STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155823	A. Building B. Wing	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southpointe Healthcare Center	4904 War Admiral Drive Indianapolis, IN 46237

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, and record review, the facility failed to ensure a self-medication administration assessment was completed for 1 of 2 residents reviewed for medications left at the bedside. (Resident 9) Finding includes: During an observation on 2/25/26 at 11:30 a.m., Resident 9 was observed in his room while sitting in his wheelchair next to the over the bed table. On top of the over the bed table and on the bedside table, located approximately three feet from the over the bed table, the following topical medications were observed: - One small sized bottle of nystatin topical powder and it was approximately one-third full of the medication. The bottle contained a pharmacy label that identified the resident's name, dated 7/21/25 for when the medication was filled, and the following instructions were listed on the label apply to groin topically 2 times per day for yeast. The pharmacy label lacked any language regarding Resident 9's ability to self-administer the medication. - One medium sized bottle of nystatin topical powder and it was approximately half full of the medication. The bottle contained a pharmacy label that identified the resident's name, dated 6/1/25 for when the medication was filled, and the following instructions were listed on the label apply to groin topically 2 times per day for yeast. The pharmacy label lacked any language regarding Resident 9's ability to self-administer the medication. - One 14-ounce container of Aquaphor Advanced Therapy Cream and it was approximately half full of the medication. The container had a pharmacy label that identified the resident's name, and dated 12/29/25 for when the medication was filled, and the following instructions were listed on the label apply to affected area topically at bedtime for dry skin. The pharmacy label lacked any language regarding Resident 9's ability to self-administer the medication. - One three-ounce can of Pro-Care Antifungal Powder and it was approximately half full of the medication. The can lacked a pharmacy label or resident identification information on the can. - One six-ounce tube of Triad Hydrophellic Wound Dressing and it was approximately half full of the medication. The tube lacked a pharmacy label or resident identification information on the tube. - One 1.76-ounce tube of Voltaren Arthritis Pain Cream and it was approximately one-third full of the medication. The tube lacked a pharmacy label or resident identification information on the tube. No staff were visible during that time. During an interview at that time, Resident 9 indicated he kept the medications in his room and administered the various medications when he needed it. On 2/26/26 at 9:00 a.m., Resident 9 was observed to not be in his room. Resident 9's room was observed. The same topical medications, as listed above, were observed on his over the bed table and on the bedside table. No staff were visible during that time. On 2/26/26 at 2:20 p.m., Resident 9 was observed to not be in his room. Resident 9's room was observed. The same topical medications, as listed above, were observed on his over the bed table and on the bedside table. No staff were visible during that time. On 2/26/26 at 2:25 p.m., Resident 9 was observed to not be in his room. During an observation of Resident 9's room with Licensed Practice Nurse (LPN) 3, the same topical medications, as listed above, were observed on his over the bed table and on the bedside table. No other staff were visible during that time. During an interview at that time, LPN 3 indicated Resident 9 had not been assessed by the nursing staff to determine if he could self-administer his medications and he did not have a physician's order for self-administering his medications. Based on facility policy, Resident 9's medications should not have been left at the bedside. On 2/26/26 at 2:35 p.m., Resident 9's clinical (continued on next page)

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

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	record was reviewed. The diagnoses included, but were not limited to, type 2 diabetes with neuropathy (nerve damage due to uncontrolled diabetes) and osteoarthritis (painful, swollen, stiff joints). Current Physician orders, dated February 2026, included, but were not limited to, the following: - Nystatin powder, apply to groin topically two times a day for Yeast for 6 months.start date 1/15/26.with an end date of 7/15/26 . - Aquaphor External Ointment (Emollient), apply to affected area topically at bedtime for dry skin.start date 12/29/25. and no end date was noted. The Annual Minimum Data Set (MDS) assessment, dated 12/6/25, indicated Resident 9 was moderately cognitively intact. Resident 9's clinical record lacked a facility self-administration of medication assessment and a physician's order allowing the resident to self-administer his own medications. During an interview on 3/2/26 at 8:10 a.m., the Executive Director (ED) indicated Resident 9's clinical record did not have any self-administering medication assessments or physician orders to self-medicate. No medications should have been left at Resident 9's bedside. On 3/2/26 at 8:05 a.m., the ED provided a copy of an undated Resident Self-Administration of Medications policy and indicated it was the current policy in use by the facility. A review of the document indicated, .resident may not self-administer medications until the assessment is completed by the IDT [Interdisciplinary Team] and determined to be safe to so do .physician/provider order is required for residents to self-administer medications . 410 IAC (Indiana Administrative Code) 16.2-3.1- 11(a)