STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	06/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS AT 30TH	5651 E 30TH STREET, INDIANAPOLIS, , 46218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. This visit included the Investigation of Intake 470211, 469931, 469406, 468045. Intake 470211 - No deficiencies related to the allegations are cited. Intake 469931- No deficiencies related to the allegations are cited. Intake 469406- No deficiencies related to the allegations are cited. Intake 468045- State deficiencies related to the allegations are cited at R0091. Survey dates: June 22 and 23, 2026 Facility number: 013347 Residential Census: 103 These State Residential	R 0000	N/A	

	Findings are cited in accordance with 410 IAC (Indiana Administrative Code) 16.2-5. Quality review completed 6/26/26.			
R 0091	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(h)(1-4) (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request. Based on interview and record review, the facility failed to develop and/or implement a resident to resident relationship policy that included a monitoring process to ensure the safety of all residents that were in relationships for 1 of 1 reportable incidents reviewed. (Resident B and Resident J)	R 0091	Survey Event ID 5GKIK11 Plan of Correction for survey conducted on 06/23/2026. Tag# R091 • What corrective actions will be accomplished for those directly affected by the deficient practice? No residents were directly harmed by the deficiency. • How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken? The facility/organization will work to develop a policy to address intimate relationships among residents of the community. Identifying the relationship and ensuring the safety of both residents involved.	06/30/2026

	Findings include: 1. The clinical record for Resident B was reviewed on 6/23/26 at 10:00 a.m. The diagnoses included, but were not limited to, hypertension (elevated blood pressure) and bipolar disorder (mood disorder with mood changes). A service plan, dated 1/1/26, indicated Resident B was cognitively intact and utilized a motorized scooter. The resident had behaviors of mood disturbance and sexual inappropriateness. 2. The clinical record for Resident J was reviewed on 6/23/26 at 10:30 a.m. The diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease (COPD) (lung disease that causes difficulty breathing). A service plan, dated 1/19/26, indicated Resident J was cognitively intact and ambulated with a walker. The resident had a behavior of consumption of alcohol in excess. Resident B and Resident J's clinical record did not include developed service plans to address their relationship with interventions in place to ensure the residents' safety for monitoring of the relationship to ensure both residents were in a		• What measures will be put into place or what systemic changes the facility will make to ensure the deficient practice does not recur? The organization will establish a policy while respecting the rights of each resident and their privacy, addressing intimate relationships. • How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? DON/ADON and Charge Nurse will update service plans as relationships are identified. • By what date will systemic changes be complete? All care plans will be updated with current relationships by 07/31/2026	

	safe and healthy relationship. A nursing note, dated 1/31/26, indicated Resident B had fallen in his apartment and needed assistance. Resident J was in Resident B's apartment at that time. Both residents who were in a relationship were arguing with each other. Resident J was asked to "step a side" so staff could assist the resident off the floor. Resident J smelled of alcohol at that time and refused to move out of the way. She had become argumentative toward the staff regarding the request and continued to refuse to leave Resident B's apartment. She stated, "This is my man!" Resident J left the apartment when emergency services/911 were notified. A nursing note, dated 2/4/26, indicated Resident B had reported that Resident J had displayed physical behaviors toward him. The emergency services were notified. Resident B reported Resident J and himself had been arguing and it "escalated." An interview was conducted with Director of Nursing (DON) and Executive Director (ED) on 6/23/26 at 12:57 p.m. They indicated Resident J and Resident B did have a on and off relationship. They had met at a rehabilitation center prior to			

	moving to the facility. Resident J had moved to the facility first. The ED had approved Resident B to stay a couple of nights with Resident J to observe the building and see if he would like to move to the facility also. Resident B liked the facility and decided to move to the facility. It was discussed at that time with both residents about living in close proximity. They both indicated it was fine to live close. Resident B was asked if he wanted to be on a different floor than Resident J, and he declined at that time. They lived on the same floor and next door from each other. Resident B was not reporting to staff their arguments were escalating. Resident J no longer resides in the facility. The residents were cognitively intact and were able to consent to be involved in a relationship. The facility did have a policy that addresses intimate resident to resident relationships related to a sexual relationship and the cognition of the individual(s) involved. An interview was conducted with Resident B on 6/23/26 at 4:09 p.m. He indicated he had met Resident J at a rehabilitation center. He decided to move to the facility. They lived on the same floor and next door from one another. The living arrangement were fine. They were in an on and off			

	again relationship. She could not handle "rejection." Their arguments had become physical, but he was not reporting to anyone. "I am an ex-marine and not scared of her." Resident B indicated when Resident J drank she would be aggressive. He got tired of it and decided to report her. The ED asked after he had fallen if he wanted to move and he declined. Resident B tried to give Resident J "the benefit of the doubt." He did choose to move after the next incident on 2/4/26. A resident to resident intimate relationship policy was provided by the DON on 6/23/26 at 11:24 a.m. It indicated, "...Purpose: The community wants to ensure protection of residents with cognitive impairment, who are unable to consent, from unwanted sexual relationships...F. The service plan will also be updated for those residents who have the capacity to consent, in order to inform staff of the sexual relationship and interventions to allow privacy as well as things to watch for to ensure that there are no negative outcomes for either resident. G. The capacity to consent will be reviewed during the assessment process or with a change in the resident's condition. H. Documentation, including the			

	evaluations will be kept in the resident's clinical record..." This citation is related to 468045.			
R 0216	Evaluation - Noncompliance 410 IAC 16.2-5-2(c)(1-4)(d) (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on observation, interview and record review, the facility failed to ensure an assessment was conducted timely to ensure a resident was able to safely administer respiratory medication herself for 1 of 5 residents reviewed for	R 0216	Plan of Correction for survey conducted on 06/23/2026. Tag# 216 • Whatcorrectiveactionswill beaccomplishedforthose directlyaffectedbythe deficient practice? No residents were directly harmed by the deficiency. • Howthefacilitywillidentityo therresidentshavingthepo tentialtobeaffectedby thesamedeficientpractice andwhatcorrectiveactions willbetaken? in-service of clinical staff to be completed, staff will be trained to report to nurse (DON, ADON, Charge Nurse), any medications they see in resident apartments. • Whatmeasureswillbeputi	06/30/2026

	medication administration. (Resident 27) Findings include: The clinical record for Resident 27 was reviewed on 6/23/26 at 11:33 a.m. The diagnoses included, but were not limited to, stroke (blood flow interrupted in the brain causing loss of oxygen to brain tissue). A physician order, dated 2/23/26, indicated Resident 27 was to receive one puff of 62.5-25 micrograms of Anoro-Ellipta inhaler daily (medication to open the airways). A self-medication assessment for Resident 27, dated 3/12/26, indicated the resident was unable to self administer inhalant medications. An observation was made of Resident 27's medication administration on 6/23/26 at 9:04 a.m., with Qualified Medication Aide (QMA) 3. QMA 3 was observed pulling the resident's medications that morning from the medication cart. During that time, QMA 3 indicated she was unable to locate the resident's 62.5-25 micrograms of Anoro-Ellipta inhaler in the medication cart. She would ask the resident if she stored her inhaler in her room. QMA 3 entered the		ntoplaceorwhatsystemicchangesthefacilitywill maketo ensurethedeficient practice doesnotrecur? Medication Administration Staff will alert nurse to missing medications and medications observed in resident apartments. • Howthecorrectiveactionwillbemonitoredtoensurethedeficientpracticewillnotrecur,whatqualityassurance programwillbeputintoplace? Clinical Staff in-service will take place immediately. Nursing staff to notify MD/NP of medications residents have at bedside and obtain orders to keep at bedside or for nursing to administer. Nurses will preform new self medication assessments on medications that are kept at bedside. • Bywhatdatewillsystemicchangesbecomplete? The in-service will be complete by 07/10/2026. Obtaining orders and completing assessments	

	resident's room to administer her pill medications, and it was confirmed by Resident 27 she did store the inhaler and administers the respiratory medications herself. The Anoro-Ellipta inhaler was observed in the resident's walker seat storage area. Resident 27 indicated QMA 3 was not allowed to remove the inhaler from her room. An interview was conducted with the Director of Nursing on 6/23/26 at 1:26 p.m. She indicated she had notified the medical provider and physician orders would be obtained for Resident 27 to store and administer her inhaler herself. A Self-Administration Program policy was provided by the Executive Director on 6/23/26 at 11:02 a.m. It indicated, "...If a prospective or current resident requests to independently manage medications, a Self-Assessment of Medication Administration is completed by a licensed nurse with the prospective or current resident to determine the individual's ability to self-administer medications. This Assessment is completed upon admission and thereafter on a biannual basis and as needed..."		will be completed by 07/31/26.	
R 0240	Health Services - Deficiency	R 0240	Plan of Correction for survey	06/30/2026

	410 IAC 16.2-5-4(d) (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on observation, interview, and record review, the faciltiy failed to ensure an insulin pen was primed prior to administering the physician's ordered dose of insulin for 1 of 5 residents randomly observed for medicaiton admnistration (Resident 103). Findings include: The clinical record for Resident 103 was reviewed on 6/23/26 at 11:05 a.m. The resident's diagnosis included, but was not limited to, diabetes (chronic condition where the body cannot properly produce or use insulin). A physician's order, dated 12/19/25, indicated Resident 103 was to receive Lispro insulin (short-acting type of insulin) 10 units subcutaneously (sq) at noon with lunch. A Level of Care Evaluation, dated 4/2/26, indicated the staff administered insulin injections for Resident 103. On 6/23/26 at 11:05 a.m., Qualified Medication Aide		conducted on 06/23/2026. Tag# 240 • Whatcorrectiveactionswill beaccomplishedforthose directlyaffectedbythe deficient practice? No residents were directly harmed by the deficiency. • How the facility willidentify otherresidentshavingthe potentialto be affected by the same deficient practice and what correctiveactions willbe taken? Inservice of clinical staff to be completed, staff will be observed during Diabetic Clinic operations on technique by nurse,(DON, ADON, Charge Nurse • Whatmeasureswillbeputi ntoplaceorwhatsystemicc hangesthefacilitywill maketoensurethedeficien tpractice doesnotrecur? Step by Step instructions were updated and placed	

	(QMA) 4 was observed administering Lispro insulin to Resident 103. QMA 4 obtained the Lispro insulin pen and removed the lid. QMA 4 then attached the needle to the hub of the insulin pen and dialed 10 units of insulin. QMA 4 then administed the insulin to Resident 103. QMA 4 did not prime the insulin pen prior to administering the injection. During an interview on 6/23/26 at 11:25 p.m., QMA 4 indicated she did not normally prime the insulin pens prior to administerig insulin. During an interview on 6/23/26 at 2:23 p.m., the Nurse Consultant (NC) indicated the facility followed manufacturer guidelines for priming insulin pens. The Instructions for Use Insulin Lispro, revised July 2023, were obtained on 6/23/26 at 11:10 a.m., from the Eli Lilly Website at https://pi.lilly.com/insulin-lispro-kwikpen-us-ifu.pdf. The instructions included: "...Prime before each injection. Priming your Pen means removing the air from the Needle and Cartridge that may collect during normal use and ensures that the Pen is working correctly. If you do not prime before each injection, you may get too much		in Diabetic Clinic above the desk where staff perform insulin administration, with exact instructions stating to prime pen with 2 units. • Howthecorrectiveactionwillbemonitoredtoensurethedeficientpracticewillnotrecur,whatqualityassuranceprogramwillbeputintoplace? Clinical Staff in-service will take place immediately. DON/ADON or Charge Nurse will observe operations of diabetic clinic to ensure staff are using proper technique. Nurse will also check weekly for placement of instructions in clinic. By what date will systemic changes be complete? The in-service will be complete by 07/10/2026. Observation of staff in clinic will occur monthly times 6 months then quarterly after that.	

	or too little insulin...To prime your Pen, turn the Dose Knob to select 2 units...Hold your Pen with the Needle pointing up. Tap the Cartridge Holder gently to collect air bubbles at the top...Continue holding your Pen with Needle pointing up. Push the Dose Knob in until it stops, and "0" is seen in the Dose Window. Hold the Dose Knob in and count to 5 slowly. You should see insulin at the tip of the Needle...."			
R 0273	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(f) (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview and record review, the facility failed to ensure the kitchen was clean, food stored was labeled, dated not expired, and the staff were monitoring and recording the dishwasher temperatures. This had a potential to effect 103 of 103 residents that resident in the facility. Findings include: A kitchen tour was conducted on 6/22/26 at 10:28 a.m. with	R 0273	Plan of Correction for survey conducted on 06/23/2026. Tag # R273 • What corrective actions will be accomplished for those directly affected by the deficient practice? No residents were directly harmed by the deficient practice. • How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken? Dietary Manager or designated person will perform daily walk	06/30/2026

	Cook 1. The dishwasher was observed. Cook 1 indicated the dishwasher was a low temperature dishwasher, and it was monitored only by the Dietary Manager (DM) and Cook 2. The DM and Cook 2 were not available that day, so logging of the temperatures were not being completed. An observation was made of the dish machine and sanitizer log posted on the wall with Cook 1. She indicated the temperature logging should be conducted three times a day. The dishwasher temperatures had not been logged since 6/18/26. The DM and Cook 2 log the temperatures in the morning. The dishwasher area, the clean dish racks, the food preparation/storage areas were observed with Cook 1. A staff person's water cup was sitting on a rack with clean dishes. Cook 1 indicated it was a previous shift staff person's water cup. The top of the dishwasher was observed with food debris. Rolling food carts were observed with food splatter. The steam table was observed with a yellow substance splattered on the knobs. The bottom racks had food debris/spillage. The flooring and drain by the food preparation area was observed with plastic lids, empty individualized coffee creamer		through of entire kitchen area and ensure the cleanliness and organization are in place. • What measures will be put into place or what systemic changes the facility will make to ensure the deficient practice does not recur? Daily check list will be completed and turned into ED or designated person, then ED or designated person will complete walk through to ensure accuracy of the cleanliness and organization. • How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? ED will keep daily checklist or copy of in binder located in their office to ensure accuracy of cleanliness and organization.	

	containers and food debris. The stove was observed with grease splatter. The walk-in refrigerator was observed with Cook 1. The following food items were observed not labeled, dated and/or opened to air: 1 opened bag of sliced bacon sitting in an open box with no label and not dated, 1 silver pan with a lid contained already baked 3 loaves of garlic bread not labeled and not dated, 2 blocks of cheese not labeled and not dated, 4 unopened bags of cabbage not labeled and not dated, and 1 bag of sausage links sitting in a brown slimy substance with odor present were opened to air with no label or date. At 10:35 a.m., an interview was conducted with Cook 1. She indicated the sausage links did have an odor. She had not served the sausage links that morning. The walk-in freezer was observed with Cook 1. An open bag of fries was observed not labeled or dated. The stand alone refrigerator in		• By what date will systemic changes be complete? Checklist in place and updated to include dishwasher and ED signature 7/10/2026. Will be on going daily check list with no stop date.	

	the food preperation area was observed with the following items not labeled, dated or expired: 2 trays of cucumbers, onions, and tomatoes were not labeled or dated, 1 pitcher of brown liquid substance was not labeled or dated, 1 silver pan with a lid contained vegetable soup was labeled 6/13. At 10:37 a.m., Cook 1 indicated she did not know what the brown liquid substance was in the pitcher, and the vegetable soup should have been thrown away. Already cooked food should be discarded 2 to 3 days after serving. All food should be closed to air, labeled and dated. An interview was conducted with the Executive Director (ED) and Corporate Dietary Staff on 6/22/26 at 10:55 a.m. Corporate Dietary Staff indicated the dishwasher was a high temperature dishwasher not a low temperature dishwasher. The temperatures should be recorded after each meal. The June 2026 daily cleaning reports were provided by the ED on 6/22/26 at 1:50. The last documented cleaning check list was on 6/19/26. There were no			

	daily cleaning reports on 6/20/26 and 6/21/26. The June 2026 dish machine and sanitizer log was provided by the ED on 6/22/26 at 1:50 p.m. It indicated the staff were recording the dishwasher temperatures once a day. The last recording of the dishwasher temperatures was on 6/18/26. The cleaning policy was provided by the ED on 6/22/26 at 1:50 p.m. It indicated, "...b) To prevent cross-contamination, kitchenware and food-contact surfaces of equipment shall be washed, rinsed, and sanitized after each use...d) The food contact surfaces of grills, griddles and similar cooking devices and the cavities and door seals of microwave ovens shall be cleaned at least once a day...The food contact surfaces of all cooking equipment shall be kept free of encrusted grease deposits and other accumulated soil. e) Non-food-contact surfaces of equipment shall be cleaned as often as necessary to keep the equipment free of accumulation of dust, dirt, and food particles, and other debris..."			
R 0407	Infection Control - Noncompliance 410 IAC 16.2-5-12(b)(1-4) (b) The facility must establish an	R 0407	Plan of Correction for survey conducted on 06/23/2026.	06/30/2026

	infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on observation, interview and record review, the facility failed to ensure infection control was maintained by staff not touching pill medications with their bare hands and failed to ensure the hub of an insulin pen was cleansed prior to applying the needle for 2 of 5 residents observed during medication administration. (Resident 28 and Resident 103) Findings include: 1. The clinical record for Resident 28 was reviewed on 6/23/26 at 11:33 a.m. The diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease (COPD) (lung disease that causes difficulty breathing).		Tag # 407 • What corrective actions will be accomplished for those directly affected by the deficient practice? No residents were directly harmed by the deficient practice. • How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken? Inservice of clinical staff to be completed, staff will be observed during medication pass and trained on what to do if pills are dropped, by nurse, (DON, ADON, Charge Nurse). • What measures will be put into place or what systemic changes the facility will make to ensure the deficient practice does not recur? Medication Administration Staff will be observed preforming medication pass by DON/ADON or Charge	

	An observation was made of a medication administration for Resident 28 with Qualified Medication Aide (QMA) 3 on 6/23/26 at 8:36 a.m. QMA 3 was observed pulling pill medications from the medication cart. The loose pill medications were stored in a thin plastic packet. QMA 3 was observed tearing the packets and dropping the pill medications in a medication cup. During that time, a light yellow-orange in color pill medication fell on the medication cart instead of medication cup. QMA 3 indicated she had dropped a pill. She then, utilizing her bare hands picked up the pill medication and placed it in the medication cup with the other medications. After, she administer the medication cup of pills to Resident 28. There were no observation of QMA 3 utilizing hand hygiene and donning gloves prior to touching the pill medication and/or discarding the dropped pill medication and replacing it with a new pill medication. An interview was conducted with QMA 3 on 6/23/26 at 9:00 a.m. She indicated she utilized hand hygiene after each residents' medication administration. 2. The clinical record for Resident 103 was reviewed on		Nurse, monthly times 6 months then quarterly after that. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? Clinical Staff in-service will take place immediately. Clinical Audit Tool was created to document observation of clinical personal during medication administration. • By what date will systemic changes be complete? The in-service will be complete by 07/10/2026. Med pass observations will take place monthly times 6 months then quarterly on going after that.	

	6/23/26 at 11:05 a.m. The resident's diagnosis included, but was not limited to, diabetes (chronic condition where the body cannot properly produce or use insulin). A physician's order, dated 12/19/25, indicated Resident 103 was to receive Lispro insulin (short-acting type of insulin) 10 units subcutaneously (sq) at noon with lunch. On 6/23/26 at 11:05 a.m., Qualified Medication Aide (QMA) 4 was observed administering Lispro insulin to Resident 103. QMA 4 obtained the Lispro insulin pen and removed the lid. QMA 4 then attached the needle to the hub of the insulin pen. QMA 4 did not cleanse the hub of the insulin pen prior to attaching the needle. During an interview on 6/23/26 at 11:25 p.m., QMA 4 indicated she normally cleansed the hub of the insulin pen prior to attaching the needle. During an interview on 6/23/26 at 2:23 p.m., the Nurse Consultant (NC) indicated the facility followed manufacturer guidelines for cleansing the hub of the insulin pen. The Instructions for Use Insulin Lispro, revised July 2023, were obtained on 6/23/26 at 11:10			

	a.m., from the Eli Lilly Website at https://pi.lilly.com/insulin-lispro-kwikpen-us-ifu.pdf. The instructions included: "...Wipe the Rubber Seal with an alcohol swab..."			
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 failed to ensure infection control was maintained by staff not utilizing hand hygiene during medication administrations for 4 of 5 residents reviewed for medication administration. (Residents' 27, 28, 42 and 57) Findings include: 1. The clinical record for Resident 28 was reviewed on 6/23/26 at 11:33 a.m. The diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease (COPD) (lung disease that causes difficulty breathing). An observation was made of a medication administration on 6/23/26 at 8:36 a.m. for	R 0414	Plan of Correction for survey conducted on 06/23/2026. Tag # 414 • What corrective actions will be accomplished for those directly affected by the deficient practice? No residents were directly harmed by the deficient practice. • How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken? Inservice of clinical staff to be completed, staff will need to show correct handwashing procedure and verbally explain ways they will prevent infection control issues to nurse (DON, ADON, Charge Nurse).	06/30/2026

	Resident 28 with Qualified Medication Aide (QMA) 3. QMA 3 was observed pulling and preparing medications from the medication cart. During that time, QMA 3 had dropped a pill medication on the medication cart. She then picked it up with her hands and placed the pill in the medication cup. After, QMA 3 left the medication cart went downstairs to replace her laptop. QMA 3 returned to the medication cart, and then administer the pill medications to the resident. During that time, she donned gloves and applied an ointment to both of the resident's arms. There was no hand hygiene observed before she pulled Resident 28's medications, after she touched one of the pill medications, after she returned to the medication cart with a new laptop nor before she donned gloves. 2. The clinical record for Resident 27 was reviewed on 6/23/26 at 11:33 a.m. The diagnoses included, but were not limited to, stroke (blood flow interrupted in the brain causing loss of oxygen to brain tissue). An observation was made of a medication administration on 6/23/26 at 9:04 a.m., for Resident 27 with QMA 3. QMA 3 was observed pulling the resident's medications from the cart. During that time, she had		• What measures will be put into place or what systemic changes the facility will make to ensure the deficient practice does not recur? Clinical Staff will be observed preforming handwashing by DON/ADON or Charge Nurse, monthly times 6 months then quarterly after that. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? Clinical Staff in-service will take place immediately. Clinical Audit Tool was created to document observation of clinical personal during handwashing. • By what date will systemic changes be complete? The in-service will be complete by 07/10/2026. Handwashing observations will take place monthly times 6 months then quarterly on going after that.	

	to go to the lower level and replace her laptop. She then returned back to the medication cart and continued to pull the resident's medications. QMA 3 had touched the medication cart's drawers, medication packets, medication boxes, keys, computer laptop, elevator buttons, water pitcher, water cups and resident's door knob. There were no observation of hand hygiene utilized prior to administration of the medications to the resident. 3. The clinical record for Resident 42 was reviewed on 6/23/26 at 11:33 a.m. The diagnoses included, but were not limited to, heart disease. An observation was made of a medication administration on 6/23/26 at 9:30 a.m. for Resident 42 with QMA 3. QMA 3 was observed pulling medications for Resident 42 at the medication cart. During that time, QMA 3 had left the medication cart and took the elevator down to the lower level floor. She then returned with more pill medications for Resident 42 and continued to prepare the medications. QMA 3 had touched a laptop, medication cart, medication packets, water pitcher, elevator buttons, and door knobs. After, she administer the pill medications to the resident.			

There was no hand hygiene after she returned from pulling the medications from the lower level and prior to administering the medications to the resident.

4. The clinical record for Resident 57 was reviewed on 6/23/26 at 11:33 a.m. The diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease (COPD) (lung disease that causes difficulty breathing).

An observation was made of a medication administration on 6/23/26 at 9:42 a.m., for Resident 57 with QMA 3. QMA 3 was observed pulling the resident's medications from the medication cart. During that time, QMA 3 was observed touching a laptop, keys, medication drawers, medication packets and the resident's door knob. There was no observation of hand hygiene prior to administration of medication to the resident.

An interview was conducted with QMA 3 on 6/23/26 at 9:00 a.m. She indicated she utilized hand hygiene after each residents' medication administration.

A hand hygiene policy was provided by the Director of Nursing on 6/23/26 at 10:51 a.m. It indicated, "...A. General Guidelines. 1. All personnel

	shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents and visitors...B. Handwashing...c. Before and after direct resident contact...r. Before and after removing gloves...C. Alcohol-Based Hand Rubs:...a. Before and after direct contact with residents; b. Before preparing or handling medications;...g. Before and after removing gloves.."			

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 SIGNATUREJamie Bowman	TITLEDirector of Nursing	(X6) DATE07/09/2026