STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENTRY PARK	901 S HASTINGS DR, BLOOMINGTON, , 47401

(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 the Investigation of Intake 467879 and 468208. Intake 467879 - No deficiencies related to the allegations. Intake 468208 - State deficiencies related to the allegations are cited at R29, R52, R53, R90, and R245. Survey date: March 18, 2026 Facility number: 013766 Residential Census: 91 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on March 23, 2026.	R 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation.	
R 0029	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(d)	R 0029	What corrective action will be accomplished for those residents found to have been	04/18/2026

	(d) Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality. Based on observation, interview, and record review the facility failed to protect a resident's right to be treated with respect and dignity when a Qualified Medication Aide (QMA) entered a resident's room to administer medications and refused to leave the room after the resident told the QMA to leave her room for 1 of 3 residents reviewed for resident's rights. (Resident B) Findings include: During an interview, on 9:14 a.m. QMA 2 indicated QMA 1 should not have tried to administer medication to Resident B when she refused them because that is her right to do so. QMA 1 should have left Resident B's room when she told him to because that is her right as well. During an interview, on 3/18/26 at 10:39 a.m. Resident B's daughter indicated, on 2/17/26 at approximately 9:30 p.m. QMA 1 had entered Resident B's room to administer her medications. Resident B told QMA 1 he didn't know what he was talking about and asked QMA 1 to leave the room. QMA		affected by the deficient practice. The resident involved was assessed for any effects of the reported incident. Resident was found to not have any psychosocial distress related to the reported incident. An investigation was initiated related to the report provided to the community. The employee involved was interviewed and placed on suspension pending investigation. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents had the potential to be affected, although no others were noted to be affected. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. Care staff will receive in-service re-training on resident rights, choices and care approaches for residents with dementia by 4/18/26.	

	1 told Resident B he couldn't leave her room. Then Resident B told QMA 1 to get out of her room. QMA 1 said okay and then, when Resident B wasn't looking QMA 1 turned and pulled an insulin pen out of his pocket and jabbed the pen into Resident B's lower right leg approximately 5 inches above the inner ankle. Resident B was immediately said ouch, was startled, pulled her leg away, and said get out of here you as*hole. At that time, grabbed the medications that had been refused and left Resident B's room. The clinical record for Resident B was reviewed, on 3/18/26 at 10:40 a.m. Diagnoses included, but were not limited to, Alzheimer's disease and diabetes. On 3/18/26 at 1:15 p.m. Resident B's daughter provided a video recordings of the interaction between Resident B and QMA 1. During a review of the video recordings observed the following: -a video recording, dated 2/17/26 from 9:26:10 p.m., until 9:26:18 p.m. QMA 1 was standing next to Resident B's bed and Resident B was lying on her right side on her bed. Resident B's nightgown stopped at the knees with her right lower		How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. **The administrator or designee will spot check resident care and medication administration to ensure compliance with resident rights. Spot checks will be conducted for ten residents per week for four weeks, five residents per week for four weeks, and as needed thereafter to ensure compliance.** By what date the systemic changes will be completed. Effective date is 4/18/2026.	

	inner leg exposed. Resident B could be heard telling QMA 1 that he didn't know what he was talking about. QMA 1 responds that he did know what he was talking about. Resident B again told QMA 1 that he didn't know what he was talking about and QMA 1 responded again that he did know what he was talking about. Resident B asked QMA 1 to go away and QMA 1 responds that he couldn't do that. Then, QMA 1 set Resident B's medications on her nightstand. The video ended. -a video recording, dated 2/17/26 from 9:26:29 p.m., until 9:26:38 p.m., in a loud voice Resident B told QMA 1 to get out of her room. QMA 1 said okay then turned to the nightstand and reaches into his right pocket. The video ended. -a video recording, dated 2/17/26 from 9:26:40 p.m., until 9:26:49 p.m., QMA 1 pulled is right hand out of his right pocket and was holding an insulin pen. While Resident B was looking away, QMA 1 turned and stuck the insulin pen into Resident B's right lower leg approximately five inches above her right inner ankle. Resident B was immediately startled, pulled her leg away, and said don't do that you as*hole. At that time, QMA 1 called Resident B a f*cking cow, picked up the refused			

	medications, and left the room. The video ended. On 3/18/26 at 10:08 a.m., the Administrator provided a copy of a facility policy, titled Resident Rights, dated 12/30/15, and indicated this was the current policy used by the facility. A review of the policy indicated residents have the right to be treated with respect and recognition of their dignity. This State citation relates to Intake 468208			
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on observation, interview, and record review, the facility failed to protect the resident's right to be free from physical abuse by a staff member for 1 of 3 residents reviewed for abuse. A Qualified	R 0052	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. The investigation of this incident resulted in the QMA being suspended pending investigation and then terminated. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.	04/18/2026

	Medication Aide (QMA) administered an injectable medication into a resident in the wrong area of the body when the resident was not aware of the injection and after the resident had already refused the medication. This deficient practice would cause a reasonable person to be fearful and mental anguish. (Resident B, QMA 1) Findings include: During an interview on 3/18/26 at 9:48 a.m., the Administer indicated approximately a month ago, the facility investigated an allegation that QMA 1 had administered an injectable medication inappropriately to Resident B. The Administrator had watched video footage from Resident B's room of the incident when Resident B's daughter reported the incident to the Administrator. The Administrator had not considered the action abuse. QMA 1 had been terminated because he had not provided the facility with his insulin certification paperwork. During an interview on 3/18/26 at 10:12 a.m., the Regional Vice President of Clinical Operations (RVP) indicated the Administrator made her aware of an allegation that QMA 1 administered insulin		**All residents had the potential to be affected. Resident interviews will be conducted regarding the cited concern to identify others potentially affected.** **Corrective action of re-training care staff on resident rights, abuse prevention, and care approaches for residents with dementia will be taken by 4/18/26.** What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. Care staff will receive re-training on resident rights, abuse prevention and care approaches for residents with dementia by 4/18/26. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. **The administrator or designee will spot check resident care and medication administration to ensure compliance with resident rights and abuse prevention. Spot checks will be conducted for ten residents per week for four weeks, five residents per week for four**	

	inappropriately. After the facility watched the video footage, the RVP was told they could not substantiate the allegation because they couldn't tell what QMA 1 had in his hand and if it actually went into her skin. The RVP was not made aware of any abuse behavior or allegations. If QMA 1 administered an injection after Resident B refused and when Resident B was not aware, that should have been reported according to the facility policy because that could have been abuse. During an interview on 3/18/26 at 10:39 a.m., Resident B's daughter indicated, on 2/17/26 at approximately 9:30 p.m., QMA 1 had entered Resident B's room to administer her medications. Resident B told QMA 1 he didn't know what he was talking about and asked QMA 1 to leave the room. QMA 1 told Resident B he couldn't leave her room. Then Resident B told QMA 1 to get out of her room. QMA 1 said okay and then, when Resident B wasn't looking QMA 1 turned and pulled an insulin pen out of his pocket and jabbed the pen into Resident B's lower right leg approximately five inches above the inner ankle. Resident B was immediately said "ouch", was startled, pulled her leg away, and said get out of here you		**weeks, and as needed thereafter to ensure compliance.** By what date the systemic changes will be completed. Effective date 4/18/2026	

	"a******". At that time, QMA 1 picked up the rest of the medication that Resident B refused and left the room. At that time, Resident B's daughter had become upset and indicated she couldn't imagine how scared Resident B must have been when she had been jabbed with a sharp object and wasn't expecting it. The clinical record for Resident B was reviewed, on 3/18/26 at 10:40 a.m. The diagnoses included, but were not limited to, Alzheimer's disease and diabetes. On 3/18/26 at 1:15 p.m., Resident B's daughter provided video recordings of the interaction between Resident B and QMA 1. During a review of the video recordings observed the following was observed: - A video recording, dated 2/17/26 from 9:26:10 p.m. until 9:26:18 p.m., QMA 1 was standing next to Resident B's bed and Resident B was lying on her right side on her bed. Resident B's nightgown stopped at the knees with her right lower inner leg exposed. Resident B could be heard telling QMA 1 that he didn't know what he was talking about. QMA 1 responded that he did know what he was talking about. Resident B again			

	told QMA 1 that he didn't know what he was talking about and QMA 1 responded again that he did know what he was talking about. Resident B asked QMA 1 to go away and QMA 1 responds that he couldn't do that. Then, QMA 1 set Resident B's medications on her nightstand. A that time, the video ended. - A video recording, dated 2/17/26 from 9:26:29 p.m. until 9:26:38 p.m., in a loud voice Resident B told QMA 1 to get out of her room. QMA 1 said okay then turned to the nightstand and reaches into his right pocket. At that time, the video ended. - A video recording, dated 2/17/26 from 9:26:40 p.m. until 9:26:49 p.m., QMA 1 pulled his right hand out of his right pocket and was holding an insulin pen. While Resident B was looking away, QMA 1 turned and jabbed the insulin pen into Resident B's right lower leg approximately five inches above her right inner ankle. Resident B was immediately startled, pulled her leg away, and said don't do that you "a******". At that time, QMA 1 called Resident B a "f****** cow", picked up the refused medications, and left the room. At that time, the video ended. On 3/18/26 at 2:15 p.m., the			

	Administrator had not notified local law enforcement. On 3/18/26 at 10:08 a.m., the Administrator provided a copy of a facility policy, titled Resident Neglect, Abuse, and Misappropriation of Property Policy, dated 12/30/15, and indicated this was the current policy used by the facility. A review of the policy indicated residents will be free from physical abuse. This citation relates to Intake 468208.			
R 0053	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(w) (w) Residents have the right to be free from verbal abuse. Based on observation, interview, and record review the facility failed to protect the resident's right to be free from verbal abuse when a Qualified Medication Aide (QMA) called a female, cognitively impaired, resident who resided on the memory care unit a f*cking cow for 1 of 3 residents reviewed for abuse. (Resident B) Findings include: During an interview, on 3/18/26 at 10:39 a.m. Resident B's daughter indicated, on 2/17/26	R 0053	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. The resident was assessed when facility was notified of this incident with no psychosocial distress noted. Care staff received resident rights and abuse prevention in service re-training to be completed by 4/18/26. The investigation of this incident resulted in the QMA being suspended pending investigation and then subsequently terminated. How the facility will identify other residents having the potential to	04/18/2026

	at approximately 9:30 p.m. QMA 1 had entered Resident B's room to administer her medications. After QMA 1 jabbed Resident B in the lower leg with a insulin pen, Resident B called QMA 1 an as*hole. Then, QMA 1 said something under his breath to Resident B but she wasn't able to hear what he said to her. The clinical record for Resident B was reviewed, on 3/18/26 at 10:40 am Diagnoses included, but were not limited to, Alzheimer's disease and diabetes. On 3/18/26 at 1:15 p.m. Resident B's daughter provided a video recordings of the interaction between Resident B and QMA 1. During a review of the video recordings observed the following: - A video recording, dated 2/17/26 from 9:26:40 p.m., until 9:26:49 p.m., QMA 1 pulled is right hand out of his right pocket and was holding an insulin pen. While Resident B was looking away, QMA 1 turned and stuck the insulin pen into Resident B's right lower leg approximately five inches above her right inner ankle. Resident B was immediately startled, pulled her leg away, and said don't do that you as*hole. At that time, QMA 1 called Resident B a f*cking		be affected by the same deficient practice and what corrective action will be taken. **All residents had the potential to be affected. Resident interviews will be conducted regarding the cited concern to identify others potentially affected.** **Corrective action of re-training care staff on resident rights, abuse prevention, and care approaches for residents with dementia will be taken by 4/18/26.** What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. Care staff will receive re-training on resident rights, abuse prevention and care approaches for residents with dementia by 4/18/26. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. **The administrator or designee will spot check resident care and medication administration to ensure compliance with resident rights and abuse prevention. Spot checks will be**	

	cow, picked up the refused medications, and left the room. The video ended. On 3/18/26 at 10:08 a.m., the Administrator provided a copy of a facility policy, titled Resident Neglect, Abuse, and Misappropriation of Property Policy, dated 12/30/15, and indicated this was the current policy used by the facility. A review of the policy indicated residents will be free from verbal abuse. This State citation relates to Intake 468208		**conducted for ten residents per week for four weeks, five residents per week for four weeks, and as needed thereafter to ensure compliance.** By what date the systemic changes will be completed. Effective date 4/18/2026	
R 0090	Administration and Management - Deficiency 410 IAC 16.2-5-1.3(g)(1-6) (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to:	R 0090	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. The Administrator, Wellness Director and Memory Care Director will receive re-training regarding state incident reporting guidelines and timely reporting. This training will be completed by the Area Vice President of Operations and/or the Regional Director of Clinical Services by 4/18/26.	04/18/2026

	(A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability.		How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. No other residents were found to be potentially affected by this practice after a review of state incident reporting process by the Administrator/designee. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. The Administrator, Wellness Director and Memory Care Director will receive in-service re-training regarding state reporting guidelines and timely reporting. This re-training will be completed by the Area Vice President of Operations and/or the Regional Director of Clinical Services by 4/18/26. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The Administrator or designee will review and audit alleged abuse reports daily to ensure timely investigation and state reporting. Regional Staff Member will conduct weekly review of these audit results for eight weeks and ongoing as	

	(6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request Based on observation, interview, and record review the facility failed to report an allegation of an inappropriate injectable medication administration in the appropriate time frame and provide accurate information in that facility reportable incident follow up; and failed to report a Qualified Medication Aide (QMA) who administered insulin without the insulin certification; and failed to report physical and verbal abuse for 2 of 2 reportable incidents reviewed. (Resident B) Findings include: 1. During an interview, on 3/18/26 at 9:00 a.m. Licensed Practical Nurse (LPN) 1 indicated if a staff member had administered insulin in Resident B's lower leg, that should have been reported as a medication error. The clinical record for Resident B was reviewed, on 3/18/26 at 9:39 a.m. Diagnoses included, but were not limited to, Alzheimer's disease and diabetes.		needed to ensure compliance. By what date the systemic changes will be completed. Effective date is 4/18/2026.	

	A current physician's order started, on 8/27/25 and discontinued, on 2/25/26, indicated Lantus Solostar 100 units/milliliter (ml) inject 10 units subcutaneously in the morning and inject 6 units subcutaneously in the evening. During an interview, on 3/18/26 at 9:48 a.m., the Administer indicated the facility investigated an allegation that QMA 1 administered an injectable medication inappropriately to Resident B. The Administrator had watched video footage from Resident B's room of the incident when Resident B's daughter reported the incident to the Administrator, on 2/19/26. The allegation was unsubstantiated because the Administrator couldn't tell what QMA 1 had in his hand and if whatever he had in his hand actually went into the skin. QMA 1 had been terminated because he had not provided the facility with his insulin certification paperwork before he had administered insulin The Administrator provided a copy of a facility reportable incident, dated 2/17/26 at 9:26 p.m. A review of the facility reportable incident indicated the following: - Incident date and time 2/17/26 at 9:26 p.m.			

	- Staff involved was QMA 1 - Resident involved was Resident B - Description added, on 2/24/26, report received, on 2/19/26 at 4:00 p.m., regarding an improper administration and placement of an insulin injection. - Follow up added, on 3/4/26, investigation had been completed and resolved. QMA 1 had not administered insulin in the wrong body site location as reported. Resident B refused the insulin and it had not been administered. On 3/18/26 at 1:15 p.m. Resident B's daughter provided a video recordings of the interaction between Resident B and QMA 1. During a review of the video recordings observed the following: - A video recording, dated 2/17/26 from 9:26:40 p.m., until 9:26:49 p.m., QMA 1 pulled his right hand out of his right pocket and was holding an insulin pen. While Resident B was looking away, QMA 1 turned and stuck the insulin pen into Resident B's right lower leg approximately five inches above her right inner ankle. Resident B was immediately startled, pulled her leg away.			

	The Lantus Solostar Insulin pen prescribing information was reviewed, on 3/18/26 at 1:22 p.m. The review indicated administer LANTUS Solostar subcutaneously into the abdominal area, thigh, or deltoid, and rotate injection sites. 2. During an interview, on 3/18/26 at 9:48 a.m., the Administer indicated QMA 1 had been terminated because he had not provided the facility with his insulin certification paperwork before he had administered insulin On 3/18/26 at 12:30 p.m., the Administrator provided a copy of QMA 1's license. There had been no certification to administer insulin added to his QMA license. On 3/18/26 at 1:28 p.m., the Administrator provided a copy of a facility policy, titled QMA Insulin Administration, dated 8/2025, and indicated this was the current policy used by the facility. A review of the policy indicated the facility will take the following steps prior to allowing a QMA to administer insulin verify QMA has appropriate state certification to administer insulin. 3. During an interview, on 3/18/26 at 9:48 a.m., the Administer indicated			

	approximately a month ago, the facility investigated an allegation that QMA 1 administered an injectable medication inappropriately to Resident B. The Administrator had watched video footage from Resident B's room of the incident when Resident B's daughter reported the incident to the Administrator. The Administrator had not considered this abuse nor had she notified local law enforcement. QMA 1 had been terminated because he had not provided the facility with his insulin certification paperwork before he had administered insulin. During an interview, on 3/18/26 at 10:12 a.m., the Regional Vice President of Clinical Operations (RVP) indicated the Administrator made her aware of an allegation that QMA 1 administered insulin inappropriately. After the facility watched the video footage, the RVP was told they could not substantiate the allegation because they couldn't tell what QMA 1 had in his hand and if it actually went into her skin. The RVP was not made aware of any abuse behavior or allegations. If QMA 1 administered an injection after Resident B refused and when Resident B was not aware, that should have been reported			

	according to the facility policy because that could have been abuse. During an interview, on 3/18/26 at 10:39 a.m. Resident B's daughter indicated, on 2/17/26 at approximately 9:30 p.m. QMA 1 had entered Resident B's room to administer her medications. Resident B told QMA 1 he didn't know what he was talking about and asked QMA 1 to leave the room. QMA 1 told Resident B he couldn't leave her room. Then Resident B told QMA 1 to get out of her room. QMA 1 said okay and then, when Resident B wasn't looking QMA 1 turned and pulled an insulin pen out of his pocket and jabbed the pen into Resident B's lower right leg approximately 5 inches above the inner ankle. Resident B was immediately said ouch, was startled, pulled her leg away, and said get out of here you as*hole. At that time, QMA 1 picked up the rest of the medication that Resident B refused and left the room. At that time, Resident B's daughter became upset and indicated she couldn't imagine how scared Resident B must have been when she had been jabbed with a sharp object and wasn't expecting it. The clinical record for Resident B was reviewed, on 3/18/26 at			

	10:40 am Diagnoses included, but were not limited to, Alzheimer's disease and diabetes. On 3/18/26 at 1:15 p.m. Resident B's daughter provided a video recordings of the interaction between Resident B and QMA 1. During a review of the video recordings observed the following: - A video recording, dated 2/17/26 from 9:26:10 p.m., until 9:26:18 p.m. QMA 1 was standing next to Resident B's bed and Resident B was lying on her right side on her bed. Resident B's nightgown stopped at the knees with her right lower inner leg exposed. Resident B could be heard telling QMA 1 that he didn't know what he was talking about. QMA 1 responds that he did know what he was talking about. Resident B again told QMA 1 that he didn't know what he was talking about and QMA 1 responded again that he did know what he was talking about. Resident B asked QMA 1 to go away and QMA 1 responds that he couldn't do that. Then, QMA 1 set Resident B's medications on her nightstand. The video ended. - A video recording, dated 2/17/26 from 9:26:29 p.m., until 9:26:38 p.m., in a loud voice Resident B told QMA 1 to get			

	out of her room. QMA 1 said okay then turned to the nightstand and reaches into his right pocket. The video ended. - A video recording, dated 2/17/26 from 9:26:40 p.m., until 9:26:49 p.m., QMA 1 pulled his right hand out of his right pocket and was holding an insulin pen. While Resident B was looking away, QMA 1 turned and stuck the insulin pen into Resident B's right lower leg approximately five inches above her right inner ankle. Resident B was immediately startled, pulled her leg away, and said don't do that you as*hole. At that time, QMA 1 called Resident B a f*cking cow, picked up the refused medications, and left the room. The video ended. On 3/18/26 at 2:15 p.m., the Administrator had not notified local law enforcement On 3/18/26 at 10:08 a.m., the Administrator provided a copy of a facility policy, titled Resident Neglect, Abuse, and Misappropriation of Property Policy, dated 12/30/15, and indicated this was the current policy used by the facility. A review of the policy indicated residents will be free from physical and verbal abuse. This State citation relates to Intake 468208			

R 0245	Health Services - Offense 410 IAC 16.2-5-4(e)(5) (5) Injectable medications shall be given only by licensed personnel. Based on observation, interview, and record review, the facility failed to ensure a Qualified Medication Aide (QMA) was certified to administer insulin (prescription medication used to treat diabetes) before the QMA administered insulin for 1 of 3 residents reviewed for medication administration. (Resident B) Findings include: During an interview on 3/18/26 at 9:48 a.m., the Administer indicated approximately a month ago, the facility investigated an allegation that QMA 1 had administered an insulin inappropriately to Resident B. The Administrator had watched video footage from Resident B's room of the incident when Resident B's daughter reported the incident to the Administrator. QMA 1 had been terminated because he had not provided the facility with his insulin certification paperwork before he administered the insulin. During an interview on 3/18/26	R 0245	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. The QMA related to this report was placed on suspension pending investigation completion and subsequently terminated due to not providing appropriate documentation regarding insulin certification. All other QMA's certifications were reviewed and verified to hold appropriate documentation of an active insulin certification. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. Insulin dependent residents had the potential to be affected by this practice with no adverse findings noted. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.	04/18/2026

	at 10:12 a.m., the Regional Vice President of Clinical Operations (RVP) indicated when she was made aware that QMA 1 administered insulin without but had not provided his insulin administration certification, she ordered the facility to remove QMA 1 from resident care areas. QMA 1 should not have been allowed to administer insulin without providing his certification. On 3/18/26 at 1:15 p.m., Resident B's daughter provided video recordings of the interaction between Resident B and QMA 1. During a review of the video recordings observed the following was observed: - A video recording, dated 2/17/26 from 9:26:10 p.m. until 9:26:18 p.m., QMA 1 was standing next to Resident B's bed and Resident B was lying on her right side on her bed. Resident B's nightgown stopped at the knees with her right lower inner leg exposed. Resident B could be heard telling QMA 1 that he didn't know what he was talking about. QMA 1 responded that he did know what he was talking about. Resident B again told QMA 1 that he didn't know what he was talking about and QMA 1 responded again that he did know what he was talking about. Resident B asked QMA 1		All QMA's will be educated by the Wellness Director or designee on the QMA scope of practice and duties pertaining to maintaining Insulin Certifications by 4/18/26. Insulin Certifications were reviewed for current QMA's to determine appropriate scope. Insulin Certification documentation will be reviewed upon new hire and newly hired QMA's will be educated on QMA scope of practice before commencement of medication administration duties involving insulin administration. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. QMA certifications were reviewed for current staff. The Administrator or designee will review monthly the completion of new hire verification of active Insulin Certification documentation of new QMA staff and review monthly current QMA staff active Insulin Certification documentation to maintain compliance. By what date the systemic changes will be completed. Effective date 4/18/2026	

to go away and QMA 1 responds that he couldn't do that. Then, QMA 1 set Resident B's medications on her nightstand. A that time, the video ended.

- A video recording, dated 2/17/26 from 9:26:29 p.m. until 9:26:38 p.m., in a loud voice Resident B told QMA 1 to get out of her room. QMA 1 said okay then turned to the nightstand and reaches into his right pocket. At that time, the video ended.

- A video recording, dated 2/17/26 from 9:26:40 p.m. until 9:26:49 p.m., QMA 1 pulled his right hand out of his right pocket and was holding an insulin pen. While Resident B was looking away, QMA 1 turned and jabbed the insulin pen into Resident B's right lower leg approximately five inches above her right inner ankle. Resident B was immediately startled, pulled her leg away, and said don't do that you "a******". At that time, QMA 1 called Resident B a "f****** cow", picked up the refused medications, and left the room. At that time, the video ended.

On 3/18/26 at 12:30 p.m., the Administrator provided a copy of QMA 1's license. There had been no certification to administer insulin added to his QMA license.

	On 3/18/26 at 1:28 p.m., the Administrator provided a copy of a facility policy, titled QMA Insulin Administration, dated 8/2025, and indicated this was the current policy used by the facility. A review of the policy indicated the facility will take the following steps prior to allowing a QMA to administer insulin verify QMA has appropriate state certification to administer insulin. This State citation relates to Intake 468208			

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 SIGNATURELisa Holstein, HFA	TITLEExecutive Director	(X6) DATE04/05/2026