

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 PRIMROSE RETIREMENT COMMUNITY OF ANDERSON		STREET ADDRESS, CITY, STATE, ZIP CODE 1118 W CROSS ST, ANDERSON, , 46011		
(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: July 22, 23, and 24, 2026 Facility number: 011806 Residential Census: 36 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed July 31, 2026.	R 0000		
R 0045	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(r)(6-9) (6) Before an interfacility transfer or discharge occurs, the facility must, on a form prescribed by the department, do the following: (A) Notify the resident of the transfer or discharge and the reasons for the move, in writing, and in a language and manner that	R 0045	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. The DON, or designee, will complete and document all identified corrections in the affected residents'	08/03/2026

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the resident understands. The health facility must place a copy of the notice in the resident ' s clinical record and transmit a copy to the following: (i) The resident. (ii) A family member of the resident if known. (iii) The resident ' s legal representative if known. (iv) The local long term care ombudsman program (for involuntary relocations or discharges only). (v) The person or agency responsible for the resident ' s placement, maintenance, and care in the facility. (vi) In situations where the resident is developmentally disabled, the regional office of the division of disability, aging, and rehabilitative services, who may assist with placement decisions. (vii) The resident ' s physician when the transfer or discharge is necessary under subdivision (4)(C), (4)(D), (4)(E), or (4)(F). (B) Record the reasons in the resident ' s clinical record. (C) Include in the notice the items described in subdivision (9). (7) Except when specified in subdivision (8), the notice of transfer or discharge required under subdivision (6) must be made by the facility at least thirty	medical records. 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. • The facility has identified that potentially any resident who discharges can be affected by this deficiency. • The corrective actions above will be applied to 100% of resident discharges, effective immediately. What measure will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur. The facility reviewed its "Resident Discharge" policy with no changes. To support consistent discharge planning and regulatory compliance, the DON, or designee, will schedule a care plan meeting upon receipt or issuance of a discharge notice, whether initiated by the resident or responsible party or issued by the facility. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance	
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(30) days before the resident is transferred or discharged. (8) Notice may be made as soon as practicable before transfer or discharge when: (A) the safety of individuals in the facility would be endangered; (B) the health of individuals in the facility would be endangered; (C) the resident ' s health improves sufficiently to allow a more immediate transfer or discharge; (D) an immediate transfer or discharge is required by the resident ' s urgent medical needs; or (E) a resident has not resided in the facility for thirty (30) days. (9) For health facilities, the written notice specified in subdivision (7) must include the following: (A) The reason for transfer or discharge. (B) The effective date of transfer or discharge. (C) The location to which the resident is transferred or discharged. (D) A statement in not smaller than 12-point bold type that reads, " You have the right to appeal the health facility ' s decision to transfer you. If you think you should not have to leave this facility, you may file a written request for a hearing with the Indiana state department of		program will be put into place. - The ED, or designee, will conduct and document audits of all resident discharges weekly for 2 months, every two weeks for the subsequent 2 months, and monthly for the following 2 months. Audit findings will be reviewed during the monthly QA meeting By what date the systemic changes will be completed. - September 1, 2026.	
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	health postmarked within ten (10) days after you receive this notice. If you request a hearing, it will be held within twenty-three (23) days after you receive this notice, and you will not be transferred from the facility earlier than thirty-four (34) days after you receive this notice of transfer or discharge unless the facility is authorized to transfer you under subdivision (8). If you wish to appeal this transfer or discharge, a form to appeal the health facility's decision and to request a hearing is attached. If you have any questions, call the Indiana state department of health at the number listed below. " . (E) The name of the director and the address, telephone number, and hours of operation of the division. (F) A hearing request form prescribed by the department. (G) The name, address, and telephone number of the state and local long term care ombudsman. (H) For health facility residents with developmental disabilities or who are mentally ill, the mailing address and telephone number of the protection and advocacy services commission. Based on interview and record review, the facility failed to ensure a care plan meeting was held regarding discharge planning and was included in the medical record for 2 of 2 residents reviewed for			
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discharge. (Resident 38 & 39)

Findings include:

1. Resident 38's clinical record was reviewed on 7/23/26 at 2:43 p.m. A discharge planning worksheet, dated 7/13/26 and signed by the DON, indicated the resident was discharging to another assisted living facility.

A 7/13/26 notice of transfer/discharge document indicated the resident was discharging to another facility. The document lacked a reason for discharge and documentation of who the transfer rights were reviewed with.

2. Resident 39's clinical record was reviewed on 7/24/26 8:57 a.m. The clinical record lacked documentation regarding discharge planning and transfer/discharge to another facility on 7/13/26.

During an interview, on 7/24/26 at 10:59 a.m., the DON indicated the clinical record should include where a resident was transferred/discharge to, the reason for discharge, who the residents left with, an inventory of resident belongings, and a recapitulation of the resident's stay.

During an interview, on 7/24/26 at 11:06 a.m., LPN 8 indicated

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	when a resident transferred to another facility, a personal inventory, discharge summary, ombudsman paperwork, and any other applicable documents are reviewed with the resident and/or their representative. Those documents are sent with the resident and communicated via telephone to the receiving facility. The review and transmission of the documents was then documented in a progress note. A current facility policy titled, "Resident Discharge," provided by the Administrator on 7/24/26 at 11:02 a.m. indicated the following: " ...1.Upon notification of a move-out, enter the information regarding the move-out in the accounting system. 2. A physician ' s order must be obtained for all discharges (does not include transfers to hospitals with subsequent transfers to higher level of care).3. When the resident moves to another location provide the resident and/or his/her family/legal advocate with copies of the resident's most current physician orders, medication record and service plan as requested in accordance with the resident ' s release of records form. A Discharge Summary (may be state specific form) and Discharge Planning Worksheet (if state required) are			
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completed. Copies of these documents are sent to the receiving facility and the originals kept in the Primrose resident medical record. It should be determined whether medications should be given to the resident, returned to the pharmacy or sent to the new facility directly. Record this in the resident ' s chart and on the Medication Release/Receipt Form. Refer to the Personal Inventory Form (in applicable States) to assure the resident ' s belongs are accounted for ...8. Collect all resident records. Place them in a folder to be archived. Resident records should be archived for the period of time required by your state ' s statutes of limitations. Keep these archived records in a secure location. The contents of the files/boxes (water resistant containers) should be clearly marked "

R 0089

Administration and Management - Noncompliance

410 IAC 16.2-5-1.3(e)(1-2)(f)

(e) An administrator shall be employed to work in each licensed health facility. For purposes of this subsection, an individual can only be employed as an administrator in one (1):

(1) health facility; or

R 0089

We respectfully request an IDR on this tag due to the fact that under our current organizational structure we do meet the requirements of this standard. We have been approved during all past annual ISDH surveys under the existing structure where both AL and MC have separate and distinct RCA Executive Directors and Directors of Nursing

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(2) hospital-based long-term care unit; at a time. (f) In the administrator's absence, an individual shall be authorized, in writing, to act on the administrator's behalf. Based on observation, interview, and record review, the facility failed to ensure the administrator was employed in a full-time capacity dedicated to only one facility's day to day operations. This deficient practice had the potential to affect 36 of 36 residents residing in the facility. Findings include: On 7/22/26 at 4:00 p.m., it was observed that Primrose Retirement Community of Anderson was a free standing assisted living facility. Primrose Retirement Community of Anderson was located on Cross Street. "Facility 2" was on Madison Avenue. The sidewalk allowing access from one facility to the other was approximately one city block in length. Review of Indiana Department of Health facility licensure information indicated Primrose Retirement Community of Anderson's operating license number was 26118061 and Facility 2's operating license	dedicated to their respective program. The dual licensure was originally pursued, to my understanding, because the ISDH directed us to adopt this structure because two different investor groups hold ownership in the buildings, one group for each (One for MC, one for AL). This year I queried Standards to determine the "why" of this structure and was advised that nothing in the current ISDH regulations for Residential Care required our current "separate but equal" structure. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. Leadership assignments were reviewed with regional leadership. A licensed administrator has been designated for Primrose Memory Care of Anderson with authority for the facility's day-to-day operations. Documentation of administrator licensure, designation, and authority will be maintained on-site. How the facility will identify other residents having the potential to be affected by the same deficient practice	
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number was 25138111 . During an interview on 7/22/26 at 10:40 a.m., Administrator 1 indicated he was the Executive Director over "Primrose Retirement Communities of Anderson" which was the combination of Primrose Retirement Community of Anderson and "Facility 2". He was the Administrator/Executive Director of Primrose Retirement Community of Anderson and was to offer Administrative oversight to Facility 2 until a Memory Care Director was hired. After a Memory Care Director was hired, he would have Administrative oversight over that director. An email statement by Administrator 1 on 7/22/26 at 3:53 p.m. indicated Administrator 1 was the administrator for both Primrose Retirement Community of Anderson and Facility 2. Confidential interviews were conducted during the survey. The confidential interviews indicated the following regarding leadership for Primrose Retirement Community of Anderson: a. For over 10 years, the Administrator over Primrose Retirement Community of Anderson had been the	and what corrective action will be taken. All residents had the potential to be affected. No resident-specific adverse outcome was identified. The facility reviewed administrator coverage and operational oversight to ensure a designated licensed administrator is assigned to the Memory Care facility. What measure will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur. The organizational structure, key personnel list, and administrator job description/assignment documentation will be reviewed and revised as needed to reflect a licensed administrator responsible for the Memory Care facility. Required notifications to the State will be completed when administrator changes occur. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put int place. Leadership will audit administrator designation, licensure, and State notification documentation monthly for three months, then quarterly for two	
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	Administrator over both buildings, including Facility 2. b. The company ran the two facilities as one campus with one leadership team. c. In the past few years, (former) Administrator 2, (former) Administrator 3, and (former) Administrator 4 had an office in Primrose Retirement Community of Anderson had been the Executive Director/Administrator for both buildings.		additional quarters. Findings will be reviewed through the quality assurance process and corrective action will be taken for any identified noncompliance. By what date the systemic changes will be completed. August 31, 2026	
R 0092	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(i)(1-2) (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded	R 0092	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice.	08/03/2026

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	announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on record review and interview, the facility failed to ensure a fire drill was conducted on every shift quarterly to ensure resident safety in the event of a fire emergency. This had the potential to affect 36 of 36 residents in the facility. Findings include: During an interview, on 7/22/26 at 9:00 a.m., the Administrator was requested to provide all fire drills since the previous annual survey to current during the entrance conference. During an interview, on 7/22/26 at 2:40 p.m., the Administrator indicated he would separate the two separate buildings' fire drills (Primrose Retirement Community of Anderson and Facility 2). The Maintenance Director was not present but would be available on 7/23/26. The Maintenance Director may have documentation of additional fire drills.		- The new Executive Director will monitor compliance with the fire drill requirement monthly and personally sign off each fire drill immediately after it is completed, in accordance with the company Fire Drill policy. The Executive Director will ensure that all fire drills occur timely relative to the company-provided calendar to ensure no drills are inadvertently missed. 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. - The ED or designee will coordinate and schedule fire drills on a monthly basis, with support from the PMT, in accordance with facility policy and applicable regulatory requirements. 100% of residents could be affected by the same deficient practice, so the above plan of correction will apply to all residents. What measure will be put into place or what systemic changes will the facility make to ensure	
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During an interview, on 7/23/26 at 10:58 a.m., the Maintenance Director indicated he conducted the fire drills, but he had only been at the facility since April 2026. He provided the fire drills he had completed since April. He did not have documentation of additional fire drills prior to his employment. The completed fire drill logs were required to include date, time, shift, signatures of those in attendance, situation during the drill, and location of the drill. Fire drills were required monthly, with shifts rotated, to ensure each shift had a fire drill every quarter. The facility had a schedule they followed for the fire drills. He was uncertain if the facility had completed the fire drills each quarter according to the schedule because he had not been there that long.

The records indicated the following: the third quarter of 2025 lacked a fire drill on third shift. The fourth quarter of 2025 lacked a second shift drill and lacked signatures of who attended the first shift drill. The first quarter of 2026 lacked a third shift drill. The second quarter of 2026 lacked a first shift drill.

that the deficient practice does not recur.

- The facility completed a review of its "Fire Drills" policy with no changes.

How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put in place.

- The ED, or designee, will conduct audits of fire drills monthly for 2 months, then every other month for two months, and quarterly for the following six months. Audit findings will be reviewed during the monthly QA meetings.

By what date the systemic changes will be completed.

- September 1, 2026.

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	The facility "Fire Drill Schedule," provided by the Maintenance Director on 7/23/26 at 11:45 a.m., indicated the following: First shift fire drills: January, April, July, and October Second shift fire drills: February, May, August, and November Third shift fire drills: March, June, September, and December During an interview, on 7/23/26 at 12:53 p.m., the Administrator indicated all fire drills were provided that were completed. The fire drills should have been completed entirely without missing information. Each quarter a fire drill was required on first, second, and third shifts. They were also required to follow the fire drill schedule. A current facility policy, revised 3/13/25, titled "Fire Drills," provided by the Administrator on 7/23/26 at 4:57 p.m., indicated the following: "Purpose: The purpose of this policy is to establish guidelines for conducting fire drills within our organization. This policy aims to ensure staff preparedness, resident safety, and proper response in the event of a fire emergency by simulating fire conditions through regular drills ... Procedure: 1. The Executive Director or designee will ensure			
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	drills are scheduled monthly (or as required by State regulations) at designated times on each shift and under various circumstances which simulate actual fire conditions"			
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.	R 0117	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. - The DON, or designee, will review the current staffing schedule to verify that at least one staff member with current First Aid and CPR certification is assigned to each shift. 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. 100% of residents have the potential of being affected by this policy. - The corrective actions above will be applied to 100% of resident discharges, effective immediately.	08/03/2026

	Based on interview and record review, the facility failed to ensure the presence of staff certified in First Aid/CPR for 2 of 21 shifts reviewed. Findings include: First Aid/CPR certifications were reviewed on 7/23/26 at 2:02 p.m. On 7/23/26 at 2:18 p.m. the DON added additional certifications to the provided First Aid/CPR binder. On 7/24/26 at 10:33 a.m., the nursing schedule for 7/16/26 through 7/23/26 indicated no First Aid certified staff were present for 7/18/26 on second shift and no CPR or First Aid certified staff were present in the building for 7/20/26 on third shift. During an interview on 7/24/26 at 11:13 a.m., the DON indicated First Aid and CPR certified staff should be present in the building 24 hours a day , seven days a week. A current facility policy titled, "Life Safety Training", provided by the Administrator on 7/24/26 at 1:16 p.m., indicated the following: "... Purpose: The purpose of this policy is to establish guidelines for life		What measure will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur. - The facility reviewed its "Life Safety Training" and "Cardiopulmonary Resuscitation (CPR)" policies with no changes. First Aid and CPR class is scheduled for 9/13/26 and 9/14/26. The DON, or designee, will review staff certification records monthly to identify First Aid and CPR certifications scheduled to expire within the following 30 days and facilitate timely renewal. Prior to publication of the staffing schedule, the DON, or designee, will review and verify that each shift includes at least one staff member with current First Aid and CPR certification. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put int place. - The ED, or designee, will conduct and document staffing audits twice a week for 1 month, then	
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	safety training to ensure the safety and wellbeing of all staff members within our organization. By providing relevant safety training, this policy aims to equip staff with the necessary knowledge and skills to respond effectively to potential life safety situations, thereby ensuring a secure environment for both employees and residents...3. Staff are required to maintain current certification/training for CPR and First Aid, in accordance with state regulations. At least one staff member who has CPR and First Aid training/certification should be on duty at all times unless otherwise required by state regulation...."		weekly for 1 month, and monthly for the following three months to verify that each shift includes at least one staff member with current First Aid and CPR certification. Audit findings will be reviewed during the monthly QA meeting. By what date the systemic changes will be completed. • August 13, 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 and interview, the facility failed to ensure food was stored properly to prevent foodborne illness. This deficient practice had the potential to affect 36 of 36 residents who received meals	R 0273	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. • The circular breaded patties, a commercial coffee shop cup, breaded okra, a plastic water bottle containing a frozen red substance, an unidentifiable meat, and frozen broccoli and cauliflower were discarded in the trash. How the facility will identify other	08/03/2026

	from the facility kitchen. Findings include: A kitchen tour, on 7/22/26 at 9:27 a.m., accompanied by the Dietary Manager, indicated the following regarding a large cabinet style freezer: Within door 7, a plastic bag containing circular breaded patties was opened to air. No opened or use by date was present on the bag. A commercial coffee shop cup was present on the top shelf. A bag labeled, "Breaded Okra" was open to air, with no opened or use by date. Within door 6, an unlabeled standard plastic water bottle containing a frozen red substance was present on the top shelf. On the second shelf of door 6, a large, unlabeled plastic bag of unidentifiable meat had no opened or use by date. A large plastic bag of frozen broccoli and cauliflower with no opened or use by date was on the same shelf.		residents having the potential to be affected by the same deficient practice and what corrective action will be taken. - The Dining Services Director completed an audit of all food storage areas. Any item that was improperly labeled, exposed to air, missing an opening or use-by date, or beyond its expiration date was immediately discarded in the trash. What measure will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur. - The facility reviewed without change its policy "Community Food-Labeling and Dating." Dining Services Director will provide additional in-service to all dining services staff by the end of August 2026. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put int place. - The Dining Services	
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	During an interview, at the time of the observation, the Dietary Manager indicated they were unsure why the unlabeled food remained in the freezer. During a kitchen tour on 7/23/26 at 8:46 a.m., the unlabeled foods and coffee cup remained. During an interview, at the time of the observation, the Dietary manager indicated no employee food or drinks should be in the food preparation areas and all food items should be clearly labeled and dated. A current facility policy titled, "Community Food- Labeling and Dating," provided by the Administrator on 7/23/26 at 10:10 a.m., indicated the following: "Purpose: To ensure appropriate rotation of ready-to-eat food and non-perishable foods to prevent or reduce foodborne illness ...General Principals: 1. Establish a date marking system and train employee accordingly. The best practice for a date marking system would be to include a label with the product name, the date it was prepared or opened ...2. Label ready-to-eat, potentially hazardous food that are prepared on-site and held for more than 24 hours. 3. Label any processed, ready-to-eat, potentially hazardous foods when opened, if they are to be		Director, or designee, will conduct audits of all food storage areas and labeling practices daily for 1 month, weekly for the subsequent 2 months, and every other week for the following 2 months. Designated staff will perform daily verification to ensure that all applicable food items are properly date-marked and that perishable foods exceeding the 7-day storage limit are neither retained nor used, in accordance with the facility's "Community Food—Labeling and Dating" policy. Audit findings will be reviewed during the facility's monthly QA meeting. The ED will review audit results with the Dining Services Director at their bi-weekly standing meeting – review, sign and date the surveillance data. He will address with the Dining Service Director any noted discrepancies from the policy. By what date the systemic changes will be completed. September 1, 2026	
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	held for more than 24 hours ...6. Serve or discard refrigerated, ready-to-eat, potentially hazardous foods within 7 days. 7. Indicate with a separate label the date prepared, the date frozen, and the date thawed of any ready-to-eat, potentially hazardous foods ...9. Follow State and local public health requirements. Monitoring: A designated employee will check daily to verify that foods are date marked appropriately and that perishable foods exceeding the 7-day time period are not being used or stored. Corrective Measure: 1. Foods that are not date marked or that exceed the 7-day time period will be discarded"			
R 0295	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(a) (a) Residents who self-medicate may keep and use prescription and nonprescription medications in their unit as long as they keep them secured from other residents. Based on observation, record review, and interview, the facility failed to ensure medications were secured in the resident's room for a resident who self-administered medications for 1 of 1 resident reviewed for medication self-administration.	R 0295	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. The identified resident received re-education regarding the facility's "Medication Storage in Resident Apartment" and "Resident Self-Management of Medications and Assessment" policies. Education is documented in the resident record.	08/03/2026

(Resident 28)

Finding includes:

On 7/22/26 at 12:21 p.m., Resident 28's room door was open. A plastic pill box (four rows of weekly pills with different colored lids for each time of day) organizer was on the counter and not secured. Multiple pills for Wednesday, Thursday, and Friday were observed in separate rows of the pill box. During an interview with Resident 28, at the time of the observation, she indicated she typically kept her medications on her counter unsecured. She did not lock up her medications when she was out of her room, nor lock her door when she was out of her room. She had just returned to the building from going out to eat. No one told her to keep her medications locked up in her room.

Resident 28's clinical record was reviewed on 7/22/26 at 12:52 p.m. Current orders included, atorvastatin (cholesterol) 20 milligrams (mg) by mouth once daily in the evening (10/23/25), bisoprolol fumarate(blood pressure/heart rate) 5 mg by mouth once daily (10/23/25), carbidopa/levodopa (Parkinson's disease) extended release 25-100 mg by mouth twice daily (10/23/25), apixaban (blood thinner) 5 mg by mouth

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 who self-administer medications will receive re-education regarding the facility's "Medication Storage in Resident Apartment" and "Resident Self-Management of Medications and Assessment" policies. The DON, or designee, will provide the education and document its completion in each resident's medical record.

What measure will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur.

- The facility completed a review of its "Medication Storage in Resident Apartment" and "Resident Self-Management of Medications and Assessment" policies with no changes needed. The DON, or designee, will incorporate

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FORM APPROVED

OMB NO. 0938-0391

twice daily (10/23/25), dapagliflozin (diabetes mellitus) 10 mg by mouth once daily (11/24/25), irbesartan (blood pressure) 75 mg by mouth once daily (10/23/25), and magnesium oxide (acid reflux) 250 mg by mouth once daily.

A 5/25/26, service plan indicated the resident remained independent with medication administration.

A 6/3/26, Medication Self-Administration Assessment indicated Resident 28 resident was required to maintain safe storage of medications per policy/regulations.

During an observation, on 7/23/26 at 2:09 p.m., Resident 28's room door was closed and unlocked. During an interview at the time of the observation, LPN 3 indicated the pill organizer was unsecured on the counter and had multiple pills in the organizer for Thursday and Friday. Residents who self-administered medications were required to keep their medication put away and locked to prevent others from getting medications that do not belong to them.

During an interview, on 7/23/26 at 3:29 p.m., the DON indicated Resident 28 self-administered her medications. The resident's medications should have been

individualized interventions into the care plan of each resident who self-administers medications, directing staff to verify daily and during routine observations that medications are securely stored within the resident's apartment. Any identified noncompliance will be documented in the resident's medical record and promptly communicated to the ED. If a resident remains noncompliant despite education and redirection, the facility will obtain and follow the resident's primary care provider's clinical recommendation. When that recommendation establishes a more restrictive safety standard than the preferences expressed by the resident's representative or facility staff, it will remain in effect unless subsequently modified in writing by the primary care provider.

How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put in place.

- Following completion of resident re-education, the ED, DON, or designee will inspect each applicable apartment to

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secured in a cabinet or drawer in the resident's room.

A current facility policy, revised 12/31/18, titled "Resident Self-Administration of Medications with Assistance from the Community Staff," provided by the Administrator on 7/23/26 at 3:52 p.m., indicated the following: "Purpose: ...The policy aims to promote resident autonomy and independence while maintaining safety and compliance with relevant state laws and regulations ...Policy Statement: The community is committed to promoting resident autonomy and dignity by allowing self-administration of medications whenever possible. However, the safety and well-being of residents remain paramount, and decisions regarding medication assistance will be based on a comprehensive evaluation of the resident's capabilities with state regulations "

verify that all medications are securely stored in a locked location. Compliance findings will be documented in each resident's medical record and reviewed during the facility's monthly QA meeting to evaluate sustained compliance and determine whether additional corrective action is warranted. The DON, or designee, will conduct audits of 3 apartments occupied by residents who self-administer medications each week for 1 month, every other week for the subsequent 2 months, and monthly for the following 3 months. The audits will be reviewed at the monthly QA meetings.

By what date the systemic changes will be completed.

- September 1, 2026

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 SIGNATUREDan Fink	TITLEExecutive Director	(X6) DATE08/17/2026
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