STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155637	A. BUILDING 00 B. WING	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CROWN POINT HEALTH CAMPUS	6685 EAST 117TH AVENUE CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00454867, IN00455245, IN00455369, IN00455441, IN00455913, and IN00456087. This visit was in conjunction with a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 2/24/25. This visit included a PSR to the Investigation of Complaints IN00453351 and IN00453429 completed on 2/24/25 and a PSR to the State Residential Licensure Survey completed 2/24/25. Complaint IN00454867 - No deficiencies related to the allegations are cited. Complaint IN00455245 - Federal/State deficiencies related to the allegations are cited at F677. Complaint IN00455369 - Federal/State deficiencies related to the allegations are cited at F692. Complaint IN00455441 - No deficiencies related to the allegations are cited. Complaint IN00455913 - Federal/State deficiencies related to the allegations are cited at F692. Complaint IN00456087 - Federal/State deficiencies related to the allegations are cited at F580, F684, and F755. Complaint IN00453351 - Not corrected. Complaint IN00453429 - Not corrected. Survey dates: April 7, 8, 9, and 10, 2025	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Natalie Porcaro	Administrator	04/21/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Facility number: 001198 Provider number: 155637 AIM number: 100471000 Census Bed Type: SNF/NF: 90 SNF: 15 Residential: 39 Total: 144 Census Payor Type: Medicare: 23 Medicaid: 53 Other: 29 Total: 105 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 4/15/25.			
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) Based on observation, record review, and interview, the facility failed to notify the physician and the resident that a medication was unavailable for 1 of 3 residents reviewed for medications. (Resident E) Finding includes: During an interview on 4/8/25 at 11:09 a.m., Resident E indicated she had not received her long-acting insulin this past Saturday and Sunday evening. She had told the nurse where to look for it but "apparently she couldn't find it." She was not sure why the nurse had not found it and was not given any further explanation.	F 0580	**Crown Point Health Campus Annual PSR Survey: 4/10/2025** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F580 Notify of changes (injury/decline/room, etc.)** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	04/17/2025

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	Record review for Resident E was completed on 4/7/25 at 3:09 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, atrial fibrillation, and multiple sclerosis. The Quarterly Minimum Data Set (MDS) assessment, dated 3/13/25, indicated the resident was cognitively intact. The Physician's Order Summary, dated 4/2025, indicated Lantus (insulin glargine, long-acting insulin) 25 units subcutaneous at bedtime. The Medication Administration Record (MAR), dated 4/2025, indicated the Lantus administrations for 4/5/25 at 8:00 p.m. and 4/6/25 at 8:00 p.m. had been marked with the code "9", which indicated to see the progress notes. An Electronic Medication Administration Record (EMAR) Note, dated 4/5/25 at 8:30 p.m., indicated the Lantus was unavailable and had not been reordered from the pharmacy because it was "trying to be refilled too soon." The pharmacy was going to send over a form for the facility to sign in order to get it refilled. The medication was not available in the emergency drug kit (EDK) supply. There was lack of documentation to indicate the physician or the resident had been made aware the insulin was unavailable. An EMAR Note, dated 4/6/25 at 8:53 p.m., indicated the Lantus had not yet been delivered from the pharmacy. There was lack of documentation to indicate the physician or the resident had been made aware the insulin was unavailable. The Progress Notes, dated 4/5/25 through 4/6/25, lacked any documentation the physician or the		**practice:** Resident E – resident and physician were notified of unavailable medication. Medication is now available and being administered per orders. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Nurses have been re-educated on: Notifying the physician and resident/resident responsible party of changes in plan of care including but not limited to: Unavailable medications New medication orders New treatment orders Refusal of care **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** DON/designee will audit 5 residents 2 times per week to ensure the physician and resident/responsible party are notified of change in condition with	

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	resident had been made aware the insulin was unavailable. During an interview on 4/9/25 at 11:26 a.m., the Interim Director of Nursing (DON) indicated the previous DON had identified that the resident had not received the insulin on 4/5/25 and 4/6/25. The DON had spoken with the nurse who worked those shifts. The nurse indicated she had called the pharmacy to reorder the insulin and was told the DON would have to sign a form to get it refilled. She had text messaged the on-call Nurse Practitioner to make them aware and there were no new orders. She had notified the resident that the insulin was unavailable and had to be reordered. The Interim DON was unable to provide any documentation the Nurse Practitioner or the resident had been made aware the insulin was unavailable. This citation relates to Complaint IN00456087. 3.1-5(a)(2) 3.1-5(a)(3)		a special focus on notification of unavailable medications. The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 4/17/2025**	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents Based on record review and interview, the facility failed to document incontinence care for a resident who was dependent on staff for activities of daily living (ADLs) for 1 of 4 residents who were reviewed for ADLs. (Resident B) Finding includes: Resident B's record was reviewed on 4/7/25 at 10:20 a.m. Diagnoses included, but were not limited to, dementia, hemiplegia and hemiparesis (weakness and paralysis) following a cerebral	F 0677	**Crown Point Health Campus Annual PSR Survey: 4/10/2025** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F677 ADL Care Provided for**	04/17/2025

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	infarction (stroke). The Discharge Minimum Data Set (MDS) assessment, dated 3/12/25, indicated the resident was severely cognitively impaired. She was totally dependent on staff for assistance with toileting and transfers. She was frequently incontinent of bladder and always incontinent of bowel. The current Care Plans indicated the resident had episodes of incontinence and was at risk for complications. Interventions included, but were not limited to, encourage fluids, provide incontinence care, and toilet at regular intervals or scheduled voiding. The CNA Task: Incontinence Care was reviewed from 3/17/25 to 4/7/25. The documentation frequency was every shift. The following dates and shifts were not documented: - 1st shift on 3/17, 3/18, and 3/24/25 - 2nd shift on 3/17, 3/18, 3/31, 4/1, and 4/4/25 - 3rd shift on 3/17, 3/29, 3/30, 3/31, and 4/3/25 During an interview on 4/9/25 at 11:30 a.m. the Interim Director of Nursing indicated the care plan for scheduled voiding would be discontinued as she was no longer a candidate for scheduled voiding. A policy titled, "Incontinence," indicated ..."c. A resident who is incontinent of bladder receives appropriate treatment and services to maintain bladder function as much as possible and prevent complications related to incontinence." This citation relates to Complaint IN00455245. 3.1-38(a)(2)(c)		**Dependent Residents** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** ADL documentation including incontinence care is being completed accordingly for Resident B. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents requiring assistance with Activities of Daily Living have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Staff were re-educated on documenting Activities of Daily Living provided including incontinence care in the medical record. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** DON/Designee will Audit 5 residents 2 times per week, to ensure Activities of Daily Living	

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			with special focus on incontinence care is documented in the medical record. Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 4/17/2025**	
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on record review and interview, the facility failed to ensure a resident received treatment and care in accordance with professional standards of practice related to a medication not administered as ordered by the physician for 1 of 3 residents reviewed for quality of care. (Resident F) Finding includes: Resident F's record was reviewed on 4/9/25 at 2:04 p.m. The diagnoses included, but were not limited to neuropathy and arthritis. A Physician's Order, dated 3/29/25, indicated guaifenesin (cough syrup) extended release (ER) 600 mg, one tablet was to be administered every 12 hours for seven days for a cough. (14 doses)	F 0684	**Crown Point Health Campus Annual PSR Survey: 4/10/2025** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F684 Quality of Care** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	04/17/2025

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	The Medication Administration Record (MAR), dated 3/2025, indicated the guaifenesin had not been administered on 3/29/25 at 9:00 p.m., 3/30/25 at 9:00 a.m. and 9:00 p.m., and 3/31/25 at 9:00 p.m. The guaifenesin was documented as given on 3/31/25 at 9:00 a.m. The MAR, dated 4/2025, indicated the guaifenesin had been administered on April 1-4, 2025 at 9:00 a.m. and 9:00 p.m., and April 5, 2025 at 9:00 a.m. The resident had not received the medication for seven days as ordered and had received 9 of the 14 doses ordered. During an interview on 4/10/25 at 9:20 a.m., the Interim Director of Nursing (IDON) acknowledged the medication had not been administered as ordered. A facility medication administration policy, dated 10/24/14 and received as current from the IDON, indicated medications were to be administered as prescribed. This citation relates to Complaint IN00456087. 3.1-37		**practice.** Resident F's remains in the facility. The physician was notified of the undocumented medication dose and no furtherer order were received. Resident F had no adverse reactions. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents with medication orders have the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** Staff were educated on: Ensuring medications are given as per physician orders Medications are documented at the time of administration in the Medication Administration Record (MAR) **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put**	

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			into place. DON/designee will review 5 residents with orders 2 times per week to ensure medications are given as per physician orders and documented on the Medication Administration Record (MAR). The Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 4/17/2025**	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance Based on observation, record review, and interview, the facility failed to provide supplements as ordered and document nutritional intake for meals for residents with weight loss for 2 of 3 residents reviewed for nutrition. (Residents D and H) Findings include: 1. On 4/8/25 at 11:24 a.m., CNA 3 was observed taking a lunch tray to Resident D. She received a cheeseburger, tater tots, pickles, and a can of soda. There was no Mighty Shake on the tray at	F 0692	**Crown Point Health Campus Annual PSR Survey: 4/10/2025** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F692 Nutrition/Hydration Status Maintenance**	04/17/2025

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	the time. During an observation and interview on 4/8/25 at 11:45 a.m., CNA 3 brought out Resident D's tray to return to the tray cart. The resident had picked at the food. There was no Mighty Shake present on the tray. Both CNA 3 and LPN 1 confirmed the resident had not received the Mighty Shake and dietary was responsible for putting those on the trays. Resident D's record was reviewed on 4/7/25 at 11:16 a.m. Diagnoses included, but were not limited to, dementia, protein-calorie malnutrition, and cognitive communication deficit. The resident weighed 100.5 pounds on 11/12/24 and the most recent weight was 96 pounds on 4/7/25. The Quarterly Minimum Data Set (MDS), dated 2/18/25, indicated the resident was severely cognitively impaired. The resident required setup assistance for eating. The current April 2025 Physician Order Summary indicated Mighty Shake twice daily, regular diet, and 1000 milliliter (ml) fluid restriction per day, nursing to provide 215 ml per shift, dietary to provide 120 ml per day, and nursing to provide Mighty Shakes, 4 ounces to be given in place of 4 ounces of fluid at lunch and dinner. The current Care Plans indicated the resident had a physician's order for a diet with fluid restriction. Interventions included, but were not limited to, provide the appropriate diet as ordered and dietary to provide 4 ounces per meal and may provide Mighty Shake twice daily.		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident D's plan of care was reviewed, and nutritional supplements are being provided as per orders. Resident H's meal consumption is being documented in the medical record per protocol **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Staff were re-educated on: Documenting resident meal consumption in the medical record Providing nutritional supplements as per orders **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Director of Nursing/designee will audit 5 residents 2 times per week to ensure meal consumption is	

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	During an interview on 4/9/25 at 11:30 a.m., the Interim Director of Nursing indicated she had no further information to provide. 2. Resident H's record was reviewed on 4/10/25 at 9:00 a.m. Diagnoses included, but were not limited to, Alzheimer's disease and dementia. The Quarterly Minimum Data Set (MDS) assessment, dated 3/10/25, indicated the resident was severely cognitively impaired and was dependent on staff for all ADLs including eating, toileting, personal hygiene, and transfers. She received hospice care. The resident weighed 154.8 pounds on 10/15/24 and 138.8 pounds on 4/2/25. The current Care Plans indicated the resident has unplanned/unexpected weight loss related to the need for end of life care. Interventions included, but were not limited to, monitor and record food intake at each meal. The CNA Task: Nutritional Intake was reviewed from 3/17- 4/10/25. There were no lunch or dinner meals documented on 3/21. There were no dinner meals documented on 3/25/25, 3/28/25, 3/30/25, 4/2/25, 4/3/25, and 4/5/25. During an interview on 4/10/25 at 10:45 a.m., the Interim Director of Nursing indicated she had no further information to provide. A facility policy titled, "Nutritional Monitoring," indicated, "...Ensure staff awareness of resident diet order, including supplements and food consistency. Ensure receipt of correct, diet, supplements, and food consistency...Monitor		being documented in the medical records and supplements with special focus on health shakes are being provided as per orders. The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 4/17/2025**	

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	each meal intake to include food, hydration, and supplement consumption. Indicate overall percentage consumed by the end of the meal..." This citation relates to Complaint IN00455369 and IN00455913. 3.1-46(a)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on record review and interview, the facility failed to ensure a resident was provided with routine medications in a timely manner by the contracted pharmacy, related to medications not available to be administered as ordered by a physician for 1 of 3 residents reviewed for medications. (Resident F) Finding includes: Resident F's record was reviewed on 4/9/25 at 2:04 p.m. The diagnoses included, but were not limited to neuropathy and arthritis. An After Visit Summary from the hospital, dated 3/28/25, indicated the resident was being treated for a urinary tract infection. The discharge orders included cephalexin (antibiotic) 500 mg (milligrams), one capsule three times a day for seven days. A Nurse's Progress Note, dated 3/29/25 at 3:32 a.m., indicated the resident was readmitted to the facility and the Physician's Discharge Orders were verified with the physician. a) The Physician's Orders, dated 3/29/25 and discontinued on 3/31/25, indicated cephalexin 500	F 0755	**Crown Point Health Campus Annual PSR Survey: 4/10/2025** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F755 Pharmacy/Svcs/Procedures/Pharmacist/Records** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident F's medications have been received and was administered per physician orders. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;**	04/17/2025

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	mg, one tablet was to be given three times a day for infection for seven days. The medication was to be started on 3/29/25 at 10 p.m. The Medication Administration Record (MAR), dated 3/2025, indicated the cephalexin 500 mg was administered on 3/29/25 at 10:00 p.m., 3/30/25 at 6:00 a.m., 2:00 p.m.,10:00 p.m. and had not been administered on 3/31/25 at 6:00 a.m. The MAR, dated 3/2025, indicated the cephalexin 500 mg had not been given on 3/31/25 at 6:00 a.m., 2:00 p.m., and 10:00 p.m. A Medication Administration Progress Note, dated 3/31/25 at 6:05 a.m., indicated the cephalexin was unable to be given due to a power outage and was unable to be obtained from the Emergency Drug Kit (EDK). A Nurse's Progress Note, dated 3/31/25 at 12:24 p.m., indicated the pharmacy was notified in regards to the delivery status and informed the facility the resident's insurance would not cover the cephalexin and they would fax the Director of Nursing (DON) for an authorization. The Unit Manager, Nurse Practitioner, DON, and POA (Power of Attorney) were notified. A Medication Administration Progress Note, dated 3/31/25 at 1:42 p.m., indicated the cephalexin 500 mg's was not available due to the insurance would not cover the cost. The Nurse Practitioner, POA, DON, and the Unit Manager were notified. A Physician's Order, dated 3/31/25 at 2:00 p.m., indicated the cephalexin 500 mg, one tablet was to be administered three times a day for five days for bronchopneumonia.		All facility residents that require pharmacy services have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Nurses were educated on: Calling the pharmacy to inquire about missing medications Notifying the physician of unavailable medications and obtaining alternative orders and/or medication hold orders until medication is available Notifying the DON/ED/Administrator of need for authorization for non-covered medication Nurses were educated on re-ordering medications before all doses are gone to prevent missed doses. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** DON/designee will randomly audit 5 residents' medications 2 times per week to ensure mediations are in the facility and available for administration. The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155637	A. BUILDING 00 B. WING	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CROWN POINT HEALTH CAMPUS	6685 EAST 117TH AVENUE CROWN POINT, IN 46307

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	The MAR, dated 4/2025, indicated the cephalexin 500 mg was started three times a day on 4/1/25 at 6:00 a.m. During an interview on 4/9/25 at 4:07 p.m., with the Interim DON (IDON), the Executive Director (ED), and the Administrator, the ED indicated there was a power outage and the generator was working and the EDK would have been functional. The IDON was unsure why the authorization had not been given by the DON. During an interview on 4/10/25 at 9:20 a.m., the IDON indicated the cephalexin 500 mg was obtained from the EDK for the 3/29/25 10:00 p.m. dose and the 3/30/25 6:00 a.m. dose. She indicated the 3/30/25 2:00 p.m. and 10:00 p.m. doses were signed out as given, though she was unsure where they obtained the medications from since the pharmacy had not delivered the medication and the medication was not removed from the EDK per the EDK records. She indicated the medication order was transcribed incorrectly indicating another pharmacy would be supplying the medication. The facility pharmacy had not indicated the insurance would not pay for the medication. The nurses and/or DON had not contacted the pharmacy to question why the medication had not been sent or about the authorization. b) A Physician's Order, dated 3/29/25, indicated guaifenesin (cough syrup) extended release (ER) 600 mg, one tablet was to be administered every 12 hours for seven days for a cough. The MAR, dated 3/2025, indicated the guaifenesin had not been administered on 3/29/25 at 9:00 p.m., 3/30/25 at 9:00 a.m. and 9:00 p.m., and 3/31/25 at 9:00 p.m. The guaifenesin was documented as		Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 4/17/2025**	

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	given on 3/31/25 at 9:00 a.m. Medication Administration Progress Notes, dated 3/29/25 at 10:08 p.m., 3/30/25 at 10:33 a.m., 3/30/25 at 10:00 p.m., and 3/31/25 at 8:00 p.m., indicated the guaifenesin had not been delivered from the pharmacy and was not available in the EDK. During an interview on 4/10/25 at 9:20 a.m., the IDON indicated the guaifenesin was transcribed incorrectly indicating another pharmacy would be supplying the medication. The facility pharmacy had not sent the medication and the guaifenesin was not available in the EDK. She was unsure where the the nurse obtained the guaifenesin for the 3/31/25 9:00 a.m. dose. A facility policy for ordering medications, dated 10/25/14 and received as current from the IDON, indicated medication orders were to be written on a medication order form and entered into an electronic medical record system. Re-admission orders were sent to the pharmacy. The facility was to indicate the name of the pharmacy supplier. This citation relates to Complaint IN00456087. 3.1-25(a)			