STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155689	A. Building B. Wing	06/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Goshen	2400 College Ave Goshen, IN 46528

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review, the facility failed to ensure a resident's physician and responsible party were notified when the resident experienced seizure activity and when antiseizure medications had not been administered in accordance with physician orders for 1 of 3 residents reviewed for notification of change of condition, (Resident N).Finding includes:On 6/1/26 at 10:00 A.M., Resident N's clinical record was reviewed. Diagnoses included but were not limited to epilepsy, dysphagia following cerebrovascular disease, psychosis, anxiety, and intellectual disability.Resident N's Physician's Orders included but were not limited to:Briviact Tablet 75 MG (Brivaracetam), to give 2 tablets two times a day at 6:00 A.M. and 6:00 P.M., for epilepsy, ordered on 07/01/24 and ongoingClobazam Oral Suspension 2.5 MG/ML, to give 5 ml one time a day for seizures, ordered on 03/24/26 and discontinued on 5/1/26A current Care Plan, initiated on 1/19/17, indicated Resident N was at risk for seizures related to epilepsy. The Care Plan interventions included to give medications as ordered, and to notify the physician and responsible party of seizure activity.Review of the Resident N's Electronic Medical Record (EMR) dated 4/1/26 through 4/30/26, indicated on 4/5/26, 4/6/26, 4/9/26, and 4/10/26, that neither the morning nor evening Briviact tablets had been administered as ordered, and on 4/14/26, 4/15/26, and 4/17/26, the Clobazam oral suspension for seizures had not been administered as ordered.Review of Resident N's Nursing Progress Notes included, but were not limited to the following:On 4/6/26 at 1:33 P.M., Nursing staff reached out to the Neurology physician regarding the Briviact medication and explained issues with the insurance coverage. The note indicated the facility was waiting for a call back from the Neurology physician's office.On 4/6/26 at 1:37P.M., Focused Nursing Charting indicated the following: Note Text: 'seizures.resident was brought back to hall by staff member, stated resident had a seizure resident V/S taken BP 143/67 93% room air 70 Pulse temp 75.6 resp 18. resident went back to activies [activities] had another seizure lasting a few seconds. The nursing note was written and signed by LPN 6.On 4/6/26 at 1:52 P.M., a General Nursing Progress Note indicated resident was brought back to hall by staff member, stated resident had a seizure resident V/S [vital signs] taken.resident went back to activities had another seizure lasting a few seconds. resident crying that her arm hurt Norco (narcotic pain medication) given for pain 10/10. NP notified.On 4/10/26 at 9:57 A.M., General Nursing Progress Note: called pharm [pharmacy] they will stat [immediate] briviact right now.On 5/29/26 at 3:00 P.M. during an interview, the Administrator indicated the resident's physician and responsible party should have been notified that the seizure medications had not been given as ordered and that the resident had experienced seizures.On 6/1/26 at 12:24 P.M., the Administrator provided a policy titled, Seizure Precautions, dated 1/2/24, indicating it was the current facility policy. The policy indicated, .If the resident has a generalized seizure: .Notify the practitioner and family.On 6/1/26 at 12:24 P.M., the Administrator provided a policy titled, Medication Administration, dated 1/2/24, indicating it was the current facility policy. The policy indicated, .Medications are administered.as ordered by the physician and in accordance with professional standards of practice .Physicians will be notified timely of medication omissions. Instructions on how to proceed (example: administer medications when it becomes available) will be followed per physician order. This citation relates to Intakes 3013839 and 3017939. 410IAC (Indiana Administrative Code) 16.2-3.1-5(a)(2)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview, observation, and record review, the facility failed to ensure 2 of 3 residents reviewed for abuse were free from verbal abuse and physical injury when a Certified Nursing Assistant (CNA) was verbally abusive to one resident (Resident R), and physically abusive as evidenced by grabbed another resident's wrist during a transfer which resulted in bruising and skin tears to the resident's arm, (Resident P). Using the reasonable person concept, the abuse likely led to emotional distress related to intimidation and anxiety for both residents (Resident R and P) and actual physical injuries for Resident P.Findings include:On 5/29/26 at 3:00 P.M., an interview with the Administrator indicated he had been informed that earlier in the day, CNA 10 had been rough with a resident. The Administrator indicated CNA 10 had been suspended pending an investigation, and all parties were being notified including the physician and Resident P's responsible party. The Administrator indicated he had observed red speckles to Resident P's wrists where the CNA had allegedly handled the resident roughly. The Administrator indicated he was going to file an incident report with the State Agency.On 6/1/26 at 8:30 A.M., the Administrator indicated he had submitted a report of an allegation of abuse to the Indiana State Department of Health Survey Report System on 5/29/26, regarding an allegation of abuse that had occurred on 5/29/26 at 4:01 A.M. The Administrator indicated Resident P's physician and family had been notified and CNA 10 had been suspended pending an investigation. On 6/1/26 at 2:15 P.M., during an observation and interview, Resident P was observed in the activity area of the facility's memory care unit. Resident P indicated she had an injury to her left forearm. Observation of the resident's left forearm revealed a skin tear in the shape of a uniformed semi-circle approximately 1/2 inch in length approximately two inches above the left wrist. A second skin tear in the same shape and approximate size was observed further up the left arm approximately three inches above the left wrist. The second skin tear had a steri-strip closer (clear plastic bandage designed to pull the edges of wounds together) in place. During an interview at that time, Resident P indicated she did not know how the injuries had occurred but that they felt sore.On 6/1/26 at 2:30 P.M., the Administrator provided Incident Report Number 271, that had been submitted to the Indiana State Department of Health Survey Report System. The report indicated an allegation of abuse that had occurred on 5/29/26 at 4:01 A.M had been reported. The Incident Report indicated CNA 11 had reported the allegation of abuse to the Administrator via telephone indicating that CNA 10 had been aggressive towards Resident P during their last shift together on the memory care unit. The report indicated CNA 11 reported that CNA 10 had grabbed Resident P by the wrist, during a toilet transfer, and had caused bruises and skin tears to the resident. The incident report indicated the type of injuries incurred were bruises to her wrist and a skin tear .05cm x 0.01cm. The Immediate action taken indicated CNA 10 had been suspended pending an investigation and that skin and pain assessments had been completed on the resident, the wound was cleaned and treated, and all parties had been notified. Preventive measures taken indicated immediate education was initiated for staff regarding abuse and abuse reporting. All interviewable residents were interviewed regarding abuse, abuse reporting and safety, and that all non-interviewable residents had received skin assessments.An Incident Interview Form, dated 6/1/26 at 9:00 A.M., indicated CNA 11 had reported that on Thursday night, 5/29/26, at approximately 12:30 A.M., she had observed CNA 10 interacting with multiple residents in a manner that raised concerns. CNA 10 indicated Resident R had not been wearing pants and appeared to have given herself a shower. Resident R asked CNA 10 for assistance and CNA 10 appeared frustrated and had told the resident that she (the resident) could do it herself. The Incident form indicated CNA 10 had raised her voice and told Resident R to go to your f-----g room. Then CNA 11 had assisted Resident R. CNA 11 indicated during rounds CNA 10 and CNA 11 had entered Resident P's room and the resident was on the toilet where she had had a bowel movement. CNA 11 indicated CNA 10 became angry and spoke (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	harshly to Resident P. Resident P appeared unwilling to stand due to the way CNA 10 was speaking to her and then CNA 10 had pulled Resident P up by her wrists. Shortly afterward, Resident P's wrist began bleeding, which CNA 11 indicated were from skin tears. CNA 11 indicated Resident P became upset and was crying and repeatedly asked CNA 10 to leave the room. CNA 11 indicated she asked CNA 10 to leave the room but CNA 10 had remained in the room approximately five minutes longer. CNA 11 indicated, at that time, CNA 10 indicated she was going to get a nurse to assess Resident Ps wrists, but no nurse came to complete an assessment. CNA 11 indicated CNA 10 had informed her that LPN 2 was too busy to assess the resident and then CNA 10 used an incontinence wipe to clean the blood from Resident P's wrists. The Incident Interview Form indicated CNA 11 had reported the incident to the Administrator on 5/29/26.An Incident Interview Form dated 6/1/26 at 10:30 A.M., indicated LPN 2 could not recall all the details of the conversation. However, he indicated on 5/29/26 at approximately 5:30 A.M., during medication pass, CNA 10 had informed him that she had been providing care to a resident and that the resident had become combative. LPN 2 indicated in the documentation, that he was unable to clearly understand all of the details CNA 10 was describing and LPN 2 did not recall whether CNA 10 had stated that she had been scratched or that the resident had been scratched but it had sounded as though the resident may have been physically restrained in some manner. LPN 2 indicated he had not witnessed the incident and could not confirm exactly what had occurred. LPN 2 advised CNA 10 to complete an incident report and provide the information to the first shift so they were aware of the situation. The Incident Interview Form indicated LPN 2 had not reported the incident to a supervisor, or Human Resource Representative and had not documented the incident.An Incident Interview Form, dated 6/1/26 at 11:16 A.M., indicated CNA 10 indicated she had been doing rounds and had observed Resident P with bowel movement residue on and around the toilet seat. CNA 10 indicated she had informed the resident that she had gotten stool everywhere. The resident had became upset and was yelling and using profanity. CNA 10 indicated Resident P had became physically aggressive toward her including scratching, kicking, and spitting. CNA 10 indicated she had sustained multiple scratches to her arms. CNA 10 indicated, at some point, CNA 11, had informed her that the resident was bleeding, so she had cleaned the areas that were bleeding and then had gone to locate LPN 2. CNA 10 indicated she had informed LPN 2 that the resident was bleeding and had requested that he assess the situation but LPN 2 indicated to her that he was passing medications and he had not assessed the resident's injuries.On 6/2/24 at 10:00 A.M., Resident P's clinical record was reviewed. The resident was admitted to Memory Care on 5/27/26 with diagnoses included but were not limited to dementia, chronic kidney disease, repeated falls, chronic obstructive pulmonary disease, and chronic kidney disease. Minimum Data Set Assessment information regarding the resident's cognitive score was not available.Resident P's Care Plans indicated the resident had skin trauma to her left forearm as a skin tear, initiated 6/1/26. Another Care Plan, initiated on 5/27/26 and revision on 5/29/26, indicated the resident required assistance with activities of daily living related to her diagnoses including a history of a fall with laceration to top left scalp, depression, dementia with behaviors, hospice care, cognitive disfunction, restlessness, agitation, and weakness. Interventions included, but were not limited to: needed assistance for personal hygiene, showering, toilet transfers and toileting hygiene.A General Nursing Progress Note, dated 5/29/26 at 4:59 P.M., indicated Resident P had been assessed by the Director of Nursing.A Focused Charting Note, dated 5/29/26 at 5: 49 P.M., indicated Alleged physical contact. Vital were completed and within normal limits.There were no assessments found or provided by the facility prior to 5/29/26 at 4:59 P.M. of Resident P's injuries.On 6/2/24 at 2:00 P.M., Resident R's clinical record was reviewed. Diagnoses included but were not limited to dementia, metabolic encephalopathy, anxiety, schizophrenia, depression, bipolar disorder. Resident R was admitted to Memory Care on 2/9/26.A Minimum Data Set (MDS) assessment, dated 5/26/26, completed for a quarterly review, indicated Resident R was cognitively intact.An Incident Interview Form dated 6/1/26, indicated Resident R reported that Everyone is good to me, except [CNA 10]. If I don't do what she says she'll jump all over my back. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	She hollers at me-I'm 61 I don't have bosses anymore.There were no documented assessments or specific documentation related to the allegation for Resident R.On 6/1/26 at 1:22 P.M., a policy titled Abuse, Mistreatment, Neglect, Exploitation, and Misappropriation, dated 7/1/25, was provided by the Administrator who indicated it was the current facility policy. The policy indicated, .Residents have the right to be free from abuse.Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. 410 IAC (Indiana Administrative Code) 3.1-27(a)(1)(b)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to fully implement their abuse policy regarding timely reporting, timely resident assessments, and immediate removal of an alleged perpetrator, when a Certified Nursing Assistant (CNA) was alleged to be verbally abusive to a resident (Resident R) and verbally and physically abusive to another, (Resident P), for 2 of 3 residents reviewed for abuse. (Resident R and P)Findings include:On 5/29/26 at 3:00 P.M., an interview with the Administrator indicated he had been informed, earlier in the day, that CNA 10 had been rough with a resident. The Administrator indicated CNA 10 had been suspended pending an investigation, and all parties were being notified including the physician and Resident P's responsible party. The Administrator indicated he had observed red speckles to Resident P's wrists where the CNA had allegedly handled the resident roughly. The Administrator indicated he was going to file an incident report with the State Agency.On 6/1/26 at 8:30 A.M., the Administrator indicated he had submitted a report of an allegation of abuse to the Indiana State Department of Health Survey Report System on 5/29/26 regarding an allegation of abuse that had occurred on 5/29/26 at 4:01 A.M. He indicated Resident P's physician and family had been notified. The Administrator indicated CNA 10 had been suspended pending an investigation, but that she had remained on the unit until the end of her shift. The Administrator indicated the allegation of abuse had not been reported to him until CNA 11 had called him, several hours after the incident, and had alleged that CNA 10 had been rough with Resident P and had been verbally abusive to Resident R. The Administrator indicated that CNA 10 had reported to LPN 2 that an incident had occurred, but LPN 2 had not followed up with an assessment nor did he notify the Administrator or the Director of Nursing of an allegation or incident. The Administrator indicated CNA 11 should have reported the allegation of abuse to the Charge Nurse, DON and Administrator, at the time of the incident. The Administrator indicated LPN 2 should have notified the DON and Administrator at the time of the allegation. The Administrator indicated an assessment on the resident was not completed timely and LPN 2 should have initiated an assessment when CNA 10 had requested it. The Administrator indicated Resident R had since been interviewed but had not verbalized any concerns.On 6/1/26 at 2:15 P.M., during an observation and interview, Resident P was observed in the activity area of the facility's memory care unit. Resident P indicated she had an injury to her left forearm. Observation of the resident's left forearm revealed a skin tear in the shape of a uniformed semi-circle approximately 1/2 inch in length approximately two inches above the left wrist. A second skin tear in the same shape and approximate size was observed further up the left arm approximately three inches above the left wrist. The second skin tear injury had a steri-strip (bandage designed to cover and pull wound edges together) closer in place. During an interview at that time, Resident P indicated she did not know how the injuries had occurred but that they felt sore.On 6/1/26 at 2:00 P.M., the Administrator provided Incident Report Number 271, the report he had submitted to the Indiana State Department of Health Survey Report System. The report indicated an allegation of abuse had occurred on 5/29/26 at 4:01 A.M. The Incident Report indicated CNA 11 had reported an allegation of abuse to the Administrator via telephone. The report indicated CNA 11 had reported that CNA 10 had been aggressive towards Resident P during their last shift together on the memory care unit. The report indicated CNA 11 had reported that CNA 10 had grabbed Resident P by the wrist during a toilet transfer and had caused bruises and skin tears to the resident. The report indicated the type of injuries incurred were bruises to her wrist and a skin tear, .05cm x 0.01cm in size. The report indicated the Immediate action taken indicated CNA 10 had been suspended pending an investigation and skin and pain assessments were completed on the resident, and her wound was cleaned and treated, and all responsible parties had been notified. The report indicated the Preventive measures taken included: immediate education started for staff regarding abuse and abuse reporting, all interviewable residents had been interviewed regarding abuse, abuse reporting and safety, and that (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	all non-interviewable residents had received skin assessments.An Incident Interview Form dated 6/1/26 at 9:00 A.M., indicated CNA 11 had reported that on Thursday night, 5/29/26 at approximately 12:30 A.M., she had observed CNA 10 interacting with multiple residents in a manner that raised concerns. CNA 11 indicated Resident R had not been wearing pants and appeared to have given herself a shower. Resident R had asked CNA 10 for assistance and CNA 10 appeared frustrated and told Resident R that she could do it herself. The Incident form indicated CNA 10 had raised her voice and told Resident R to go to your f---ing room. Then CNA 11 indicated she had provided assistance to Resident R. CNA 11 also indicated during rounds, CNA 10 and CNA 11 had entered Resident P's room and the resident was on the toilet, where she had had a bowel movement. CNA 11 indicated CNA 10 became angry and had spoken harshly to Resident P. Resident P appeared unwilling to stand up due to the way CNA 10 had been speaking to her and so CNA 10 had pulled Resident P by her wrists. Shortly afterward, Resident P's wrist began bleeding, which CNA 11 indicated were from new skin tears. CNA 11 indicated Resident P became upset, was crying and repeatedly asked CNA 10 to leave her room. CNA 11 indicated she also asked CNA 10 to leave the room but CNA 10 had remained in the room approximately five minutes longer. CNA 11 indicated, at that time, CNA 10 left the room and told CNA 11 that she was going to get a nurse to assess Resident Ps wrists. However, no nurse came to complete an assessment or care for the wounds CNA 11 indicated CNA 10 informed her that LPN 2 was too busy to assess the resident so CNA 10 used an incontinence wipe to clean the blood from Resident P's wrists. The Incident Interview Form indicated CNA 11 had reported the incident to the Administrator on 5/29/26.An Incident Interview Form dated 6/1/26 at 10:30 A.M., indicated LPN 2 was unable to recall all the details of the conversation, however, he indicated on 5/29/26 at approximately 5:30 A.M., during medication pass, CNA 10 had informed him that she had been providing care to a resident and that the resident had become combative. LPN 2 indicated in the documentation that he was unable to clearly understand all of the details CNA 10 had been describing and LPN 2 had not recalled whether CNA 10 stated that she had been scratched or that the resident had been scratched but it had sounded as though the resident may have been physically restrained in some manner. LPN 2 indicated he had not witnessed the incident and could not confirm exactly what had occurred. LPN 2 had advised CNA 10 to complete an incident report and provide the information to the first shift so they would be aware of the situation. The Incident Interview Form indicated LPN 2 had not reported the incident to a supervisor, or Human Resource Representative and had not completed any documentation regarding the incident.An Incident Interview Form dated 6/1/26 at 11:16 A.M., indicated CNA 10 indicated she had been completing rounds and had observed Resident P with bowel movement residue on and around the toilet seat. CNA 10 informed the resident that she had gotten stool everywhere. The resident became upset and was yelling and using profanity. CNA 10 indicated Resident P became physically aggressive toward her, including scratching, kicking, and spitting at her. CNA 10 indicated she had sustained multiple scratches to her arms from Resident P. CNA 10 indicated at some point CNA 11 had informed her that resident was bleeding. She indicated she had she cleaned the wounds and then had gone to locate LPN 2. CNA 10 indicated she had informed LPN 2 that the resident was bleeding and had requested that he assess the situation but LPN2 had informed her that he was too busy passing medications and had not assessed the resident.A review of CNA 10's Employee Timesheet indicated the CNA had punched-in for work on 5/28/26 at 1:14 P.M. and had punched out on 5/29/26 at 6:11 A.M.On 6/2/24 at 10:00 A.M., Resident P's clinical record was reviewed. The resident was admitted to Memory Care on 5/27/26 with diagnoses included but were not limited to dementia, chronic kidney disease, repeated falls, chronic obstructive pulmonary disease, and chronic kidney disease.Minimum Data Set Assessment information was not available.Resident P's Care Plans indicated the resident had skin trauma to her left forearm as a skin tear. The plan had been initiated on 6/1/26. Another Care Plan, initiated on 5/27/26 and revised on 5/29/26, indicated the resident required assistance with activities of daily living related to her diagnoses including a history of a fall with laceration to top left scalp, depression, (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dementia with behaviors, hospice care, cognitive disfunction, restlessness, agitation, and weakness. Interventions included needs assistance for personal hygiene, showering, toilet transfers and toileting hygiene.A General Progress Note, dated 5/29/26 at 4:59 P.M., indicated Resident P had been assessed by the Director of Nursing.A Focused Nursing Charting Note, dated 5/29/26 at 5: 49 P.M., indicated: Alleged physical contact. Vital were completed and within normal limits. There were no other assessments found or provided by the facility prior to 5/29/26 at 4:59 P.M. regarding the abuse and injuries incurred from alleged abuse.On 6/2/24 at 2:00 P.M., Resident R's clinical record was reviewed. Diagnoses included but were not limited to dementia, metabolic encephalopathy, anxiety, schizophrenia, depression, bipolar disorder. Resident R was admitted to Memory Care on 2/9/26.A Minimum Data Set assessment dated [DATE] for Quarterly Assessment, indicated Resident R was cognitively intact.An Incident Interview Form dated 6/1/26, indicated Resident R had reported that Everyone is good to me, except [CNA 10]. If I don't do what she says she'll jump all over my back. She hollers at me-I'm 61 I don't have bosses anymore.There were no documented assessments or follow up notes related to the allegation of verbal abuse for Resident R.On 6/1/26 at 1:22 P.M., a policy titled Abuse, Mistreatment, Neglect, Exploitation, and Misappropriation, dated 7/1/25, was provided by the Administrator who indicated it was the current facility policy. The policy indicated, .Residents have the right to be free from abuse.Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.Care Team members should immediately report all such allegations to the Administrator and to the Department of Health in accordance with the procedures in this policy .If an injury is observed /suspected, Care Team Members should not move the resident/patient until an assessment is completed by a nurse supervisor for possible injuries .If a Care Team Member is accused or suspected. Facility should immediately remove that Care Team Member from the facility . 410 IAC (Indiana Administrative Code) 3.1-28(a)(c)(d)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review, the facility failed to ensure antiseizure medications were available and administered in accordance with physician orders for 1 of 3 residents reviewed for medication administration, (Resident N). This deficient practice resulted in the resident displaying seizure activity.Finding includes:On 6/1/26 at 10:00 A.M., Resident N's clinical record was reviewed. Diagnoses included but were not limited to epilepsy, dysphagia following cerebrovascular disease, psychosis, anxiety, and intellectual disability.Resident N's Physician's Orders included but were not limited to;Briviact Tablet 75 MG (Brivaracetam), to give 2 tablets two times a day at 6:00 A.M. and 6:00 P.M., for epilepsy, ordered on 07/01/24 and ongoing, andClobazam Oral Suspension 2.5 MG/ML, to give 5 ml one time a day for seizures, ordered on 03/24/26 and discontinued on 5/1/26.A Care Plan dated 1/19/17, indicated Resident N was at risk for seizures related to epilepsy. The Care Plan interventions included to give medications as ordered. Review of the Resident N's Electronic Medical Record (EMR) dated 4/1/26 through 4/30/26, indicated on 4/5/26, 4/6/26, 4/9/26, and 4/10/26, that neither the morning nor evening Briviact tablets were administered as ordered, and on 4/14/26, 4/15/26, and 4/17/26, Clobazam oral suspension for seizures was not administered as ordered.Review of Resident N's Progress Notes included but were not limited to the following:On 4/6/26 at 1:33 P.M., indicated Nursing staff reached out to Neurology regarding Briviact and explained issues with insurance. The facility was waiting for a call back.On 4/6/26 at 1:37P.M., Focused Charting. Note Text: seizures.resident was brought back to hall by staff member, stated resident had a seizure resident V/S taken BP 143/67 93% room air 70 Pulse temp 75.6 resp 18. resident went back to activies [activities] had another seizure lasting a few seconds. Signed by Licensed Practical Nurse (LPN) 6.On 4/6/26 at 1:52 P.M., General Progress Note, resident was brought back to hall by staff member, stated resident had a seizure resident V/S [vital signs] taken.resident went back to activities had another seizure lasting a few seconds. resident crying that her arm hurt norco given for pain 10/10. NP notified.On 4/10/26 at 9:57 A.M., General Progress Note: called pharm [pharmacy] they will stat [immediate] briviact right now.On 5/29/26 at 3:00 P.M. during an interview, the Administrator indicated he did not know why Resident N had not received prescribed seizure medications as ordered. The Administrator indicated that the Director of Nursing at the time the medications were not available was no longer at the facility and had not notified him that the resident's seizure medication had not been given as ordered. On 6/1/26 at 12:24 P.M., the Administrator provided a policy titled, Seizure Precautions, dated 1/2/24, indicating it was the current facility policy. The policy indicated, .If the resident has a generalized seizure: administer medications as prescriber or ordered. Notify the practitioner and family.On 6/1/26 at 12:24 P.M., the Administrator provided a policy titled, Medication Administration, dated 1/2/24, indicating it was the current facility policy. The policy indicated, .Medications are administered.as ordered by the physician and in accordance with professional standards of practice.Medications that are not readily available for administration will be obtained from the Emergency Kit, drop shipped from the pharmacy, or obtained from an alternative pharmacy.Physicians will be notified timely of medication omissions. Instructions on how to proceed (example: administer medications when it becomes available) will be followed per physician order. This citation relates to Intakes 3013839 and 3017939.410IAC (Indiana Code) 16.2-3.1-37(a)