 marked "NA" for one of the two daily doses. 8/20/25 marked "NA" for one of the two daily doses. 8/26/25 marked blank for one of the two daily doses. 8/27/25 marked "NA" for both of the two daily doses. 9/17/25 marked "SL" (sleeping) for one of the two daily doses, and marked blank for the other dose. 9/19/25 marked "NA" Melatonin 3mg: 8/26/25 marked blank 9/17/25 marked blank Timolol mal solution 0.5%: 8/7/25 marked "NA" Lorazepam 0.5mg: 9/24/25 marked "NA" Resident H's clinical record lacked documentation related to why medications were not available and notification to the			

	physician related to the missed doses.			
R 0243	Health Services - Deficiency 410 IAC 16.2-5-4(e)(3) (3) The individual administering the medication shall document the administration in the individual ' s medication and treatment records that indicate the: (A) time; (B) name of medication or treatment; (C) dosage (if applicable); and (D) name or initials of the person administering the drug or treatment. Based on interview and record review, the facility failed to ensure staff that administered medications documented that they administered the medication for 1 of 3 residents reviewed for medication administration. (Resident G) Finding includes: On 10/8/25 at 7:40 A.M., Resident G's clinical record was reviewed. Diagnosis included, but was not limited to, diabetes mellitus. Current physician orders included, but were not limited to:	R 0243	The resident record was reviewed, and the resident was immediately assessed. No adverse effects were noted for the resident. The QMA involved was counseled on proper documentation requirements and scope of practice. All current medication administration records were reviewed to ensure documentation is complete for all residents receiving medications. Any missing documentation was properly corrected. All licensed nurses and QMAs were re-educated on proper medication documentation requirements including real-time charting in the MAR following each medication pass. All new nursing employees will receive training during the orientation process. The director of nursing or designee will monitor medication documentation daily for two weeks, then weekly for four weeks, and monthly thereafter. Results of ongoing audits will be	11/10/2025

	Lantus insulin injection, 23 Units subcutaneously once daily, dated 7/16/25. Resident G's Medication Administration Record (MAR) from August 2025 through October 2025 indicated the following dates Lantus was administered with Qualified Medication Aide (QMA) 9's signature. Progress notes documented by QMA 9 indicated the Lantus had been administered by a nurse: 8/1/25 8/4/25 8/9/25 through 8/10/25 8/15/25 8/18/25 8/19/25 8/24/25 through 8/26/25 8/28/25 8/29/25 9/1/25 9/2/25 9/4/25 through 9/9/25 9/11/25 9/12/25		reviewed during monthly QA meetings to evaluate compliance and determine if further monitoring or retraining is required.	

	9/15/25 9/16/25 9/18/25 9/20/25 9/25/25 9/26/25 9/29/25 9/30/25 10/3/25 10/6/25 10/7/25 On 10/9/25 at 1:39 P.M., QMA 3 indicated staff should not have documented in the MAR that they gave insulin if a nurse actually gave it, even with a note in the progress notes. She indicated staff should only documented what they did. She further indicated if a QMA was on duty, but a nurse came to give the insulin, the nurse should go in and document that they gave it. On 10/10/25 at 10:37 A.M., the Administrator provided a current Resident Medication Administration policy, dated 2/2019, that indicated "Medications are to be prepared, administered and documented by a qualified staff			

	member per state guidelines" On 10/10/25 at 9:15 A.M., the Administrator provided a current non-dated Licensed Practical Nurse (LPN) job description that indicated "Prepares, administers and records medications in accordance with facility policy" This citation relates to Complaint IN00464374. Based on interview and record review, the facility failed to ensure staff that administered medications documented that they administered the medication for 1 of 3 residents reviewed for medication administration. (Resident G) Finding includes: On 10/8/25 at 7:40 A.M., Resident G's clinical record was reviewed. Diagnosis included, but was not limited to, diabetes mellitus. Current physician orders included, but were not limited to: Lantus insulin injection, 23 Units subcutaneously once daily, dated 7/16/25. Resident G's Medication Administration Record (MAR) from August 2025 through October 2025 indicated the following dates Lantus was administered with Qualified Medication Aide (QMA) 9's			

	signature. Progress notes documented by QMA 9 indicated the Lantus had been administered by a nurse: 8/1/25 8/4/25 8/9/25 through 8/10/25 8/15/25 8/18/25 8/19/25 8/24/25 through 8/26/25 8/28/25 8/29/25 9/1/25 9/2/25 9/4/25 through 9/9/25 9/11/25 9/12/25 9/15/25 9/16/25 9/18/25 9/20/25 9/25/25 9/26/25			

	9/29/25 9/30/25 10/3/25 10/6/25 10/7/25 On 10/9/25 at 1:39 P.M., QMA 3 indicated staff should not have documented in the MAR that they gave insulin if a nurse actually gave it, even with a note in the progress notes. She indicated staff should only documented what they did. She further indicated if a QMA was on duty, but a nurse came to give the insulin, the nurse should go in and document that they gave it. On 10/10/25 at 10:37 A.M., the Administrator provided a current Resident Medication Administration policy, dated 2/2019, that indicated "Medications are to be prepared, administered and documented by a qualified staff member per state guidelines" On 10/10/25 at 9:15 A.M., the Administrator provided a current non-dated Licensed Practical Nurse (LPN) job description that indicated "Prepares, administers and records medications in accordance with facility policy"			

	This citation relates to Complaint IN00464374.			
R 0245	Health Services - Offense 410 IAC 16.2-5-4(e)(5) (5) Injectable medications shall be given only by licensed personnel. Based on observation, interview, and record review, the facility failed to ensure qualified staff administered insulin for 1 of 3 residents reviewed for medication administration. (Resident G) Finding includes: On 10/8/25 at 7:40 A.M., Resident G's clinical record was reviewed. Diagnosis included, but was not limited to, diabetes mellitus. Current physician orders included, but were not limited to: Lantus insulin injection, 23 Units subcutaneously once daily, dated 7/16/25. Resident G's Medication Administration Record (MAR) from August 2025 through October 2025 indicated Qualified Medication Aide (QMA) 9 administered Lantus on the following dates:	R 0245	The residents involved were assessed with no adverse outcomes noted. Insulin administration was immediately restricted to certified nurses and properly credentialed QMAs. The QMA's involved were removed from insulin administration duties and re-educated on scope of practice requirements. Current QMA certification records were reviewed to verify insulin competency and training compliance. No other uncertified staff were found to have administered insulin. QMAs and nursing staff were re-educated on the QMA scope of practice, specifically that only certified personnel may administer insulin. The DON or designee will verify insulin certification status before allowing any QMAs to administer insulin.	11/10/2025

	8/23/25 (no note to indicate administered by licensed staff) 9/22/25 (no note to indicate administered by licensed staff) Resident G's Medication Administration Record (MAR) from August 2025 through October 2025 indicated QMA 5 administered Lantus on the following dates: 9/21/25 (no note to indicate administered by licensed staff) 9/23/25 (no note to indicate administered by licensed staff) 9/24/25 (no note to indicate administered by licensed staff) 9/27/25 (no note to indicate administered by licensed staff) 10/1/25 (no note to indicate administered by licensed staff) 10/5/25 (no note to indicate administered by licensed staff) 10/8/25 (no note to indicate administered by licensed staff) On 10/9/25 at 9:12 A.M. employee records were reviewed. QMA 9 and QMA 5's certification did not include insulin administration, and were not qualified to administer insulin. On 10/9/25 at 1:39 P.M., QMA 3 indicated QMAs that were not		The DON or designee will audit insulin administration records daily for one week, then monthly for one month, ensuring that only certified staff administer insulin. Audit results will be reviewed in monthly QA meetings to verify continued compliance.	

certified should not have administered insulin.

On 10/10/25 at 10:37 A.M., the Administrator provided a current Resident Medication Administration policy, dated 2/2019, that indicated "Medications are to be prepared, administered and documented by a qualified staff member per state guidelines"

This citation relates to Complaint IN00464374.

Based on observation, interview, and record review, the facility failed to ensure qualified staff administered insulin for 1 of 3 residents reviewed for medication administration. (Resident G)

Finding includes:

On 10/8/25 at 7:40 A.M., Resident G's clinical record was reviewed. Diagnosis included, but was not limited to, diabetes mellitus.

Current physician orders included, but were not limited to:

Lantus insulin injection, 23 Units subcutaneously once daily, dated 7/16/25.

Resident G's Medication Administration Record (MAR) from August 2025 through October 2025 indicated Qualified Medication Aide

	(QMA) 9 administered Lantus on the following dates: 8/23/25 (no note to indicate administered by licensed staff) 9/22/25 (no note to indicate administered by licensed staff) Resident G's Medication Administration Record (MAR) from August 2025 through October 2025 indicated QMA 5 administered Lantus on the following dates: 9/21/25 (no note to indicate administered by licensed staff) 9/23/25 (no note to indicate administered by licensed staff) 9/24/25 (no note to indicate administered by licensed staff) 9/27/25 (no note to indicate administered by licensed staff) 10/1/25 (no note to indicate administered by licensed staff) 10/5/25 (no note to indicate administered by licensed staff) 10/8/25 (no note to indicate administered by licensed staff)			

	On 10/9/25 at 9:12 A.M. employee records were reviewed. QMA 9 and QMA 5's certification did not include insulin administration, and were not qualified to administer insulin. On 10/9/25 at 1:39 P.M., QMA 3 indicated QMAs that were not certified should not have administered insulin. On 10/10/25 at 10:37 A.M., the Administrator provided a current Resident Medication Administration policy, dated 2/2019, that indicated "Medications are to be prepared, administered and documented by a qualified staff member per state guidelines" This citation relates to Complaint IN00464374.			

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 SIGNATURESusan Wiley	TITLERDCS	(X6) DATE10/31/2025