STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREEK OF WASHINGTON	297 SOUTH 100 EAST, WASHINGTON, , 47501

(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. Survey dates: October 2, 3, 6, 2025 Facility number: 004904 Residential Census: 15 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on October 8, 2025.	R 0000	N/A	
R 0216	Evaluation - Noncompliance 410 IAC 16.2-5-2(c)(1-4)(d) (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status.	R 0216	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Director of Nursing (DON) completed self-administration medication assessment on 10/6/2025 for resident-104. 2. How the facility will identify other	10/27/2025

	(2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on observation, interview, and record review, the facility failed to ensure an assessment was completed timely for a resident to self-administer medications for 1 of 3 residents reviewed for self administration of medications. (Resident 104) Finding includes: On 10/2/25 at 9:30 A.M., an albuterol inhaler and a bottle of Flonase nasal spray were observed on the resident's nightstand. At that time, the resident indicated she administered those medications on her own when she needed them.		residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents had the potential to be affected by this deficient practice. DON was educated by Regional Director of Nursing (RDN) on 10/7/2025 of importance of self-medications assessments being completed if meds are in the residents' apartments. Audit completed on 10/7/2025 to ensure all residents with medications in their apartment had a self-medication assessment completed. 3. What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur: DON educated staff on 10/10/2025 to notify DON if medications are noted in resident apartments. DON will ensure all residents with medication in the apartment have a completed self-medication assessment completed. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The DON is responsible for sustained compliance. The	

	On 10/2/25 at 1:50 P.M., Resident 104's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus type II, asthma, allergies, and dementia. Current Physician Orders included, but were not limited to, resident requires medication to be administered per qualified staff except inhalers and nasal sprays. Resident may keep at the bed side and administer to self. The clinical record lacked a self administration assessment since 5/14/24. During an interview on 10/3/25 at 10:25 A.M., the Administrator indicated Resident 104 no longer self administered medications. During an interview on 10/3/25 at 11:15 A.M., Licensed Practical Nurse (LPN) 22 indicated Resident 104 did self administer her albuterol inhaler and Flonase nasal spray. On 10/3/25 at 1:11 P.M., the Administrator indicated the resident should have had an assessment at least annually and as needed for self-administering her own medications. She should have had one done but it must have been missed.		DON/designee will complete audits by reviewing 2 residents to ensure if medications are in apartment that a self-medication assessment has been completed to ensure their safety. This will be completed weekly for 4 weeks, then monthly for 3 months. The audit will be discussed at monthly QI meetings. QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. 5. By what date will the systemic changes be completed? 10/27/2025	

	On 10/6/25 at 10:25 A.M., a current Resident Self-Administered Medication Policy, last revised February 23, 2022, was provided by the Administrator and indicated, "It is [company name] policy to ensure residents are assessed to determine independence with managing their medications as well as ensure safe storage and delivery ... Residents are assessed upon move-in, every 6 months, and if a significant change is identified, for the continued ability to self-manage medications ... " Based on observation, interview, and record review, the facility failed to ensure an assessment was completed timely for a resident to self-administer medications for 1 of 3 residents reviewed for self administration of medications. (Resident 104) Finding includes: On 10/2/25 at 9:30 A.M., an albuterol inhaler and a bottle of Flonase nasal spray were observed on the resident's nightstand. At that time, the resident indicated she administered those medications on her own when she needed them. On 10/2/25 at 1:50 P.M., Resident 104's clinical record was reviewed. Diagnoses			

included, but were not limited to, diabetes mellitus type II, asthma, allergies, and dementia.

Current Physician Orders included, but were not limited to, resident requires medication to be administered per qualified staff except inhalers and nasal sprays. Resident may keep at the bed side and administer to self.

The clinical record lacked a self administration assessment since 5/14/24.

During an interview on 10/3/25 at 10:25 A.M., the Administrator indicated Resident 104 no longer self administered medications.

During an interview on 10/3/25 at 11:15 A.M., Licensed Practical Nurse (LPN) 22 indicated Resident 104 did self administer her albuterol inhaler and Flonase nasal spray.

On 10/3/25 at 1:11 P.M., the Administrator indicated the resident should have had an assessment at least annually and as needed for self-administering her own medications. She should have had one done but it must have been missed.

On 10/6/25 at 10:25 A.M., a current Resident Self-Administered Medication

	Policy, last revised February 23, 2022, was provided by the Administrator and indicated, "It is [company name] policy to ensure residents are assessed to determine independence with managing their medications as well as ensure safe storage and delivery ... Residents are assessed upon move-in, every 6 months, and if a significant change is identified, for the continued ability to self-manage medications ... "			
R 0241	Health Services - Offense 410 IAC 16.2-5-4(e)(1) (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on observation, interview, and record review, the facility failed to ensure that insulin was administered according to manufacturer's guidance. Insulin was administered from a Humalog Kwikpen without priming (eliminating air bubbles) the pen prior to insulin being administered to the resident for	R 0241	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: On 10/6/25, Nurse-22 was re-educated by Director of Nursing (DON) on insulin pen administration per manufacturer recommendations. Re-education was conducted immediately by DON to qualified nursing staff on administration of medications, specifically including priming of the Humalog Kwikpen prior to administering insulin. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents receiving insulin had the potential to be affected by this deficient practice. Following	10/27/2025

	1 of 1 residents reviewed for insulin administration. (Resident 115) Finding includes: On 10/2/25 at 12:28 P.M., Licensed Practical Nurse (LPN) 22 was observed checking his blood sugar and preparing insulin for Resident 115. Resident 115's blood sugar reading was 155. LPN 22 failed to prime the Humalog Kwikpen with two units of insulin prior to administering 2 units of insulin to Resident 115. On 10/3/25 at 1:30 P.M., Resident 115's clinical record was reviewed. Diagnoses included, but was not limited to, diabetes mellitus type II. Current physician orders included, but were not limited to, the following: Humalog Kwikpen 100 units/milliliter (mL), inject subcutaneously three times a day per sliding scale: 151-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units, 401-450=12 units and notify Medical Doctor (MD).		re-education with LPN-22 on 10/6/25, return demonstration was performed successfully. Insulin pen administration education was provided to all medication passers by DON on 10/9/2025. 3. What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur: On 10/6/2025 LPN-22 received a written disciplinary action related to insulin administration. DON or designee will monitor compliance with insulin administration with 2 return demonstrations weekly for 4 weeks, then monthly for 3 months. All new medication administration staff will be educated as part of the peer-to-peer check-off. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The DON is responsible for sustained compliance. The DON/designee will complete audits by reviewing 2 insulin administration demonstrations weekly for 4 weeks, then monthly for 3 months. The audit will be discussed at monthly QI meetings. QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance.	

	During an interview on 10/3/25 at 1:11 P.M., the Administrator indicated nursing staff should prime an insulin pen prior to administering insulin to residents. A current Humalog Kwikpen manufacturer's guide, revised July 2023, indicated " ... Prime before each injection ... if you do not prime before each injection, you may get too much or too little insulin ... " On 10/6/25 at 10:25 A.M., the Administrator indicated there was not a policy for insulin administration but they would follow the manufacturer's guidelines. Based on observation, interview, and record review, the facility failed to ensure that insulin was administered according to manufacturer's guidance. Insulin was administered from a Humalog Kwikpen without priming (eliminating air bubbles) the pen prior to insulin being administered to the resident for 1 of 1 residents reviewed for insulin administration. (Resident 115) Finding includes: On 10/2/25 at 12:28 P.M., Licensed Practical Nurse (LPN) 22 was observed checking his blood sugar and preparing insulin for Resident 115.		5. By what date will the systemic changes be completed? 10/27/2025	

Resident 115's blood sugar reading was 155. LPN 22 failed to prime the Humalog Kwikpen with two units of insulin prior to administering 2 units of insulin to Resident 115.

On 10/3/25 at 1:30 P.M., Resident 115's clinical record was reviewed. Diagnoses included, but was not limited to, diabetes mellitus type II.

Current physician orders included, but were not limited to, the following:

Humalog Kwikpen 100 units/milliliter (mL), inject subcutaneously three times a day per sliding scale: 151-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units, 401-450=12 units and notify Medical Doctor (MD).

During an interview on 10/3/25 at 1:11 P.M., the Administrator indicated nursing staff should prime an insulin pen prior to administering insulin to residents.

A current Humalog Kwikpen manufacturer's guide, revised July 2023, indicated " ... Prime before each injection ... if you do not prime before each injection, you may get too much or too little insulin ... "

On 10/6/25 at 10:25 A.M., the Administrator indicated there

	was not a policy for insulin administration but they would follow the manufacturer's guidelines.			
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 interview, observation, and record review, the facility failed to ensure food was stored in accordance with professional standards for 2 of 2 kitchen observations. Staff touched food with their bare hands, foods were not labeled properly, and bags were open to air in the freezer. Findings include: 1. During an observation on 10/2/25 at 9:44 A.M., the freezer was observed with the following items: Churros were in a bag that was open to air, no open date. The same was observed on 10/3/25 at 11:12 A.M.	R 0273	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: All items improperly stored were discarded immediately on 10/6/25. All kitchen staff were re-educated by Executive Director (ED) on 10/7/25 on proper food storage including dating of items to ensure knowledge & application. Hand washing education was completed by Director of Nursing (DON) on 10/7/25. Dining Service Director (DSD) verified appropriate temp logs and educated dining staff on 10/7/25. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents had the potential to be affected by this deficient practice. Auditing and staff education completed on 10/7/25. 3. What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur:	10/27/2025

	Unknown item was wrapped in a clear wrap, unlabeled and undated. Unknown item was wrapped in a clear wrap, unlabeled and undated. Homestyle pure beef hamburgers in a brown box open to air, no open date. During the same observation, the following were observed in the refrigerator: 14 Hot dogs were covered in plastic with a large cut on the bag and open to air, no open date. The same was observed on 10/3/25 at 11:12 A.M. A silver bowl with a clear plastic around it that was unlabeled and undated. Cheese slices in a clear bag that was unlabeled and undated. 2. The facility lacked a temperature log for October for the refrigerator, freezer, and the facility lacked a chemical test log for the dishwasher. 3. During an observation on 10/2/25 at 11:55 A.M., Cook 1 washed hands with less than 2 second lather, placed gloves on, and temped the following food items: chicken, gravy, peas, and mashed potatoes. After temping, Cook 1 did not change		Dining Service Director (DSD) educated all dining staff on appropriate temperatures and the temperature log, as well as infection control and food storage on 10/7/25. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The ED is responsible for sustained compliance. The ED/designee will complete audits by reviewing temperature log binder and food storage weekly for 4 weeks, then monthly for 3 months. The audit will be discussed at monthly QI meetings. QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. 5. By what date will the systemic changes be completed? 10/27/2025	

	gloves and used tongs and scoops to plate the food. Cook 1 then used the same gloved hands and tore the chicken off of the bone for a resident. Cook 1 removed her gloves, washed hands with less than 5 second lather, put on a new pair of gloves, and used the tongs and scoops to put the food on the plates. Using the same gloved hands, Cook 1 tore chicken off the bone, then she removed a plate with a hot dog out of the microwave. Again not changing gloves, she held the hot dog with her left hand to obtain the temperature of the hot dog. After that, she used both gloved hands to open a hot dog bun bag and grabbed a hot dog bun. Cook 1 failed to wash hands or change gloves between tasks or handing food. During an interview on 10/3/25 at 11:13 A.M., the Dietary Manager indicated food items should be labeled, items should not be open to air, staff should use scissors to cut the food off of the bone, food items should not be touched with soiled gloves, temperatures and the dishwasher chemical log should be logged daily, and hands should be washed according to the paper that was on the paper towel dispenser that indicated hands should be lathered for 20 seconds. On 10/5/25 at 10:25 A.M., the			

Administrator provided the following current policies:

Food Storage: " ...Food Service Director will inspect and ensure that all opened foods are properly dated and stored daily ...You must show the following information: Name of the food. Date of storage. Use by Date. Time of storage. Employee initial ..."

Infection Control-Hand Washing: "In all aspects of services, staff will comply with infection control practices that prevent or minimize the spread of infection, ensure the prevision of a safe, sanitary, and comfortable environment ...When employees should wash hands: 1) Before, during, and after preparing food ..."

Based on interview, observation, and record review, the facility failed to ensure food was stored in accordance with professional standards for 2 of 2 kitchen observations. Staff touched food with their bare hands, foods were not labeled properly, and bags were open to air in the freezer.

Findings include:

1. During an observation on 10/2/25 at 9:44 A.M., the freezer was observed with the following items:

Churros were in a bag that was

	open to air, no open date. The same was observed on 10/3/25 at 11:12 A.M. Unknown item was wrapped in a clear wrap, unlabeled and undated. Unknown item was wrapped in a clear wrap, unlabeled and undated. Homestyle pure beef hamburgers in a brown box open to air, no open date. During the same observation, the following were observed in the refrigerator: 14 Hot dogs were covered in plastic with a large cut on the bag and open to air, no open date. The same was observed on 10/3/25 at 11:12 A.M. A silver bowl with a clear plastic around it that was unlabeled and undated. Cheese slices in a clear bag that was unlabeled and undated. 2. The facility lacked a temperature log for October for the refrigerator, freezer, and the facility lacked a chemical test log for the dishwasher. 3. During an observation on 10/2/25 at 11:55 A.M., Cook 1 washed hands with less than 2 second lather, placed gloves on,			

	and temped the following food items: chicken, gravy, peas, and mashed potatoes. After temping, Cook 1 did not change gloves and used tongs and scoops to plate the food. Cook 1 then used the same gloved hands and tore the chicken off of the bone for a resident. Cook 1 removed her gloves, washed hands with less than 5 second lather, put on a new pair of gloves, and used the tongs and scoops to put the food on the plates. Using the same gloved hands, Cook 1 tore chicken off the bone, then she removed a plate with a hot dog out of the microwave. Again not changing gloves, she held the hot dog with her left hand to obtain the temperature of the hot dog. After that, she used both gloved hands to open a hot dog bun bag and grabbed a hot dog bun. Cook 1 failed to wash hands or change gloves between tasks or handing food. During an interview on 10/3/25 at 11:13 A.M., the Dietary Manager indicated food items should be labeled, items should not be open to air, staff should use scissors to cut the food off of the bone, food items should not be touched with soiled gloves, temperatures and the dishwasher chemical log should be logged daily, and hands should be washed according to the paper that was on the paper towel dispenser that indicated			

	hands should be lathered for 20 seconds. On 10/5/25 at 10:25 A.M., the Administrator provided the following current policies: Food Storage: " ...Food Service Director will inspect and ensure that all opened foods are properly dated and stored daily ...You must show the following information: Name of the food. Date of storage. Use by Date. Time of storage. Employee initial ..." Infection Control-Hand Washing: "In all aspects of services, staff will comply with infection control practices that prevent or minimize the spread of infection, ensure the prevision of a safe, sanitary, and comfortable environment ...When employees should wash hands: 1) Before, during, and after preparing food ..."			
R 0298	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(2) (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility;	R 0298	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: A refrigerator audit was completed on 10/6/25. All clinical staff were educated by Director of Nursing (DON) on 10/7/25 about refrigerator temperature log per policy.	10/27/2025

	(C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. Based on observation, interview, and record review, the facility failed to ensure safe medication storage practices for 1 of 1 medication storage rooms observed. The medication storage room and medication refrigerator temperatures were not taken and recorded daily on the log record. Finding includes: On 10/2/25 at 11:41 A.M., a Medication Room/Refrigerator Temperature Log Record for September 2025 was observed hanging on the medication storage room door in the nurse's office. There were extra insulin pens for the residents inside the refrigerator. At that time, Licensed Practical Nurse (LPN) 22 indicated staff were supposed to check the temperatures every day.		2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents had the potential to be affected by this deficient practice. All medications stored in the medication refrigerator were reviewed on 10/6/25. No residents were adversely affected. 3. What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur: DON re-education was completed on 10/7/25 with all medication administration staff about policy requiring refrigerator temperatures checks and log documentation. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The DON is responsible for sustained compliance. The DON/designee will complete audits by reviewing temperature logs weekly for 4 weeks, then monthly for 3 months. The audit will be discussed at monthly QI meetings.	

	The log record was reviewed and temperatures for the following days were not completed: 9/8/25 9/19/25 9/20/25 9/21/25 9/2625 9/27/25 9/2825 9/29/25 9/30/25 10/1/25 During an interview on 10/3/25 at 1:11 P.M., the Administrator indicated staff should be checking the medication storage room and medication refrigerator temperatures daily and recording them on the log record. On 10/3/25 at 1:11 P.M., a current Medication Storage Policy was requested but not provided during the survey period. Based on observation, interview, and record review, the facility failed to ensure safe medication storage practices for		QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. 5. By what date will the systemic changes be completed? 10/27/2025	

	1 of 1 medication storage rooms observed. The medication storage room and medication refrigerator temperatures were not taken and recorded daily on the log record. Finding includes: On 10/2/25 at 11:41 A.M., a Medication Room/Refrigerator Temperature Log Record for September 2025 was observed hanging on the medication storage room door in the nurse's office. There were extra insulin pens for the residents inside the refrigerator. At that time, Licensed Practical Nurse (LPN) 22 indicated staff were supposed to check the temperatures every day. The log record was reviewed and temperatures for the following days were not completed: 9/8/25 9/19/25 9/20/25 9/21/25 9/2625 9/27/25 9/2825 9/29/25			

	9/30/25 10/1/25 During an interview on 10/3/25 at 1:11 P.M., the Administrator indicated staff should be checking the medication storage room and medication refrigerator temperatures daily and recording them on the log record. On 10/3/25 at 1:11 P.M., a current Medication Storage Policy was requested but not provided during the survey period.			
R 0406	Infection Control - Offense 410 IAC 16.2-5-12(a) (a) The facility must establish and maintain an infection control practice designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of diseases and infection. Based on observation, interview, and record review, the facility failed to ensure the use of safe and sanitary environment to help prevent the development and transmission of diseases and infection for 3 of 5 medication passes observed. Gloves were not worn during insulin administration. Hands were not sanitized prior to or after medication	R 0406	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: On 10/6/2025 Director of Nursing (DON) provided education to LPN-22 on infection control practices with medication administration. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents had the potential to be affected by this deficient practice. On 10/10/2025 DON provided education to all med passers on infection control related to	10/27/2025

	administration. (Resident 115, Resident 201, Resident 122) Findings include: 1. On 10/2/25 at 12:28 A.M., Licensed Practical Nurse (LPN) 22 was observed checking a blood sugar and preparing insulin for Resident 115. Resident 115's blood sugar reading was 155. LPN 22 failed to use hand hygiene prior to and after administering insulin. She also failed to wear gloves while administering insulin to Resident 115. 2. On 10/2/25 at 11:37 A.M., LPN 22 was observed prepping and passing medications to Resident 201. LPN 22 failed to use hand hygiene prior to and after administering her medications. 3. On 10/3/25 at 11:22 A.M., LPN 22 was observed prepping and passing medications to Resident 122. LPN 22 failed to use hand hygiene prior to and after administering her medications. During an interview on 10/3/25 at 1:11 P.M., the Administrator indicated nursing staff should sanitize their hands before and after passing medications to residents and gloves should be worn when administering insulin. On 10/6/25 at 10:27 A.M., the		medication administration. 3. What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur: On 10/6/2025 LPN-22 received a written disciplinary action related to infection control of medication administration. On 10/10/2025 DON completed education for all med passers related to infection control during medication administration. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The DON is responsible for sustained compliance. The DON/designee will complete infection control audits r/t medication administration weekly for 4 weeks, then monthly for 3 months. The audit will be discussed at monthly QI meetings. QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. 5. By what date will the systemic changes be completed?	

	Administrator indicated they did not have a policy about hand sanitizing between medication passes, but that would be their policy. Based on observation, interview, and record review, the facility failed to ensure the use of safe and sanitary environment to help prevent the development and transmission of diseases and infection for 3 of 5 medication passes observed. Gloves were not worn during insulin administration. Hands were not sanitized prior to or after medication administration. (Resident 115, Resident 201, Resident 122) Findings include: 1. On 10/2/25 at 12:28 A.M., Licensed Practical Nurse (LPN) 22 was observed checking a blood sugar and preparing insulin for Resident 115. Resident 115's blood sugar reading was 155. LPN 22 failed to use hand hygiene prior to and after administering insulin. She also failed to wear gloves while administering insulin to Resident 115. 2. On 10/2/25 at 11:37 A.M., LPN 22 was observed prepping and passing medications to Resident 201. LPN 22 failed to use hand hygiene prior to and after administering her medications.		10/27/2025	

	3. On 10/3/25 at 11:22 A.M., LPN 22 was observed prepping and passing medications to Resident 122. LPN 22 failed to use hand hygiene prior to and after administering her medications. During an interview on 10/3/25 at 1:11 P.M., the Administrator indicated nursing staff should sanitize their hands before and after passing medications to residents and gloves should be worn when administering insulin. On 10/6/25 at 10:27 A.M., the Administrator indicated they did not have a policy about hand sanitizing between medication passes, but that would be their policy.			

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 SIGNATUREYoko Swanson	TITLEExecutive Director RCA	(X6) DATE10/21/2025