

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/24/2026	
NAME OF PROVIDER OR SUPPLIER TIPTON PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 460 FORKS OF THE WABASH WAY, HUNTINGTON, , 46750					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...			(X5) COMPLETION DATE	
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. This visit included the Investigation of Intakes 470535, 470562, and 470720. Intake 470535- No deficiencies related to the allegations are cited. Intake 470562- State deficiencies related to the allegations are cited at R0297. Intake 470720- State deficiencies related to the allegations are cited at R0297. Survey dates: July 22, 23, and 24, 2026 Facility number: 003376 Residential Census: 27 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed July	R 0000	Submission of this Plan of Correction does not constitute an admission of the alleged deficiency or agreement with the findings. The Plan of Correction is submitted to comply with regulatory requirements and outlines the actions the community will take to ensure compliance.				

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	29, 2026.			
R 0117	Personnel - Deficiency 410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review, the facility failed to ensure a cardiopulmonary resuscitation certified staff	R 0117	Plan of Correction Element Action Plan Details STEP #1: Affected Residents No specific residents experienced negative outcomes. The Business Office Assistant/ED completed an audit of all employee CPR certificates. STEP #2: Potential Residents All 27 residents residing in the facility had the potential to be affected. The Business Office Assistant/ED completed a 100% audit of all current employee files to compile an accurate roster of active, unexpired CPR certificates. Any clinical employee without an active CPR certification will be enrolled into a class and compliant by 8/24/26. STEP #3: Systemic Changes All current clinical employees without an active CPR certification will be enrolled into a class and compliant by 8/24/26. All new clinical team members	08/24/2026

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member was on-site for six out of forty-two shifts reviewed for staffing. Findings include: A review of staffing schedules for the prior seven days, provided by the Administrator on 7/24/26 at 9:58 a.m., indicated the following: On 7/17/26, no cardiopulmonary resuscitation (CPR) certified staff were present for second shift. On 7/20/26, no cardiopulmonary resuscitation (CPR) certified staff were present for third shift. On 7/21/26, no cardiopulmonary resuscitation (CPR) certified staff were present for third shift. On 7/22/26, no cardiopulmonary resuscitation (CPR) certified staff were present for third shift. During an interview, on 7/24/26 at 10:32 a.m., the Administrator indicated all shifts should have staff members who are CPR certified. A current facility policy, dated 6/10/24, titled "Staffing, Emergency Training, Cardiopulmonary Resuscitation (CPR) and First Aid Training," provided by the Administrator, on 3/21/25 at 11:43 a.m., indicated the following: "...5.		will complete CPR and First Aid within 90 days of hire. Executive Director or designee will track CPR/First Aid Certifications monthly, flagging certifications expiring within 60 days. STEP #4: Monitoring The Executive Director or a designated manager will audit daily shift schedules 5 times per week for 4 weeks, then weekly for 12 weeks. Executive Director or designee will continue to track CPR/First Aid Certifications monthly, flagging certifications exp Date of Compliance August 24, 2026	
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	Each Community must have at least one (1) staff member trained in CPR and First Aid on duty and on the premises at all times...."			
R 0121	Personnel - Noncompliance 410 IAC 16.2-5-1.4(f)(1-4) (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.	R 0121	Plan of Correction Element Action Plan Details STEP #1: Affected Residents No specific residents experienced negative outcomes. The Business Office Assistant/ED completed an audit of all active personnel files to verify TB skin test compliance. STEP #2: Potential Residents All 27 residents had the potential to be exposed due to undocumented personnel. The Business Office Assistant/Administrator completed a 100% retrospective audit of all active personnel files to verify that employment TB skin tests were performed and records contain clear timestamped readings. Any personnel found not in compliance was administered tuberculin as part of a new two-step skin test. STEP #3: Systemic Changes ED or designee will audit all new hire employee files to ensure valid TB test has been administered and properly documented before employee is actively staffing. STEP #4: Monitoring The ED or designee will audit	08/28/2026

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(2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.

(3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings.

(4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.

Based on record review and interview, the facility failed to accurately document the administration of and results of mandatory tuberculin (TB) skin tests performed prior to employment for 1 of 5 employees reviewed for health screenings. (Activity Director)

Findings include:

A review of current employee records was completed on 7/23/26 at 2:00 p.m.

Activity Director (AD) 8's personnel file lacked accurately completed TB skin tests. AD 8's first step TB was administered on 4/20/26 and read on 4/22/26. A second step TB test was

100% of new hire medical files monthly for 6 months. Any incomplete forms result in the employee being pulled from staffing until a valid skin test has been performed.

ED will audit 10% of employee files monthly to ensure TB screening is documented appropriately and up-to-date. Any incomplete forms will result in employee being pulled from staffing until a valid test is performed and on file.

Date of Compliance

August 28, 2026

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administered 5/20/26 and read 5/22/26. The testing information lacked the times the tests were administered and the results were read.

During an interview, on 7/24/26 at 10:32 a.m., the Administrator indicated she did not have any other information regarding staff members tuberculin testing.

A current facility policy, dated 6/10/24, titled "Tuberculosis Care Staff," provided by the Administrator, on 7/24/26 at 12:39 p.m., indicated the following: "...The community will screen all care staff for tuberculosis (TB) infection and disease, per state regulations prior to the start of employment and annually thereafter...."

The Mantoux Tuberculin Skin Testing Fact Sheet from the Centers for Disease Control and Prevention (CDC) website at https://www.cdc.gov/tb/publications/factsheets/testing/Tuberculin_Skin_Testing_Information_for_Health_Care_Providers.pdf accessed on 7/27/26 at 1:44 p.m., guidance included: "...The skin test reaction should be read between 48 and 72 hours after administration by a health care worker trained to read TST results. A patient who does not return within 72 hours will need to be rescheduled for another skin test...."

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R 0151	Sanitation & Safety Standards -Noncompliance 410 IAC 16.2-5-1.5(h) (h) Any pet housed in a facility shall have periodic veterinary examinations and required immunizations. Based on record review and interview, the facility failed to ensure pets residing within the facility had received the required vaccinations for 2 of 4 pets reviewed for vaccinations. Findings include: Facility documents provided by the Administrator, on 7/22/26 at 10:56 a.m., indicated the facility had four pets in the facility. Resident 11's pet's clinical health record from the veterinarian, provided on 7/22/26 at 10:56 a.m. by the Administrator, indicated the pet had an examination on 9/17/24. The pet had just received its viral health and rabies vaccine. The pet was due for its yearly viral vaccine 9/2025. Resident 17's pet's clinical health record from the veterinarian, provided on 7/22/26 at 10:56 a.m. by the Administrator, indicated the pet had an examination on 4/19/25. The pet had just received its	R 0151	Plan of Correction Element Action Plan Details STEP #1: Affected Residents No specific residents experienced negative outcomes. The Business Office Assistant/ED completed an audit of veterinary records for all pets currently residing in the community. STEP #2: Potential Residents All 27 facility residents had the potential to encounter unvaccinated animals. The Business Office Assistant/ED completed an audit of veterinary records for all pets currently residing in the community. Pets not in compliance were scheduled for veterinary updates. Current health certificates proving state required rabies vaccination were successfully obtained and placed in the community log. STEP #3: Systemic Changes The Executive Director updated the "Pet" binder. The ED or designee will track vaccination due dates of all pets in the community and notify ED and pet owner on the first of the month when the pet vaccination is due to expire in the next month. Executive Director or designee will review pet vaccination records at time of move-in to ensure vaccination requirements are met.	08/22/2026
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	viral health and rabies vaccine. The pet was due for its yearly viral and rabies vaccine on 4/19/26. During an interview, on 7/24/26 at 10:32 a.m., the Administrator indicated that Resident 17's pet vaccinations were up to date. All other pet vaccinations were expired. Pets were required to have up to date vaccinations. A current facility policy, dated 5/22, titled "Pet Addendum," provided by the Administrator, on 7/24/26 at 12:39 p.m., indicated the following: "...1. The pet must be properly licensed, registered and vaccinated in accordance with applicable state and local/city laws, regulations, rules and ordinances at all times...."		ED or designee will ensure pet records are added to vaccination tracker upon move-in STEP #4: Monitoring The Executive Director or a designee will audit the pet compliance tracking log on the 1st of every month for the next 6 months, then 3 months, then ongoing monthly. Date of Compliance August 22, 2026	
R 0273	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(f) (f) All food preparation and serving areas (excluding areas in residents' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to ensure food was stored and prepared in a sanitary manner. This deficient	R 0273	Plan of Correction Element Action Plan Details STEP #1: Affected Residents No specific residents experienced negative outcomes. Dietary staff discarded the uncovered and undated items in the refrigerator. Cook 4 was re-educated on glove compliance and sanitary steam table procedures. STEP #2: Potential Residents All 27 residents receiving meals	08/21/2026

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practice had the potential to affect 27 of 27 residents receiving meals from the kitchen. Findings include: 1. A kitchen observation, on 7/22/26 at 9:22 a.m., indicated the following: The lid to the trash can next to the hand-washing station was propped up behind a pipe that lead to the ice machine. In a refrigerator, there was orange Jello dessert in single serve dessert dishes that were uncovered and undated. Dietary Employee (DE) 4 indicated staff had used the Jello for medication pass and hadn't covered the desserts back up. Small paper cups with French and ranch dressing were left half uncovered and undated. There was a tray of mixed fruit in dessert bowls that were all uncovered and undated. White cake with chocolate icing on individual plates were all uncovered. A plastic covered small bowl of potato salad was undated. Bulk flour and sugar scoops		had the potential to be affected by cross-contamination. The Dietary Manager inspected all food storage items currently inside the refrigerator and dry pantry to ensure proper covering and dating. Any uncovered/undated items were discarded. Dry goods were dated. STEP #3: Systemic Changes All staff inservice education on safe preparation, storage, & service of food, cross contamination, and infection control, and sanitary steam table procedures to be completed by 8/21. STEP #4: Monitoring The Executive Director or designee will conduct unannounced kitchen sanitation audits daily 5 days per week for 4 weeks, then 3 times per week for an additional 4 weeks, then weekly for 4 weeks. Date of Compliance August 21, 2026	
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were left sitting on top of a plastic lid, exposed to air and possible contaminants.

The bulk flour container had two dates. One sticker indicated 11/18/24 while the other sticker was dated 3/9/26.

The bulk sugar bin had an illegible date on the container.

During an interview, on 7/24/26 at 9:20 a.m., the Dietary Manager indicated all items in the refrigerator should be covered.

2. During a lunch observation, on 7/24/26 at 12:12 p.m., the following was observed:

Cook 4 was wearing gloves. She rested her hands on the white ledge of the steam table. She was plating meatloaf, asparagus and broccoli cheese soup. She turned to a drawer behind her, opened the drawer, pulled out a ladle to use in the soup, and closed the drawer. She spilled some soup on the edge of the bowl, wiped the spill away with her gloved right thumb before placing the bowl on the tray for service.

Lids of the steam table were all resting in the kitchen sink behind her. After the first wave of residents had been served, she took the lids out of the kitchen sink and placed them

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back on top of the food on the steam table.

During an interview, Cook 4 indicated she should not have wiped soup from the edge of the bowl with her hand. The sink was not cleaned before placing the steam table lids there to rest. She should not have placed the lids on the steam table after they were placed in the sink.

During an interview, on 7/24/26 at 10:28 a.m., the Administrator indicated all items in the kitchen refrigerator should be covered and labeled. Dietary Employees should not be touching numerous items with the same gloves.

A current undated facility policy, titled "Food Storage Guidelines," provided by the Administrator, on 7/24/26 at 12:39 p.m., indicated the following: "...All food items must be labeled using food storage labels. Prepared foods must be stored in an appropriate container with an airtight lid or cellophane, and labeled with the type of food, date and use by date...."

A current undated facility policy, titled "Culinary Sanitation Policy," provided by the Administrator, on 7/24/26 at 12:39 p.m., indicated the following: "...Purpose. To

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	ensure the highest standards of cleanliness and sanitation across all culinary operations including back-of-house, front-of-house, bar areas, satellite kitchens, bistros and hospitality stations...."			
R 0274	Food and Nutritional Services - Noncompliance 410 IAC 16.2-5-5.1(g)(1-3) (g) There shall be an organized food service department directed by a supervisor competent in food service management and knowledgeable in sanitation standards, food handling, food preparation, and meal service. (1) The supervisor must be one (1) of the following: (A) A dietitian. (B) A graduate or student enrolled in and within one (1) year from completing a division approved, minimum ninety (90) hour classroom instruction course that provides classroom instruction in food service supervision who has a minimum of one (1) year of experience in some aspect of institutional food service management. (C) A graduate of a dietetic technician program approved by the American Dietetic Association. (D) A graduate of an accredited college or university or within one	R 0274	Plan of Correction Element Action Plan Details STEP #1: Affected Residents No specific residents experienced negative outcomes. The ED enrolled the current Dietary Manager in an approved ServSafe certification course. STEP #2: Potential Residents All 27 residents had the potential to be affected by the deficiency. ED immediately reviewed ServeSafe certifications for dining staff. Dietary Manager was enrolled in ServeSafe Manager training. STEP #3: Systemic Changes ServeSafe certifications will be tracked by the ED or designee and any licenses due to expire within 60 days will be brought to ED's attention for scheduling recertification. Certified staff who have a certification expire will be removed from the schedule until recertification is achieved. STEP #4: Monitoring The Executive Director or designee	08/30/2026

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(1) year of graduating from an accredited college or university with a degree in foods and nutrition or food administration with a minimum of one (1) year of experience in some aspect of food service management. (E) An individual with training and experience in food service supervision and management. (2) If the supervisor is not a dietitian, a dietitian shall provide consultant services on the premises at peak periods of operation on a regularly scheduled basis. (3) Food service staff shall be on duty to ensure proper food preparation, serving, and sanitation. Based on interview and record review, the facility failed to employ a qualified Dietary Manager. This deficient practice had the potential to affect 27 of 27 residents who received meals from the facility kitchen. Findings include: During an interview, on 7/23/26 at 2:10 p.m., the Administrator indicated they did not have anyone in the building who was serve safe certified. The Dietary Manager's (DM) serve safe certification expired a few months ago. During an interview, on 7/24/26		will audit the certification binder to monthly for any license/certification expiring within 60 days. Monthly review will be ongoing. Date of Compliance August 30, 2026	
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	at 9:20 a.m., the DM indicated her serve safe certification expired 3/18/26. She was in the process of working with the Administrator to get her certification renewed. A policy was requested on 7/24/26 but was not obtained from the facility.			
R 0297	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(c)(1) (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on observation, interview, and record review, the facility failed to ensure residents received medications as ordered for 2 of 3 residents reviewed for medication administration (Residents B and D) and failed to ensure the reconciliation of narcotic medications to mitigate the risk of misappropriation for 1 of 1 medication cart observed.	R 0297	Plan of Correction Element Action Plan Details STEP #1: Affected Residents Resident B's physician orders were fully profiled and confirmed with the pharmacy provider. Resident D's omitted medication windows were reviewed by her physician to ensure clinical stability. The incomplete narcotic shift logs were flagged for review. STEP #2: Potential Residents The Regional Director of Resident Care executed a 100% facility-wide audit of all active resident MAR charts from the past 30 days to catch any other omitted medications or missing pharmacy-profile linkages. Discrepancies in medication administration were reported to resident PCP for further orders. STEP #3: Systemic Changes Admission standard updated to request 72 hr supply of meds	08/25/2026

Findings include:

1. Review of an anonymous intake submitted to the Indiana Department of Health on 7/9/26 at 12:27 p.m. indicated Resident B did not receive her medication for four days after being newly admitted to the facility.

Resident B's clinical record was reviewed on 7/22/26 at 12:03 p.m. Diagnosis included chronic pain, hypertension, heart failure, and chronic kidney disease.

Current orders included acetaminophen (pain) 325 milligrams (mg) twice daily (start date 7/20/26) atenolol (antihypertensive) 25 mg daily (start date 7/20/26), lidocaine pain relief patch daily, leave on for 12 hours before removing for 12 hours (start date 7/20/26), pantoprazole (antacid) 40 mg daily (start date 7/20/26), rosuvastatin (slows plaque buildup) 10 mg daily (start date 7/20/26), torsemide (diuretic) 10 mg daily (start date 7/20/26), and valsartan (antihypertensive) 320 mg daily (start date 7/20/26).

Resident B did not have any active physician orders from 7/3/26 through 7/6/26.

A July 2026 Medication Administration Record (MAR) indicated Resident B did not have any medications

provided by resident admitting from home or healthcare facility if meds are not already community from pharmacy at time of admission. Any admission orders received after 1 pm day of admission will be manually entered into the eMAR.

All QMA's re-educated on controlled medication storage and shift to shift count requirement. Will continue to use an electronic blind count as well as implement a physical logbook with employee signatures.

Shift count logs are reviewed daily by ED or designee for completion. Failure to follow narcotics control policy will be addressed at time of discovery with disciplinary action.

STEP #4: Monitoring

The DHW or a licensed nurse designee will audit automated electronic MAR records and e-narcotic logs as well as any manual logs daily for 30 days, then 3 times a week for 60 days and then monthly. Discrepancies will be addressed according to company policy.

Date of Compliance

August 25, 2026

administered during her stay at the facility from 7/3/26 through 7/6/26.

During an interview, on 7/22/26 at 2:35 p.m., QMA 10 indicated she did not recall passing any medication for Resident B. Resident B never had any medication in the medication cart during her time in the facility.

During an interview, on 7/23/26 at 9:18 a.m., QMA 8 indicated she did not recall passing any medication on Resident B during her stay in the facility. They did not have any medication orders or medications for Resident B.

During an interview, on 7/23/26 at 10:55 a.m., the Regional Nurse Consultant indicated the facility had faxed Resident B's medication orders to the pharmacy. The pharmacy did not "profile" the medications, so there were no medications in the system. Typically, it would be the DON's responsibility to make sure a resident's medications were ordered and delivered.

During an interview, on 7/23/26 at 1:38 p.m., the Administrator indicated the DON from a sister facility completed Resident B's admission assessment. Paper physician orders were faxed to the pharmacy. Per the

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pharmacy, they reached out to the facility but were told there was no nurse on duty that weekend to accept orders.

2. Resident D's clinical record was reviewed on 7/23/26 at 9:58 a.m. Diagnoses included anemia, diabetes, hypertension, irritable bowel syndrome with diarrhea, chronic atrial fibrillation (irregular heartbeat).

Current orders included amlodipine (antihypertensive) 5 mg daily, atorvastatin (cholesterol) 40 mg daily, bumetanide (diuretic/water pill) 1 mg daily, Eliquis (blood thinner) 2.5 mg daily, isosorbide mononitrate (antihypertensive) 10mg daily, mirtazapine (antidepressant) 7.5 mg daily and sitagliptin (lowers blood sugars) 100 mg daily.

A July 2026 MAR indicated Resident D did not receive her medications as follows:

8:00 a.m. doses on July 3rd of amlodipine, bumetanide, Eliquis, Jardiance and isosorbide mononitrate

6:00 p.m. doses on July 15th for atorvastatin, Eliquis and mirtazapine

6:00 p.m. doses on July 20th for atorvastatin, Eliquis and mirtazapine

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During an interview, on 7/23/26 at 9:18 a.m., QMA 8 indicated it appeared Resident D's July MAR report was missing completed medication administrations.

During an interview, on 7/24/26 at 10:33 a.m., the Regional Nurse Consultant indicated Resident D's July MAR appeared to be missing medication administration doses.

3. Review of an anonymous report submitted to Indiana Department of Health on 7/1/26 indicated resident narcotics were not being counted and reconciled.

During an interview, on 7/22/26 at 1:17 p.m., QMA 9 indicated shift to shift narcotic reconciliation was completed in the computer system after each exchange of keys.

During an interview, on 7/23/26 at 9:18 a.m., QMA 8 indicated the narcotic count was completed by two staff members in the computer. The count was completed after each change in staff.

A 30-day narcotic count log was provided by the Regional Nurse consultant, on 7/23/26 at 11:46 a.m., and indicated the following:

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7/22/26- second shift narcotic count was missing			
7/21/26- first, second, and third shift narcotic shift count was missing			
7/20/26- second and third shift narcotic count was missing			
7/19/26- third shift narcotic count was missing			
7/18/26- first and third shift narcotic count was missing			
7/17/26- third shift narcotic count was missing			
7/15/26- third shift narcotic count was missing			
7/14/26- third shift narcotic count was missing			
7/13/26- first and third shift narcotic count was missing			
7/12/26- third shift narcotic count was missing			
7/11/26- second shift narcotic count was missing			
7/9/26- third shift narcotic count was missing			
7/8/26- first, second and third shift narcotic count was missing			
7/7/26- third shift narcotic count was missing			
7/6/26- third shift narcotic count			

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was missing

7/5/26- first, second, and third
shift narcotic count was missing

7/4/26- third shift narcotic count
was missing

7/3/26- first shift narcotic count
was missing

7/2/26- third shift narcotic count
was missing

7/1/26- third shift narcotic count
was missing

6/30/26- first and third shift
narcotic count was missing

6/29/26- third shift narcotic
count was missing

6/28/26- first and third shift
narcotic count was missing

6/27/26- third shift narcotic
count was missing

6/26/26- first and third shift
narcotic count was missing

6/25/26- third shift narcotic
count was missing

During an interview, on 7/24/26
at 12:36 p.m., the Regional
Nurse Consultant indicated she
was unable to pull a copy of the
narcotic count sheet to show
which two staff members
verified the narcotic count at the
time of reconciliation. Narcotic
counts were to be completed

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FORM APPROVED

OMB NO. 0938-0391

after each shift.

A current facility policy, dated 2/6/20, titled "Medication Services," provided by the Administrator, on 7/24/26 at 12:39 p.m., indicated the following: "...Policy: The Community offers medication ordering and medication assistance/ administration services. The Executive Director will ensure that medication-related services required for or requested by each resident are provided...."

A current facility policy, dated 2/6/20, titled "Medication Services," provided by the Administrator, on 7/24/26 at 12:39 p.m., indicated the following: "...Policy: The Community offers medication ordering and medication assistance/ administration services. The Executive Director will ensure that medication-related services required for or requested by each resident are provided...."

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FORM APPROVED

OMB NO. 0938-0391

A current facility policy, dated 6/10/24, titled "Controlled Substance Management," provided by the Administrator, on 7/24/26 at 12:39 p.m., indicated the following: "...2. Any time keys are passed, both staff members will count all Controlled Substances, and sign-off on the Controlled Substance Shift Count Form...." This citation relates to Intakes 470562 and 470720.			
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATUREMelissa Quinn	TITLEED	(X6) DATE08/13/2026
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