STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STORYPOINT GRANGER	6330 N FIR RD, GRANGER, , 46530

(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 7, 8, and 9, 2025 Facility number: 012229 Census Bed Type: Residential: 133 Census Payor Type: Other: 133 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review completed on 10/17/2025	R 0000		
R 0144	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(a) (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and	R 0144	R144- Sanitation and Safety Standards – Deficiency This Plan of Correction is submitted in accordance with regulatory requirements and does not constitute an	10/31/2025

	shall provide reasonable comfort for all residents. Based on observation and interview, the facility failed to maintain the carpeting in good repair for 2 of 3 floors. (1st and 2nd floor) Finding includes: During an observation on 10/7/2025 at 1:21 P.M., the carpet outside the 2nd floor east elevator was buckled, frayed, and a portion had been taped down to the floor. The high traffic areas of the 1st floor carpeting near the activity room, dining room and the east elevator was stained with dark colored discoloration and dirt. During an interview on 10/9/2025 at 11:04 A.M., the Maintenance Lead indicated on 10/14/2025, the carpet manufacturer was scheduled to come to the facility to train them on cleaning and maintaining the carpets. He indicated he was aware of the tape on the carpet, but not the buckling and wrinkles. He indicated the buckled and wrinkled carpet presented a trip hazard for the residents. On 10/9/2025 at 11:15 A.M. the Maintenance Lead provided a current policy dated 2/27/2023 and titled, "Carpet Cleaning Schedule." The policy indicated,		admission of fault. The facility respectfully requests a **desk review in lieu of a post-survey revisit.** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** **The carpet outside the 2nd floor east elevator was re-seamed and glued to eliminate buckling and eliminate unsafe condition. The high traffic areas of the 1st floor carpeting near the activity room, dining room, and the east elevator were extracted to remove dark colored discoloration and dirt.** ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:***	

	"...The housekeeping lead will be utilizing the carpet cleaning schedule to identify areas around the community that will need specific carpet cleaning frequencies...." Based on observation and interview, the facility failed to maintain the carpeting in good repair for 2 of 3 floors. (1st and 2nd floor) Finding includes: During an observation on 10/7/2025 at 1:21 P.M., the carpet outside the 2nd floor east elevator was buckled, frayed, and a portion had been taped down to the floor. The high traffic areas of the 1st floor carpeting near the activity room, dining room and the east elevator was stained with dark colored discoloration and dirt. During an interview on 10/9/2025 at 11:04 A.M., the Maintenance Lead indicated on 10/14/2025, the carpet manufacturer was scheduled to come to the facility to train them on cleaning and maintaining the carpets. He indicated he was aware of the tape on the carpet, but not the buckling and wrinkles. He indicated the buckled and wrinkled carpet presented a trip hazard for the residents. On 10/9/2025 at 11:15 A.M. the Maintenance Lead provided a		**All residents have the potential to be affected by the deficient practice.** ***What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur:*** **Maintenance and Housekeeping staff were educated on Environmental Safety Checks Preventative Maintenance Policy, Common Area Carpet Cleaning Schedule, and ShawContract Carpet Maintenance Checklist** ***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 in place:*** **Maintenance Director/Designee will audit common area carpets 3x weekly for 1 month and 1x**	

	current policy dated 2/27/2023 and titled, "Carpet Cleaning Schedule." The policy indicated, "...The housekeeping lead will be utilizing the carpet cleaning schedule to identify areas around the community that will need specific carpet cleaning frequencies...."		**weekly for 3 months. Any deficiencies that pose a safety hazard or are overly soiled will be corrected immediately.** ***By what date the systemic changes will be completed:*** **10/31/2025**	
R 0154	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(k) (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation, interview and record review,the facility failed to ensure kitchen cooking equipment was maintained in a sanitary manner, including the ovens and the char broiler for 1 of 3 kitchen/kitchenettes observed. (Main Kitchen) This had the potential to affect 133 of 133 residents who received food from the kitchen.	R 0154	R154- Sanitation and Safety Standards – Deficiency This Plan of Correction is submitted in accordance with regulatory requirements and does not constitute an admission of fault. The facility respectfully requests a**desk review in lieu of a post-survey revisit.** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** **The char broiler and ovens in main kitchen were thoroughly cleaned** ***How other residents having the potential to be***	10/31/2025

	Finding includes: During the initial tour of the Main Kitchen, on 10/7/2025 at 10:05 A.M. with the Executive Chef, the char broiler and two ovens had a heavy build-up of a black substance on the cooking surfaces and insides of the overs. During a follow-up visit of the Main Kitchen, on 10/8/2025 at 10:15 A.M. with the Dining Supervisor (DS), the char broiler and two ovens continued to have a heavy build-up of a black substance on the cooking surfaes and insides of the ovens. During an interview with the DS,on 10/9/2025 at 10:20 A.M., the DS acknowledged the build up of a black substance on the char broiler and two ovens. The DS indicated the facility used checklists and the ovens were cleaned monthly and the char grill should have been cleaned once a week. However, the DS indicated the char grill was a newer purchase and the grill had not been added to the cleaning schedule yet. On 10/8/2025 at 1:45 P.M., the Executive Director (ED) provided an undated checklist titled, "Cleaning List" and identified it as the cleaning list currently used by the facility. The cleaning list indicated,		***affected by the same deficient practice will be identified and what corrective action(s) will be taken:*** **All residents have the potential to be affected by the deficient practice.** ***What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur:*** **Culinary staff were educated that all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair.** **Staff were educated on kitchen cleaning list and char broiler was added to weekly kitchen cleaning list.** ***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 in place:*** **Executive Chef/Designee will conduct daily inspections of kitchen equipment for cleanliness for 1 month and then 2x weekly for 3 months.** **Executive chef will review completed kitchen cleaning logs**	

	"Ovens would be cleaned monthly...." On 10/8/2025 at 1:45 P.M., the ED provided a policy, dated 2/8/2022 and titled, "Cleaning Log Schedule." The ED indicated the policy was the one currently used by the facility. The policy indicated, "...1. Purpose. The purpose of the Cleaning Log Schedule is to ensure that our kitchens are maintaining a level of safety and sanitation upheld in our audits...4. Procedure. 1. The Cleaning Log is to be performed and checked daily during each shift....4. Follow up of leader to hold culinary employees accountable for results...." Based on observation, interview and record review,the facility failed to ensure kitchen cooking equipment was maintained in a sanitary manner, including the ovens and the char broiler for 1 of 3 kitchen/kitchenettes observed. (Main Kitchen) This had the potential to affect 133 of 133 residents who received food from the kitchen. Finding includes: During the initial tour of the Main Kitchen, on 10/7/2025 at 10:05 A.M. with the Executive Chef, the char broiler and two ovens had a heavy build-up of a black substance on the cooking surfaces and insides of the		**weekly for 3 months to ensure compliance with cleaning schedules and sanitation standards.** ***By what date the systemic changes will be completed:*** **10/31/2025**	

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R 0246	Health Services - Deficiency 410 IAC 16.2-5-4(e)(6) (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. 2. The clinical record for Resident 5 was reviewed on 10/8/2025 at 10:15 A.M. Resident 5's current medications include: Ondansetron HCL Tablet 4 mg (milligrams), give 1 tablet by mouth every 6 hours as needed for nausea and vomiting. The July 2025 Medication	R 0246	R246- Health Services - Deficiency This Plan of Correction is submitted in accordance with regulatory requirements and does not constitute an admission of fault. The facility respectfully requests a**desk reviewin lieu of a post-survey revisit.** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** **The QMAs involved in the cited incidents were re-educated on the facility's "Medication as Needed (PRN)" Policy, emphasizing that nurse authorization must be**	10/31/2025

	Administration Record (MAR) indicated Resident 5 received Ondansetron HCl on 7/15/2025, administered by a QMA. The August 2025 MAR indicated Resident 5 received Ondansetron HCl from a QMA on the following days: 8/11/2025, 8/21/2025 and 8/23/2025, administered by a QMA. Resident 5's clinical record lacked the documentation the QMA had received prior authorization of the administration of Ondansetron HCl from a licensed nurse. During an interview, on 10/9/2025 at 10:15 A.M., the Assistant Director of Wellness indicated she was unable to locate documentation in the Electonic Medical Record (EMR) regarding nurse permission for the PRN's given by QMAs on the following dates: 7/15/2025, 8/11/2025, 8/21/2025 and 8/23/2025. During an interview, on 10/9/2025 at 10:20 A.M., QMA 2 indicated the QMA should have followed a process for administering a PRN medication. QMA 2 indicated she would have asked the resident to rate their pain or describe their symptoms and then called the nurse for permission to administer a		**obtained prior to each PRN administration.** **Resident 5 and Resident 9's medication records were reviewed to confirm no adverse effects related to the PRN administrations.** ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:*** **All residents receiving PRN medications have the potential to be affected** ***What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur:*** **All QMAs and licensed nursing staff were re-educated on the PRN Medication Authorization Policy, including the procedure for contacting the nurse, triage nurse, obtaining approval, and documenting the interaction in the**	

	medication. If there was no nurse at the facility, she would have called the Triage service and notified them of the resident's symptoms, then she would have documented nurse permission to administer the medication in the EMR. On 10/8/2025 at 2:11 P.M., the Director of Wellness provided a policy titled, "Medication as Needed (PRN)," dated 5/18/2022 and indicated the policy was the one currently used by the facility. The policy indicated, "...Administer previously ordered pro re nata (PRN) medication only if authorization is obtained from the facility's licensed nurse on duty or on call. If authorization is obtained, the QMA must do the following...Document in the resident record that the facility's licensed nurse was contacted..." Based on record review and interview, the facility failed to ensure a PRN (as needed) medication administered by a QMA was approved by a licensed nurse for 2 of 10 residents reviewed for medications. (Residents 9 and 5) Finding includes: 1. A record review was completed, on 10/8/2025 at 1:20 P.M. Resident 9's diagnoses included, but were not limited to:		**EMR.** **All QMA's were educated on QMA Job Description (Scope of Practice), specifically "All refusal of medication and need for PRN medication will be under the guidance of a licensed nurse".** ***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 in place:*** **The Wellness Director/Designee will review 5 residents for PRN medication administrations 3x weekly for 1 month, then 1x weekly for 3 months to verify nurse authorization and proper documentation in the EMR.** ***By what date the systemic changes will be completed:*** **10/31/2025**	

	dementia, anxiety disorder and hypertensive heart disease. Resident 9 had a Physician's order indicating she was to receive 0.25 mg lorazepam (anti-anxiety medication) PRN (as needed) three times a day for agitation. Resident 9's July 2025 and August 2025 Medication Administration Records (MAR) indicated a PRN 0.25 mg dose of lorazepam had been administered on 7/18/2025 at 11:34 A.M., 8/4/2025 at 12:12 P.M. and 8/8/2025 at 4:36 P.M. by a Qualified Medication Aide (QMA). Resident 9's record lacked the documentation a nurse had given approval to administer the PRN lorazepam before the QMA had administered the medication for the listed dates. During an interview on 10/8/2025 at 2:11 P.M., the Wellness Director indicated there should have been documentation that the QMA had authorization from a nurse to administer the PRN lorazepam. 2. The clinical record for Resident 5 was reviewed on 10/8/2025 at 10:15 A.M. Resident 5's current medications include: Ondansetron HCL Tablet 4 mg (milligrams), give 1 tablet by			

mouth every 6 hours as needed for nausea and vomiting.

The July 2025 Medication Administration Record (MAR) indicated Resident 5 received Ondansetron HCl on 7/15/2025, administered by a QMA.

The August 2025 MAR indicated Resident 5 received Ondansetron HCl from a QMA on the following days: 8/11/2025, 8/21/2025 and 8/23/2025, administered by a QMA.

Resident 5's clinical record lacked the documentation the QMA had received prior authorization of the administration of Ondansetron HCl from a licensed nurse.

During an interview, on 10/9/2025 at 10:15 A.M., the Assistant Director of Wellness indicated she was unable to locate documentation in the Electonic Medical Record (EMR) regarding nurse permission for the PRN's given by QMAs on the following dates: 7/15/2025, 8/11/2025, 8/21/2025 and 8/23/2025.

During an interview, on 10/9/2025 at 10:20 A.M., QMA 2 indicated the QMA should have followed a process for administering a PRN medication. QMA 2 indicated she would have asked the resident to rate their pain or

	describe their symptoms and then called the nurse for permission to administer a medication. If there was no nurse at the facility, she would have called the Triage service and notified them of the resident's symptoms, then she would have documented nurse permission to administer the medication in the EMR. On 10/8/2025 at 2:11 P.M., the Director of Wellness provided a policy titled, "Medication as Needed (PRN)," dated 5/18/2022 and indicated the policy was the one currently used by the facility. The policy indicated, "...Administer previously ordered pro re nata (PRN) medication only if authorization is obtained from the facility's licensed nurse on duty or on call. If authorization is obtained, the QMA must do the following...Document in the resident record that the facility's licensed nurse was contacted..." Based on record review and interview, the facility failed to ensure a PRN (as needed) medication administered by a QMA was approved by a licensed nurse for 2 of 10 residents reviewed for medications. (Residents 9 and 5) Finding includes: 1. A record review was			

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	medication. QMA 2 indicated she would have asked the resident to rate their pain or describe their symptoms and then called the nurse for permission to administer a medication. If there was no nurse at the facility, she would have called the Triage service and notified them of the resident's symptoms, then she would have documented nurse permission to administer the medication in the EMR. On 10/8/2025 at 2:11 P.M., the Director of Wellness provided a policy titled, "Medication as Needed (PRN)," dated 5/18/2022 and indicated the policy was the one currently used by the facility. The policy indicated, "...Administer previously ordered pro re nata (PRN) medication only if authorization is obtained from the facility's licensed nurse on duty or on call. If authorization is obtained, the QMA must do the following...Document in the resident record that the facility's licensed nurse was contacted..." Based on record review and interview, the facility failed to ensure a PRN (as needed) medication administered by a QMA was approved by a licensed nurse for 2 of 10 residents reviewed for medications. (Residents 9 and 5)			

Finding includes:

1. A record review was completed, on 10/8/2025 at 1:20 P.M. Resident 9's diagnoses included, but were not limited to: dementia, anxiety disorder and hypertensive heart disease.

Resident 9 had a Physician's order indicating she was to receive 0.25 mg lorazepam (anti-anxiety medication) PRN (as needed) three times a day for agitation.

Resident 9's July 2025 and August 2025 Medication Administration Records (MAR) indicated a PRN 0.25 mg dose of lorazepam had been administered on 7/18/2025 at 11:34 A.M., 8/4/2025 at 12:12 P.M. and 8/8/2025 at 4:36 P.M. by a Qualified Medication Aide (QMA). Resident 9's record lacked the documentation a nurse had given approval to administer the PRN lorazepam before the QMA had administered the medication for the listed dates.

During an interview on 10/8/2025 at 2:11 P.M., the Wellness Director indicated there should have been documentation that the QMA had authorization from a nurse to administer the PRN lorazepam.

2. The clinical record for Resident 5 was reviewed on

10/8/2025 at 10:15 A.M. Resident 5's current medications include: Ondansetron HCL Tablet 4 mg (milligrams), give 1 tablet by mouth every 6 hours as needed for nausea and vomiting.

The July 2025 Medication Administration Record (MAR) indicated Resident 5 received Ondansetron HCl on 7/15/2025, administered by a QMA.

The August 2025 MAR indicated Resident 5 received Ondansetron HCl from a QMA on the following days: 8/11/2025, 8/21/2025 and 8/23/2025, administered by a QMA.

Resident 5's clinical record lacked the documentation the QMA had received prior authorization of the administration of Ondansetron HCl from a licensed nurse.

During an interview, on 10/9/2025 at 10:15 A.M., the Assistant Director of Wellness indicated she was unable to locate documentation in the Electonic Medical Record (EMR) regarding nurse permission for the PRN's given by QMAs on the following dates: 7/15/2025, 8/11/2025, 8/21/2025 and 8/23/2025.

During an interview, on 10/9/2025 at 10:20 A.M., QMA 2 indicated the QMA should have

	followed a process for administering a PRN medication. QMA 2 indicated she would have asked the resident to rate their pain or describe their symptoms and then called the nurse for permission to administer a medication. If there was no nurse at the facility, she would have called the Triage service and notified them of the resident's symptoms, then she would have documented nurse permission to administer the medication in the EMR. On 10/8/2025 at 2:11 P.M., the Director of Wellness provided a policy titled, "Medication as Needed (PRN)," dated 5/18/2022 and indicated the policy was the one currently used by the facility. The policy indicated, "...Administer previously ordered pro re nata (PRN) medication only if authorization is obtained from the facility's licensed nurse on duty or on call. If authorization is obtained, the QMA must do the following...Document in the resident record that the facility's licensed nurse was contacted..." Based on record review and interview, the facility failed to ensure a PRN (as needed) medication administered by a QMA was approved by a licensed nurse for 2 of 10 residents reviewed for medications. (Residents 9 and			

5)

Finding includes:

1. A record review was completed, on 10/8/2025 at 1:20 P.M. Resident 9's diagnoses included, but were not limited to: dementia, anxiety disorder and hypertensive heart disease.

Resident 9 had a Physician's order indicating she was to receive 0.25 mg lorazepam (anti-anxiety medication) PRN (as needed) three times a day for agitation.

Resident 9's July 2025 and August 2025 Medication Administration Records (MAR) indicated a PRN 0.25 mg dose of lorazepam had been administered on 7/18/2025 at 11:34 A.M., 8/4/2025 at 12:12 P.M. and 8/8/2025 at 4:36 P.M. by a Qualified Medication Aide (QMA). Resident 9's record lacked the documentation a nurse had given approval to administer the PRN lorazepam before the QMA had administered the medication for the listed dates.

During an interview on 10/8/2025 at 2:11 P.M., the Wellness Director indicated there should have been documentation that the QMA had authorization from a nurse to administer the PRN lorazepam.

R 0247	Health Services - Deficiency 410 IAC 16.2-5-4(e)(7) (7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident. Based on record review and interview, the facility failed to notify a Physician about medication errors for 2 of 7 residents whose medications were reviewed. (Resident 5 and 9) Finding includes: During a medication administration observation on 10/8/2025 at 8:35 A.M., Qualified Medication Aide (QMA) 3 obtained a blood pressure and pulse from Resident 9 before she administered a 50 milligrams (mg) tablet of atenolol (anti-hypertensive) to the resident. QMA 3 indicated the resident's systolic blood pressure was 108 and her heart rate was 53. Resident 9's record review was completed on 10/8/2025 at 1:00 P.M. Diagnoses included, but were not limited to rheumatic heart disease, hypertension, nonrheumatic mitral valve	R 0247	R247- Health Services - Deficiency This Plan of Correction is submitted in accordance with regulatory requirements and does not constitute an admission of fault. The facility respectfully requests a**desk reviewin lieu of a post-survey revisit.** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** **The Wellness Director reviewed the medication records for Residents 5 and 9. The attending physicians and residents designated representatives were notified of the medication administration errors. Both residents were assessed with no adverse effects noted.** **QMA 3 involved was re-educated on the facility’s Medication Error and Medication Administration Policies**	11/19/2025

	disordered and congestive heart failure. A current Physician's order indicated Resident 9 was to receive 50 mg of atenolol by mouth two times a day related to hypertension. The medication was to be held if the resident's systolic blood pressure was less than 110 or if her heart rate was less than 55. A review of Resident 9's September and October 2025 Medication Administration Record (MAR) indicated the resident had been given 50 mg of atenolol when her systolic blood pressure had been less than 110 or her heart rate had been less than 55 on the following dates: -On 9/4/2025 at 8:00 P.M., Resident 9's systolic blood pressure was 109. -On 9/22/2025 at 8:00 P.M., Resident 9's systolic blood pressure was 104. -On 10/2/2025 at 8:00 P.M., Resident 9's systolic blood pressure was 101. -On 10/8/2025 at 8:35 A.M., Resident 9's systolic blood pressure was 108 and her pulse was 53. Resident 9's record lacked the documentation the Physician had been notified on any of the		***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:*** **All residents have the potential to be affected by this deficient practice.** ***What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur:*** **All QMAs and nursing staff were educated on facility Medication Administration Policy** ***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 in place:*** **The Wellness Director/Designee will identify residents with medications requiring any monitoring of vital signs before or after administration. The wellness director/designee will audit**	

	dates listed above when atenolol was given to the resident when it should have been held. During an interview on 10/8/2025 at 2:05 P.M., the Wellness Director indicated Resident 9 should not have received 50 mg of atenolol anytime her systolic blood pressure had been below 110 or her heart rate had been below 55. The WD indicated the Physician should be notified any time a medication was given in error and a note should be added to the resident's record. A follow-up chart review was completed on 10/9/2025 at 8:40 A.M. Resident 9's record still lacked the documentation the Physician had been notified of any medication errors on 9/4, 9/22, 10/2 or 10/8/2025. During an interview on 10/9/2025 at 9:05 A.M., QMA 3 indicated she had administered Resident 9's atenolol on 10/8/2025 when the medication should have been held due to the resident's systolic blood pressure and her heart rate. During an interview on 10/9/2025 at 9:15 A.M., the Assistant Director of Nursing (ADON) indicated when a medication error was made, the facility would assess the resident, notify the resident's		**those residents' medication administration record daily for 4 weeks and then daily for 2 weeks and ongoing monthly to ensure medications are being administered within parameters.** **All medications not being administered within parameters will have a medication error report completed to ensure monitoring of the adverse reactions, proper physician notification and documentation.** **Any staff identified not adhering to the medication administration record will be reeducated or reprimanded according to policy up to and including termination** ***By what date the systemic changes will be completed:*** **11/19/2025**	

	Power of Attorney and make a note in the resident's chart. The ADON indicated Resident 9's record lacked the documentation to indicate the resident's POA or Physician had been notified or a set of vitals had been taken after the resident had been administered a medication in error on 9/4, 9/22, 10/2 or 10/8/2025. On 10/8/2025 at 1:47 P.M., the Executive Director (ED) provided a policy dated, 4/11/2022 and titled "Medication Administration". The ED indicated the policy was the one currently used by the facility. The policy indicated, "...Administration... 2. Medications are administered in accordance with written orders of the attending Healthcare provider...." On 10/9/2025 at 11:00 A.M., the Executive Director (ED) provided a policy dated, 9/26/2023 and titled "Medication Error". The ED indicated the policy was the one currently used by the facility. The policy indicated, "...1. Medication error is defined as any medication given or not given according to physician orders... 2. When a medication error occurs, immediate action shall be taken as necessary to protect the resident's well-being. 3. Resident vital signs will be obtained... 5. Notifications: a.			

	The resident's physician shall be notified of the medication error promptly b. The Wellness Leader shall be notified promptly... c. The resident's designated representative shall be notified... 6. Documentation: a. A medication error report form shall be completed. b. Document the medication incident in the resident's chart not section...." 2. The record for Resident 5 was reviewed on 10/8/2025 at 10:15 A.M. Diagnoses, included but were not limited to: Parkinson's disease, depression, rheumatic heart disease, hypertension and heart failure. Resident 5's current medications include: *Acetaminophen Oral Tablet 500 mg (milligrams), give 1 tablet every 8 hours for analgesic, *Levothyroxine Sodium Oral Tablet 50 mcg (micrograms), give 1 tablet by mouth in the morning for thyroid. A review of the July 2025 Medication Administration Record (MAR) indicated Resident 5 had not received her scheduled morning doses of Levothyroxine and Tylenol on 7/10/2025. A review of the September 2025 MAR indicated Resident 5 had not received her scheduled			

	morning dose of Levothyroxine on 9/14/2025. Resident 5's clinical record failed to evidence physician notification for any of the missed doses of Levothyroxine and Tylenol. During an interview, on 10/8/2025 at 1:42 P.M., the Director of Wellness indicated Director of Wellness if staff did not administer a medication, the Qualified Medication Aide (QMA) would have had to notify the supervising nurse so that the nurse could have notified the provider of the reason the resident did not take the medication. This should have been documented in the resident's record. On 10/8/2025 at 1:45 P.M., the Executive Director provided a policy titled, "Medication Administration," dated 4/11/2022 and indicated the policy was the one currently used by the facility. The policy indicated, "...If a dose of regularly scheduled medication is withheld, refused, or given at a time other than the scheduled time...an explanatory note is entered on the reverse side of the record..." Based on record review and interview, the facility failed to notify a Physician about medication errors for 2 of 7			

residents whose medications were reviewed. (Resident 5 and 9)

Finding includes:

During a medication administration observation on 10/8/2025 at 8:35 A.M., Qualified Medication Aide (QMA) 3 obtained a blood pressure and pulse from Resident 9 before she administered a 50 milligrams (mg) tablet of atenolol (anti-hypertensive) to the resident. QMA 3 indicated the resident's systolic blood pressure was 108 and her heart rate was 53.

Resident 9's record review was completed on 10/8/2025 at 1:00 P.M. Diagnoses included, but were not limited to rheumatic heart disease, hypertension, nonrheumatic mitral valve disordered and congestive heart failure.

A current Physician's order indicated Resident 9 was to receive 50 mg of atenolol by mouth two times a day related to hypertension. The medication was to be held if the resident's systolic blood pressure was less than 110 or if her heart rate was less than 55.

A review of Resident 9's September and October 2025 Medication Administration Record (MAR) indicated the

resident had been given 50 mg of atenolol when her systolic blood pressure had been less than 110 or her heart rate had been less than 55 on the following dates:

-On 9/4/2025 at 8:00 P.M., Resident 9's systolic blood pressure was 109.

-On 9/22/2025 at 8:00 P.M., Resident 9's systolic blood pressure was 104.

-On 10/2/2025 at 8:00 P.M., Resident 9's systolic blood pressure was 101.

-On 10/8/2025 at 8:35 A.M., Resident 9's systolic blood pressure was 108 and her pulse was 53.

Resident 9's record lacked the documentation the Physician had been notified on any of the dates listed above when atenolol was given to the resident when it should have been held.

During an interview on 10/8/2025 at 2:05 P.M., the Wellness Director indicated Resident 9 should not have received 50 mg of atenolol anytime her systolic blood pressure had been below 110 or her heart rate had been below 55. The WD indicated the Physician should be notified any time a medication was given in error and a note should be

	added to the resident's record. A follow-up chart review was completed on 10/9/2025 at 8:40 A.M. Resident 9's record still lacked the documentation the Physician had been notified of any medication errors on 9/4, 9/22, 10/2 or 10/8/2025. During an interview on 10/9/2025 at 9:05 A.M., QMA 3 indicated she had administered Resident 9's atenolol on 10/8/2025 when the medication should have been held due to the resident's systolic blood pressure and her heart rate. During an interview on 10/9/2025 at 9:15 A.M., the Assistant Director of Nursing (ADON) indicated when a medication error was made, the facility would assess the resident, notify the resident's Power of Attorney and make a note in the resident's chart. The ADON indicated Resident 9's record lacked the documentation to indicate the resident's POA or Physician had been notified or a set of vitals had been taken after the resident had been administered a medication in error on 9/4, 9/22, 10/2 or 10/8/2025. On 10/8/2025 at 1:47 P.M., the Executive Director (ED) provided a policy dated, 4/11/2022 and titled "Medication Administration". The ED			

	indicated the policy was the one currently used by the facility. The policy indicated, "...Administration... 2. Medications are administered in accordance with written orders of the attending Healthcare provider...." On 10/9/2025 at 11:00 A.M., the Executive Director (ED) provided a policy dated, 9/26/2023 and titled "Medication Error". The ED indicated the policy was the one currently used by the facility. The policy indicated, "...1. Medication error is defined as any medication given or not given according to physician orders... 2. When a medication error occurs, immediate action shall be taken as necessary to protect the resident's well-being. 3. Resident vital signs will be obtained... 5. Notifications: a. The resident's physician shall be notified of the medication error promptly b. The Wellness Leader shall be notified promptly... c. The resident's designated representative shall be notified... 6. Documentation: a. A medication error report form shall be completed. b. Document the medication incident in the resident's chart not section...." 2. The record for Resident 5 was reviewed on 10/8/2025 at 10:15 A.M. Diagnoses, included but were not limited to:			

	Parkinson's disease, depression, rheumatic heart disease, hypertension and heart failure. Resident 5's current medications include: *Acetaminophen Oral Tablet 500 mg (milligrams), give 1 tablet every 8 hours for analgesic, *Levothyroxine Sodium Oral Tablet 50 mcg (micrograms), give 1 tablet by mouth in the morning for thyroid. A review of the July 2025 Medication Administration Record (MAR) indicated Resident 5 had not received her scheduled morning doses of Levothyroxine and Tylenol on 7/10/2025. A review of the September 2025 MAR indicated Resident 5 had not received her scheduled morning dose of Levothyroxine on 9/14/2025. Resident 5's clinical record failed to evidence physician notification for any of the missed doses of Levothyroxine and Tylenol. During an interview, on 10/8/2025 at 1:42 P.M., the Director of Wellness indicated Director of Wellness if staff did not administer a medication, the Qualified Medication Aide (QMA) would have had to notify the supervising nurse so that			

	the nurse could have notified the provider of the reason the resident did not take the medication. This should have been documented in the resident's record. On 10/8/2025 at 1:45 P.M., the Executive Director provided a policy titled, "Medication Administration," dated 4/11/2022 and indicated the policy was the one currently used by the facility. The policy indicated, "...If a dose of regularly scheduled medication is withheld, refused, or given at a time other than the scheduled time...an explanatory note is entered on the reverse side of the record..." Based on record review and interview, the facility failed to notify a Physician about medication errors for 2 of 7 residents whose medications were reviewed. (Resident 5 and 9) Finding includes: During a medication administration observation on 10/8/2025 at 8:35 A.M., Qualified Medication Aide (QMA) 3 obtained a blood pressure and pulse from Resident 9 before she administered a 50 milligrams (mg) tablet of atenolol (anti-hypertensive) to the resident. QMA 3 indicated the			

resident's systolic blood pressure was 108 and her heart rate was 53.

Resident 9's record review was completed on 10/8/2025 at 1:00 P.M. Diagnoses included, but were not limited to rheumatic heart disease, hypertension, nonrheumatic mitral valve disordered and congestive heart failure.

A current Physician's order indicated Resident 9 was to receive 50 mg of atenolol by mouth two times a day related to hypertension. The medication was to be held if the resident's systolic blood pressure was less than 110 or if her heart rate was less than 55.

A review of Resident 9's September and October 2025 Medication Administration Record (MAR) indicated the resident had been given 50 mg of atenolol when her systolic blood pressure had been less than 110 or her heart rate had been less than 55 on the following dates:

-On 9/4/2025 at 8:00 P.M., Resident 9's systolic blood pressure was 109.

-On 9/22/2025 at 8:00 P.M., Resident 9's systolic blood pressure was 104.

-On 10/2/2025 at 8:00 P.M., Resident 9's systolic blood

pressure was 101.

-On 10/8/2025 at 8:35 A.M., Resident 9's systolic blood pressure was 108 and her pulse was 53.

Resident 9's record lacked the documentation the Physician had been notified on any of the dates listed above when atenolol was given to the resident when it should have been held.

During an interview on 10/8/2025 at 2:05 P.M., the Wellness Director indicated Resident 9 should not have received 50 mg of atenolol anytime her systolic blood pressure had been below 110 or her heart rate had been below 55. The WD indicated the Physician should be notified any time a medication was given in error and a note should be added to the resident's record.

A follow-up chart review was completed on 10/9/2025 at 8:40 A.M. Resident 9's record still lacked the documentation the Physician had been notified of any medication errors on 9/4, 9/22, 10/2 or 10/8/2025.

During an interview on 10/9/2025 at 9:05 A.M., QMA 3 indicated she had administered Resident 9's atenolol on 10/8/2025 when the medication should have been held due to the resident's systolic blood

	pressure and her heart rate. During an interview on 10/9/2025 at 9:15 A.M., the Assistant Director of Nursing (ADON) indicated when a medication error was made, the facility would assess the resident, notify the resident's Power of Attorney and make a note in the resident's chart. The ADON indicated Resident 9's record lacked the documentation to indicate the resident's POA or Physician had been notified or a set of vitals had been taken after the resident had been administered a medication in error on 9/4, 9/22, 10/2 or 10/8/2025. On 10/8/2025 at 1:47 P.M., the Executive Director (ED) provided a policy dated, 4/11/2022 and titled "Medication Administration". The ED indicated the policy was the one currently used by the facility. The policy indicated, "...Administration... 2. Medications are administered in accordance with written orders of the attending Healthcare provider...." On 10/9/2025 at 11:00 A.M., the Executive Director (ED) provided a policy dated, 9/26/2023 and titled "Medication Error". The ED indicated the policy was the one currently used by the facility. The policy indicated, "...1. Medication error			

	is defined as any medication given or not given according to physician orders... 2. When a medication error occurs, immediate action shall be taken as necessary to protect the resident's well-being. 3. Resident vital signs will be obtained... 5. Notifications: a. The resident's physician shall be notified of the medication error promptly b. The Wellness Leader shall be notified promptly... c. The resident's designated representative shall be notified... 6. Documentation: a. A medication error report form shall be completed. b. Document the medication incident in the resident's chart not section...." 2. The record for Resident 5 was reviewed on 10/8/2025 at 10:15 A.M. Diagnoses, included but were not limited to: Parkinson's disease, depression, rheumatic heart disease, hypertension and heart failure. Resident 5's current medications include: *Acetaminophen Oral Tablet 500 mg (milligrams), give 1 tablet every 8 hours for analgesic, *Levothyroxine Sodium Oral Tablet 50 mcg (micrograms), give 1 tablet by mouth in the morning for thyroid. A review of the July 2025			

	Medication Administration Record (MAR) indicated Resident 5 had not received her scheduled morning doses of Levothyroxine and Tylenol on 7/10/2025. A review of the September 2025 MAR indicated Resident 5 had not received her scheduled morning dose of Levothyroxine on 9/14/2025. Resident 5's clinical record failed to evidence physician notification for any of the missed doses of Levothyroxine and Tylenol. During an interview, on 10/8/2025 at 1:42 P.M., the Director of Wellness indicated Director of Wellness if staff did not administer a medication, the Qualified Medication Aide (QMA) would have had to notify the supervising nurse so that the nurse could have notified the provider of the reason the resident did not take the medication. This should have been documented in the resident's record. On 10/8/2025 at 1:45 P.M., the Executive Director provided a policy titled, "Medication Administration," dated 4/11/2022 and indicated the policy was the one currently used by the facility. The policy indicated, "...If a dose of regularly scheduled medication			

is withheld, refused, or given at a time other than the scheduled time...an explanatory note is entered on the reverse side of the record..."

Based on record review and interview, the facility failed to notify a Physician about medication errors for 2 of 7 residents whose medications were reviewed. (Resident 5 and 9)

Finding includes:

During a medication administration observation on 10/8/2025 at 8:35 A.M., Qualified Medication Aide (QMA) 3 obtained a blood pressure and pulse from Resident 9 before she administered a 50 milligrams (mg) tablet of atenolol (anti-hypertensive) to the resident. QMA 3 indicated the resident's systolic blood pressure was 108 and her heart rate was 53.

Resident 9's record review was completed on 10/8/2025 at 1:00 P.M. Diagnoses included, but were not limited to rheumatic heart disease, hypertension, nonrheumatic mitral valve disordered and congestive heart failure.

A current Physician's order indicated Resident 9 was to receive 50 mg of atenolol by mouth two times a day related

to hypertension. The medication was to be held if the resident's systolic blood pressure was less than 110 or if her heart rate was less than 55.

A review of Resident 9's September and October 2025 Medication Administration Record (MAR) indicated the resident had been given 50 mg of atenolol when her systolic blood pressure had been less than 110 or her heart rate had been less than 55 on the following dates:

-On 9/4/2025 at 8:00 P.M., Resident 9's systolic blood pressure was 109.

-On 9/22/2025 at 8:00 P.M., Resident 9's systolic blood pressure was 104.

-On 10/2/2025 at 8:00 P.M., Resident 9's systolic blood pressure was 101.

-On 10/8/2025 at 8:35 A.M., Resident 9's systolic blood pressure was 108 and her pulse was 53.

Resident 9's record lacked the documentation the Physician had been notified on any of the dates listed above when atenolol was given to the resident when it should have been held.

During an interview on 10/8/2025 at 2:05 P.M., the

	Wellness Director indicated Resident 9 should not have received 50 mg of atenolol anytime her systolic blood pressure had been below 110 or her heart rate had been below 55. The WD indicated the Physician should be notified any time a medication was given in error and a note should be added to the resident's record. A follow-up chart review was completed on 10/9/2025 at 8:40 A.M. Resident 9's record still lacked the documentation the Physician had been notified of any medication errors on 9/4, 9/22, 10/2 or 10/8/2025. During an interview on 10/9/2025 at 9:05 A.M., QMA 3 indicated she had administered Resident 9's atenolol on 10/8/2025 when the medication should have been held due to the resident's systolic blood pressure and her heart rate. During an interview on 10/9/2025 at 9:15 A.M., the Assistant Director of Nursing (ADON) indicated when a medication error was made, the facility would assess the resident, notify the resident's Power of Attorney and make a note in the resident's chart. The ADON indicated Resident 9's record lacked the documentation to indicate the resident's POA or Physician had been notified or a set of vitals			

had been taken after the resident had been administered a medication in error on 9/4, 9/22, 10/2 or 10/8/2025.

On 10/8/2025 at 1:47 P.M., the Executive Director (ED) provided a policy dated, 4/11/2022 and titled "Medication Administration". The ED indicated the policy was the one currently used by the facility. The policy indicated, "...Administration... 2. Medications are administered in accordance with written orders of the attending Healthcare provider...."

On 10/9/2025 at 11:00 A.M., the Executive Director (ED) provided a policy dated, 9/26/2023 and titled "Medication Error". The ED indicated the policy was the one currently used by the facility. The policy indicated, "...1. Medication error is defined as any medication given or not given according to physician orders... 2. When a medication error occurs, immediate action shall be taken as necessary to protect the resident's well-being. 3. Resident vital signs will be obtained... 5. Notifications: a. The resident's physician shall be notified of the medication error promptly b. The Wellness Leader shall be notified promptly... c. The resident's designated representative shall be notified... 6. Documentation:

	a. A medication error report form shall be completed. b. Document the medication incident in the resident's chart not section...." 2. The record for Resident 5 was reviewed on 10/8/2025 at 10:15 A.M. Diagnoses, included but were not limited to: Parkinson's disease, depression, rheumatic heart disease, hypertension and heart failure. Resident 5's current medications include: *Acetaminophen Oral Tablet 500 mg (milligrams), give 1 tablet every 8 hours for analgesic, *Levothyroxine Sodium Oral Tablet 50 mcg (micrograms), give 1 tablet by mouth in the morning for thyroid. A review of the July 2025 Medication Administration Record (MAR) indicated Resident 5 had not received her scheduled morning doses of Levothyroxine and Tylenol on 7/10/2025. A review of the September 2025 MAR indicated Resident 5 had not received her scheduled morning dose of Levothyroxine on 9/14/2025. Resident 5's clinical record failed to evidence physician notification for any of the missed doses of Levothyroxine and			

	Tylenol. During an interview, on 10/8/2025 at 1:42 P.M., the Director of Wellness indicated Director of Wellness if staff did not administer a medication, the Qualified Medication Aide (QMA) would have had to notify the supervising nurse so that the nurse could have notified the provider of the reason the resident did not take the medication. This should have been documented in the resident's record. On 10/8/2025 at 1:45 P.M., the Executive Director provided a policy titled, "Medication Administration," dated 4/11/2022 and indicated the policy was the one currently used by the facility. The policy indicated, "...If a dose of regularly scheduled medication is withheld, refused, or given at a time other than the scheduled time...an explanatory note is entered on the reverse side of the record..."			
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.	R 0273	R273- Food and Nutritional Services - Deficiency – DeficiencyThis Plan of Correction is submitted in accordance with regulatory requirements and does not constitute an admission of fault.The facility respectfully requests a**desk review in lieu of a**	10/31/2025

	Based on observation and interview, the facility failed to ensure food was stored in a sanitary manner for 1 of 1 kitchens and 2 of 2 kitchenettes observed. This had the potential to affect all 133 residents who received food from the kitchen and kitchenettes. (Main Kitchen, North and South Kitchenettes) Finding includes: During the initial tour of the kitchen and two kitchenettes of the facility on 10/7/2025 from 10:05 A.M. to 10:40 A.M. with the Executive Chef (EC), the following was observed: -The Main Kitchen had a container of Parmesan cheese with an expiration date of 10/3/2025, a container of spinach had an expiration date of 10/5/2025 and an opened gallon of apple cider did not have an opened on or use by dates in the walk-in cooler. The cooks cooler had an unsealed bag of Swiss cheese without an opened on or use by date. The cooks freezer had a bag of opened cheddar cheese and a bag of opened chicken nuggets without an opened on or use by date. -The North Kitchenette had a pitcher of thickened water, an opened container of butter, an opened container of whipped		**post-survey revisit.** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** **All expired and improperly labeled food items were immediately discarded from the Main Kitchen and both North and South Kitchenettes. Resident personal food containers in kitchenettes were reviewed and discarded if expired or unlabeled.** ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:*** **All residents have the potential to be affected by the deficient practice.** ***What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur:*** **Staff were educated on facility Proper Food Storage Policy and Food Safety.** ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what***	

	cream and a resident's personal food container without an opened on or use by date on them. -The South Kitchenette had a pitcher of thickened cranberry juice and a resident's personal food container without an opened on or use by date on them. During an interview with the EC on 10/7/2025 at 10:40 A.M., the EC indicated all food that had been opened or removed from its original packaging, should be labeled with the date the container was opened and the date the product needed to be used by. The EC indicated residents were able to store their own food in the unit kitchenettes, but the food should have been labeled with the resident's name, room number, the date the container was opened/received and the use by date. On 10/8/2025 at 1:45 P.M., the Executive Director (ED) provided a policy dated 1/28/2022 and titled, "Proper Food Storage", and indicated it was the policy currently used by the facility. The policy indicated, "...Keep foods properly wrapped or covered and dated with date opened and dated expires... All cooked or prepped foods need to be in containers that are covered, tabled, and dated with		***quality assurance program will be put in place:*** **The Executive Chef/Designee will conduct daily inspections of the Main Kitchen and both Satellite kitchens for 1 month, then 2x weekly for 3 months.** ***By what date the systemic changes will be completed:*** **10/31/2025**	

	date made and date expires...When to date mark foods: anytime the original packaging is opened... How to date mark foods: apply masking tape or label to the container, write today's date, draw an arrow, write the date six days from today...." Based on observation and interview, the facility failed to ensure food was stored in a sanitary manner for 1 of 1 kitchens and 2 of 2 kitchenettes observed. This had the potential to affect all 133 residents who received food from the kitchen and kitchenettes. (Main Kitchen, North and South Kitchenettes) Finding includes: During the initial tour of the kitchen and two kitchenettes of the facility on 10/7/2025 from 10:05 A.M. to 10:40 A.M. with the Executive Chef (EC), the following was observed: -The Main Kitchen had a container of Parmesan cheese with an expiration date of 10/3/2025, a container of spinach had an expiration date of 10/5/2025 and an opened gallon of apple cider did not have an opened on or use by dates in the walk-in cooler. The cooks cooler had an unsealed bag of Swiss cheese without an opened on or use by date. The cooks freezer had a bag of			

	opened cheddar cheese and a bag of opened chicken nuggets without an opened on or use by date. -The North Kitchenette had a pitcher of thickened water, an opened container of butter, an opened container of whipped cream and a resident's personal food container without an opened on or use by date on them. -The South Kitchenette had a pitcher of thickened cranberry juice and a resident's personal food container without an opened on or use by date on them. During an interview with the EC on 10/7/2025 at 10:40 A.M., the EC indicated all food that had been opened or removed from its original packaging, should be labeled with the date the container was opened and the date the product needed to be used by. The EC indicated residents were able to store their own food in the unit kitchenettes, but the food should have been labeled with the resident's name, room number, the date the container was opened/received and the use by date. On 10/8/2025 at 1:45 P.M., the Executive Director (ED) provided a policy dated 1/28/2022 and titled, "Proper			

	Food Storage", and indicated it was the policy currently used by the facility. The policy indicated, "...Keep foods properly wrapped or covered and dated with date opened and dated expires... All cooked or prepped foods need to be in containers that are covered, tabled, and dated with date made and date expires...When to date mark foods: anytime the original packaging is opened... How to date mark foods: apply masking tape or label to the container, write today's date, draw an arrow, write the date six days from today...."			
R 0414	Infection Control - Deficiency 410 IAC 16.2-5-12(k) (k) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Based on observation, interview and record review, the facility staff failed to follow standards of care regarding handwashing while administering medications during 3 of 5 medication administration observations. (QMA 3) Finding includes: During medication administration observations, on	R 0414	R414- Infection Control - Deficiency This Plan of Correction is submitted in accordance with regulatory requirements and does not constitute an admission of fault. The facility respectfully requests a**desk reviewin lieu of a post-survey revisit.** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** **QMA 3 was re-educated on**	10/31/2025

	10/8/2025 from 8:35 A.M. to 9:08 A.M., the Qualified Medication Aide (QMA) 3 administered medications without washing her hands on the following times: -At 8:35 A.M., QMA 3 administered a nasal spray and an inhaler to Resident 5, but she had not washed her hands before she administered the medications. -At 8:58 A.M., QMA 3 prepared and administered Resident 11's medications, but she had not washed her hands before she prepared the medications, before she had administered the medications or after she had left the resident's room. -At 9:08 A.M., QMA prepared and administered Resident 12's medications, but had not washed her hands before she prepared the medications, before she administered the medications or after she left the resident's room. During an interview with the Wellness Director (WD) on 10/8/2025 at 2:10 P.M., the WD indicated QMA 3 should have washed her hands after she entered the resident's room and before medications were administered, after she left the room and before preparing any resident's medications. During an interview with QMA 3		**the facility's Medication Administration Policy specifically the requirement to wash hands before and after administering medications to each resident.** **No negative outcomes were identified for residents affected by this deficient practice.** ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:*** **All residents have the potential to be affected by the deficient practice.** ***What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur:*** **All licensed nurses and QMAs were re-educated on hand hygiene expectations prior to and after medication administration. All licensed nurses and QMA's were educated on facility Medication Administration**	

	on 10/9/2025 at 9:05 A.M., QMA 3 indicated she had not washed her hands during the medication administration observations or before preparing the resident's medications. On 10/8/2025 at 1:47 P.M., the Executive Director (ED) provided a policy dated, 4/11/2022 and titled "Medication Administration". The ED indicated the policy was the one currently used by the facility. The policy indicated, "...8. Hands are washed before and after administration of topical, ophthalmic, otic, parenteral, enteral, rectal and vaginal medications...." Based on observation, interview and record review, the facility staff failed to follow standards of care regarding handwashing while administering medications during 3 of 5 medication administration observations. (QMA 3) Finding includes: During medication administration observations, on 10/8/2025 from 8:35 A.M. to 9:08 A.M., the Qualified Medication Aide (QMA) 3 administered medications without washing her hands on the following times: -At 8:35 A.M., QMA 3 administered a nasal spray and an inhaler to Resident 5, but		**Policy** ***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 in place:*** **The Wellness Director/Designee will conduct random hand hygiene and medication pass observations a minimum of 3x weekly for 1 month and 1x weekly for 3 additional months to ensure consistent compliance.** **Any noncompliance observed will result in immediate re-education and follow-up observation.** ***By what date the systemic changes will be completed:*** **10/31/2025**	

she had not washed her hands before she administered the medications.

-At 8:58 A.M., QMA 3 prepared and administered Resident 11's medications, but she had not washed her hands before she prepared the medications, before she had administered the medications or after she had left the resident's room.

-At 9:08 A.M., QMA prepared and administered Resident 12's medications, but had not washed her hands before she prepared the medications, before she administered the medications or after she left the resident's room.

During an interview with the Wellness Director (WD) on 10/8/2025 at 2:10 P.M., the WD indicated QMA 3 should have washed her hands after she entered the resident's room and before medications were administered, after she left the room and before preparing any resident's medications.

During an interview with QMA 3 on 10/9/2025 at 9:05 A.M., QMA 3 indicated she had not washed her hands during the medication administration observations or before preparing the resident's medications.

On 10/8/2025 at 1:47 P.M., the Executive Director (ED) provided a policy dated,

	4/11/2022 and titled "Medication Administration". The ED indicated the policy was the one currently used by the facility. The policy indicated, "...8. Hands are washed before and after administration of topical, ophthalmic, otic, parenteral, enteral, rectal and vaginal medications...."			

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 SIGNATURECraig Clemons	TITLEExecutive Director	(X6) DATE11/20/2025