STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING _____ B. WING _____	C 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00460080, IN00460134, IN00454025, and IN00457898. Complaint IN00454025 - Federal/state deficiencies related to the allegations are cited at F755. Complaint IN00457898 - No deficiencies related to the allegations are cited. Complaint IN00460080 - No deficiencies related to the allegations are cited. Complaint IN00460134 - No deficiencies related to the allegations are cited. Survey dates: June 11 and 12, 2025 Facility number: 000149 Provider number: 155245 AIM number: 100266840 Census Bed Type: SNF/NF: 69 Total: 69 Census Payor Type: Medicare: 1 Medicaid: 55 Other: 13 Total: 69 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 16, 2025.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the disposition of a resident's oxycodone-acetaminophen medication that had been delivered by pharmacy was handled and	F 755	Past noncompliance: no plan of correction required.	

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F 755	Continued From page 2	F 755		

stored securely; resulting in missing 60 tablets of a resident's narcotic medication for 1 of 4 residents reviewed for medication reconciliation. (Resident B)

Findings include:

The clinical record for Resident B was reviewed on 6/11/25 at 2:00 p.m. The diagnoses included, but were not limited to, stroke, heart disease, and kidney disease.

A physician's order, dated 1/1/25, indicated Resident B was to receive oxycodone-acetaminophen (narcotic pain medication; also known as Percocet) 10-325 milligrams (mg) every four hours as needed for pain.

A pharmacy control drug record, dated 1/17/25, indicated, on 2/18/25 at 4:32 p.m., Resident B had 29 tablets remaining in a medication bubble card of the 10-325 milligrams of oxycodone-acetaminophen.

A pharmacy delivery form, dated 2/19/25 at 10:15 a.m., indicated Registered Nurse (RN) 2 had received the pharmacy delivery that morning of 60 tablets of 10-325 milligrams of oxycodone-acetaminophen for Resident B.

An incident reported to the Indiana Department of Health, dated 2/20/25, indicated the facility was missing 60 tablets of narcotic medication for Resident B that was delivered on 2/19/25, day shift. The evening and night shift nurses, on 2/19/25, did not observe the 60 narcotic tablets for Resident B on their shift. The day shift nurse (RN 1), who worked on 2/19/25, had not returned

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F 755	Continued From page 3	F 755		

to work on 2/20/25. The resident had reported he was not in pain and had not missed any doses of his oxycodone-acetaminophen medication. The resident's oxycodone-acetaminophen 10-325 mg medication had been replaced by the pharmacy. The Indianapolis Metropolitan Police Department and Attorney General's office had been notified.

The incident investigation file was provided by the Executive Director (ED) on 6/12/25 at 9:30 a.m. The file included, but was not limited to, the following:

A text message document by Former ED to RN 1's phone dated 2/20/25 at 7:03 p.m. It indicated the facility was trying to reach her to get a statement regarding an investigation going on at the facility. The message stated she was suspended, and he had requested her to call into the facility.

A written statement by RN 2, dated 2/20/25, indicated "On 2/19/25, I received a shipment of medications I received 3 narcotic gave 2 to QMA [Qualified Medication Aide] and 1 to the nurse [RN 1] on the carts. Received 60 pills and on the next morning I counted the cart and the narcotic was not in the cart. All cart was checked and the med [medication] room and narcotics was nowhere to be found. Call and reported this to DON [Director of Nursing] at the start of the shift."

A written statement by QMA 4, on 2/20/25, indicated "On 2/19/25, @ approx [at approximately] 1530 [3:30 p.m.] I counted the cart with [RN 1], and I did not see [Resident B]'s 60 count oxy [oxycodone-acetaminophen] in the narcotic box."

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F 755	Continued From page 4	F 755		

A written statement by Licensed Practical Nurse (LPN) 5, on 2/20/25, indicated "Came into work on 2/19/25 @ 16:00 [at 4:00 p.m.] to start the shift. After my shift on 2/20/25, I received a call from [DON] asking if I seen [Resident B] oxycodone in cart a card of 60 and I stated I couldn't recall what the amount was but he does have oxycodone in cart. She stated yes, but it was a new card delivered on 2/19/25 am [a.m.] shift. I stated I didn't see that card once I started my shift on 2/19/25. She stated [QMA 4] didn't see it either [with] her count."

An interview was conducted with RN 2 on 6/11/25 at 3:11 p.m. She indicated, on 2/19/25, the pharmacy delivered 60 tablets of oxycodone-acetaminophen for Resident B. She handed the narcotic record sheet and the 60 tablets of oxycodone to RN 1 to place in the medication cart. The next day, on 2/20/25, RN 1 was supposed to work, but did not show up that morning. The mediation cart was counted. The new card of 60 tablets of oxycodone-acetaminophen nor the narcotic record sheet for that medication was able to be located in the medication cart. There was no record the medication was added to the medication cart. The other medication carts and the medication supply room were searched. The narcotic medication was unable to be located. The DON and ED were notified. The pharmacy delivered another supply. Resident B did have a supply of oxycodone, so he did not go without his medication. The surveillance video was reviewed. The video footage confirmed after pharmacy delivered, she handed off the narcotic record sheet and the resident's oxycodone-acetaminophen to RN 1. It did not show what she did with the medication after. An

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F 755	Continued From page 5	F 755		

investigation was started. RN 1 would not return phone calls to give any explanation of what happened to Resident B's 60 tablets of oxycodone-acetaminophen. RN 1 worked in the facility for approximately a week.

An interview was conducted with QMA 4 on 6/11/25 at 3:15 p.m. She indicated RN 1 had started employment with the facility on 2/13/25. RN 1 had worked the day shift, on 2/19/25, but did not return for her day shift on 2/20/25. The medication cart was counted. Resident B's 60 tablets of oxycodone-acetaminophen nor the narcotic record sheet that was delivered on 2/19/25, were in the medication cart.

An interview was conducted with the Regional Director of Operations (RDO) on 6/12/25 at 9:00 a.m. He indicated the video surveillance footage was reviewed. The footage showed RN 2 had handed Resident B's oxycodone-acetaminophen medication card of 60 tablets and narcotic record sheet to RN 1. RN 1 placed the medication that had been handed to her in a folder/envelope on top of the medication cart. The footage did not show her removing the folder from the medication cart. The video footage was no longer available to review due to the authorities now have possession of it.

An interview was conducted with the DON on 6/12/25 at 11:13 a.m. She indicated she currently had been confirming when narcotic medications were delivered by the pharmacy they were recorded and placed in the medication cart.

An interview was conducted with RN 1 on 6/12/25 at 11:38 a.m. She indicated she had worked at the facility for approximately a week and a half to

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F 755	Continued From page 6	F 755		

two weeks. The last day she worked at the facility was on 2/19/25. She was supposed to work on 2/20/25, but did not return to the facility. The facility was "very unorganized. I was worried about my license." She had terminated her position without notice. On 2/19/25, she cannot recall being given a resident's 60 tablets of oxycodone. If she was handed a resident's medication; she would have added the narcotic medications on the narcotic sheet the staff were required to count daily on each shift.

A "Controlled Medications - Administration" policy was provided by the ED on 6/12/25 at 9:22 a.m. It indicated, "...Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and record keeping in the facility, in accordance with federal and state laws and regulations...Medications listed in Schedules II are stored under double lock in a locked cabinet or safe designed for that purpose, separate from all other medications. A controlled medication accountability record is prepared when receiving or checking in a Schedule II... The following information is completed. Name of resident, Prescription number, Name, strength..., and dosage form of medication, Date received, Quantity received, Name of person receiving medication supply..."

The Past Noncompliance began on 2/19/25. The deficient practice was corrected, on 2/21/25, after the facility implemented a systemic plan that included the following: audits completed of all medication carts that contained narcotic medication; nurses and qualified medication aides were educated on narcotic medication administration, misappropriation of property, and

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F 755	Continued From page 7 abuse policy; and medication was reordered from the pharmacy. This citation relates to Complaint IN00454025. 3.1-25(e)(2) 3.1-25(e)(3)	F 755		