STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155443	A. BUILDING 00 B. WING	03/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF MUNCIE, THE	2400 CHATEAU DR MUNCIE, IN 47303

(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 a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00455755, IN00455668, and IN00456510. Complaint IN00455755 - No deficiencies related to the allegations are cited. Complaint IN00455668 - Federal deficiencies related to the allegations are cited at F602, F609, and F755. Complaint IN00456510 - No deficiencies related to the allegations are cited. Survey dates: March 25, 26, 27, 28, and 31, 2025 Facility number: 000310 Provider number: 155443 AIM number: 100288970 Census Bed Type: SNF/NF: 46 Total: 46 Census Payor Type: Medicare: 4 Medicaid: 28 Other: 14 Total: 46 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed April 8, 2025.	F 0000	Preparation and/or execution of this plan of correction in general, or this corrective action does not constitute an admission agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan or correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 05/12/2025. Facility respectfully requests a desk review.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Robin Huston	Administrator	05/08/2025

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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F 0582 SS=D Bldg. 00	483.10(g)(17)(18)(i)-(v) Medicaid/Medicare Coverage/Liability Notice Based on interview and record review, the facility failed to ensure a SNF-ABN (Skilled Nursing Facility-Advance Beneficiary Notice of Non-coverage) and NOMNC (Notice of Medicare Non-coverage) was provided following the end of Medicare skilled services for 2 of 2 residents who discharged from Medicare services and remained in the facility. (Residents 14 and 10) Findings included: On 3/25/25 at 3:00 p.m. the SNF (Skilled Nursing Facility) Beneficiary Protection Notification Review forms were reviewed and indicated the following: 1. Resident 14's last covered day of Part A service was 9/24/24. The resident was required to pay for services starting on 9/25/24 A NOMNC signed by their guardian was dated 9/23/24, one day prior to the end of service. The resident did not receive an ABN and remained in the facility after the end of service date. 2. Resident 10 had an ABN signed by the resident on 1/10/25, one week after services ended. The ABN stated "...Beginning on 1/3/25, you may have to pay out of pocket for this care if you do not have other insurance that may cover these costs...", but lacked in any information about an estimated cost of services after covered services ended. Resident 10 did not receive a NOMNC. Their last day of covered service was 1/3/25 and the resident remained in the facility after. During an interview with the Administrator on 3/28/25 at 10:33 a.m., she indicated that she was	F 0582	F 582 Medicaid/Medicare Coverage/Liability Notice It is the policy of this facility to ensure a SNF-ABN and NOMNC was provided following the end of Medicare skilled services. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. The SSD/Designee provided resident 10 with ABN on 9/26/2024, for end of services dated 9/24/2024. The SSD/Designee provided resident 14 with a NOMNC on 1/05/2025, for end of services on 1/3/2025. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. The SSD/Designee completed a 90 day look back for residents with an end of service stay and verified a NONMC and ABN were given to the residents timely. Any concerns were immediately addressed. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur. The Administrator in-serviced the	05/12/2025

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	unsure why the proper forms were not given to the residents. She was not the administrator when the forms were completed. SSD 11 handled the beneficiary paperwork at that time. During an interview with SSD 11 on 3/28/25 at 10:35 a.m., she indicated she was unsure why residents had not received the proper paperwork. No additional information was provided. The previous administrator handled the beneficiary paperwork. During an interview on 3/31/25 at 12:28 p.m., the Administrator indicated she could not find a beneficiary policy and would check with SSD 11. No additional paperwork or policies were provided before facility exit on 3/31/25. 3.1-4(f)(3)		BOM and SSD on the NOMNC and ABN policy on 4/08/2025. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The Administrator/Designee will audit residents with an end of services stay and verify the NOMNC and ABN were given to the resident/responsible party timely five times a week x 4 weeks, then 3 times a week x 4 weeks, then once a week x 4 months. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. By what date the systemic changes for each deficiency will be complete. 5/12/2025.	

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F 0602 SS=E Bldg. 00	483.12 Free from Misappropriation/Exploitation Based on record review and interview, the facility failed to prevent the misappropriation of residents' medications for 4 of 7 residents reviewed for misappropriation. (Residents J, F, H, and G) This deficiency had the potential to affect 16 of 46 residents who had controlled medications stored in facility's the medication carts. Findings include: Review of an Indiana State Department of Health facility reported incident, dated 3/16/25 at 12:16 p.m., indicated the facility initiated an investigation of misappropriation of Resident J's medications. The incident was identified on 3/16/25 at 10:25 a.m. LPN 9 was the staff member involved and suspended until further notice. The police were notified on 3/16/25. The brief description indicated LPN 14 reported Resident J's oxycodone-acetaminophen (narcotic pain reliever) card was not in the medication drawer and the order had been discontinued when she came back on shift following LPN 9's duty. An order for oxycodone (narcotic pain reliever) as needed had been put back in from the previous day. The DON called LPN 9 who indicated Resident J was itching last night from the oxycodone-acetaminophen. She had received an order to resume the oxycodone as needed and destroyed the oxycodone-acetaminophen. A follow up on 3/21/25 indicated the investigation was completed. Additional residents were found with controlled medication discrepancies. The following medication discrepancies were identified: Resident J had 28 tablets of oxycodone-acetaminophen unaccounted for, Resident F had 58 tablets of tramadol (narcotic	F 0602	F 602 – Free from misappropriation/exploitation It is the intent of this facility to prevent misappropriation of residents' medications. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Residents J, F, H and G were assessed by the DON/Designee on 3/16/2025 and no negative outcome. The DON/Designee notified the Pharmacy on 4/15/2025 and resident were not charged for the missing medications. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All residents that currently reside in the facility have the potential to be affected by the alleged deficient practice, therefore, this plan of correction applies to all residents that reside in the facility. An audit was completed on 3/19/25 by the DON/Designee of all narcotics delivered from 1/24/25 to 3/17/25 to identify any narcotics that could not be accounted for. Additionally, an audit was completed on 4/7/25 by the	05/12/2025

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	pain reliever) unaccounted for with missing narcotic count sheets, Resident H had six tablets of oxycodone/acetaminophen unaccounted for, and Resident G had 28 tablets of oxycodone unaccounted for. The oxycodone-acetaminophen narcotic count sheet for resident J was not located and there were no witnesses when LPN 9 allegedly destroyed resident J's oxycodone-acetaminophen tablets. Resident J denied any concerns of itching. LPN 9 was requested to provide a drug screen and failed to present for drug testing. Instead, she called and resigned, "stating she had to now take care of her father." 1. Resident J's clinical record was reviewed on 3/26/25 at 3:38 p.m. The resident discharged from the facility on 3/22/25. Diagnoses included abnormal posture, scoliosis, and chronic pain syndrome. A physician's order, dated 3/15/25, included oxycodone-acetaminophen 10-325 milligrams (mg) - give one tablet by mouth every four hours as needed for pain. The order was discontinued on 3/16/25 at 5:40 a.m. A physician's order, dated 3/13/25, included oxycodone hydrochloride 10 mg - give one tablet by mouth every 4 hours as needed for pain. The order was held from 3/15/25 to 3/16/25. It was discontinued on 3/22/25. Review of the pharmacy "Monthly Controlled Drug Report" indicated the facility received 30 tablets of oxycodone-acetaminophen 10-325 mg on 3/13/25 for Resident J. Review of the Medication Administration Record for March 2025 indicated the resident received		DON/Designee of all narcotics delivered from 3/15/25 to 4/7/25. The audit showed no further narcotics that were not accounted for. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur. The DON or designee completed education with facility staff on the Abuse Prevention Program including ensuring residents were free from abuse including misappropriation of property on 4/12/2025. Licensed nurses and QMAs were educated on disposition of controlled substances and drug diversion on 4/14/2025. Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated. How the corrective action will be monitored to ensure the deficient practice will not recur, ie what quality assurance program will be put into place. The DON or designee will audit narcotic packing slips, pharmacy controlled substances report and narcotic count sheets to ensure delivered medications are properly administered and destroyed as applicable five times weekly x 4 weeks, then three times weekly x 4 weeks then three times monthly	

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	two tablets of oxycodone-acetaminophen 10-325 mg out of the 30 tablets delivered to the facility. The two tablets were administered by LPN 9 and the order was discontinued by LPN 9. A record of disposition was not completed. (This left 28 tablets unaccounted for.) The clinical record lacked a Controlled Drug Record/Disposition Form. An admission Minimum Data Set (MDS) assessment, dated 2/20/25, indicated the resident was cognitively intact. The resident experienced frequent pain. A current care plan, dated 2/13/25, indicated the resident was at risk for potential pain related to chronic pain syndrome and fibromyalgia. Interventions included, administer the medications as ordered (2/13/25) and observe for the effectiveness of the intervention. A Nurse's note, dated 3/16/25 at 5:45 a.m., indicated the pharmacy was called regarding the resident's pain medication. The provider had not sent the prescription, but they had the ability to pull the medication from house stock. The clinical record lacked any indication the resident reported itching. 2. Resident F's clinical record was reviewed on 3/26/25 at 3:56 p.m. Diagnoses included chronic obstructive pulmonary disease, solitary pulmonary nodule, and weakness. A physician's order, dated 12/16/24, included tramadol hydrochloride - give two tablets by mouth every six hours for pain. The order was discontinued on 3/13/25 by LPN 9.		x four months. Results will be forwarded to QAPI committee for further recommendations and resolution as necessary. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. By what date the systemic changes for each deficient will be completed. Date: 5/12/2025	

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	A current physician's order, dated 1/14/25, included methadone hydrochloride (narcotic pain reliever) oral concentrate 10 milligrams (mg)/milliliter (ml) - give 1 ml by mouth every four hours as needed for pain. Review of the pharmacy "Monthly Controlled Drug Report" indicated the facility received 52 tablets of tramadol hydrochloride 50 mg on 3/4/25, and 54 tablets of tramadol hydrochloride 50 mg on 3/9/25. A Controlled Drug Record/Disposition Form dated 3/4/25 indicated 30 doses were recorded on receipt. The clinical record lacked a Controlled Drug Record/Disposition Form for the remaining 22 tablets delivered on 3/4/25. The clinical record lacked a Controlled Drug Record/Disposition Form for the 54 tablets delivered on 3/9/25. Review of the resident's Medication Administration Record for March 2025 indicated the resident received 48 tablets of tramadol hydrochloride 50 mg out of the 106 tablets delivered to the facility. (This left 58 tramadol tablets unaccounted for.) A quarterly Minimum Data Set (MDS) assessment, dated 3/1/25, indicated the resident had moderate cognitive impairment. The resident had a chronic condition that may result in a life expectancy of less than six months. A current care plan, dated 3/21/24, indicated the resident was at an increased risk for pain/discomfort related to osteoporosis and chronic disease processes. Interventions included analgesic medication as ordered (3/21/24).			

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	3. Resident H's clinical record was reviewed on 3/26/25 at 2:09 p.m. Diagnoses included malignant neoplasm of the pancreas and subsequent encounter of unspecified fracture of the shaft of the left femur. The resident discharged on 3/3/25. A physician's order, dated 2/17/25, included oxycodone-acetaminophen 5-325 mg - give one tablet by mouth every eight hours for moderate to severe pain. The order was discontinued on 2/24/25. A physician's order, dated 2/24/25, included oxycodone-acetaminophen 5-325 mg - give 1 tablet by mouth every 8 hours for pain. The order was discontinued on 3/4/25. A physician's order, dated 3/3/25, indicated the resident may be discharged home with all medications except narcotics. The clinical record lacked a record of disposition for the resident's 30 tablets of oxycodone-acetaminophen delivered on 2/24/25. Review of the resident's MAR for February 2025 indicated the resident received 13 tablets of oxycodone-acetaminophen 5-325 mg from 2/24/25 through 2/28/25. The resident's MAR for March 2025 indicated the resident received eight tablets from 3/1/25 through 3/3/25. (This left nine oxycodone-acetaminophen tablets unaccounted for.) A handwritten note on the MAR indicated 30 tablets of oxycodone-acetaminophen were delivered to the facility on 2/24/25. An admission Minimum Data Set (MDS) assessment, dated 2/21/25, indicated the resident was cognitively intact. The resident required opioid pain relievers in the assessment period.			

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	A current care plan, dated 2/17/25, indicated the resident was at a potential risk for pain. Interventions included medications as ordered (3/21/24). A Nurse's note, dated 3/3/25 at 3:52 p.m., indicated the resident was discharged home with all of his medications except narcotics. During an interview on 3/31/25 at 11:37 a.m., LPN 10 indicated she had discharged Resident H on 3/3/25 and narcotics were not sent with the resident. The resident's narcotics remained secured in the medication cart drawer when she did shift-to-shift narcotic count with LPN 9 at the end of her shift. She had not participated in any destruction of the resident's controlled medications. The destruction of controlled medications were never done alone and required the presence of the DON or ADON along with another nurse. 4. Resident G's clinical record was reviewed on 3/26/25 at 3:25 p.m. Diagnoses included primary osteoarthritis, right knee and pain in right knee. The resident discharged on 2/12/25. A physician's order, dated 2/3/25, included oxycodone-acetaminophen 10-325 mg - give one tablet by mouth every six hours as needed for moderate pain. This order was discontinued on 2/6/25 A physician's order, dated 2/5/24, included oxycodone-acetaminophen 10-325 mg - give one tablet by mouth every four hours as needed for pain. Give two tablets by mouth for moderate to severe pain. The order was discontinued on 2/6/25.			

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	A physician's order, dated 2/6/25, included oxycodone-acetaminophen 10-325 mg - give one tablet by mouth every four hours as needed for pain. The order was discontinued on 2/11/25. A physician's order, dated 2/6/25, included oxycodone-acetaminophen 10-325 mg - give two tablets by mouth every four hours as needed for moderate to severe pain. The order was discontinued on 2/11/25. A physician's order, dated 2/11/25, included oxycodone-acetaminophen 10-325 mg - give one tablet by mouth every four hours as needed for pain. The order was discontinued on 2/14/25. Review of the pharmacy "Monthly Controlled Drug Report" indicated the facility received eight tablets of oxycodone-acetaminophen 10-325 mg on 2/3/25, 42 tablets of oxycodone-acetaminophen 10-325 mg on 2/4/25, and 30 tablets of oxycodone-acetaminophen 10-325 mg on 2/6/24. Three tablets were dispensed from the emergency drug supply. The clinical record lacked a record of disposition for the 42 tablets delivered on 2/4/25. A Controlled Drug Record/Disposition Form dated 2/6/25 indicated 26 tablets were destroyed. Review of the resident's Medication Administration Record for February 2025 indicated the resident received 29 tablets of oxycodone-acetaminophen 10-325 mg out of the 83 tablets delivered/pulled to the facility. (This left 28 tablets unaccounted for.) An admission Minimum Data Set (MDS) assessment, dated 2/10/25, indicated the resident was cognitively intact. The resident was taking			

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	opioid pain reliever during the assessment period. A current care plan, dated 2/4/25, indicated the resident had a potential for pain related to a history of right knee pain. Interventions included administer medications as ordered (2/4/25). During an interview on 3/31/25 at 12:50 p.m., LPN 7 indicated she was the nurse on duty when Resident G left against medical advice on 2/12/25. She indicated the resident did not have medications sent with him when he left the facility. The resident's regular medication and controlled medications remained locked in the medication cart on the 300 Unit medication cart when she completed her shift-to-shift narcotic count with LPN 9 on 2/12/25. She was unaware what happened to the resident's medications after her shift ended. She had not been a part of the destruction of the resident's medications. It had never been acceptable to destroy controlled medications alone and she had never seen anyone who destroyed controlled medications alone. Destruction of controlled medication required the presence of the DON or ADON. The staff were recently in-serviced on the importance of shift-to-shift narcotic counts with both staff members present at each shift change. The count required staff to include the resident's name on any cards, sheets, or medications added or removed on the shift-to-shift narcotic count log. They were also required to ensure the accuracy, then sign and submit the pharmacy delivery sheets to the DON. A review of the facility investigation file, provided by the Administrator on 3/26/25 at 2:59 p.m., contained the following information: A typed statement from the DON, dated 3/19/25,			

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	indicated she was called by LPN 14 on 3/16/25 at 10:19 a.m. who reported Resident J's oxycodone-acetaminophen medication had been discontinued and was not in the drawer. She had spoken with a nurse who worked last night and indicated she had not destroyed any medication. LPN 14 had tried to call LPN 9 who worked the night shift prior to her shift, but she could not get an answer. On 3/16/25 at 10:22 a.m., the DON left a message for LPN 9 to return her call as soon as possible. She contacted the previous Administrator and the Corporate Nurse Consultant 4 for verification of the appropriate steps. On 3/16/25 at 10:30 a.m. the DON spoke with LPN 9 via telephone. LPN 9 explained she received an order to resume Resident J's order for oxycodone as needed because the resident told her she was itching from the oxycodone-acetaminophen. LPN 9 had destroyed the oxycodone-acetaminophen herself by putting it in the Drug Buster while she sat at the nurses' station. She explained she put the narcotic sheet in the box outside the MDS Office after she destroyed the medication. LPN 9 explained she did not think about needing a witness. The DON notified LPN 9 that she was suspended. On 3/16/25 at 10:50 a.m., the DON spoke with the Charge Nurse 15 who indicated Resident J denied any reports of itching to the nurse over the night shift. On 3/16/25 at 10:54 a.m., the DON spoke with LPN 9 again via telephone and LPN 9 then confirmed the resident had not reported any itching. LPN 9 explained, in previously employment, she always destroyed narcotics herself because she was			

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	often the only nurse on duty. On 3/16/25 at 12:11 p.m., the previous Administrator notified the DON that LPN 9 needed to submit a drug test as soon as possible. On 3/16/25 at 12:14 p.m., the DON attempted to unsuccessfully reach LPN 9 via telephone. A text message was sent and requested LPN 9 to call the DON. On 3/16/25 at 1:16 p.m., the DON attempted to reach LPN 9 again via telephone. Another text message was sent asking for a returned call. LPN 9 called back, and the DON asked her to come to the facility to get a drug test. She asked if she could come tomorrow, and the DON explained it needed done as soon as possible. LPN 9 indicated she would come into the facility. On 3/16/25 at 4:41 p.m., the DON sent LPN 9 a text asking if she had gotten her drug test yet. On 3/16/25 at 5:19 p.m., the DON received a call from LPN 9 and indicated she had fallen asleep and was going in to get her drug test. On 3/16/25 at 6:45 p.m., the DON received a text from LPN 9. The text stated, "I'm resigning effective immediately ...." On 3/17/25, the DON contacted pharmacy services and obtained a report of all narcotics delivered since LPN 9 began employment. On 3/19/25, the DON completed a review of all narcotics delivered. Discrepancies were found in the above-mentioned residents' medication reconciliations as follows: Resident J: Discrepancy - 28 tablets of oxycodone-acetaminophen 10-325 mg Resident F: Discrepancy - 58 tablets of tramadol 50 mg			

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	Resident H: Discrepancy - Six tablets of oxycodone-acetaminophen 10-325 mg Resident G: Discrepancy - 28 tablets of oxycodone-acetaminophen A hand-written statement from QMA 8, dated 3/19/25, indicated on 3/14/25 Resident F's tramadol was in the medication cart when he counted off with LPN 9 at the end of his shift. A hand-written statement from LPN 6, dated 3/19/25, indicated Resident H discharged home without any narcotics. The resident's narcotics were left in the narcotic drawer. She had no idea what happened to them after that. A hand-written statement from LPN 7, dated 3/19/25, indicated Resident G left against medical advice. No medications were sent with the resident. Narcotics were left in the narcotic drawer. During an interview on 3/31/25 at 12:15 p.m., the DON indicated LPN 9 had administered medications from all the medication carts in the facility prior to her resignation. The DON was unable to provide copies of the pharmacy delivery receipts for the time that was audited because they had not been kept. She found the Shift-to-Shift Narcotic Count Logs were lacking accuracy because staff had not recorded the medications and sheets added and removed each time. During an interview on 3/31/25 at 12:39 p.m., the DON indicated five residents received controlled medications on the Memory Care Unit medication cart, four residents received controlled medications on the 300 Unit medication cart, and seven residents received controlled medications			

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	on the 400 Unit medication cart. A current facility policy, dated 10/22/22, titled "ABUSE PREVENTION PROGRAM," provided by the Administrator after facility entrance on 3/25/25, indicated the following: "Policy... It is the policy of this facility to prevent resident abuse, neglect, mistreatment, and misappropriation of resident property...." This citation relates to Complaint IN00455668. 3.1-28(a)			
F 0609 SS=E Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations Based on record review and interview, the facility failed to report misappropriation of resident medications to the appropriate agencies within the required timeframe for 4 of 7 residents reviewed for misappropriation. (Residents F, G, H, and J) This deficiency had the potential to affect 16 of 46 residents who had controlled medications stored in the facility's the medication carts. Findings include: Review of an Indiana State Department of Health facility reported incident, dated 3/16/25 at 12:16 p.m., indicated the facility initiated an investigation of misappropriation of Resident J's medications. The incident was identified on 3/16/25 at 10:25 a.m. LPN 9 was the staff member involved and suspended until further notice. The police were notified on 3/16/25. The brief description indicated LPN 14 reported Resident J's oxycodone-acetaminophen (narcotic pain reliever) card was not in the medication drawer and the order had been discontinued when she came back	F 0609	F 609 Reporting Violations It is the policy of this facility to report misappropriation of resident's medications to the appropriate agencies within the required timeframe. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. The DON/Designee assessed residents F, G, H and J on 3/25/2025, 3/26/2025 and no negative outcome related to the alleged deficient practice. The DON/Designee assessed residents with stored controlled medications in the medication carts on 4/14/2025 and no negative outcome. The Adm/Designee reported LPN 9 to the Attorney General on	05/12/2025

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	on shift following LPN 9's duty. An order for oxycodone (narcotic pain reliever) as needed had been put back in from the previous day. The DON called LPN 9 who indicated Resident J was itching last night from the oxycodone-acetaminophen. She had received an order to resume the oxycodone as needed and destroyed the oxycodone-acetaminophen. A follow up on 3/21/25 indicated the investigation was completed. Additional residents were found with controlled medication discrepancies. The following medication discrepancies were identified: Resident J had 28 tablets of oxycodone-acetaminophen unaccounted for, Resident F had 58 tablets of tramadol (narcotic pain reliever) unaccounted for with missing narcotic count sheets, Resident H had six tablets of oxycodone/acetaminophen (narcotic pain reliever) unaccounted for, and Resident G had 28 tablets of oxycodone unaccounted for. The oxycodone-acetaminophen narcotic count sheet for resident J was not located and there were no witnesses when LPN 9 allegedly destroyed resident J's Percocet tablets. Resident J denied any concerns of itching. LPN 9 was requested to provide a drug screen and failed to present for drug testing. Instead, she called and resigned, "stating she had to now take care of her father." Review of the facility investigation on 3/26/25 at 2:59 p.m. lacked indication that LPN 9 was reported to the Attorney General Office for professional licensing. During an interview on 3/28/25 at 2:50 p.m., the Administrator indicated she was unable to provide information that the facility had previously reported LPN 9 to the Attorney General Office prior to the survey.		3/28/2025. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All residents who have controlled medications stored in the medication carts have the potential to be affected, therefore, this plan of correction applies to all residents receiving controlled medications. An audit was completed on 3/19/25 of all narcotics delivered from 1/24/25 to 3/17/25 to identify any narcotics that could not be accounted for by the DON/Designee. Additionally, an audit was completed on 4/7/25 of all narcotics delivered from 3/15/25 to 4/7/25 by the DON/Designee. The audit showed no further narcotics that were not accounted for. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur. The Regional Director of Operations in-serviced the DON and Administrator on reporting misappropriation of controlled medications to the State Attorney General timely on 3/28/2025. Additionally, any staff member that fails to comply with the points of this in-service with be further educated and/or disciplined as	

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	During an interview on 3/31/25 at 12:39 p.m., the DON indicated LPN 9 had worked on all the medication carts in the building. Five residents received controlled medications from the Memory Care Unit medication cart, four residents received controlled medications from the 300 Unit medication cart and seven residents received controlled medications from the 400 Unit medication cart. The facility did not have a policy regarding timely reporting to State Agencies. They followed the Indiana State guidelines for reporting misappropriation. During an interview on 3/31/25 at 1:35 p.m., the Administrator indicated LPN 9 should have been reported to the Office of Attorney General for misappropriation when the facility reported it to the Indiana Department of Health. She was not at the facility when the misappropriation was identified. She did not know why it was not timely reported to the Attorney General Office. Cross reference F602. This citation relates to complaint IN00455668. 3.1-28(c)		indicated. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The Administrator will review all unusual occurrences to ensure reporting to the proper agencies x 6 months. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. By what date the systemic changes for each deficiency will be complete. DATE: 5/12/2025	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, interview, and record review, the facility failed to provide oxygen and humidity as ordered for 1 of 1 resident reviewed for oxygen. (Resident F) Finding includes:	F 0695	F695 It is the policy and practice of this facility to ensure residents who need respiratory care receive oxygen and humidity per physician orders.	05/12/2025

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	During an observation on 3/25/25 at 11:27 a.m., Resident F was in her bed asleep with oxygen on via nasal cannula at 5 liters per minute (lpm). The humidity bottle attached to the oxygen concentrator was empty and dated 3/21/25. During an observation on 3/25/25 at 3:10 p.m., the resident was seated in a wheelchair with her oxygen on via nasal cannula and attached to an oxygen concentrator. The oxygen was on at 5 lpm and the humidification bottle was empty. During an observation on 3/26/25 at 11:18 a.m., the resident was in bed asleep with the oxygen on at 5 lpm via nasal cannula. The humidification bottle was empty and dated 3/21/25. Resident F's clinical record was reviewed on 3/26/25 at 3:56 p.m. Diagnoses included chronic obstructive pulmonary disease, solitary pulmonary nodule, and weakness. A current physician order, dated 7/22/24, included oxygen at three liters per minute via nasal cannula. A current physician order, dated 7/22/24, included a humidification bottle change once weekly and as needed for humidity. A quarterly Minimum Data Set (MDS) assessment, dated 3/1/25, indicated the resident had moderate cognitive impairment. The resident had a chronic condition that may result in a life expectancy of less than six months. Special services included oxygen therapy. A current care plan, dated 8/11/24, indicated the resident was at risk for respiratory distress related to a left lung pulmonary nodule/lung cancer.		What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident F was assessed on 4/7/25 with no adverse effects noted by the DON/Designee. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? An audit was completed by the DON/Designee on 4/7/25 of all residents to ensure proper orders including liter flow and humidification and care plans were in place. Any concerns were immediately addressed. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Licensed nurses and Qualified Medication Aides were educated by the Director of Nursing on the policy “Oxygen administration” on or before 4/18/2025. Anyone who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated. How will the corrective action be monitored to ensure the deficient practice will not recure, i.e., what quality assurance program will be put into place? Director of Nursing or designee will complete the Oxygen Observation	

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	Interventions included monitoring respiratory status frequently (8/11/24) and oxygen as ordered per the physician (9/11/24). During an interview on 3/26/25 at 4:56 p.m., LPN 7 indicated the resident's oxygen was on via nasal cannula at 5 lpm. The humidity canister was empty. She indicated the resident typically required 2-3 lpm. LPN 7 had not been informed of any changes nor had hospice left any notes. During an interview on 3/26/25 at 5:00 p.m., LPN 7 indicated the resident's hospice binder did not have any notes regarding a change in the orders for oxygen. The resident's oxygen was ordered at 3 lpm. The physician orders should have been followed and the humidity should not have been empty. During an interview on 3/28/25 at 11:46 a.m., the CNA 5 indicated the resident was very cooperative with care. She had never known the resident to change her own oxygen settings, as her vision was impaired. She required staff assistance with her oxygen needs. During an interview on 3/28/25 at 1:10 p.m., the DON indicated she had contacted hospice on 3/26/25 and confirmed no changes had been made to the resident's oxygen orders. The resident's oxygen flow rate and humidity should have been provided for the resident as it was ordered. A current facility policy, undated, titled "OXYGEN ADMINISTRATION," provided by the DON on 3/28/25 at 1:17 p.m., indicated the following: "Policy... It is the policy of this facility to provide oxygen to maintain levels of saturation to residents as needed and as ordered by the attending physician... 1. Check orders for		Audit to ensure proper oxygen settings and humidification are in place five times a week for four weeks, then three times week for four weeks, then once a week x four months Results will be forwarded to QAPI committee for further recommendations and resolution as necessary. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. By what date will the systemic changes for each deficiency be completed? 5/12/2025	

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	accurate oxygen liter flow... 4. Tubing, humidifier bottles and filters will be changed, cleaned, and maintained no less than weekly and PRN [as needed]...." 3.1-47(a)(6)			
F 0700 SS=D Bldg. 00	483.25(n)(1)-(4) Bedrails Based on record review and interview, the facility failed to accurately complete assessments to prevent a cognitively impaired resident from entrapment between a mattress and a side rail/grab bar. (Resident B) Finding includes: Resident B's record was reviewed on 03/31/25 at 12:52 p.m. Diagnosis included unspecified dementia in other diseases classified elsewhere, delusional disorders, muscle wasting and atrophy, and other frontotemporal neurocognitive disorder. An admission mobility assessment, dated 1/22/25, indicated Resident B did not require side rails/enablers. A side rails assessment, dated 1/22/25, indicated Resident B did not require side rails. A physician's order, dated 1/24/24, indicated an enabler bar to help patient transfer, reposition, and turn. A bed mobility care plan, initiated 1/24/25, indicated Resident B utilized enabler bars for bed mobility. Interventions included the following: enabler on bed per resident request, resident quality of life to be maintained and side	F 0700	F 700 Bedrails It is the policy of this facility to ensure assessments are completely accurately to prevent resident entrapment between a mattress and a side rail/grab bar. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. The side rail assessment was updated 3/14/25 for resident B and again on 4/8/25 by the DON/Designee. Resident B was assessed on 4/8/25 with no negative outcomes noted by the DON/Designee. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken. Side rail assessments were completed for all residents on 4/10/25. Physician orders and care plans were updated as applicable by the DON/Designee.	05/12/2025

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	rails/enabler assessment quarterly and as needed (PRN). A quarterly Minimum Data Set (MDS) assessment, dated 2/13/25, indicated Resident B was severely impaired and required supervision from staff for transfer, bed mobility, and walking. Resident B did not utilize any mobility devices. A nursing progress note, dated 3/11/25 at 9:15 a.m., indicated Resident B was found on their knees beside the bed with their head between the mattress and the side rail. The side rail was in the up position. Staff assisted Resident B from the floor back into the bed. Resident B was assessed for injuries and pain. The left side of Resident B's face had some redness. Resident B voiced no pain. The side rail was lowered. The resident family and doctor were notified. A physician's order, dated 3/11/25, indicated to discontinue enabler bars. An Interdisciplinary team (IDT) note, dated 3/12/25 at 3:48 p.m., indicated Resident B was found on the floor beside the bed on their knees. The resident's head was noted to be between the mattress and the enabler bar. The resident was immediately assessed by licensed nurse who noted redness to the left side of his face which quickly dissipated. The root cause of the fall was the resident attempted to self-transfer from bed. The immediate intervention was to remove the enabler bars from bed. The care plan to be reviewed and updated. A side rails assessment, dated 3/14/25, indicated Resident B did not require side rails. During an interview, on 3/31/25 at 1:46 p.m., LPN 6		What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur. Nursing staff were in serviced on the “Side Rails/Enabler Bars policy on or before 4/28/2025. Additionally, any staff that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place. DON/Designee will review ten residents weekly for four weeks then five residents weekly for four weeks then three residents weekly for four months to ensure side rail assessments are completed accurately and to ensure physician orders and care plans are in place, if applicable. By what date the systemic changes for each deficiency will be completed. 5/12/2025	

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	indicated a resident would need to be assessed by physical therapy for enabler bars and nursing would get a physician's order before the bars were put into place. If a resident had a fall and was found to have their head stuck between the mattress and the enabler bars, there would be a full assessment completed, and the enabler bars would likely be removed. During an interview, on 3/31/25 at 1:51 p.m., the DON indicated a resident would be assessed for mobility issues prior to enabler bars being utilized. If a resident was found caught between the mattress and the enabler bars, the staff would immediately assess the resident for injury and completed any assessments necessary. The resident's family and physician would be notified. The IDT would discuss the incident, review care plans, and orders. An undated, current facility policy, titled, "Side Rails/Enabler Bars", provided by the DON on 3/31/25 at 3:45 p.m., indicated the following: "It is the intent of the facility to provide the licensed medical staff with a process for the evaluation, documentation needs and necessary interventions relating to side rails/enabler bars evaluation and utilization.... Enabler bars attach to the bed, so they are to be considered "side rails"... 1. The IDT will discuss the predisposing factors that resulted in the conclusion that a side rail(s) or enabler bar(s) evaluation and utilization may be needed. 2. The side rail/enabler bar screen will be completed... 3. If upon completion of the evaluation, the IDT reaches the conclusion that a side rail(s) or enabler bar(s) is needed, the least restrictive side rail(s) or enabler bar(s) that is appropriate for the resident's specific situation will be implemented... If it is determined that an enabler is to be used strictly for enabling more			

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	independence in bed mobility and not as a restraint this will be indicated on the assessment screen as well as the care plan... 4. The medical symptoms and related diagnosis that supports the use of the side rail(s) or enabler bar(s) will be documented on the side rails/enabler bar evaluation screen... 10. Residents who have side rail(s) or enabler bar(s) will be re-evaluated at least quarterly or in the event of a change of condition..." 3.1-45(2)			
F 0732 SS=D Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information Based on observation, interview, and record review, the facility failed to post complete nurse staffing information daily for residents and visitors. This deficiency had the potential to affect 46 of 46 residents in the facility. Finding includes: During an observation, on 3/25/25 at 9:30 a.m., the "Daily Report of Nursing Staff" was posted on the wall by the receptionist desk. The posting was dated 3/21/25. During an observation on 3/26/25 at 9:37 a.m., the "Daily Report of Nursing Staff" remained unchanged, showing 3/25/24. During an observation on 3/26/25 at 2:37 p.m., the "Daily Report of Nursing Staff" remained unchanged, showing 3/25/24. During an observation on 3/27/25 at 9:48 a.m., the "Daily Report of Nursing Staff" was posted on the wall by the receptionist desk. The posting was	F 0732	F 732 Posted Nurse Staffing Information The facility must post daily the BIPA which provides nurse staffing information. This will include the date, total number and actual hours worked by licensed and unlicensed personnel providing direct care for the residents. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. The DON/Designee assessed all residents in the facility on 4/23/2025 and no negative outcome. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	05/12/2025

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	dated 3/26/25. During an observation on 3/27/25 at 1:42 p.m., the "Daily Report of Nursing Staff" remained unchanged showing 3/26/25. During an observation on 3/27/25 at 3:41 p.m., the "Daily Report of Nursing Staff" remained unchanged showing 3/26/25. During an observation on 3/28/25 at 9:21 a.m., the "Daily Report of Nursing Staff" remained unchanged showing 3/26/25. During an interview, on 3/31/25 at 9:00 a.m., the Administrator indicated the scheduler was responsible for updating the staff posting. This posting was supposed to be completed every morning. During an interview, on 3/31/25 at 11:48 a.m., QMA 8 indicated he was responsible for ensuring the staffing posted was updated daily at the beginning of each day. However, he was often needed to cover shifts and would work as a QMA providing resident care and updated the staff posting as quickly as possible. A current facility policy, dated 4/24/23, titled "Guidelines for BIPA Staffing Posting Requirement," provided by the Administrator on 3/31/25 at 9:00 a.m., indicated the following: "... 1.) SNF's and NF's must post daily, at the beginning of each shift, the facility specific shift schedule for the 24 hour period, the number and category of nursing staff employed or contracted by the facility for each 24 hour period, as well as the total number of hours worked by licensed and unlicensed nursing staff who are directly responsible for resident care...."		action will be taken. Residents who reside in the facility have the potential to be affected by this deficient practice, therefore this plan of correction applies to all residents that reside in the facility. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur. The Administrator/Designee inserviced the Director of Nursing and Scheduler on the Policy “Guidelines for BIPA Staffing Posting Requriement on 4/08/25. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The Administrator/Designee will audit the BIPA staffing posting and location 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then once a week x 4 months. If the facility is within 95% compliance at the end of the 4 months, then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been	

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			addressed. However, any patterns will be identified. Any written Action Plan will be monitored by the Administrator weekly until resolved. By what date the systemic changes for each deficiency will be complete. 5/12/2025	
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia Based on record review and interview, the facility failed to provide individualized interventions to prevent resident to resident physical altercations for cogntively impaired residents with dementia for 1 of 4 residents reviewed for physical altercations. (Resident B) Finding includes: Review of an Indiana State Department of Health facility reported incident, dated 1/22/25 at 8:30 p.m., indicated the facility initiated an investigation of a resident to resident altercation. The incident was identified on 1/22/25 at 8:30 p.m. The brief description indicated Resident B had entered another residents room and refused to leave. The other resident made contact with his hand to Resident B's chest. The nurse removed Resident B from the room. The immediate actions taken were separation of the residents and Resident B was given a one to one staff supervision. Resident B was assessed for injury and/or pain. The police were notified. A follow-up on 1/31/25 indicated the investigation was complete without any findings. No further behaviors noted and care plans updated as	F 0744	F744 – Treatment/Services for Dementia It is the policy of this facility to provide individualized interventions to prevent resident to resident physical altercations for the cognitively impaired resident with dementia. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident B care plan was reviewed and revised by the SSD/designee to include specific, individualized interventions on 4/18/2025. The DON/Designee assessed resident on 1/22/2025. The SSD/designee assessed the resident x 72 hours on 1/22/2025 and no negative outcome related to the incident. How will other residents having the	05/12/2025

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	needed. Resident B's clinical record was reviewed on 3/27/25 at 3:45 p.m. Diagnosis included dementia in other diseases classified elsewhere with moderate behavioral disturbances, mood disorder due to know physiological condition with mixed features, delusional disorder, and unspecified dementia with agitation. A current care plan, initiated on 1/23/25, indicated the resident had been noted to have altercations with other residents. Interventions included the following: establish if resident has any needs (1/23/25), provide resident with one on one as needed (1/23/25), redirect resident as needed (1/23/25), and remove resident from areas of other residents immediately (1/23/25). A current care plan, initiated on 1/27/25, indicated the resident had been noted to wander and will go in and out of other resident rooms due to confusion related to dementia and requires a secure unit. Interventions included the following: assessments as necessary (1/27/25), one on one as needed (1/27/25), and redirect resident as needed (1/27/25). A 1/22/25 nursing progress note indicated Resident B wandered into another residents room and was hit in the chest. The incident was unwitnessed. Resident B was taken back to his room and a small red area was noted to his chest. The resident's family and physician was notified. The police were notified. A 1/23/25 nursing progress note indicated Resident B had one to one staff supervision. The resident had not rested on this shift, was exit seeking, and difficult to re-direct. The resident		potential to be affected by the same deficient practice be identified and what corrective action will be taken? The SSD/Designee reviewed care plans interventions for resident that are cognitively impaired with dementia and behaviors on DATE and any concerns identified were addressed and care plans update with interventions. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Nursing staff were educated by the Director of Nursing/Designee on the guidelines for handling and addressing behavioral emergencies and on Dementia Training on or before 4/14/2025. Additionally, any staff that fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated. How will the corrective action be monitored to ensure the deficient practice will not recure, i.e., what quality assurance program will be put into place? The SSD/Designee will audit 10 care plans weekly for four weeks, then 5 residents weekly for four weeks, then 3 residents weekly x four months for residents that are cognitively impaired with dementia and behavior and new admissions, re-admissions and new behaviors.	

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	wandered into other resident rooms. A 1/23/25 social service note indicated Resident B was given one to one staff supervision after an incident the previous day. Staff continued to walk with the resident and tried to redirect. The interventions lasted for a short time and the resident was "on the move" again. The resident was moved to a new room, since the previous room shared a bathroom with another resident. The resident was confused upon seeing another person from the bathroom and believed someone was in his home. A 1/24/25 behavior charting note indicated Resident B was ambulating in the lounge and became agitated with a Certified Nursing Assistant (CNA) when redirection to the bathroom was attempted. Resident B drew back his fist as if to strike the CNA. Resident B urinated on the lounge floor. A 1/26/25 nursing progress note indicated the resident continued with one to one staff supervision. The resident was ambulating in the hallways and attempting to enter other residents rooms. Staff continued to redirect and offer snacks and beverages. A 1/27/25 social service note indicated the Interdepartmental team (IDT) met and discussed the one on one staff supervision for Resident B. The resident was easily redirected and had no further incidents with other residents. The one to one staff supervision was discontinued at this time. A 1/29/25 behavior charting note indicated Resident B was participating in an activity and became angry; he started hitting staff. The		Results will be forwarded to QAPI committee for further recommendations and resolution as necessary. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. By what date will the systemic changes for each deficiency be completed? 5/12/2025	

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	resident was pushing chairs and the treatment cart around. Redirection was ineffective. Staff reached out to family for assistance. A 1/29/25 nursing progress note indicated the resident picked up a chair and was carrying it towards the exit doors. Staff was able to redirect and remove the chair from the resident. Resident became tearful. The physician was notified and staff was given a new order. The physician indicated the resident might require an outside provider for a psychiatric evaluation and treatment. A 1/30/25 behavior charting note indicated the resident was angry and agitated. He was ambulating in the hallways, pushing the treatment cart, and removing items from the medication cart. Staff attempts at redirection were ineffective. A 1/31/25 daily skilled nursing note indicated the resident was awake and walked nude to the nurse station. Staff needed multiple attempts to get the resident dressed. He remained at the nurse station for roughly 20 minutes attempting to open the door. He was seen ambulating the hallways. A 1/31/25 nurses note indicated Resident B attempted to urinate on the hallway wall. He became combative when staff make attempts to redirect. Staff was able to direct Resident B to the bathroom, but he returned to the hallway and urinated in the hall. A 1/31/25 nurses note indicated the resident attempted to pull down his own pants. Staff attempts to redirect were difficult. The resident hung onto the side rail in the hallway to resist being redirected to the bathroom. The resident allowed staff to assist him into a wheelchair.			

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A 2/1/25 behavior charting note indicated Resident B was wandering the halls and into other residents' rooms. The resident was agitated with staff and redirection attempts were ineffective. The resident pushed a staff member out of the way in an attempt to enter a room on the female hallway. Resident B was witnessed mocking another resident and sticking his tongue out toward that resident while in the common areas. Resident was resistant to care and was grabbing or striking out at staff.

A 2/2/25 behavior charting note indicated Resident B was wandering in and out of his room pulling his pants and brief down. The resident become agitated and resistive to redirections and interventions were ineffective.

A 2/3/25 behavior charting note indicated the resident was ambulating the hallway and began to disrobe in the dining room. Resident became agitated and struck out at staff when redirection was attempted. The staff attempts at redirection were ineffective.

A 2/4/25 nursing progress note indicated Resident B entered into another resident's room. Resident B was struck across the left cheek. Staff immediately separated the residents. Resident B was placed on one to one staff supervision. The resident was sent to the emergency room for evaluation and treatment.

Review of an Indiana State Department of Health facility reported incident, dated 2/4/25 at 7:44 p.m., indicated the facility initiated an investigation of a resident to resident altercation. The incident was identified on 2/4/25 at 7:44 p.m. The brief description indicated Resident B had entered

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	another residents room uninvited. The other resident made contact with his hand to Resident B's left cheek. The nurse removed Resident B from the room. The immediate actions taken were separation of the residents and Resident B was given one to one staff supervision. The family and physician were notified. The physician ordered Resident B sent to the emergency room for evaluation. The care plan was reviewed and updated as deemed appropriate. The police were notified. A follow-up was not provided. A current physician order, dated 1/22/25, indicated to take one risperidone (an anti-psychotic medication) 1 milligram (mg) tablet by mouth 3 times a day with a .50 mg tablet to equal 1.5 mg total. A current physicians order, dated 1/22/25 indicated to take one risperidone (an anti-psychotic medication) 0.5 mg tablet by mouth 3 times a day with a 1 mg tablet to equal 1.5 mg total. A current physicians order, dated 2/24/25, indicated to take one Wellbutrin XL (an anti-depressant medication) extended release 150 mg tablet by mouth in the morning for depression. A current physicians order, dated 3/5/25, indicated to take two amitriptyline HCI (an anti-depressant medication) 25 mg tablet by mouth in the evening for mood disorders. A quarterly Minimum Data Set (MDS) assessment, dated 2/13/25, indicated Resident B was not cognitively intact, had difficulty focusing, and had disorganized or incoherent thoughts. He displayed physical and verbal behaviors towards others and wandering. He required supervision			

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	from staff for transfer, bed mobility, and walking. During an interview, on 3/31/25 at 12:02 p.m., SSD 11 indicated Resident B was wandering on the locked unit and was difficult to re-direct. He was to meet with the psychiatric provider tomorrow. The SSD was part of the IDT meeting where it was decided to discontinue Resident B's one to one staff supervision. The documentation indicated he had not had any other resident to resident incidents. This resident was new to the facility at the time of the first incident and he went through a difficult adjustment period. The staff had taken all the appropriate actions to prevent another resident to resident altercation. She indicated one on one staff supervision was not a long term option for the facility During an interview, on 3/31/25 at 1:02 p.m., the ADON indicated she was part of the IDT meeting on 1/27/25. The resident was new to the facility when the first incident happened. The one on one staff supervision was removed when he had no further behaviors. The ADON indicated if the resident had remained on one to one staff supervision while adjusting to the facility, the second incident could have been avoided. During an interview, on 3/31/25 at 1:08 p.m. CNA 13 indicated Resident B wandered the hallways and stood outside other residents' rooms, looking inside. The resident had slapped at staff and some redirection did not work. The facility staff utilized the resident's family and hospice staff for assistance with his continued behaviors. During an interview, on 3/31/25 at 1:16 p.m., LPN 6 indicated Resident B continued to wander the hallways, but he wasn't going into other residents rooms as much. The facility staff attempted to			

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	redirect the resident but he could get agitated. They utilized his family and hospice staff for assistance with his behaviors. A current facility policy, dated 10/22/22, titled, "Abuse Prevention Program", provided by the Administrator on 3/25/25 at time of entrance, indicated the following: " It is the policy of this facility to prevent resident abuse, neglect, mistreatment, and misappropriation of resident property...The facility will take steps to prevent mistreatment while the investigation is underway...Prevention:... As part of the social history assessment and MDS assessments, staff will identify resident with increased vulnerability for abuse, neglect, mistreatment or who have needs and behaviors that might lead to conflict. Through the care planning process, staff will identify any problems, goals, and approaches which would reduce the chances of mistreatment for these residents. Staff will continue to monitor the goals and approaches on a regular basis..." 3.1-37(a)			
F 0755 SS=E Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on observation, interview, and record review, the facility failed to ensure the shift-to-shift narcotic count sheets were completed and signed for 2 of 3 medication carts reviewed. (300 Unit and 400 Unit medication carts). This deficiency had the potential to affect 11 of 46 residents who received controlled medications from the 200 Unit and 300 Unit medication carts. Findings include:	F 0755	F755 Pharmacy Services/Procedures/Pharmacist/ Records It is the policy of this facility to ensure the shift to shift narcotic count sheets are completed and signed. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice.	05/12/2025

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	1. During a medication storage observation with the ADON on 3/28/25 at 12:43 p.m., the 400 Unit medication cart shift-to-shift narcotic count log lacked signatures or a count from the in-coming nurse and off-going staff members during shift change at the beginning of day shift on 3/28/25. It also lacked a shift-to-shift narcotic count or signature from the in-coming and off-going staff members when the cart was exchanged around approximately 12:30 p.m. on 3/28/25. During an interview on 3/28/25 at 12:43 p.m. the ADON indicated the 400 Unit medication cart shift-to shift narcotic log had not been completed by QMA 8 on 3/28/25 at the beginning of the day shift. The ADON had recently taken over the 400 Unit medication cart from QMA 8 to administer the insulin and they had not completed the shift-to shift narcotic count. The shift-to shift narcotic count should have been completed with each exchange of the medication cart. This was an opportunity for misappropriation of medications. During an interview on 3/28/25 at 12:47 p.m., QMA 8 indicated he had not signed the shift-to-shift narcotic count when he took over the 400 Unit Medication cart at 6:00 a.m. on 3/28/24. The medication reconciliation should have been completed with each exchange of the medication cart. Review of the 400 Unit "Shift-to-Shift Narcotic Count Sheets" from 3/1/25 to 3/28/25 lacked the following information: a. 3/4/25: 7:00 p.m. - 11:00 p.m. - Count completion b. 3/5/25: 7:00 a.m. - 11:00 p.m. - Count completion		The DON/Designee assessed residents on the 300 and 400 hallway receiving controlled medications on 4/16/2025 and no negative outcome related to the alleged deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken. The DON/Designee completed narcotic count with the shift nurses/QMAs on 4/16/25 with no issues identified. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur. The DON/Designee educated licensed nurses and qualified medication aides regarding "Guidelines for Controlled Substance Medications" on 4/14/2025. Additionally, any staff that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place. The Director of Nursing/designee will audit shift to shift narcotic count sheets for verification of	

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	c. 3/5/25: 11:00 p.m. - 7:00 a.m. - Count completion d. 3/6/25: 3:00 p.m. - 11:00 p.m. - Count completion e. 3/6/25: 11:00 p.m. - 7:00 a.m. - In-coming signature f. 3/6/25: 7:00 a.m. - 5:00 p.m. - Count completion and off-going signature g. 3/6/25: 5:00 p.m. - 11:00 p.m. - Count completion h. 3/8/25: 3:00 p.m. - 7:00 p.m. - Count completion i. 3/9/25: 7:00 p.m. - 7:00 a.m. - Count discrepancy (scored through without explanation) j. 3/15/25: 7:00 p.m. - 7:00 a.m. - Count discrepancy (scored through without explanation and illegible) k. 3/20/25: 11:00 p.m. - 7:00 a.m. - Count completion and discrepancy l. 3/27/25: 11:00 p.m. - 7:00 a.m. - In-coming signature m. 3/28/25: 7:00 a.m. - 12:30 p.m.- Count completion, in-coming signature, and off-going signature 2. During an interview on 3/28/24 at 12:44 p.m., QMA 8 indicated the 300 Unit medication cart shift-to-shift narcotic count log had not been completed for his shift. The form for 3/27/25 from 11:00 p.m. - 7:00 a.m. lacked the in-coming nurse signature. Prior to providing a copy, he signed the form and filled in the blanks for his shift dated 3/28/25 from 7:00 a.m. to 3:00 p.m. The form should have been completed at the beginning of his shift. Review of the 300 Unit "Shift-to-Shift Narcotic Count Sheets" from 3/1/25 to 3/28/25 lacked the following information: a. 3/1/25: No shift marked b. 3/3/25: 7:00 a.m. - 7:00 p.m. - Count completion and in-coming signature		completed and signed five times weekly x four weeks, then three times weekly x four weeks then weekly x four months to ensure count is completed. If the facility is within 95% compliance at the end of 4 months, the monitoring will be stopped. During the monthly QAPI meeting, monitoring will be reviewed, and any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution . By what date the systemic changes for each deficiency will be completed. 5/12/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155443	A. BUILDING 00 B. WING	03/31/2025

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	c. 3/4/25: 7:00 a.m. - 10:00 a.m. shift- Count completion d. 3/4/2: 10:00 a.m. - Count completion and in-coming signature e. 3/8/25: 7:00 a.m. - 7:00 p.m. - Count completion f. 3/8/25: 11:00 p.m. - 7:00 a.m. - Count discrepancy (marked error without explanation) g. 3/13/25: 3:00 p.m. - 7:00 p.m. - Count discrepancy (scored through without explanation) h. 3/14/25: 3:00 p.m. - 11:00 p.m. - Count completion, in-coming signature, and off-going signature i. 3/15/25: 7:00 a.m. - 11:00 p.m. - Count completion j. 3/15/25: 11:00 p.m. - 7:00 a.m. - Count discrepancy (scored through without explanation) k. 3/18/25: 7:00 a.m. - 3:00 p.m. - Count completion l. 3/18/25: 3:00 p.m. - 7:00 a.m. - Count completion m. 3/23/25: 7:00 a.m. - 11:00 p.m. - Count completion n. 3/26/25: 7:00 a.m. - 7:00 p.m. - Count completion o. 3/28/25: 7:00 a.m. - 3:00 p.m. - Count completion, in-coming signature, and off- going signature During an interview on 3/28/25 at 12:56 p.m., the DON indicated she was aware the facility was deficient for shift-to-shift narcotic counts because she identified the problem in March 2025 when she audited for misappropriation of medications. Staff had been in-serviced regarding shift-to-shift narcotic counts. She had not yet completed her audit on 3/28/25. A current facility policy, dated 7/22/23, titled "GUIDELINES for Controlled Substance Medications - an Overview," provided by the DON on 3/31/25 at 12:39 p.m., indicated the following: "...Shift-to Shift Controlled Substance/Medication Counting: At each shift change, a physical inventory of controlled			

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	substances/medications as well as any other medications selected by the facility to closely "track" will be conducted by 2 licensed nurses. This will be documented on the Shift Change Accountability Record For Controlled Substances Form. This will include a count cards/bottles & corresponding "sheets" to be documented on the Narcotic Counts Sheets - shift to shift. Additionally, whenever there is an exchange of "keys," there will be a count completed...." This citation relates to Complaint IN00455668. 3.1-25(e)(2)			
F 0865 SS=E Bldg. 00	483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(QAPI Prgm/Plan, Disclosure/Good Faith Attmpt Based on record review and interview, the facility failed to develop and implement approaches to maintain a Quality Assurance and Performance Improvement (QAPI) program to prevent repeat deficiencies. Finding includes: Review of the Summary Statement of Deficiencies, for the facility's last annual Recertification and State Licensure Survey completed on 5/17/24, indicated the facility failed to ensure controlled medication counts were completed and acknowledgements signed to account for controlled medications. The plan of correction indicated, "During the monthly QAPI meeting, monitoring will be reviewed, and any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution".	F 0865	F 865 QAPI Program/Plan It is the intent of this facility to develop and implement approaches to maintain a QAPI program to prevent repeat practices. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. No residents were identified in the alleged cited practice. The DON/Designee completed an action plan for drug diversion/narcotic reconciliation on 4/16/2025. The QAPI committee reviewed the action plan during the QAPI meeting on 4/18/2025. How other residents having the	05/12/2025

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	During an interview, on 3/31/25 at 3:53 p.m., the Social Services Director indicated the QAA committee meets monthly to review facility concerns. The committee utilized an online program to assist with streamlining the process, assessing trends, and documentation of these meetings. During a follow- up interview, on 3/31/25 at 4:00 p.m. the Regional Director of Operations indicated if the facility was found to have a concern that was previously cited, they would ensure the previous plan of correction had been completed. A previous plan of correction would be completed within six months and then discontinued. If issues remained, the problem would be put into the QAPI program, and a Performance Improvement Plan (PIP) would be developed. The current shift to shift narcotic count concern was found just days before the March QAPI meeting. The concern was discussed in the QAPI meeting on 3/18/25, but a PIP was not put into place immediately at the meeting. The facility's annual survey started on 3/25/25 and the QAA committee was unable to get one in place. Repeat concerns regarding lack of shift-to-shift narcotic counts and signatures were cited during the March 31, 2025, survey as follows: Based on observation, interview, and record review, the facility failed to ensure the Shift-to-Shift Narcotic Count Sheets were completed and signed for 2 of 3 medication carts reviewed. (300 Unit and 400 Unit medication carts). This deficiency had the potential to affect 11 of 46 residents who received controlled medications from the 200 Unit and 300 Unit medication carts. A current facility policy, revised 3/9/22, titled,		potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All residents that reside in the facility have the potential to be affected by the cited practice, therefore, this plan of correction applies to all residents that reside in the facility. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur. The Regional Director of Operations/Designee in-serviced the Department Leaders on the policy “Quality Assurance/Performance Improvement” and when repeated issues are identified to implement an action plan on 4/18/2025. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The ADM/Designee will discuss the citations received by the Indiana Department of Health for the last 24 months and will any action plans or repeated deficiency for any patterns and update or write a new action plan,	

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	"Quality Assurance/Performance Improvement Program(QAPI)," provided by the Administrator at entrance, indicated the following: "... It is the intent of this facility to conduct an on-going Quality Assurance/Performance Improvement (QAPI) program designed to systematically monitor, evaluate, and improve the quality and appropriateness of resident care... 6. The facility will identify areas for QAPI monitoring and tools/resources to be utilized. These monitoring activities should focus on those processes that significantly affect resident outcomes. 7. The QAPI committee will review, and coordinate audits and assessments based on the QAPI process. Completion of additional audits and assessments will be determined by concerns identified through the QAPI committee. Criteria for selecting additional aspects of care for performance improvement are based on the following:... d. Problem areas- the aspect of care has tended in the past to produce problems for staff or residents...12. Based on audit findings, plan will be developed, and tasks assigned to appropriate employees to include required completion dates." Cross reference F755. 3.1-52(b)(2)		action plans will be resolved as needed monthly x 6 months. If the facility is within 95% compliance at the end of the 6 months the monitoring will be stopped. By what date the systemic changes for each deficiency will be complete 5/12/2025.	