STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEACOAST AT SUMMERS POINTE LLC	1 SUNSET DRIVE, WINCHESTER, , 47394

(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: April 22 and 23, 2026 Facility number: 013838 Residential Census: 33 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed May 1, 2026.	R 0000		
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	R 0246	*QMA 4 has been reeducated on PRN medication administration* *As all residents with PRN drugs ordered could be affected, the following corrective actions were taken.* *All QMA's have been reeducated on the PRN medication administration policy*	05/15/2026

	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. Based on record review and interview, the facility failed to ensure a QMA obtained authorization to administer medications ordered on an as needed (PRN) basis and documented the authorization in the clinical record for 1 of 7 resident reviewed for PRN medications administered by QMAs. (Resident 25) Finding includes: Resident 25's clinical record was reviewed on 4/22/27 at 2:35 p.m. Diagnoses included unspecified dementia and restless leg syndrome. Current orders included tramadol 50 milligrams (mg) tablet (opiate pain medication) every six hours as needed for pain (1/14/26). Review of the Medication Administration Record (MAR) indicated the following PRN medications were administered by a QMA and lacked authorization from a licensed nurse:		*and QMA scope of practice. Any newly hired qualified staff shall receive said education at the time of orientation.* *As a means of quality assurance, the Director of Nursing or designee shall be responsible to audit all PRN medications given to confirm compliance at least three times weekly for four weeks, once weekly for two months, and then at least monthly for three months, ensuring monitoring for six months.* *Should concerns be identified, immediate corrective action shall be taken, re-education provided, and the frequency of auditing increased or extended as warranted.*	

	2/13/26 at 6:12 p.m., tramadol 50 mg tablet, 2/16/26 at 2:25 p.m., tramadol 50 mg tablet, and 3/2/26 at 7:37 p.m., tramadol 50 mg tablet A 4/21/26, current service plan indicated the resident's medications were administered by the licensed nurse/QMA. During an interview on 4/22/26 at 3:45 p.m., QMA 4 indicated QMAs were required to obtain authorizations from a nurse prior to administration of a PRN medication. The authorization and reason for the PRN medication was required to be documented in the resident's clinical record. The documentation must include who provided the authorization in a PRN medication note. On 4/23/26 at 1:40 p.m., the DON indicated QMAs were required to obtain authorization from a licensed nurse prior to the administration of PRN medications. The authorization must be documented in the clinical record. On 4/23/26 at 2:23 p.m., the DON indicated she did not have any further information to provide regarding the resident's administration of PRN medications on 2/13/26,			

	2/16/26, and 3/2/26. The facility followed Indiana Department of Health guidelines regarding the QMA Scope of Practice. A current undated document, titled " QUALIFIED MEDICATION AIDE Scope of Practice," provided by the Corporate Nurse Consultant on 4/23/26 at 3:07 p.m., indicated the following: "The following tasks are within the scope of practice for the QMA... (11) Administer previously ordered pro re nata (PRN) medication only if authorization is obtained, the QMA must do the following: (A) Document in the resident record symptoms indicating the need for the medication and time the symptoms occurred. (B) Document in the resident record that the facility's licensed nurse was contacted, symptoms were described, and permission was granted to administer the medication, including the time of contact. (C) Obtain permission to administer the medication each time the symptoms occur in the resident. (D) Ensure that the resident's record is cosigned by the licensed nurse who gave the permission by the end of the nurse's shift, or if the nurse was on call, by the end of the nurse's next tour of duty...."			
R 0304	Pharmaceutical Services - Deficiency	R 0304	*The facility has experienced no concerns in regard to drug*	05/15/2026

	410 IAC 16.2-5-6(e) (e) Medicine or treatment cabinets or rooms shall be appropriately locked at all times except when authorized personnel are present. All Schedule II drugs administered by the facility shall be kept in individual containers under double lock and stored in a substantially constructed box, cabinet, or mobile drug storage unit. Based on observation, interview, and record review, the facility failed to ensure controlled medications were appropriately secured to prevent potential misappropriation of medications for 2 of 2 medication carts reviewed for medication storage. (Medication cart #1 and Medication cart #2) Findings include: 1. During a medication storage observation of medication cart one (1) , accompanied by Qualified Medication Aide (QMA) 3, on 4/23/26 at 12:01 p.m., the controlled substances drawer contained controlled medications. The drawer was opened by QMA 3 with a key. During an interview at the time of the observation, QMA 3 indicated narcotics were not counted with another staff member for verification. At the end of her shift the medication		*diversion/inaccurate controlled substance counts. However, upon identification of the potential concern, the practice was reviewed and revised to ensure only the qualified person on each shift has access to the scheduled drugs kept under double lock and stored in a substantially constructed cabinet within the mobile drug storage unit.* *As all residents with scheduled drugs ordered could be affected, thefollowing corrective actions were taken.* *The current system of securing the medications to ensure medication cabinets remain appropriately locked at all times except when authorized personnel are present has been reviewed and revised. Said revisions include the confirmation via reconciliation of controlled substance counts at the end of each shift with signed verification of the same and the securing of the secondary controlled substance drawer to ensure only the authorized staff on shift has access to both the controlled substance drawer key as well as the code for the medication cart wherein the drawer is located.* *All applicable staff have been educated as to the revised system. Any newly hired*	

	cart keys were placed in a locked treatment cart in the nurse's station. The treatment cart was locked using a numeric keypad lock. All nursing staff knew the code for the treatment cart. 2. During a medication storage observation of medication cart 2, accompanied by QMA 3 on 4/23/26 at 12:19 p.m., the controlled substances drawer contained controlled medications. The narcotic drawer was opened by QMA 3 with a key. During an interview at the time of the observation, QMA 3 indicated medications were passed from 7:00 a.m. to 8:00 p.m. Controlled substances were counted alone unless another nurse or QMA worked a half-shift. No one was assigned to the mediation carts on night shift since only CNAs worked. She was unable to hand the medication cart keys to the next shift. On 4/23/26 at 1:29 p.m., the DON indicated nursing staff count controlled substances by themselves unless another nursing staff member worked a half-shift. At the end of the shift, the keys for both medication carts were placed in a locked treatment cart in the nurse's station. The treatment was		*qualified staff shall receive said education at the time of orientation.* *As a means of quality assurance, the Administrator shall be responsible to audit the revised system to confirm compliance with reconciliation and appropriate security of the controlled substances at least three times weekly for four weeks, once weekly for two months, and then at least monthly for three months, ensuring monitoring for six months.*	

	locked with a keypad lock. A total of three QMAs, one Licensed Practical Nurse (LPN) and the DON had access to the key code. An undated facility policy titled, "Medication Storage Policy", provided by the Corporate Nurse Consultant on 4/23/26 at 3:49 p.m., indicated the following: "...The facility ensure that all medications are stored, secured, and maintained in accordance with Indiana state regulations, manufacturer guidelines, and accepted standards of practice to protect resident safety and medication integrity ...3. Controlled Substances A perpetual inventory log shall be maintained for all controlled substances. Counts must be completed each shift change and documented. Any discrepancies must be reported immediately per facility incident reporting procedures. 10. Documentation and Monitoring Routine audits of medication storage area shall be conducted at least monthly ...11. Staff Training. Staff handling medications must receive initial and ongoing training on medication storage requirements. Training shall include security, infection control, and regulatory compliance ...."			

R 0409	Infection Control - Noncompliance 410 IAC 16.2-5-12(d) (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on record review and interview, the facility failed to ensure residents' clinical records included an annual health statement for 7 of 7 residents reviewed for annual health statements. (Resident 33, Resident 35, Resident 36, Resident 28, Resident 20, Resident 25, and Resident 5) Findings include: 1. Resident 33's clinical record was reviewed on 4/22/26 at 9:44 a.m. Diagnoses included atrial fibrillation, hypothyroidism, and obstructive sleep apnea. The record lacked an annual health statement. 2. Resident 35's clinical record was reviewed on 4/22/26 at 10:34 a.m. Diagnoses included congestive heart failure, chronic obstructive pulmonary disease, and malnutrition. The record lacked an annual health	R 0409	*All applicable staff have been reeducated on the Annul Health Statement policy.* *As all residents could be affected, thefollowing corrective actions were taken.* *All applicable staff have been reeducated on the Annual Health Statement policy. All resident physicians were notified and new annual health statements have been received for 100% of residents and added to physician's orders. Any newly hired qualified staff shall receive said education at the time of orientation. New admission orders will request annual health statement from physician.* *As a means of quality assurance, the Director of Nursing or designee shall be responsible to audit new admissions to confirm compliance at least three times weekly for four weeks, once weekly for two months, and then at least monthly for three months, ensuring monitoring for six months.*	05/15/2026

	statement. 3. Resident 36's clinical record was reviewed on 4/22/26 at 11:31 a.m. Diagnoses included pneumonia, atrial fibrillation (abnormal heart rhythm) and shortness of breath. The record lacked an annual health statement. 4. Resident 28's clinical record was reviewed on 4/22/26 at 12:46 p.m. Diagnoses included Alzheimer's disease, hypertension, anxiety, and restless leg syndrome. The record lacked an annual health statement. 5. Resident 20's clinical record was reviewed on 4/22/26 at 12:57 p.m. Diagnoses included chronic kidney disease and cerebral infarction without residual deficits. The record lacked an annual health statement. 6. Resident 25's clinical record was reviewed on 4/22/27 at 2:35 p.m. Diagnoses included unspecified dementia and restless leg syndrome. The record lacked an annual health statement. 7. Resident 5's clinical record was reviewed on 4/22/26 at 3:58 p.m. Diagnosis included hypertensive heart disease with heart failure, myoneural disorder, and acute kidney		*Should concerns be identified, immediate corrective action shall be taken, re-education provided, and the frequency of auditing increased or extended as warranted.*	

	failure. The record lacked an annual health statement. During an interview on 4/23/26 at 2:22 p.m., the Corporate Nurse Consultant indicated she was not able to find the above residents' annual health statements. She did not have any further information to provide. A current facility policy, undated, titled " POLICY: Annual Health Statement Review," provided by the Corporate Nurse Consultant on 4/23/26 at 3:07 p.m., indicated the following: "Policy Statement... The community shall ensure that each resident has a current health status evaluation on file that is reviewed and updated at least annually, or more frequently as needed, in accordance with applicable Indiana regulations...."			
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 utilize hand hygiene for infection prevention	R 0414	*QMA 4 has been reeducated on infection control policy and hand washing protocol.* *As all residents could be affected, thefollowing corrective actions were taken.* *All staff have been reeducated on the infection control policy and handwashing protocol with return demonstration. Any newly hired qualified staff shall receive*	05/15/2026

	and control during medication administration for 3 of 6 random medication administration observations. (Resident 12, Resident 14, and Resident 18) Findings include: During a continuous medication administration on 4/22/26 at 12:15 p.m., QMA 4 handed a cup of medications to an unidentified resident in the dining room then collected the empty medication cup in her right hand and disposed of the cup in the trash. She returned to the medication cart, unlocked the cart, used the keyboard to look up the next resident for medication administration. QMA 4 retrieved the following medication out of Medication Cart 1 for Resident 12: acetaminophen (pain) extra strength 1000 milligrams (mg). She locked the cart, poured a cup of water from the pitcher, and handed the pill cup and the water cup to Resident 12 in the dining room. Resident 12 took the medication in the cup and handed the pill cup back to QMA 4. QMA 4 disposed of the used medication cup, typed on the keyboard, moved to Medication Cart 2, and typed in the code to unlock the cart. On 4/22/26 at 12:19 p.m., QMA 4 retrieved the following medication out of Medication Cart 2 for resident 14:		*said education at the time of orientation.* *As a means of quality assurance, the Director of Nursing or designee shall be responsible to audit handwashing to confirm compliance at least three times weekly for four weeks, once weekly for two months, and then at least monthly for three months, ensuring monitoring for six months.* *Should concerns be identified, immediate corrective action shall be taken, re-education provided, and the frequency of auditing increased or extended as warranted.*	

	acetaminophen (pain) 1000 mg. She poured a cup of water and handed the medication cup and water to Resident 14 in the dining room. Resident 14 took the medication and handed the pill cup back to QMA 4. QMA 4 touched the dining room table with her left hand and used her left hand to pat Resident 14 on the shoulder. She used her right hand to dispose of the used medication cup, typed with her hands on the keyboard, then continued to prepare medication for Resident 18. On 4/22/26 at 12:25 p.m., QMA 4 used her right hand to open Resident 18's door to ensure the resident was available. She returned to Medication Cart 2, unlocked the cart with her right hand on the numeric pad, and retrieved the following medications for Resident 18: hydralazine (blood pressure) 25 mg, losartan potassium (blood pressure) 100 mg, metformin hydrochloride (diabetes) 500 mg, metoprolol succinate (blood pressure/heart rate) extended release 100 mg, potassium chloride extended release 20 milliequivalents (mEq), vitamin B12 extended release 1000 micrograms, and women's daily multivitamin with minerals one tablet. She poured a cup of water and delivered the medication cup and water to the resident. Resident 18 took the medication and handed the pill and water cup back to QMA 4.			

	QMA 4 disposed of the cups in the resident's waste basket, exited the room, shut the resident's door, picked up the computer from Medication Cart 2, and returned to Medication Cart 1. She used her right hand on the keypad to unlock Medication Cart 1 and moved some items around in Medication Cart 1. The observation ended on 4/22/26 at 12:38 p.m. Hand hygiene was not performed at any time during the continuous medication administration observations. During an interview on 4/22/26 at 3:38 p.m., QMA 4 indicated she had not performed hand hygiene during the medication administration observation for the above mentioned residents because she was nervous. She should have completed hand hygiene before starting her medication pass and after each resident administration. Hand hygiene was also required when entering and exiting residents' rooms and after touching surfaces. Hand hygiene was important to prevent contamination and the spread of bacteria. On 4/23/26 at 1:40 p.m., the DON indicated staff should have performed hand hygiene between the administration of each resident's medications			

	during medication administration. A current facility policy, last revised 3/2020, titled "Infection Prevention & Control," provided by the Corporate Nurse Consultant on 4/22/26 at 12:20 p.m., indicated the following: "PURPOSE: To minimize the risk of transmission of infection to staff members and residents. POLICY: It is the policy of this community to prevent and/or minimize the spread of infectious diseases through infection control practices based on a variety of resources including but not limited to, guidelines from The Centers for Disease Control and Prevention (CDC)...."			

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 SIGNATUREStaci Keen	TITLEExecutive Director	(X6) DATE05/15/2026