

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155694	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/15/2025
NAME OF PROVIDER OR SUPPLIER Betz Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 116 Betz Rd Auburn, IN 46706	

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)
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Based on observation, interview and record review the facility failed to ensure staff were present for medication administration for 2 of 3 residents reviewed (Resident B, Resident C). Findings include: 1. During an interview, on 9/15/25 at 10:10 AM, Resident B's family indicated the facility often left medications at bedside. Resident B's family indicated Resident B could not self administer their own medications safely. Resident B's record was reviewed on 9/15/25 at 10:35 AM, diagnoses included end stage renal disease. There were no self administration of medications evaluations documented for Resident B. There were no physician orders for self administration of medications for Resident B. 2. During an observation, on 9/15/25 at 11:23 AM, Resident C's medications were observed at bedside. During an interview, on 9/15/25 at 11:23 AM, Resident C indicated Licensed Practical Nurse (LPN) 3 placed his medications at bedside for his lunch. Resident C indicated he didn't receive lunch until around 1 PM. During an interview, on 9/15/25 at 11:28 PM, LPN 3 indicated no residents in the facility were able to self-administer their medications. LPN 3 indicated she placed Resident C's medications at bedside to take during his lunch. LPN 3 indicated no medications were allowed at bedside. During an interview, on 9/15/25 at 12:09 PM, the Director of Nursing (DON) indicated no residents were able to self-administer their medications. The DON indicated Resident C's medications should not be left at bedside. Resident C's record was reviewed on 9/15/25 at 11:46 AM. Diagnoses included end stage renal disease and type 2 diabetes mellitus. There were no physician orders for self administration of medication for Resident C. An admission care plan, dated 8/7/25, indicated the nurse was to administered Resident C's medications as ordered. An admission Minimum Data Set (MDS) assessment, indicated Resident C had a Brief Interview of Mental Status (BIMS) of 15/15 (cognitively intact). There were no self-administration of medication evaluations documented for Resident C. During an interview, on 9/15/25 at 11:17 AM, Registered Nurse (RN) 4 indicated medications were never left at bedside. RN 4 indicated the nurse waited for the resident to take the medication prior to the nurse leaving the room. A policy, last revised 1/2015, titled Self Administration of Medications, was provided by the Regional Nurse on 9/15/25 at 12:11 PM. The policy indicated a self-administration assessment and order were completed for residents who self-administered medications. This finding relates to Intake 2595411. 3. 1-25(b)(3)</p>

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
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