

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15A011	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER Especially Kidz Health & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 2325 S Miller St Shelbyville, IN 46176	

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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>(continued on next page)</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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observation, interview and record review, the facility failed to ensure a staff member administered medications as ordered by the physician and did not falsify resident records for 3 of 3 residents reviewed for medication receipt. (Residents E, F, G, and Licensed Practical Nurse 3) This deficient practice was corrected on 7-9-25, prior to the start of the survey, and was therefore past noncompliance. The facility implemented a systemic plan that included the following actions: in-service education to nursing staff related to the policies and procedures regarding safe medication administration and prompt reporting of any resident or staff concerns to management, conducted a review of residents medication orders, narcotic orders and correct narcotic counts, observations of medication administrations and dismissal of Licensed Practical Nurse 3, with ongoing review presented to the Quality Assessment and Assurance (QAA) Committee for review. Findings include: In an interview with the Executive Director (ED) on 9-16-25 at 12:30 p.m., she indicated on the afternoon of 7-4-25, Licensed Practical Nurse (LPN) 3 was found to have not administered medications to a minimum of three residents and possibly more residents. She indicated on 7-6-25, the Director of Nursing (DON) was contacted by other staff with concerns LPN 3 may not have administered medications as ordered on the afternoon of 7-4-25. The ED indicated she did not learn of this concern until she arrived for duty on 7-7-25, at which time, an investigation was underway. She indicated the facility's hall cameras were reviewed on 7-7-25, by the administrative team for the afternoon of 7-4-25. She indicated from viewing the camera footage, it definitely looked like he had pulled three of the residents' narcotics and threw them away or pocketed them. Actually, it looked like he did not pass any meds for his 3:00 p.m. to 7:00 p.m., shift on the vent unit. After the narcotics were pulled, the cameras did not show he went into any of those residents' rooms to actually administer them. We met with him on 7-7-25, and suspended him, pending the investigation. We continued the investigation and terminated him, effective 7-9-25. We did report this to the AG's [State of Indiana Attorney General's] office and they have accepted it for review, but we have not heard anymore from the AG's office and no one has been here to investigate it yet. The ED clarified LPN 3's termination also included concerns the facility had previously dealt with related to LPN 3 not following facility policies related to not clocking in and out. The ED added the facility offered him the opportunity to write a statement, but he refused. As he was leaving the building, he slammed the door between the front lobby and the building and then went to Vent 1 and yelled that he had been suspended for three days to at least two staff, maybe others heard him. [He] Made a statement that he wasn't going to sign anything and that he didn't need to put up with this 'fing b-----t, as he went to clock out, then left the building. The ED provided a copy of the timeline of the facility's camera footage for 7-4-25 from 2:46:49 p.m. to 7:04:37 p.m., of the facility's Vent 2 unit. The timeline indicated as follows: 18:50:08 [6:50:08 p.m.] first medication popped [removed from medication card]; 18:51:23 [6:51:23 p.m.] [Name of LPN 3] appears to toss medication in near bye [sic] trash can.; 18:51:48 [6:51:48 p.m.] put 2nd medication card down. 18:52 [6:52 p.m.] 3rd medication [laid] down; 18:52:17 [6:52:17 p.m.] [Name of LPN 3] transferred med(s) to other hand; 18:52:36 [6:52:36 p.m.] [Name of LPN 3] places medication(s) in pocket; 18:53 [6:53 p.m.] [Name of LPN 3] closes narc [narcotic] binder, meds back in narc box (never went into any resident rooms afterwards). 19:04:37 [7:04:37 p.m.] [Name of LPN 3] left unit. In an observation and interview on 9-17-25 at 10:00 a.m., with the ED and Assistant ED, they utilized the Assistant ED's cellular phone to show or view a limited review of facility camera footage from 7-4-25 at/around 6:50 p.m. until 6:55 p.m., of LPN 3 on the ventilator unit at the medication carts, identified as medication carts E and F. The ED and Assistant ED identified the person in the camera footage as LPN 3. LPN 3 was observed to lay his cell phone onto the top of one of the two medication carts, then unlocked the medication cart and then unlocked the secured narcotic drawer. He then moved a water pitcher on top of the cart. He then was observed to obtain the narcotic binder, which houses logs for each narcotic by resident which staff were to sign out any time a narcotic is obtained to administer to a resident. LPN 3 was then observed to obtain a narcotic card from the narcotic drawer and removed the medication, placing into his bare hand, then was observed to record information into the narcotic binder He then was observed to toss something from his hand directly towards the far end of med cart. A second narcotic medication card was observed to be obtained from the narcotic drawer and removed the medication into his bare hand and then signed the narcotic binder. It was difficult to ascertain if the medication remained in his hand or placed in his pocket. It was not placed into a medication cup. A third narcotic medication card was obtained from the narcotic drawer and then removed from the card and into his bare hand. LPN 3 then</p>		