STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	11/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIMROSE OF NEWBURGH	9800 LINCOLN AVE, NEWBURGH, , 47630

(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 Intakes IN00465594 and IN00465742. Intake IN00465594 - State deficiencies related to the allegations are cited at R241, R243, and R247. Intake IN00465742 - No deficiencies related to the allegations are cited. Survey dates: October 30, 31, and November 3, 2025 Facility number: 013846 Residential Census: 68 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on November 7, 2025.	R 0000		

R 0095	Administration and Management -Noncompliance 410 IAC 16.2-5-1.3(l)(1-2) (l) In facilities that are required under IC 12-10-5.5 to submit an Alzheimer's and dementia special care unit disclosure form, the facility must designate a director for the Alzheimer's and dementia special care unit. The director shall have an earned degree from an educational institution in a health care, mental health, or social service profession or be a licensed health facility administrator. The director shall have a minimum of one (1) year work experience with dementia or Alzheimer's residents, or both, within the past five (5) years. Persons serving as a director for an existing Alzheimer's and dementia special care unit at the time of adoption of this rule are exempt from the degree and experience requirements. The director shall have a minimum of twelve (12) hours of dementia-specific training within three (3) months of initial employment as the director of the Alzheimer's and dementia special care unit and six (6) hours annually thereafter to: (1) meet the needs or preferences, or both, of cognitively impaired residents; and (2) gain understanding of the current standards of care for residents with dementia. Based on interview and record review, the facility failed to	R 0095	DON will complete 12 hours of dementia specific training within 3 months of initial employment and maintain 6 hours annually thereafter DON will complete annual dementia specific training and maintain 6 hours of training annually DON will complete remaining 9 hours of dementia specific training in Relias by 11/29/25 DON will complete 4.5 hours of training week of 11/17/25 and 4.5 hours of training week of 11/24/25 to be in compliance with state requirement. Executive Director or designee will audit required trainings of all staff weekly x 3 months, then 2x monthly for 2 months, then monthly thereafter for compliance with all staff	11/14/2025

	ensure the Dementia Care Director had twelve hours of dementia-specific training within three months of initial employment as the director of the dementia care unit. (Director of Nursing) Finding includes: On 10/31/25 at 8:28 A.M., the employee files were reviewed. The Director of Nursing (DON) was listed as the Dementia Care Director with a start date of 7/23/25. The DON lacked nine dementia-specific inservices completed within the first three months of initial employment. On 11/3/25 at 8:53 A.M., the Administrator indicated that the DON was the Dementia Care Director and had been in that role for over three months, and no other dementia inservices had been completed. On 11/3/25 at 12:00 P.M., the DON provided a current Philosophy of Health Services and Roles of Nursing/Clinical Team policy, dated 1/1/15, that indicated "It is the policy ...to adhere to all applicable State Licensing Regulations and Local Requirements ...in the provision of health and wellness services to our residents. It is expected that all employees ...will be knowledgeable of these requirements and strive to meet their intent in the provision of			

services to our residents".

Based on interview and record review, the facility failed to ensure the Dementia Care Director had twelve hours of dementia-specific training within three months of initial employment as the director of the dementia care unit. (Director of Nursing)

Finding includes:

On 10/31/25 at 8:28 A.M., the employee files were reviewed. The Director of Nursing (DON) was listed as the Dementia Care Director with a start date of 7/23/25. The DON lacked nine dementia-specific inservices completed within the first three months of initial employment.

On 11/3/25 at 8:53 A.M., the Administrator indicated that the DON was the Dementia Care Director and had been in that role for over three months, and no other dementia inservices had been completed.

On 11/3/25 at 12:00 P.M., the DON provided a current Philosophy of Health Services and Roles of Nursing/Clinical Team policy, dated 1/1/15, that indicated "It is the policy ...to adhere to all applicable State Licensing Regulations and Local Requirements ...in the provision of health and wellness services to our residents. It is expected that all employees ...will be

	knowledgeable of these requirements and strive to meet their intent in the provision of services to our residents".			
R 0241	Health Services - Offense 410 IAC 16.2-5-4(e)(1) (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. 4. During an anonymous interview on 10/31/25 at 9:35 A.M., it was indicated that Resident B's podiatrist had allegedly clipped or cut the resident's little toe and the wound was not cleaned for five days by facility staff. It was indicated the facility did not call the resident's emergency contact to notify them of what had happened or that the toe looked infected. The resident was taken to the Emergency Room on 3/25/25 where the resident was admitted and received Intravenous (IV) Antibiotics for seven days. The resident returned to the facility on 4/8/25 with new orders for dressing changes daily and	R 0241	Residents B, C, G and E were not administered insulin correctly per company policy with priming of insulin pens. Resident B order for wound care not properly transcribed into existing MAR Auditing of all resident records for diagnosis of diabetes who are insulin dependent to ensure is denoted on individual charts. Daily weights will be added to indicated resident charts and updated to reflect on resident profiles which will be turned in to DON/ADON designee daily Medication administration records will be updated for nurses only to administer insulin. Daily weights will be added to indicated resident charts and updated to reflect on resident profiles which will be turned in to DON/ADON designee daily. Employee files to be updated with records indicating have been trained/certified in insulin administration. New orders to be reviewed by DON/ADON or designee daily to ensure proper transcription practices chart. 10 charts to be audited weekly for 1 month, 5 charts audited for 1 month until compliance with health profile has been made up to date. Daily	11/14/2025

	assistance from home health twice a week. It was indicated that during the healing process a portion of the little toe had fallen off. On 10/31/35 at 11:30 A.M., Resident B's left foot was observed. The fifth toe was observed to be crusted to the fifth metatarsal (foot bone in the middle of the foot). The skin was red and orange colored in that area. On 10/31/25 at 11:35 A.M., Resident B's clinical record was reviewed. Diagnoses included, but were not limited to, Age-related osteoporosis without current pathological fracture, essential hypertension, and hyperlipidemia. A faxed physician order, dated 3/11/25, indicated: Left fourth toe - cleanse site daily with saline. Then apply with bandage for five days until healed. Use gel sleeve on left fifth toe to help decrease friction between digits, will need assistance with applying sleeve. The clinical record indicated the gel sleeves were dispensed to the facility on 3/11/25.		weights will be added to indicated resident charts and updated to reflect on resident profiles which will be turned in to DON/ADON designee daily for monitoring. DON/designee will audit daily weights weekly for 30 days then monthly thereafter. Training to be completed reflective of company policy starting 11/24/25. Medication pass audits to be completed on all qualified staff weekly x1 month, then 2x/week for 1 month then monthly for 4 months. Orders will be reviewed in medical record daily by DON/ADON or designee	

	The Medication Administration Record (MAR) for March 2025 was reviewed and lacked the physician's order for wound care received on 3/11/25. The clinical record lacked any documentation of the assessment of the wound in the progress notes. During an interview on 11/3/25 at 9:18 A.M., the Director of Nursing (DON) indicated that she did not know about the order from the podiatrist on the 3/11/25 or why it was not on the Medication Administration Record (MAR). She did not know why there was no documentation about the wound in the nurses' notes. On 11/3/25 at 11:56 A.M., the Administrator proved a current policy "Communicating with Resident's Physician" dated 1/1/15. The policy indicated to "incorporate all orders from resident's health care provider into resident's medication/treatment record ...". On 11/3/25 at 12:00 P.M., a current Insulin Pen Device policy, dated 9/23/2019, indicated, " ...Priming the insulin pen. a. Dial 2 units by turning the dose selector clockwise. b. With the needle pointing up, push on the plunger, and watch to see that at least one drop of insulin appears on the tip of the			

needle. Repeat this procedure if needed until at least one drop of insulin appears ..."

On 11/3/25 at 12:00 P.M., a current Insulin Administration policy, revised 12/31/2018, was received and indicated, " ...Wash hands thoroughly ..."

On 11/3/25 at 12:00 P.M., the Administrator provided a current Administration of Medications policy, last revised 12/31/18, that indicated "Medications are administered in accordance with written orders of the physician or other authorized prescriber".

On 11/3/25 at 12:37 P.M., the DON indicated that QMAs were expected to follow their scope of practice.

On 11/3/25 at 12:45 P.M., the QMA Scope of Practice was reviewed. It indicated "The following tasks shall NOT be included in the QMA scope of practice: (1) Administer medication by the injection route, including the following: ... (C) Subcutaneous route".

This citation relates to Intake IN00465594.

2. During an observation on 10/30/25 at 10:59 A.M., Licensed Practical Nurse (LPN) 5 administered insulin to Resident G. LPN 5 removed insulin lispro kwikpen 100unit/ml (milliliter), placed the needle on,

set the pen to 6 units, entered the room, lathered her hands for an 8 second hand lather, donned gloves, cleaned Resident G's right arm with an alcohol swab and injected the insulin. LPN 5 failed to prime the insulin pen before she administered insulin to Resident G.

During an interview on 10/30/25 at 11:02 A.M., LPN 5 indicated the insulin pen should have been primed the first time the insulin pen was opened and did not need to be primed after the first use.

During an interview on 11/3/25 at 9:18 A.M., the Director of Nursing (DON) indicated hands should have been lathered for 40-60 seconds when hand hygiene was performed.

On 10/30/25 at 1:27 P.M., Resident G's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus and hypertension.

Current physician orders included, but were not limited to:

Insulin lispro kwikpen 100U (units)/ML (milliliter) subcutaneous injection, inject 6 units before meals, may self administer after nurse verifies, dated 8/13/24.

Lantus (insulin) injection 100/ML subcutaneous injection, inject

	25 units at bedtime, dated 6/3/25. Resident G's October 2025 medication administration record (MAR) indicated the following times insulin lispro was administered by a non-insulin certified QMA: 10/11/25 at 11:30 A.M. 10/11/25 at 4:30 P.M. 10/15/25 at 4:30 P.M. Resident G's October 2025 MAR indicated the following times insulin lispro was self administered, but not verified by a licensed nurse prior to administration: 10/1/25 at 8:00 A.M. 10/1/25 at 4:30 P.M. 10/3/25 at 8:00 A.M. 10/3/25 at 11:30 A.M. 10/5/25 at 8:00 A.M. 10/6/25 at 4:30 P.M. 10/9/25 at 4:30 P.M. 10/10/25 at 4:30 P.M. 10/12/25 at 8:00 A.M. 10/12/25 at 11:30 A.M. 10/12/25 at 4:30 P.M.			

	10/13/25 at 4:30 P.M. 10/15/25 at 8:00 A.M. 10/15/25 at 11:30 A.M. 10/16/25 at 4:30 P.M. 10/18/25 at 8:00 A.M. 10/19/25 at 4:30 P.M. 10/24/25 at 4:30 P.M. 10/28/25 at 11:30 A.M. 10/28/25 at 4:30 P.M. 10/29/25 at 8:00 A.M. 10/29/25 at 11:30 A.M. Resident G's October 2025 medication administration record (MAR) indicated the following times Lantus was administered by a non-insulin certified QMA: 10/12/25 at 8:00 P.M. Resident G's October 2025 MAR indicated the following times Lantus was self administered, but not verified by a licensed nurse prior to administration: 10/1/25 at 8:00 P.M. 10/4/25 at 8:00 P.M. 10/6/25 at 8:00 P.M.			

	10/9/25 at 8:00 P.M. 10/10/25 at 8:00 P.M. 10/15/25 at 8:00 P.M. 10/16/25 at 8:00 P.M. 10/17/25 at 8:00 P.M. 10/18/25 at 8:00 P.M. 10/19/25 at 8:00 P.M. 10/20/25 at 8:00 P.M. 10/24/25 at 8:00 P.M. 10/28/25 at 8:00 P.M. Based on observation, interview, and record review, the facility failed to ensure medication administration and nursing care was provided by qualified staff and according to physician orders for 3 of 3 residents reviewed for insulin use (Resident G, Resident E, Resident C) and 1 of 1 residents reviewed for wounds (Resident B). QMAs not certified to administer insulin had documented on twelve different occasions that insulin was administered to two different residents.(Resident C and Resident G) An insulin pen was not primed prior to administration. Daily weights were not completed and wound care was not provided.			

Findings include:

1. On 10/30/25 at 11:04 A.M., Resident C's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus.

Physician orders included but were not limited to:

Humalog (a fast-acting insulin) 100 units per milliliter (units/mL) - Inject subcutaneously as directed per sliding scare before meals. If blood glucose is 150-180, give 1 unit; 190-229, give 2 units; 230-269, give 3 units; 270-299, give 4 units; if blood glucose is greater than or equal to 300, give 5 units and recheck blood glucose at next ordered time, dated 9/7/25

A review of the Medication Administration Record (MAR) for September and October 2025 indicated QMAs without insulin certification gave insulin to Resident C on the following days:

9/13/25 at 7:00 A.M. (given by QMA 7)

9/19/25 at 7:00 A.M. (given by QMA 7)

9/20/25 at 7:00 A.M. (given by QMA 30)

9/29/25 at 4:00 P.M. (given by QMA 16)

	10/5/25 at 7:00 A.M. (given by QMA 30) 10/12/25 at 7:00 A.M. (given by QMA 30) 10/12/25 at 11:00 A.M. (given by QMA 30) 10/15/25 at 11:00 A.M. (given by QMA 30) 10/29/25 at 11:00 A.M. (given by QMA 30) On 11/3/25 at 9:09 A.M., the Director of Nursing (DON) indicated that a QMA must be insulin certified to give insulin. 3. On 10/30/25 at 11:30 A.M., Resident E's clinical record was reviewed. Diagnosis included, but was not limited to, type 2 diabetes mellitus. Physicians orders included, but were not limited to: --Daily Weight at 8:00 A.M. A review of the September and October 2025 Medication Administration Record lacked documentation that Resident E's Physicians Orders were completed as ordered on the following dates: Daily Weight: September 9, 11, 13, 17, 18, 19, and 26, 2025			

	During an interview on 11/3/25 at 9:58 A.M., the Director of Nursing (DON) indicated staff should have followed Physician's Orders and completed the daily weight. 4. During an anonymous interview on 10/31/25 at 9:35 A.M., it was indicated that Resident B's podiatrist had allegedly clipped or cut the resident's little toe and the wound was not cleaned for five days by facility staff. It was indicated the facility did not call the resident's emergency contact to notify them of what had happened or that the toe looked infected. The resident was taken to the Emergency Room on 3/25/25 where the resident was admitted and received Intravenous (IV) Antibiotics for seven days. The resident returned to the facility on 4/8/25 with new orders for dressing changes daily and assistance from home health twice a week. It was indicated that during the healing process a portion of the little toe had fallen off. On 10/31/35 at 11:30 A.M., Resident B's left foot was observed. The fifth toe was observed to be crusted to the fifth metatarsal (foot bone in the middle of the foot). The skin was red and orange colored in that area.			

	On 10/31/25 at 11:35 A.M., Resident B's clinical record was reviewed. Diagnoses included, but were not limited to, Age-related osteoporosis without current pathological fracture, essential hypertension, and hyperlipidemia. A faxed physician order, dated 3/11/25, indicated: Left fourth toe - cleanse site daily with saline. Then apply with bandage for five days until healed. Use gel sleeve on left fifth toe to help decrease friction between digits, will need assistance with applying sleeve. The clinical record indicated the gel sleeves were dispensed to the facility on 3/11/25. The Medication Administration Record (MAR) for March 2025 was reviewed and lacked the physician's order for wound care received on 3/11/25. The clinical record lacked any documentation of the assessment of the wound in the progress notes. During an interview on 11/3/25 at 9:18 A.M., the Director of Nursing (DON) indicated that she did not know about the order from the podiatrist on the 3/11/25 or why it was not on the Medication Administration Record (MAR). She did not know why there was no			

documentation about the wound in the nurses' notes.

On 11/3/25 at 11:56 A.M., the Administrator proved a current policy "Communicating with Resident's Physician" dated 1/1/15. The policy indicated to "incorporate all orders from resident's health care provider into resident's medication/treatment record ...".

On 11/3/25 at 12:00 P.M., a current Insulin Pen Device policy, dated 9/23/2019, indicated, " ...Priming the insulin pen. a. Dial 2 units by turning the dose selector clockwise. b. With the needle pointing up, push on the plunger, and watch to see that at least one drop of insulin appears on the tip of the needle. Repeat this procedure if needed until at least one drop of insulin appears ..."

On 11/3/25 at 12:00 P.M., a current Insulin Administration policy, revised 12/31/2018, was received and indicated, " ...Wash hands thoroughly ..."

On 11/3/25 at 12:00 P.M., the Administrator provided a current Administration of Medications policy, last revised 12/31/18, that indicated "Medications are administered in accordance with written orders of the physician or other authorized prescriber".

On 11/3/25 at 12:37 P.M., the DON indicated that QMAs were

expected to follow their scope of practice.

On 11/3/25 at 12:45 P.M., the QMA Scope of Practice was reviewed. It indicated "The following tasks shall NOT be included in the QMA scope of practice: (1) Administer medication by the injection route, including the following: ... (C) Subcutaneous route".

This citation relates to Intake IN00465594.

2. During an observation on 10/30/25 at 10:59 A.M., Licensed Practical Nurse (LPN) 5 administered insulin to Resident G. LPN 5 removed insulin lispro kwikpen 100unit/ml (milliliter), placed the needle on, set the pen to 6 units, entered the room, lathered her hands for an 8 second hand lather, donned gloves, cleaned Resident G's right arm with an alcohol swab and injected the insulin. LPN 5 failed to prime the insulin pen before she administered insulin to Resident G.

During an interview on 10/30/25 at 11:02 A.M., LPN 5 indicated the insulin pen should have been primed the first time the insulin pen was opened and did not need to be primed after the first use.

During an interview on 11/3/25 at 9:18 A.M., the Director of

Nursing (DON) indicated hands should have been lathered for 40-60 seconds when hand hygiene was performed.

On 10/30/25 at 1:27 P.M., Resident G's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus and hypertension.

Current physician orders included, but were not limited to:

Insulin lispro kwikpen 100U (units)/ML (milliliter) subcutaneous injection, inject 6 units before meals, may self administer after nurse verifies, dated 8/13/24.

Lantus (insulin) injection 100/ML subcutaneous injection, inject 25 units at bedtime, dated 6/3/25.

Resident G's October 2025 medication administration record (MAR) indicated the following times insulin lispro was administered by a non-insulin certified QMA:

10/11/25 at 11:30 A.M.

10/11/25 at 4:30 P.M.

10/15/25 at 4:30 P.M.

Resident G's October 2025 MAR indicated the following times insulin lispro was self administered, but not verified by a licensed nurse prior to

	administration: 10/1/25 at 8:00 A.M. 10/1/25 at 4:30 P.M. 10/3/25 at 8:00 A.M. 10/3/25 at 11:30 A.M. 10/5/25 at 8:00 A.M. 10/6/25 at 4:30 P.M. 10/9/25 at 4:30 P.M. 10/10/25 at 4:30 P.M. 10/12/25 at 8:00 A.M. 10/12/25 at 11:30 A.M. 10/12/25 at 4:30 P.M. 10/13/25 at 4:30 P.M. 10/15/25 at 8:00 A.M. 10/15/25 at 11:30 A.M. 10/16/25 at 4:30 P.M. 10/18/25 at 8:00 A.M. 10/19/25 at 4:30 P.M. 10/24/25 at 4:30 P.M. 10/28/25 at 11:30 A.M. 10/28/25 at 4:30 P.M. 10/29/25 at 8:00 A.M. 10/29/25 at 11:30 A.M.			

	Resident G's October 2025 medication administration record (MAR) indicated the following times Lantus was administered by a non-insulin certified QMA: 10/12/25 at 8:00 P.M. Resident G's October 2025 MAR indicated the following times Lantus was self administered, but not verified by a licensed nurse prior to administration: 10/1/25 at 8:00 P.M. 10/4/25 at 8:00 P.M. 10/6/25 at 8:00 P.M. 10/9/25 at 8:00 P.M. 10/10/25 at 8:00 P.M. 10/15/25 at 8:00 P.M. 10/16/25 at 8:00 P.M. 10/17/25 at 8:00 P.M. 10/18/25 at 8:00 P.M. 10/19/25 at 8:00 P.M. 10/20/25 at 8:00 P.M. 10/24/25 at 8:00 P.M. 10/28/25 at 8:00 P.M. Based on observation, interview, and record review, the facility failed to ensure			

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Findings include:

1. On 10/30/25 at 11:04 A.M., Resident C's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus.

Physician orders included but were not limited to:

Humalog (a fast-acting insulin) 100 units per milliliter (units/mL) - Inject subcutaneously as directed per sliding scare before meals. If blood glucose is 150-180, give 1 unit; 190-229, give 2 units; 230-269, give 3 units; 270-299, give 4 units; if blood glucose is greater than or equal to 300, give 5 units and recheck blood glucose at next ordered time, dated 9/7/25

	A review of the Medication Administration Record (MAR) for September and October 2025 indicated QMAs without insulin certification gave insulin to Resident C on the following days: 9/13/25 at 7:00 A.M. (given by QMA 7) 9/19/25 at 7:00 A.M. (given by QMA 7) 9/20/25 at 7:00 A.M. (given by QMA 30) 9/29/25 at 4:00 P.M. (given by QMA 16) 10/5/25 at 7:00 A.M. (given by QMA 30) 10/12/25 at 7:00 A.M. (given by QMA 30) 10/12/25 at 11:00 A.M. (given by QMA 30) 10/15/25 at 11:00 A.M. (given by QMA 30) 10/29/25 at 11:00 A.M. (given by QMA 30) On 11/3/25 at 9:09 A.M., the Director of Nursing (DON) indicated that a QMA must be insulin certified to give insulin. 3. On 10/30/25 at 11:30 A.M., Resident E's clinical record was reviewed. Diagnosis included, but was not limited to, type 2			

diabetes mellitus.

Physicians orders included, but were not limited to:

--Daily Weight at 8:00 A.M.

A review of the September and October 2025 Medication Administration Record lacked documentation that Resident E's Physicians Orders were completed as ordered on the following dates:

Daily Weight:

September 9, 11, 13, 17, 18, 19, and 26, 2025

During an interview on 11/3/25 at 9:58 A.M., the Director of Nursing (DON) indicated staff should have followed Physician's Orders and completed the daily weight.

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A faxed physician order, dated 3/11/25, indicated:

Left fourth toe - cleanse site daily with saline. Then apply with bandage for five days until healed. Use gel sleeve on left fifth toe to help decrease friction between digits, will need assistance with applying sleeve.

The clinical record indicated the gel sleeves were dispensed to the facility on 3/11/25.

The Medication Administration

	Record (MAR) for March 2025 was reviewed and lacked the physician's order for wound care received on 3/11/25. The clinical record lacked any documentation of the assessment of the wound in the progress notes. During an interview on 11/3/25 at 9:18 A.M., the Director of Nursing (DON) indicated that she did not know about the order from the podiatrist on the 3/11/25 or why it was not on the Medication Administration Record (MAR). She did not know why there was no documentation about the wound in the nurses' notes. On 11/3/25 at 11:56 A.M., the Administrator proved a current policy "Communicating with Resident's Physician" dated 1/1/15. The policy indicated to "incorporate all orders from resident's health care provider into resident's medication/treatment record ...". On 11/3/25 at 12:00 P.M., a current Insulin Pen Device policy, dated 9/23/2019, indicated, " ...Priming the insulin pen. a. Dial 2 units by turning the dose selector clockwise. b. With the needle pointing up, push on the plunger, and watch to see that at least one drop of insulin appears on the tip of the needle. Repeat this procedure if			

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A review of the Medication Administration Record (MAR) for September and October 2025 indicated QMAs without insulin certification gave insulin to Resident C on the following days:

9/13/25 at 7:00 A.M. (given by QMA 7)

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	During an interview on 11/3/25 at 9:58 A.M., the Director of Nursing (DON) indicated staff should have followed Physician's Orders and completed the daily weight. 4. During an anonymous interview on 10/31/25 at 9:35 A.M., it was indicated that Resident B's podiatrist had allegedly clipped or cut the resident's little toe and the wound was not cleaned for five days by facility staff. It was indicated the facility did not call the resident's emergency contact to notify them of what had happened or that the toe looked infected. The resident was taken to the Emergency Room on 3/25/25 where the resident was admitted and received Intravenous (IV) Antibiotics for seven days. The resident returned to the facility on 4/8/25 with new orders for dressing changes daily and assistance from home health twice a week. It was indicated that during the healing process a portion of the little toe had fallen off. On 10/31/35 at 11:30 A.M., Resident B's left foot was observed. The fifth toe was observed to be crusted to the fifth metatarsal (foot bone in the middle of the foot). The skin was red and orange colored in that area.			

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On 11/3/25 at 11:56 A.M., the Administrator proved a current policy "Communicating with Resident's Physician" dated 1/1/15. The policy indicated to "incorporate all orders from resident's health care provider into resident's medication/treatment record ...".

On 11/3/25 at 12:00 P.M., a current Insulin Pen Device policy, dated 9/23/2019, indicated, " ...Priming the insulin pen. a. Dial 2 units by turning the dose selector clockwise. b. With the needle pointing up, push on the plunger, and watch to see that at least one drop of insulin appears on the tip of the needle. Repeat this procedure if needed until at least one drop of insulin appears ..."

On 11/3/25 at 12:00 P.M., a current Insulin Administration policy, revised 12/31/2018, was received and indicated, " ...Wash hands thoroughly ..."

On 11/3/25 at 12:00 P.M., the Administrator provided a current Administration of Medications policy, last revised 12/31/18, that indicated "Medications are administered in accordance with written orders of the physician or other authorized prescriber".

On 11/3/25 at 12:37 P.M., the DON indicated that QMAs were

expected to follow their scope of practice.

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This citation relates to Intake IN00465594.

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Nursing (DON) indicated hands should have been lathered for 40-60 seconds when hand hygiene was performed.

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Current physician orders included, but were not limited to:

Insulin lispro kwikpen 100U (units)/ML (milliliter) subcutaneous injection, inject 6 units before meals, may self administer after nurse verifies, dated 8/13/24.

Lantus (insulin) injection 100/ML subcutaneous injection, inject 25 units at bedtime, dated 6/3/25.

Resident G's October 2025 medication administration record (MAR) indicated the following times insulin lispro was administered by a non-insulin certified QMA:

10/11/25 at 11:30 A.M.

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10/15/25 at 4:30 P.M.

Resident G's October 2025 MAR indicated the following times insulin lispro was self administered, but not verified by a licensed nurse prior to

	administration: 10/1/25 at 8:00 A.M. 10/1/25 at 4:30 P.M. 10/3/25 at 8:00 A.M. 10/3/25 at 11:30 A.M. 10/5/25 at 8:00 A.M. 10/6/25 at 4:30 P.M. 10/9/25 at 4:30 P.M. 10/10/25 at 4:30 P.M. 10/12/25 at 8:00 A.M. 10/12/25 at 11:30 A.M. 10/12/25 at 4:30 P.M. 10/13/25 at 4:30 P.M. 10/15/25 at 8:00 A.M. 10/15/25 at 11:30 A.M. 10/16/25 at 4:30 P.M. 10/18/25 at 8:00 A.M. 10/19/25 at 4:30 P.M. 10/24/25 at 4:30 P.M. 10/28/25 at 11:30 A.M. 10/28/25 at 4:30 P.M. 10/29/25 at 8:00 A.M. 10/29/25 at 11:30 A.M.			

	Resident G's October 2025 medication administration record (MAR) indicated the following times Lantus was administered by a non-insulin certified QMA: 10/12/25 at 8:00 P.M. Resident G's October 2025 MAR indicated the following times Lantus was self administered, but not verified by a licensed nurse prior to administration: 10/1/25 at 8:00 P.M. 10/4/25 at 8:00 P.M. 10/6/25 at 8:00 P.M. 10/9/25 at 8:00 P.M. 10/10/25 at 8:00 P.M. 10/15/25 at 8:00 P.M. 10/16/25 at 8:00 P.M. 10/17/25 at 8:00 P.M. 10/18/25 at 8:00 P.M. 10/19/25 at 8:00 P.M. 10/20/25 at 8:00 P.M. 10/24/25 at 8:00 P.M. 10/28/25 at 8:00 P.M. Based on observation, interview, and record review, the facility failed to ensure			

medication administration and nursing care was provided by qualified staff and according to physician orders for 3 of 3 residents reviewed for insulin use (Resident G, Resident E, Resident C) and 1 of 1 residents reviewed for wounds (Resident B). QMAs not certified to administer insulin had documented on twelve different occasions that insulin was administered to two different residents.(Resident C and Resident G) An insulin pen was not primed prior to administration. Daily weights were not completed and wound care was not provided.

Findings include:

1. On 10/30/25 at 11:04 A.M., Resident C's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus.

Physician orders included but were not limited to:

Humalog (a fast-acting insulin) 100 units per milliliter (units/mL) - Inject subcutaneously as directed per sliding scare before meals. If blood glucose is 150-180, give 1 unit; 190-229, give 2 units; 230-269, give 3 units; 270-299, give 4 units; if blood glucose is greater than or equal to 300, give 5 units and recheck blood glucose at next ordered time, dated 9/7/25

	A review of the Medication Administration Record (MAR) for September and October 2025 indicated QMAs without insulin certification gave insulin to Resident C on the following days: 9/13/25 at 7:00 A.M. (given by QMA 7) 9/19/25 at 7:00 A.M. (given by QMA 7) 9/20/25 at 7:00 A.M. (given by QMA 30) 9/29/25 at 4:00 P.M. (given by QMA 16) 10/5/25 at 7:00 A.M. (given by QMA 30) 10/12/25 at 7:00 A.M. (given by QMA 30) 10/12/25 at 11:00 A.M. (given by QMA 30) 10/15/25 at 11:00 A.M. (given by QMA 30) 10/29/25 at 11:00 A.M. (given by QMA 30) On 11/3/25 at 9:09 A.M., the Director of Nursing (DON) indicated that a QMA must be insulin certified to give insulin. 3. On 10/30/25 at 11:30 A.M., Resident E's clinical record was reviewed. Diagnosis included, but was not limited to, type 2			

diabetes mellitus.

Physicians orders included, but were not limited to:

--Daily Weight at 8:00 A.M.

A review of the September and October 2025 Medication Administration Record lacked documentation that Resident E's Physicians Orders were completed as ordered on the following dates:

Daily Weight:

September 9, 11, 13, 17, 18, 19, and 26, 2025

During an interview on 11/3/25 at 9:58 A.M., the Director of Nursing (DON) indicated staff should have followed Physician's Orders and completed the daily weight.

4. During an anonymous interview on 10/31/25 at 9:35 A.M., it was indicated that Resident B's podiatrist had allegedly clipped or cut the resident's little toe and the wound was not cleaned for five days by facility staff. It was indicated the facility did not call the resident's emergency contact to notify them of what had happened or that the toe looked infected. The resident was taken to the Emergency Room on 3/25/25 where the resident was admitted and received Intravenous (IV)

Antibiotics for seven days. The resident returned to the facility on 4/8/25 with new orders for dressing changes daily and assistance from home health twice a week. It was indicated that during the healing process a portion of the little toe had fallen off.

On 10/31/35 at 11:30 A.M., Resident B's left foot was observed. The fifth toe was observed to be crusted to the fifth metatarsal (foot bone in the middle of the foot). The skin was red and orange colored in that area.

On 10/31/25 at 11:35 A.M., Resident B's clinical record was reviewed. Diagnoses included, but were not limited to, Age-related osteoporosis without current pathological fracture, essential hypertension, and hyperlipidemia.

A faxed physician order, dated 3/11/25, indicated:

Left fourth toe - cleanse site daily with saline. Then apply with bandage for five days until healed. Use gel sleeve on left fifth toe to help decrease friction between digits, will need assistance with applying sleeve.

The clinical record indicated the gel sleeves were dispensed to the facility on 3/11/25.

The Medication Administration

	Record (MAR) for March 2025 was reviewed and lacked the physician's order for wound care received on 3/11/25. The clinical record lacked any documentation of the assessment of the wound in the progress notes. During an interview on 11/3/25 at 9:18 A.M., the Director of Nursing (DON) indicated that she did not know about the order from the podiatrist on the 3/11/25 or why it was not on the Medication Administration Record (MAR). She did not know why there was no documentation about the wound in the nurses' notes. On 11/3/25 at 11:56 A.M., the Administrator proved a current policy "Communicating with Resident's Physician" dated 1/1/15. The policy indicated to "incorporate all orders from resident's health care provider into resident's medication/treatment record ...". On 11/3/25 at 12:00 P.M., a current Insulin Pen Device policy, dated 9/23/2019, indicated, " ...Priming the insulin pen. a. Dial 2 units by turning the dose selector clockwise. b. With the needle pointing up, push on the plunger, and watch to see that at least one drop of insulin appears on the tip of the needle. Repeat this procedure if			

needed until at least one drop of insulin appears ..."

On 11/3/25 at 12:00 P.M., a current Insulin Administration policy, revised 12/31/2018, was received and indicated, " ...Wash hands thoroughly ..."

On 11/3/25 at 12:00 P.M., the Administrator provided a current Administration of Medications policy, last revised 12/31/18, that indicated "Medications are administered in accordance with written orders of the physician or other authorized prescriber".

On 11/3/25 at 12:37 P.M., the DON indicated that QMAs were expected to follow their scope of practice.

On 11/3/25 at 12:45 P.M., the QMA Scope of Practice was reviewed. It indicated "The following tasks shall NOT be included in the QMA scope of practice: (1) Administer medication by the injection route, including the following: ... (C) Subcutaneous route".

This citation relates to Intake IN00465594.

2. During an observation on 10/30/25 at 10:59 A.M., Licensed Practical Nurse (LPN) 5 administered insulin to Resident G. LPN 5 removed insulin lispro kwikpen 100unit/ml (milliliter), placed the needle on, set the pen to 6 units, entered

	the room, lathered her hands for an 8 second hand lather, donned gloves, cleaned Resident G's right arm with an alcohol swab and injected the insulin. LPN 5 failed to prime the insulin pen before she administered insulin to Resident G. During an interview on 10/30/25 at 11:02 A.M., LPN 5 indicated the insulin pen should have been primed the first time the insulin pen was opened and did not need to be primed after the first use. During an interview on 11/3/25 at 9:18 A.M., the Director of Nursing (DON) indicated hands should have been lathered for 40-60 seconds when hand hygiene was performed. On 10/30/25 at 1:27 P.M., Resident G's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus and hypertension. Current physician orders included, but were not limited to: Insulin lispro kwikpen 100U (units)/ML (milliliter) subcutaneous injection, inject 6 units before meals, may self administer after nurse verifies, dated 8/13/24. Lantus (insulin) injection 100/ML subcutaneous injection, inject 25 units at bedtime, dated			

	6/3/25. Resident G's October 2025 medication administration record (MAR) indicated the following times insulin lispro was administered by a non-insulin certified QMA: 10/11/25 at 11:30 A.M. 10/11/25 at 4:30 P.M. 10/15/25 at 4:30 P.M. Resident G's October 2025 MAR indicated the following times insulin lispro was self administered, but not verified by a licensed nurse prior to administration: 10/1/25 at 8:00 A.M. 10/1/25 at 4:30 P.M. 10/3/25 at 8:00 A.M. 10/3/25 at 11:30 A.M. 10/5/25 at 8:00 A.M. 10/6/25 at 4:30 P.M. 10/9/25 at 4:30 P.M. 10/10/25 at 4:30 P.M. 10/12/25 at 8:00 A.M. 10/12/25 at 11:30 A.M. 10/12/25 at 4:30 P.M.			

	10/13/25 at 4:30 P.M. 10/15/25 at 8:00 A.M. 10/15/25 at 11:30 A.M. 10/16/25 at 4:30 P.M. 10/18/25 at 8:00 A.M. 10/19/25 at 4:30 P.M. 10/24/25 at 4:30 P.M. 10/28/25 at 11:30 A.M. 10/28/25 at 4:30 P.M. 10/29/25 at 8:00 A.M. 10/29/25 at 11:30 A.M. Resident G's October 2025 medication administration record (MAR) indicated the following times Lantus was administered by a non-insulin certified QMA: 10/12/25 at 8:00 P.M. Resident G's October 2025 MAR indicated the following times Lantus was self administered, but not verified by a licensed nurse prior to administration: 10/1/25 at 8:00 P.M. 10/4/25 at 8:00 P.M. 10/6/25 at 8:00 P.M.			

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Findings include:

1. On 10/30/25 at 11:04 A.M., Resident C's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus.

Physician orders included but were not limited to:

Humalog (a fast-acting insulin) 100 units per milliliter (units/mL) - Inject subcutaneously as directed per sliding scare before meals. If blood glucose is 150-180, give 1 unit; 190-229, give 2 units; 230-269, give 3 units; 270-299, give 4 units; if blood glucose is greater than or equal to 300, give 5 units and recheck blood glucose at next ordered time, dated 9/7/25

A review of the Medication Administration Record (MAR) for September and October 2025 indicated QMAs without insulin certification gave insulin to Resident C on the following days:

9/13/25 at 7:00 A.M. (given by QMA 7)

9/19/25 at 7:00 A.M. (given by QMA 7)

9/20/25 at 7:00 A.M. (given by QMA 30)

9/29/25 at 4:00 P.M. (given by QMA 16)

	10/5/25 at 7:00 A.M. (given by QMA 30) 10/12/25 at 7:00 A.M. (given by QMA 30) 10/12/25 at 11:00 A.M. (given by QMA 30) 10/15/25 at 11:00 A.M. (given by QMA 30) 10/29/25 at 11:00 A.M. (given by QMA 30) On 11/3/25 at 9:09 A.M., the Director of Nursing (DON) indicated that a QMA must be insulin certified to give insulin. 3. On 10/30/25 at 11:30 A.M., Resident E's clinical record was reviewed. Diagnosis included, but was not limited to, type 2 diabetes mellitus. Physicians orders included, but were not limited to: --Daily Weight at 8:00 A.M. A review of the September and October 2025 Medication Administration Record lacked documentation that Resident E's Physicians Orders were completed as ordered on the following dates: Daily Weight: September 9, 11, 13, 17, 18, 19, and 26, 2025			

	During an interview on 11/3/25 at 9:58 A.M., the Director of Nursing (DON) indicated staff should have followed Physician's Orders and completed the daily weight. 4. During an anonymous interview on 10/31/25 at 9:35 A.M., it was indicated that Resident B's podiatrist had allegedly clipped or cut the resident's little toe and the wound was not cleaned for five days by facility staff. It was indicated the facility did not call the resident's emergency contact to notify them of what had happened or that the toe looked infected. The resident was taken to the Emergency Room on 3/25/25 where the resident was admitted and received Intravenous (IV) Antibiotics for seven days. The resident returned to the facility on 4/8/25 with new orders for dressing changes daily and assistance from home health twice a week. It was indicated that during the healing process a portion of the little toe had fallen off. On 10/31/35 at 11:30 A.M., Resident B's left foot was observed. The fifth toe was observed to be crusted to the fifth metatarsal (foot bone in the middle of the foot). The skin was red and orange colored in that area.			

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documentation about the wound in the nurses' notes.

On 11/3/25 at 11:56 A.M., the Administrator proved a current policy "Communicating with Resident's Physician" dated 1/1/15. The policy indicated to "incorporate all orders from resident's health care provider into resident's medication/treatment record ...".

On 11/3/25 at 12:00 P.M., a current Insulin Pen Device policy, dated 9/23/2019, indicated, " ...Priming the insulin pen. a. Dial 2 units by turning the dose selector clockwise. b. With the needle pointing up, push on the plunger, and watch to see that at least one drop of insulin appears on the tip of the needle. Repeat this procedure if needed until at least one drop of insulin appears ..."

On 11/3/25 at 12:00 P.M., a current Insulin Administration policy, revised 12/31/2018, was received and indicated, " ...Wash hands thoroughly ..."

On 11/3/25 at 12:00 P.M., the Administrator provided a current Administration of Medications policy, last revised 12/31/18, that indicated "Medications are administered in accordance with written orders of the physician or other authorized prescriber".

On 11/3/25 at 12:37 P.M., the DON indicated that QMAs were

expected to follow their scope of practice.

On 11/3/25 at 12:45 P.M., the QMA Scope of Practice was reviewed. It indicated "The following tasks shall NOT be included in the QMA scope of practice: (1) Administer medication by the injection route, including the following: ... (C) Subcutaneous route".

This citation relates to Intake IN00465594.

2. During an observation on 10/30/25 at 10:59 A.M., Licensed Practical Nurse (LPN) 5 administered insulin to Resident G. LPN 5 removed insulin lispro kwikpen 100unit/ml (milliliter), placed the needle on, set the pen to 6 units, entered the room, lathered her hands for an 8 second hand lather, donned gloves, cleaned Resident G's right arm with an alcohol swab and injected the insulin. LPN 5 failed to prime the insulin pen before she administered insulin to Resident G.

During an interview on 10/30/25 at 11:02 A.M., LPN 5 indicated the insulin pen should have been primed the first time the insulin pen was opened and did not need to be primed after the first use.

During an interview on 11/3/25 at 9:18 A.M., the Director of

Nursing (DON) indicated hands should have been lathered for 40-60 seconds when hand hygiene was performed.

On 10/30/25 at 1:27 P.M., Resident G's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus and hypertension.

Current physician orders included, but were not limited to:

Insulin lispro kwikpen 100U (units)/ML (milliliter) subcutaneous injection, inject 6 units before meals, may self administer after nurse verifies, dated 8/13/24.

Lantus (insulin) injection 100/ML subcutaneous injection, inject 25 units at bedtime, dated 6/3/25.

Resident G's October 2025 medication administration record (MAR) indicated the following times insulin lispro was administered by a non-insulin certified QMA:

10/11/25 at 11:30 A.M.

10/11/25 at 4:30 P.M.

10/15/25 at 4:30 P.M.

Resident G's October 2025 MAR indicated the following times insulin lispro was self administered, but not verified by a licensed nurse prior to

	administration: 10/1/25 at 8:00 A.M. 10/1/25 at 4:30 P.M. 10/3/25 at 8:00 A.M. 10/3/25 at 11:30 A.M. 10/5/25 at 8:00 A.M. 10/6/25 at 4:30 P.M. 10/9/25 at 4:30 P.M. 10/10/25 at 4:30 P.M. 10/12/25 at 8:00 A.M. 10/12/25 at 11:30 A.M. 10/12/25 at 4:30 P.M. 10/13/25 at 4:30 P.M. 10/15/25 at 8:00 A.M. 10/15/25 at 11:30 A.M. 10/16/25 at 4:30 P.M. 10/18/25 at 8:00 A.M. 10/19/25 at 4:30 P.M. 10/24/25 at 4:30 P.M. 10/28/25 at 11:30 A.M. 10/28/25 at 4:30 P.M. 10/29/25 at 8:00 A.M. 10/29/25 at 11:30 A.M.			

	Resident G's October 2025 medication administration record (MAR) indicated the following times Lantus was administered by a non-insulin certified QMA: 10/12/25 at 8:00 P.M. Resident G's October 2025 MAR indicated the following times Lantus was self administered, but not verified by a licensed nurse prior to administration: 10/1/25 at 8:00 P.M. 10/4/25 at 8:00 P.M. 10/6/25 at 8:00 P.M. 10/9/25 at 8:00 P.M. 10/10/25 at 8:00 P.M. 10/15/25 at 8:00 P.M. 10/16/25 at 8:00 P.M. 10/17/25 at 8:00 P.M. 10/18/25 at 8:00 P.M. 10/19/25 at 8:00 P.M. 10/20/25 at 8:00 P.M. 10/24/25 at 8:00 P.M. 10/28/25 at 8:00 P.M. Based on observation, interview, and record review, the facility failed to ensure			

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Findings include:

1. On 10/30/25 at 11:04 A.M., Resident C's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus.

Physician orders included but were not limited to:

Humalog (a fast-acting insulin) 100 units per milliliter (units/mL) - Inject subcutaneously as directed per sliding scare before meals. If blood glucose is 150-180, give 1 unit; 190-229, give 2 units; 230-269, give 3 units; 270-299, give 4 units; if blood glucose is greater than or equal to 300, give 5 units and recheck blood glucose at next ordered time, dated 9/7/25

	A review of the Medication Administration Record (MAR) for September and October 2025 indicated QMAs without insulin certification gave insulin to Resident C on the following days: 9/13/25 at 7:00 A.M. (given by QMA 7) 9/19/25 at 7:00 A.M. (given by QMA 7) 9/20/25 at 7:00 A.M. (given by QMA 30) 9/29/25 at 4:00 P.M. (given by QMA 16) 10/5/25 at 7:00 A.M. (given by QMA 30) 10/12/25 at 7:00 A.M. (given by QMA 30) 10/12/25 at 11:00 A.M. (given by QMA 30) 10/15/25 at 11:00 A.M. (given by QMA 30) 10/29/25 at 11:00 A.M. (given by QMA 30) On 11/3/25 at 9:09 A.M., the Director of Nursing (DON) indicated that a QMA must be insulin certified to give insulin. 3. On 10/30/25 at 11:30 A.M., Resident E's clinical record was reviewed. Diagnosis included, but was not limited to, type 2			

	diabetes mellitus. Physicians orders included, but were not limited to: --Daily Weight at 8:00 A.M. A review of the September and October 2025 Medication Administration Record lacked documentation that Resident E's Physicians Orders were completed as ordered on the following dates: Daily Weight: September 9, 11, 13, 17, 18, 19, and 26, 2025 During an interview on 11/3/25 at 9:58 A.M., the Director of Nursing (DON) indicated staff should have followed Physician's Orders and completed the daily weight.			
R 0243	Health Services - Deficiency 410 IAC 16.2-5-4(e)(3) (3) The individual administering the medication shall document the administration in the individual ' s medication and treatment records that indicate the: (A) time; (B) name of medication or treatment; (C) dosage (if applicable); and	R 0243	Auditing of all resident records for diagnosis of diabetes who are insulin dependent to ensure is denoted on individual charts. Daily weights will be added to indicated resident charts and updated to reflect on resident profiles which will be turned in to DON/ADON or designee daily. Medication administration records will be updated for nurses only to administer insulin. Daily weights	11/14/2025

	(D) name or initials of the person administering the drug or treatment. Based on interview and record review, the facility failed to ensure that the individual who administered insulin to a resident was the individual that documented the administration in the resident's medication record. (Resident C) Finding includes: On 10/30/25 at 11:04 A.M., Resident C's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus. Physician orders included, but were not limited to: Humalog (a fast-acting insulin) 100 units per milliliter (units/mL) - Inject subcutaneously as directed per sliding scare before meals. If blood glucose is 150-180, give 1 unit; 190-229, give 2 units; 230-269, give 3 units; 270-299, give 4 units; if blood glucose is greater than or equal to 300, give 5 units and recheck blood glucose at next ordered time, dated 9/7/25 A review of the Medication Administration Record (MAR) for September and October 2025 included the following days that the staff who documented the insulin		will be added to indicated resident charts and updated to reflect on resident profiles which will be turned in to DON/ADON designee daily Audits of all resident charts to be completed by 11/24/25 for diabetic residents to be denoted in chart. 10 charts to be audited weekly for 1 month, 5 charts audited for 1 month until compliance with health profile has been made up to date. Daily weights will be added to indicated resident charts and updated to reflect on resident profiles which will be turned in to DON/ADON designee daily for monitoring. Training to be completed reflective of company policy starting 11/24/25. Medication pass audits to be completed on all qualified staff weekly x1 month, then 2x/week for 1 month then monthly for 4 months	

	administration was not the staff who administered the insulin: 9/14/25 at 7:00 A.M. (QMA 30 indicated "nurse did insulin") 9/14/25 at 11:00 A.M. (QMA 30 indicated "nurse did insulin") 9/14/25 at 4:00 P.M. (QMA 30 indicated "nurse did insulin") 9/15/25 at 4:00 P.M. (QMA 30 indicated "nurse did resident insulin") 9/16/25 at 11:00 A.M. (QMA 30 indicated "nurse did insulin") 9/20/25 at 11:00 A.M. (QMA 28 indicated Licensed Practical Nurse (LPN) 5 "administered") 9/21/25 at 11:00 A.M. (QMA 28 indicated "LPN 5 administered") 9/21/25 at 4:00 P.M. (QMA 28 indicated "LPN 5 administered") 9/24/25 at 4:00 P.M. (QMA 30 indicated "nurse did it") 9/27/25 at 4:00 P.M. (QMA 14 indicated "given by nurse LPN 11") 10/1/25 at 7:00 A.M. (QMA 30 indicated "nurse administered") 10/8/25 at 4:00 P.M. (QMA 22 indicated "nurse DON passed med") 10/21/25 at 4:00 P.M. (QMA 9			

indicated "by DON")

10/25/25 at 4:00 P.M. (QMA 9 indicated "gave by LPN 11")

On 11/3/25 at 9:09 A.M., the Director of Nursing (DON) indicated the nurse who gave the insulin should have documented the administration of the insulin. She indicated that sometimes a nurse would forget to "click off" on the administration and the QMA would do it for them.

On 11/3/25 at 11:30 A.M., the DON provided a current Administration of Medications - General Guidelines policy, dated 1/1/15, that indicated "Medication administration is documented on the resident's Medication Administration Record (MAR) at the time that it occurs".

On 11/3/25 at 12:00 P.M., the DON provided a current Documentation Standards policy, dated 1/1/15, that indicated "Clinical documentation will be accurate ... The RN (Registered Nurse) and/or LPN will complete required sections of resident documentation".

This citation relates to Intake IN00465594.

Based on interview and record review, the facility failed to ensure that the individual who

	administered insulin to a resident was the individual that documented the administration in the resident's medication record. (Resident C) Finding includes: On 10/30/25 at 11:04 A.M., Resident C's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus. Physician orders included, but were not limited to: Humalog (a fast-acting insulin) 100 units per milliliter (units/mL) - Inject subcutaneously as directed per sliding scare before meals. If blood glucose is 150-180, give 1 unit; 190-229, give 2 units; 230-269, give 3 units; 270-299, give 4 units; if blood glucose is greater than or equal to 300, give 5 units and recheck blood glucose at next ordered time, dated 9/7/25 A review of the Medication Administration Record (MAR) for September and October 2025 included the following days that the staff who documented the insulin administration was not the staff who administered the insulin: 9/14/25 at 7:00 A.M. (QMA 30 indicated "nurse did insulin")			

	9/14/25 at 11:00 A.M. (QMA 30 indicated "nurse did insulin") 9/14/25 at 4:00 P.M. (QMA 30 indicated "nurse did insulin") 9/15/25 at 4:00 P.M. (QMA 30 indicated "nurse did resident insulin") 9/16/25 at 11:00 A.M. (QMA 30 indicated "nurse did insulin") 9/20/25 at 11:00 A.M. (QMA 28 indicated Licensed Practical Nurse (LPN) 5 "administered") 9/21/25 at 11:00 A.M. (QMA 28 indicated "LPN 5 administered") 9/21/25 at 4:00 P.M. (QMA 28 indicated "LPN 5 administered") 9/24/25 at 4:00 P.M. (QMA 30 indicated "nurse did it") 9/27/25 at 4:00 P.M. (QMA 14 indicated "given by nurse LPN 11") 10/1/25 at 7:00 A.M. (QMA 30 indicated "nurse administered") 10/8/25 at 4:00 P.M. (QMA 22 indicated "nurse DON passed med") 10/21/25 at 4:00 P.M. (QMA 9 indicated "by DON") 10/25/25 at 4:00 P.M. (QMA 9 indicated "gave by LPN 11") On 11/3/25 at 9:09 A.M., the			

	Director of Nursing (DON) indicated the nurse who gave the insulin should have documented the administration of the insulin. She indicated that sometimes a nurse would forget to "click off" on the administration and the QMA would do it for them. On 11/3/25 at 11:30 A.M., the DON provided a current Administration of Medications - General Guidelines policy, dated 1/1/15, that indicated "Medication administration is documented on the resident's Medication Administration Record (MAR) at the time that it occurs". On 11/3/25 at 12:00 P.M., the DON provided a current Documentation Standards policy, dated 1/1/15, that indicated "Clinical documentation will be accurate ... The RN (Registered Nurse) and/or LPN will complete required sections of resident documentation". This citation relates to Intake IN00465594.			
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	R 0247	MD to be notified of all resident's incidents and an incident report will be made in individual resident charts In-service completed by ED, DON and ADON completed on 11/19/25	11/14/2025

	medication administration when there are any actual or potential detrimental effects to the resident. Based on interview and record review, the facility failed to notify the physician of errors in medication administration for 3 of 3 resident records reviewed for insulin. Insulin doses were not communicated with the physician when missed. (Resident G, Resident C, Resident E) Findings include: 1. On 10/30/25 at 1:27 P.M., Resident G's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus and hypertension. Current physician orders included, but were not limited to: Insulin lispro kwikpen 100U (units)/ML (milliliter) subcutaneous injection, inject 6 units before meals, may self administer after nurse verifies, dated 8/13/24. Resident G's October 2025 medication administration record (MAR) indicated the following times administration of insulin lispro was left blank: 10/2/25 at 4:30 P.M. 10/3/25 at 4:30 P.M.		regarding notification of individual resident incidents Daily monitoring of resident incidents by ED, DON, ADON or designee and will be part of monthly in-servicing for clinical staff starting 11/19/25. See R241 for further plan of correction notes	

	10/5/25 at 4:30 P.M. 10/10/25 at 11:30 A.M. 10/14/25 at 11:30 A.M. 10/14/25 at 4:30 P.M. 10/18/25 at 11:30 A.M. 10/22/25 at 8:00 A.M. 10/22/25 at 11:30 A.M. 10/29/25 at 4:30 P.M. Resident G's clinical record lacked documentation that the physician was notified of any missed doses of insulin for the month of October 2025. 3. On 10/30/25 at 11:04 A.M., Resident C's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus. Physician orders included, but were not limited to: Humalog (a fast-acting insulin) 100 units per milliliter (units/mL) - Inject subcutaneously as directed per sliding scare before meals. If blood glucose is 150-180, give 1 unit; 190-229, give 2 units; 230-269, give 3 units; 270-299, give 4 units; if blood glucose is greater than or equal to 300, give 5 units and recheck blood glucose at next ordered time, dated 9/7/25			

	A review of the Medication Administration Record (MAR) for September and October 2025 indicated Humalog insulin 100 units/mL was not given on the following days: 9/10/25 at 7:00 A.M. 9/10/25 at 11:00 A.M. 9/10/25 at 4:00 P.M. 9/12/25 at 11:00 A.M. 9/12/25 at 4:00 P.M. 9/15/25 at 7:00 A.M. 9/16/25 at 7:00 A.M. 9/17/25 at 4:00 P.M. 9/18/25 at 4:00 P.M. 9/19/25 at 11:00 A.M. 9/20/25 at 4:00 P.M. 9/22/25 at 11:00 A.M. 9/23/25 at 7:00 A.M. 9/23/25 at 11:00 A.M. 9/24/25 at 7:00 A.M. 9/26/25 at 4:00 P.M. 9/27/25 at 7:00 A.M. 9/29/25 at 11:00 A.M 10/1/25 at 4:00 P.M.			

	10/2/25 at 4:00 P.M. 10/3/25 at 7:00 A.M. 10/3/25 at 4:00 P.M. 10/4/25 at 7:00 A.M. 10/9/25 at 4:00 P.M. 10/10/25 at 11:00 A.M. 10/10/25 at 4:00 P.M. 10/12/25 at 4:00 P.M. 10/14/25 at 7:00 A.M. 10/14/25 at 11:00 A.M. 10/14/25 at 4:00 P.M. 10/15/25 at 7:00 A.M. 10/16/25 at 7:00 A.M. 10/18/25 at 7:00 A.M. 10/19/25 at 4:00 P.M. 10/22/25 at 7:00 A.M. 10/22/25 at 11:00 A.M. 10/28/25 at 7:00 A.M. 10/28/25 at 11:00 A.M. 10/28/25 at 4:00 P.M. 10/29/25 at 7:00 A.M. 10/29/25 at 4:00 P.M. The clinical record lacked documentation to indicate the			

physician was notified of the missed doses of insulin.

On 11/3/25 at 12:10 P.M., the Director of Nursing (DON) indicated there was no way to know if insulin had been given or not when left blank in the MAR. She indicated when insulin was not given staff should have notified the physician and documented that notification in the clinical record.

On 11/3/25 at 12:00 P.M., the Administrator provided a current Documentation Standards policy, last revised 5/31/23, that indicated "Clinical documentation will be accurate, complete, timely, and by exception ... Clinical documentation will be factual and pertinent information about residents"

This citation relates to Intake IN00465594.

2. On 10/30/25 at 11:30 A.M., Resident E's clinical record was reviewed. Diagnosis included, but was not limited to, type 2 diabetes mellitus.

Physicians orders included, but were not limited to:

Lantus (insulin) injection 100/ml (milliliter) - inject 15 units subcutaneously once daily, start date 8/4/25.

A review of the September and

October Medication Administration Record lacked documentation that Resident E's Lantus was administered as ordered on the following dates:

October 5 and 9, 2025

The clinical record lacked documentation to indicate the physician was notified of the missed doses of Lantus.

Based on interview and record review, the facility failed to notify the physician of errors in medication administration for 3 of 3 resident records reviewed for insulin. Insulin doses were not communicated with the physician when missed. (Resident G, Resident C, Resident E)

Findings include:

1. On 10/30/25 at 1:27 P.M., Resident G's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus and hypertension.

Current physician orders included, but were not limited to:

Insulin lispro kwikpen 100U (units)/ML (milliliter) subcutaneous injection, inject 6 units before meals, may self administer after nurse verifies, dated 8/13/24.

Resident G's October 2025 medication administration

record (MAR) indicated the following times administration of insulin lispro was left blank:

10/2/25 at 4:30 P.M.

10/3/25 at 4:30 P.M.

10/5/25 at 4:30 P.M.

10/10/25 at 11:30 A.M.

10/14/25 at 11:30 A.M.

10/14/25 at 4:30 P.M.

10/18/25 at 11:30 A.M.

10/22/25 at 8:00 A.M.

10/22/25 at 11:30 A.M.

10/29/25 at 4:30 P.M.

Resident G's clinical record lacked documentation that the physician was notified of any missed doses of insulin for the month of October 2025.

3. On 10/30/25 at 11:04 A.M., Resident C's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus.

Physician orders included, but were not limited to:

Humalog (a fast-acting insulin) 100 units per milliliter (units/mL) - Inject subcutaneously as directed per sliding scare before meals. If blood glucose is 150-180, give 1 unit; 190-229,

	give 2 units; 230-269, give 3 units; 270-299, give 4 units; if blood glucose is greater than or equal to 300, give 5 units and recheck blood glucose at next ordered time, dated 9/7/25 A review of the Medication Administration Record (MAR) for September and October 2025 indicated Humalog insulin 100 units/mL was not given on the following days: 9/10/25 at 7:00 A.M. 9/10/25 at 11:00 A.M. 9/10/25 at 4:00 P.M. 9/12/25 at 11:00 A.M. 9/12/25 at 4:00 P.M. 9/15/25 at 7:00 A.M. 9/16/25 at 7:00 A.M. 9/17/25 at 4:00 P.M. 9/18/25 at 4:00 P.M. 9/19/25 at 11:00 A.M. 9/20/25 at 4:00 P.M. 9/22/25 at 11:00 A.M. 9/23/25 at 7:00 A.M. 9/23/25 at 11:00 A.M. 9/24/25 at 7:00 A.M.			

	9/26/25 at 4:00 P.M. 9/27/25 at 7:00 A.M. 9/29/25 at 11:00 A.M 10/1/25 at 4:00 P.M. 10/2/25 at 4:00 P.M. 10/3/25 at 7:00 A.M. 10/3/25 at 4:00 P.M. 10/4/25 at 7:00 A.M. 10/9/25 at 4:00 P.M. 10/10/25 at 11:00 A.M. 10/10/25 at 4:00 P.M. 10/12/25 at 4:00 P.M. 10/14/25 at 7:00 A.M. 10/14/25 at 11:00 A.M. 10/14/25 at 4:00 P.M. 10/15/25 at 7:00 A.M. 10/16/25 at 7:00 A.M. 10/18/25 at 7:00 A.M. 10/19/25 at 4:00 P.M. 10/22/25 at 7:00 A.M. 10/22/25 at 11:00 A.M. 10/28/25 at 7:00 A.M. 10/28/25 at 11:00 A.M.			

10/28/25 at 4:00 P.M.

10/29/25 at 7:00 A.M.

10/29/25 at 4:00 P.M.

The clinical record lacked documentation to indicate the physician was notified of the missed doses of insulin.

On 11/3/25 at 12:10 P.M., the Director of Nursing (DON) indicated there was no way to know if insulin had been given or not when left blank in the MAR. She indicated when insulin was not given staff should have notified the physician and documented that notification in the clinical record.

On 11/3/25 at 12:00 P.M., the Administrator provided a current Documentation Standards policy, last revised 5/31/23, that indicated "Clinical documentation will be accurate, complete, timely, and by exception ... Clinical documentation will be factual and pertinent information about residents"

This citation relates to Intake IN00465594.

2. On 10/30/25 at 11:30 A.M., Resident E's clinical record was reviewed. Diagnosis included, but was not limited to, type 2 diabetes mellitus.

Physicians orders included, but

were not limited to:

Lantus (insulin) injection 100/ml (milliliter) - inject 15 units subcutaneously once daily, start date 8/4/25.

A review of the September and October Medication Administration Record lacked documentation that Resident E's Lantus was administered as ordered on the following dates:

October 5 and 9, 2025

The clinical record lacked documentation to indicate the physician was notified of the missed doses of Lantus.

Based on interview and record review, the facility failed to notify the physician of errors in medication administration for 3 of 3 resident records reviewed for insulin. Insulin doses were not communicated with the physician when missed. (Resident G, Resident C, Resident E)

Findings include:

1. On 10/30/25 at 1:27 P.M., Resident G's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus and hypertension.

Current physician orders included, but were not limited to:

Insulin lispro kwikpen 100U

(units)/ML (milliliter) subcutaneous injection, inject 6 units before meals, may self administer after nurse verifies, dated 8/13/24.

Resident G's October 2025 medication administration record (MAR) indicated the following times administration of insulin lispro was left blank:

10/2/25 at 4:30 P.M.

10/3/25 at 4:30 P.M.

10/5/25 at 4:30 P.M.

10/10/25 at 11:30 A.M.

10/14/25 at 11:30 A.M.

10/14/25 at 4:30 P.M.

10/18/25 at 11:30 A.M.

10/22/25 at 8:00 A.M.

10/22/25 at 11:30 A.M.

10/29/25 at 4:30 P.M.

Resident G's clinical record lacked documentation that the physician was notified of any missed doses of insulin for the month of October 2025.

3. On 10/30/25 at 11:04 A.M., Resident C's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus.

Physician orders included, but

	were not limited to: Humalog (a fast-acting insulin) 100 units per milliliter (units/mL) - Inject subcutaneously as directed per sliding scare before meals. If blood glucose is 150-180, give 1 unit; 190-229, give 2 units; 230-269, give 3 units; 270-299, give 4 units; if blood glucose is greater than or equal to 300, give 5 units and recheck blood glucose at next ordered time, dated 9/7/25 A review of the Medication Administration Record (MAR) for September and October 2025 indicated Humalog insulin 100 units/mL was not given on the following days: 9/10/25 at 7:00 A.M. 9/10/25 at 11:00 A.M. 9/10/25 at 4:00 P.M. 9/12/25 at 11:00 A.M. 9/12/25 at 4:00 P.M. 9/15/25 at 7:00 A.M. 9/16/25 at 7:00 A.M. 9/17/25 at 4:00 P.M. 9/18/25 at 4:00 P.M. 9/19/25 at 11:00 A.M. 9/20/25 at 4:00 P.M.			

	9/22/25 at 11:00 A.M. 9/23/25 at 7:00 A.M. 9/23/25 at 11:00 A.M. 9/24/25 at 7:00 A.M. 9/26/25 at 4:00 P.M. 9/27/25 at 7:00 A.M. 9/29/25 at 11:00 A.M 10/1/25 at 4:00 P.M. 10/2/25 at 4:00 P.M. 10/3/25 at 7:00 A.M. 10/3/25 at 4:00 P.M. 10/4/25 at 7:00 A.M. 10/9/25 at 4:00 P.M. 10/10/25 at 11:00 A.M. 10/10/25 at 4:00 P.M. 10/12/25 at 4:00 P.M. 10/14/25 at 7:00 A.M. 10/14/25 at 11:00 A.M. 10/14/25 at 4:00 P.M. 10/15/25 at 7:00 A.M. 10/16/25 at 7:00 A.M. 10/18/25 at 7:00 A.M. 10/19/25 at 4:00 P.M.			

	10/22/25 at 7:00 A.M. 10/22/25 at 11:00 A.M. 10/28/25 at 7:00 A.M. 10/28/25 at 11:00 A.M. 10/28/25 at 4:00 P.M. 10/29/25 at 7:00 A.M. 10/29/25 at 4:00 P.M. The clinical record lacked documentation to indicate the physician was notified of the missed doses of insulin. On 11/3/25 at 12:10 P.M., the Director of Nursing (DON) indicated there was no way to know if insulin had been given or not when left blank in the MAR. She indicated when insulin was not given staff should have notified the physician and documented that notification in the clinical record. On 11/3/25 at 12:00 P.M., the Administrator provided a current Documentation Standards policy, last revised 5/31/23, that indicated "Clinical documentation will be accurate, complete, timely, and by exception ... Clinical documentation will be factual and pertinent information about residents"			

This citation relates to Intake IN00465594.

2. On 10/30/25 at 11:30 A.M., Resident E's clinical record was reviewed. Diagnosis included, but was not limited to, type 2 diabetes mellitus.

Physicians orders included, but were not limited to:

Lantus (insulin) injection 100/ml (milliliter) - inject 15 units subcutaneously once daily, start date 8/4/25.

A review of the September and October Medication Administration Record lacked documentation that Resident E's Lantus was administered as ordered on the following dates:

October 5 and 9, 2025

The clinical record lacked documentation to indicate the physician was notified of the missed doses of Lantus.

Based on interview and record review, the facility failed to notify the physician of errors in medication administration for 3 of 3 resident records reviewed for insulin. Insulin doses were not communicated with the physician when missed. (Resident G, Resident C, Resident E)

Findings include:

1. On 10/30/25 at 1:27 P.M., Resident G's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus and hypertension.

Current physician orders included, but were not limited to:

Insulin lispro kwikpen 100U (units)/ML (milliliter) subcutaneous injection, inject 6 units before meals, may self administer after nurse verifies, dated 8/13/24.

Resident G's October 2025 medication administration record (MAR) indicated the following times administration of insulin lispro was left blank:

10/2/25 at 4:30 P.M.

10/3/25 at 4:30 P.M.

10/5/25 at 4:30 P.M.

10/10/25 at 11:30 A.M.

10/14/25 at 11:30 A.M.

10/14/25 at 4:30 P.M.

10/18/25 at 11:30 A.M.

10/22/25 at 8:00 A.M.

10/22/25 at 11:30 A.M.

10/29/25 at 4:30 P.M.

Resident G's clinical record lacked documentation that the physician was notified of any

missed doses of insulin for the month of October 2025.

3. On 10/30/25 at 11:04 A.M., Resident C's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus.

Physician orders included, but were not limited to:

Humalog (a fast-acting insulin) 100 units per milliliter (units/mL) - Inject subcutaneously as directed per sliding scare before meals. If blood glucose is 150-180, give 1 unit; 190-229, give 2 units; 230-269, give 3 units; 270-299, give 4 units; if blood glucose is greater than or equal to 300, give 5 units and recheck blood glucose at next ordered time, dated 9/7/25

A review of the Medication Administration Record (MAR) for September and October 2025 indicated Humalog insulin 100 units/mL was not given on the following days:

9/10/25 at 7:00 A.M.

9/10/25 at 11:00 A.M.

9/10/25 at 4:00 P.M.

9/12/25 at 11:00 A.M.

9/12/25 at 4:00 P.M.

9/15/25 at 7:00 A.M.

	9/16/25 at 7:00 A.M. 9/17/25 at 4:00 P.M. 9/18/25 at 4:00 P.M. 9/19/25 at 11:00 A.M. 9/20/25 at 4:00 P.M. 9/22/25 at 11:00 A.M. 9/23/25 at 7:00 A.M. 9/23/25 at 11:00 A.M. 9/24/25 at 7:00 A.M. 9/26/25 at 4:00 P.M. 9/27/25 at 7:00 A.M. 9/29/25 at 11:00 A.M 10/1/25 at 4:00 P.M. 10/2/25 at 4:00 P.M. 10/3/25 at 7:00 A.M. 10/3/25 at 4:00 P.M. 10/4/25 at 7:00 A.M. 10/9/25 at 4:00 P.M. 10/10/25 at 11:00 A.M. 10/10/25 at 4:00 P.M. 10/12/25 at 4:00 P.M. 10/14/25 at 7:00 A.M. 10/14/25 at 11:00 A.M.			

	10/14/25 at 4:00 P.M. 10/15/25 at 7:00 A.M. 10/16/25 at 7:00 A.M. 10/18/25 at 7:00 A.M. 10/19/25 at 4:00 P.M. 10/22/25 at 7:00 A.M. 10/22/25 at 11:00 A.M. 10/28/25 at 7:00 A.M. 10/28/25 at 11:00 A.M. 10/28/25 at 4:00 P.M. 10/29/25 at 7:00 A.M. 10/29/25 at 4:00 P.M. The clinical record lacked documentation to indicate the physician was notified of the missed doses of insulin. On 11/3/25 at 12:10 P.M., the Director of Nursing (DON) indicated there was no way to know if insulin had been given or not when left blank in the MAR. She indicated when insulin was not given staff should have notified the physician and documented that notification in the clinical record. On 11/3/25 at 12:00 P.M., the Administrator provided a current Documentation Standards policy, last revised 5/31/23, that indicated "Clinical			

documentation will be accurate, complete, timely, and by exception ... Clinical documentation will be factual and pertinent information about residents"

This citation relates to Intake IN00465594.

2. On 10/30/25 at 11:30 A.M., Resident E's clinical record was reviewed. Diagnosis included, but was not limited to, type 2 diabetes mellitus.

Physicians orders included, but were not limited to:

Lantus (insulin) injection 100/ml (milliliter) - inject 15 units subcutaneously once daily, start date 8/4/25.

A review of the September and October Medication Administration Record lacked documentation that Resident E's Lantus was administered as ordered on the following dates:

October 5 and 9, 2025

The clinical record lacked documentation to indicate the physician was notified of the missed doses of Lantus.

Based on interview and record review, the facility failed to notify the physician of errors in medication administration for 3 of 3 resident records reviewed for insulin. Insulin doses were

not communicated with the physician when missed. (Resident G, Resident C, Resident E)

Findings include:

1. On 10/30/25 at 1:27 P.M., Resident G's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus and hypertension.

Current physician orders included, but were not limited to:

Insulin lispro kwikpen 100U (units)/ML (milliliter) subcutaneous injection, inject 6 units before meals, may self administer after nurse verifies, dated 8/13/24.

Resident G's October 2025 medication administration record (MAR) indicated the following times administration of insulin lispro was left blank:

10/2/25 at 4:30 P.M.

10/3/25 at 4:30 P.M.

10/5/25 at 4:30 P.M.

10/10/25 at 11:30 A.M.

10/14/25 at 11:30 A.M.

10/14/25 at 4:30 P.M.

10/18/25 at 11:30 A.M.

10/22/25 at 8:00 A.M.

	10/22/25 at 11:30 A.M. 10/29/25 at 4:30 P.M. Resident G's clinical record lacked documentation that the physician was notified of any missed doses of insulin for the month of October 2025. 3. On 10/30/25 at 11:04 A.M., Resident C's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus. Physician orders included, but were not limited to: Humalog (a fast-acting insulin) 100 units per milliliter (units/mL) - Inject subcutaneously as directed per sliding scare before meals. If blood glucose is 150-180, give 1 unit; 190-229, give 2 units; 230-269, give 3 units; 270-299, give 4 units; if blood glucose is greater than or equal to 300, give 5 units and recheck blood glucose at next ordered time, dated 9/7/25 A review of the Medication Administration Record (MAR) for September and October 2025 indicated Humalog insulin 100 units/mL was not given on the following days: 9/10/25 at 7:00 A.M. 9/10/25 at 11:00 A.M.			

	9/10/25 at 4:00 P.M. 9/12/25 at 11:00 A.M. 9/12/25 at 4:00 P.M. 9/15/25 at 7:00 A.M. 9/16/25 at 7:00 A.M. 9/17/25 at 4:00 P.M. 9/18/25 at 4:00 P.M. 9/19/25 at 11:00 A.M. 9/20/25 at 4:00 P.M. 9/22/25 at 11:00 A.M. 9/23/25 at 7:00 A.M. 9/23/25 at 11:00 A.M. 9/24/25 at 7:00 A.M. 9/26/25 at 4:00 P.M. 9/27/25 at 7:00 A.M. 9/29/25 at 11:00 A.M 10/1/25 at 4:00 P.M. 10/2/25 at 4:00 P.M. 10/3/25 at 7:00 A.M. 10/3/25 at 4:00 P.M. 10/4/25 at 7:00 A.M. 10/9/25 at 4:00 P.M. 10/10/25 at 11:00 A.M.			

	10/10/25 at 4:00 P.M. 10/12/25 at 4:00 P.M. 10/14/25 at 7:00 A.M. 10/14/25 at 11:00 A.M. 10/14/25 at 4:00 P.M. 10/15/25 at 7:00 A.M. 10/16/25 at 7:00 A.M. 10/18/25 at 7:00 A.M. 10/19/25 at 4:00 P.M. 10/22/25 at 7:00 A.M. 10/22/25 at 11:00 A.M. 10/28/25 at 7:00 A.M. 10/28/25 at 11:00 A.M. 10/28/25 at 4:00 P.M. 10/29/25 at 7:00 A.M. 10/29/25 at 4:00 P.M. The clinical record lacked documentation to indicate the physician was notified of the missed doses of insulin. On 11/3/25 at 12:10 P.M., the Director of Nursing (DON) indicated there was no way to know if insulin had been given or not when left blank in the MAR. She indicated when insulin was not given staff should have notified the			

	physician and documented that notification in the clinical record. On 11/3/25 at 12:00 P.M., the Administrator provided a current Documentation Standards policy, last revised 5/31/23, that indicated "Clinical documentation will be accurate, complete, timely, and by exception ... Clinical documentation will be factual and pertinent information about residents" This citation relates to Intake IN00465594. 2. On 10/30/25 at 11:30 A.M., Resident E's clinical record was reviewed. Diagnosis included, but was not limited to, type 2 diabetes mellitus. Physicians orders included, but were not limited to: Lantus (insulin) injection 100/ml (milliliter) - inject 15 units subcutaneously once daily, start date 8/4/25. A review of the September and October Medication Administration Record lacked documentation that Resident E's Lantus was administered as ordered on the following dates: October 5 and 9, 2025 The clinical record lacked documentation to indicate the physician was notified of the			

	missed doses of Lantus. Based on interview and record review, the facility failed to notify the physician of errors in medication administration for 3 of 3 resident records reviewed for insulin. Insulin doses were not communicated with the physician when missed. (Resident G, Resident C, Resident E) Findings include: 1. On 10/30/25 at 1:27 P.M., Resident G's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus and hypertension. Current physician orders included, but were not limited to: Insulin lispro kwikpen 100U (units)/ML (milliliter) subcutaneous injection, inject 6 units before meals, may self administer after nurse verifies, dated 8/13/24. Resident G's October 2025 medication administration record (MAR) indicated the following times administration of insulin lispro was left blank: 10/2/25 at 4:30 P.M. 10/3/25 at 4:30 P.M. 10/5/25 at 4:30 P.M.			

	10/10/25 at 11:30 A.M. 10/14/25 at 11:30 A.M. 10/14/25 at 4:30 P.M. 10/18/25 at 11:30 A.M. 10/22/25 at 8:00 A.M. 10/22/25 at 11:30 A.M. 10/29/25 at 4:30 P.M. Resident G's clinical record lacked documentation that the physician was notified of any missed doses of insulin for the month of October 2025. 3. On 10/30/25 at 11:04 A.M., Resident C's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus. Physician orders included, but were not limited to: Humalog (a fast-acting insulin) 100 units per milliliter (units/mL) - Inject subcutaneously as directed per sliding scare before meals. If blood glucose is 150-180, give 1 unit; 190-229, give 2 units; 230-269, give 3 units; 270-299, give 4 units; if blood glucose is greater than or equal to 300, give 5 units and recheck blood glucose at next ordered time, dated 9/7/25 A review of the Medication Administration Record (MAR)			

	for September and October 2025 indicated Humalog insulin 100 units/mL was not given on the following days: 9/10/25 at 7:00 A.M. 9/10/25 at 11:00 A.M. 9/10/25 at 4:00 P.M. 9/12/25 at 11:00 A.M. 9/12/25 at 4:00 P.M. 9/15/25 at 7:00 A.M. 9/16/25 at 7:00 A.M. 9/17/25 at 4:00 P.M. 9/18/25 at 4:00 P.M. 9/19/25 at 11:00 A.M. 9/20/25 at 4:00 P.M. 9/22/25 at 11:00 A.M. 9/23/25 at 7:00 A.M. 9/23/25 at 11:00 A.M. 9/24/25 at 7:00 A.M. 9/26/25 at 4:00 P.M. 9/27/25 at 7:00 A.M. 9/29/25 at 11:00 A.M 10/1/25 at 4:00 P.M. 10/2/25 at 4:00 P.M.			

	10/3/25 at 7:00 A.M. 10/3/25 at 4:00 P.M. 10/4/25 at 7:00 A.M. 10/9/25 at 4:00 P.M. 10/10/25 at 11:00 A.M. 10/10/25 at 4:00 P.M. 10/12/25 at 4:00 P.M. 10/14/25 at 7:00 A.M. 10/14/25 at 11:00 A.M. 10/14/25 at 4:00 P.M. 10/15/25 at 7:00 A.M. 10/16/25 at 7:00 A.M. 10/18/25 at 7:00 A.M. 10/19/25 at 4:00 P.M. 10/22/25 at 7:00 A.M. 10/22/25 at 11:00 A.M. 10/28/25 at 7:00 A.M. 10/28/25 at 11:00 A.M. 10/28/25 at 4:00 P.M. 10/29/25 at 7:00 A.M. 10/29/25 at 4:00 P.M. The clinical record lacked documentation to indicate the physician was notified of the			

missed doses of insulin.

On 11/3/25 at 12:10 P.M., the Director of Nursing (DON) indicated there was no way to know if insulin had been given or not when left blank in the MAR. She indicated when insulin was not given staff should have notified the physician and documented that notification in the clinical record.

On 11/3/25 at 12:00 P.M., the Administrator provided a current Documentation Standards policy, last revised 5/31/23, that indicated "Clinical documentation will be accurate, complete, timely, and by exception ... Clinical documentation will be factual and pertinent information about residents"

This citation relates to Intake IN00465594.

2. On 10/30/25 at 11:30 A.M., Resident E's clinical record was reviewed. Diagnosis included, but was not limited to, type 2 diabetes mellitus.

Physicians orders included, but were not limited to:

Lantus (insulin) injection 100/ml (milliliter) - inject 15 units subcutaneously once daily, start date 8/4/25.

A review of the September and October Medication

	Administration Record lacked documentation that Resident E's Lantus was administered as ordered on the following dates: October 5 and 9, 2025 The clinical record lacked documentation to indicate the physician was notified of the missed doses of Lantus.			
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 proper sanitation and safe food handling for 2 of 2 kitchens observed. Kitchen staff touched food with bare hands and soiled gloves, food was not labeled, food was not covered, temperature logs were not completed, hair was not covered with hairnet, debris was on the floor, the drink dispencer was dirty, and scoops were stored inside bulk containers. (Main Kitchen, Memory Care Kitchen) Findings include:	R 0273	Dining Director/Executive Director/Director of Memory Care to complete audits of sanitation, temp logs, glove use, proper storage of food, disinfecting practices in the dietary department starting 11/21/25 Dining Director, Executive Director and Director of Memory Care will implement comprehensive staff training on proper sanitation and safe food handling including proper use of gloves, effective hand washing in kitchen/dining areas, proper hair net usage, proper equipment and cleanliness, proper temperature log documentation in both communities. Director of Dining will meet with each staff member individually starting 11/21/25. Dietician will provide training for all staff on 12/2/24. Audits will be completed 3x per week on food prep/handling/hair net/sanitation/temp logs compliance for 30 days, then 2x per week for 1 month, then 1x per week for month and then monthly.	11/14/2025

	1. On 10/30/25 at 8:54 A.M., the following was observed in the main kitchen: Reach-in refrigerator: container of mayonnaise, no open date container of Italian dressing dated "9/2" on lid container of pickle relish dated "9-16" on lid container of maraschino cherries, no open date liquid in red pitcher, not labeled lettuce, bacon, tomatoes, shredded cheese, cubed meat, onions, pickles, cherry tomatoes, and sliced cheese all in separate bowls setting in a dishpan, not labeled container of brown gravy, label indicated prep date "10/21" container of ham salad, not labeled container of spaghetti sauce, prep date "10/20" container of light brown liquid, label on container was blank Reach-in freezer: four bowls of ice cream, not labeled and open to air		Attempted to send policy, received error message, would not save.	

brown bag, not labeled

four pieces of dessert, not labeled and open to air

32 oz bottle of blue Gatorade

Bread cart:

nine muffins, not labeled

two hamburger bun bags, not labeled

two hot dog bun bags, not labeled

five full, 2 half loaves of bread, not labeled

Bulk containers:

container flour, not labeled with scoop inside

container of sugar, not labeled with scoop inside

container of breadcrumbs, not labeled with uncovered scoop laying on top

container of cornmeal, not labeled

container of brown sugar, not labeled with spoon inside

Reach-in refrigerator in the dry storage area:

queso block of cheese, open to air, not labeled

carton of heavy cream, not

labeled

bag of spinach, not labeled

opened bag of white and yellow shredded cheese, not labeled

opened bag of white cheese, not labeled

opened bag of parmesan cheese, not labeled

Dry storage:

opened bottle of orange sauce, manufacturer's best by date: 7/18/25

opened bag of spiral noodles, not labeled

Freezer in dry storage area:

Opened bag of mixed vegetables, covered in ice, not labeled and open to air

Opened bag of pizza crusts, not labeled and open to air

Dish drying rack over by the dishwasher:

baked chocolate chip cookies on a cookie sheet, uncovered

On 10/30/25 at 9:16 A.M., all temperature logs of the food served and dishwasher for 10/1/25-10/29/25, were provided by the Dietary Manager.

The dishwasher log was not

completed in the morning or evening from 10/7/25 through 10/29/25.

The following were meals served without temperatures logged:

10/1/25-breakfast, lunch, dinner

10/2/25-breakfast, lunch, dinner

10/3/25-breakfast, lunch, dinner

10/4/25-breakfast, lunch, dinner

10/6/25-dinner

10/7/25-breakfast, lunch, dinner

10/8/25-breakfast, lunch, dinner

10/9/25-breakfast and lunch

10/12/25-dinner

10/13/25-dinner

10/14/25-breakfast and lunch

10/15/25-breakfast and lunch

10/16/25-breakfast and lunch

10/18/25-breakfast, lunch, dinner

10/19/25-breakfast and lunch

10/20/25-breakfast, lunch, dinner

10/21/25-breakfast, lunch, dinner

10/23/25-breakfast, lunch, dinner

10/24/25-dinner

10/25/25-breakfast, lunch, dinner

10/26/25-breakfast, lunch, dinner

2. On 10/30/25 at 9:24 A.M., kitchen staff was observed pushing a food cart from the Main Kitchen past the first floor nurse's station, out the door, into the parking lot, and into the other building with several food items on the cart. There was a pan of lettuce on top of the cart that was not covered.

3. During an observation of the Main Kitchen on 10/30/25 at 12:16 P.M., the following was observed:

Cook 4 was not wearing a hairnet over his beard and taking the temperatures of the food to be served. He cleaned the thermometer with his apron and the rag from the sanitizing bucket in between the different foods.

Cook 8 carried lettuce out into kitchen and washed it with her bare hands, then made a sandwich with it, and set it on the serving table to be served.

Cook 4 had gloves on. He was touching the utensil handles,

eating surface of plates, picking potatoes up, opening the warmer, touching meal tickets, opening the French fry bag, touching fryer handle, and touching the food on plates to move them.

Cook 8 grabbed two slices of bread and put them in the toaster with her bare hands.

4. On 10/30/25 at 8:57 A.M., during the initial tour of the Memory Care Kitchen with Kitchen Aide 17 and the Dietary Manager, the following was observed:

Kitchen Aide 17's hair was not completely covered with a hair net.

In the resident refrigerator, the following was observed:

1 bottle of relish with no name or open date

1 bottle of mustard with no name or open date

1 bottle of chocolate syrup no name or open date

1 bottle of caramel syrup no name or open date

1 bottle of strawberry syrup with no name or open date

1 bottle of thickener with no open date

	1 container of Hawaiian punch with no name or open date 1 container of prune juice with no name or open date 1 container of crescent rolls with no name but had an expiration date of 6/20/25 2 containers of cake icing with no name or open date 1 stick of butter with no open date In the resident freezer, the following was observed: 1 package of pancakes with no name or open date 2 breakfast bowls with no name 1 package of pancakes with no name or open date 2 breakfast bowls with no name 1 container of egg sandwiches with no name or open date The coffee machine in the kitchen had old drippings in the holding area and the dispenser had dried coffee. The juice dispenser was observed with the following: Orange juice had dripped in the storage area			

Apple juice had dripped in the storage area

Sticky residue above the dispensers and on the metal back splash.

In the reach-in refrigerator, the following was observed:

White debris on the bottle shelf

1 bag of tater-tots with no open date

1 container of burritos with no label, prep date, and lacked covering

The stove was observed with the following:

large streaks of white on the front of the stove

1 large area of yellow substance on the left side on the floor

The following was observed in the Dry Storage area:

1 bunch of over ripe banana with no date

1 box of corn starch with no open date

1 container of granola with prep dated 9/25/24 with no use by date

1 container of candy sprinkles in a bowl with plastic wrap with no open date

1 large container of white powder with no label, no open date, and is covered with plastic wrap

1 container of brown sugar with no date and prep date of 9/9/25

1 container of croutons that had open date of 9/4/25 and use by date of 10/24/25

1 bag of tortillas with no open date

1 large container of chocolate icing with no open date

The floor of the dry storage had the following:

several pieces of onion debris on the floor

1 package of mayonnaise

1 box of old dishes

The walk-in freezer was observed to have the following:

1 grape on floor

1 red dish on floor

2 containers of yellow fluid with no label, prep date or use by date

2 containers of brown colored fluid with no label, prep date, or use by date

1 container of orange colored fluid with no label, prep dated,

	or use by date 1 bottle of barbeque sauce with no open date 1 bowl of chicken with no prep date 1 container of sausage patties with no open date. On 10/30/25 at 10:04 A.M., the Dietary Manager provided a temperature log for the refrigerator that lacked the following days for the month of October: October 3, October 10-14, October 10-31. 5. On 10/31/25 at 8:40 A.M., during a random observation of the Memory Care Kitchen the following was observed: juice dispenser had sticky substance on the back splash orange juice dispenser with drippings floor of the dry storage has onion debris 1 box of dishes on the floor During an interview on 10/30/25 at 9:11 A.M., the Dietary Manager indicated the dishwasher temperatures should be checked and logged twice daily, once in the A.M., and once in the P.M. Food			

temperatures should be taken and logged prior to every meal.

During an interview on 10/30/25 at 9:15 A.M., Kitchen Aide 17 indicated that the drink dispensers should be cleaned after each meal.

During an interview on 10/30/25 at 9:40 A.M., the Dietary Manager indicated that there should be no debris in the refrigerator, and food should have a label, open date, and use by date.

During an interview on 10/31/25 at 9:35 A.M., the Dietary Manager indicated all food should be covered, and have a label that indicated date received, date opened or prepped and an expiration date. Leftovers should be kept for three days and then discarded. Staff should not touch food with bare hands or contaminated gloves. Beards should be covered by hairnet. Staff should not use their apron or cleaning rag when cleaning the thermometer and use the appropriate wipes provided.

During an interview on 10/31/25 at 10:25 A.M., the Dietary Manager indicated that containers should be covered.

On 11/3/25 at 11:56 A.M., the Administrator provided a current policy "Food Safety and Sanitation" dated 11/19/19. The

policy indicated " ...when a food product is opened make sure to provide an open date when opened .... personal hygiene requires State hair net requirements ...equipment must always be kept clean ...temperature should be taken twice daily ... "

On 11/3/25 at 10:30 A.M., a non-dated current Food Safety and Sanitation Policy was provided by the Administrator and indicated, " ... they must take proper steps to ensure sanitary surroundings and food that is safe to eat ... When a food product is opened, make sure that you add the date when it was opened ... To prevent food-borne illness, dietary staff must have good personal hygiene and adhere to appropriate work habits, which maintain a sanitary environment ... During food preparation, food items that will not be cooked, before being served to a resident should be handled with utensils or gloved hands. Anything that is ready to eat must be handled with gloves ... During meal service, ALL food items should be handled with utensils or gloved hands ... Avoid handling the eating surface of glasses, dishes ... gloves need to be changed often when working with food ... Wrap, cover, or seal all refrigerated and frozen foods ... all food must have a use-by

date ... All leftover prepared foods must be stored in an appropriate container and covered with an airtight lid or cellophane ... "

Based on observation, interview, and record review, the facility failed to ensure proper sanitation and safe food handling for 2 of 2 kitchens observed. Kitchen staff touched food with bare hands and soiled gloves, food was not labeled, food was not covered, temperature logs were not completed, hair was not covered with hairnet, debris was on the floor, the drink dispencer was dirty, and scoops were stored inside bulk containers. (Main Kitchen, Memory Care Kitchen)

Findings include:

1. On 10/30/25 at 8:54 A.M., the following was observed in the main kitchen:

Reach-in refrigerator:

container of mayonnaise, no open date

container of Italian dressing dated "9/2" on lid

container of pickle relish dated "9-16" on lid

container of maraschino cherries, no open date

	liquid in red pitcher, not labeled lettuce, bacon, tomatoes, shredded cheese, cubed meat, onions, pickles, cherry tomatoes, and sliced cheese all in separate bowls setting in a dishpan, not labeled container of brown gravy, label indicated prep date "10/21" container of ham salad, not labeled container of spaghetti sauce, prep date "10/20" container of light brown liquid, label on container was blank Reach-in freezer: four bowls of ice cream, not labeled and open to air brown bag, not labeled four pieces of dessert, not labeled and open to air 32 oz bottle of blue Gatorade Bread cart: nine muffins, not labeled two hamburger bun bags, not labeled two hot dog bun bags, not labeled			

five full, 2 half loaves of bread, not labeled

Bulk containers:

container flour, not labeled with scoop inside

container of sugar, not labeled with scoop inside

container of breadcrumbs, not labeled with uncovered scoop laying on top

container of cornmeal, not labeled

container of brown sugar, not labeled with spoon inside

Reach-in refrigerator in the dry storage area:

queso block of cheese, open to air, not labeled

carton of heavy cream, not labeled

bag of spinach, not labeled

opened bag of white and yellow shredded cheese, not labeled

opened bag of white cheese, not labeled

opened bag of parmesan cheese, not labeled

Dry storage:

opened bottle of orange sauce, manufacturer's best by date:

7/18/25

opened bag of spiral noodles, not labeled

Freezer in dry storage area:

Opened bag of mixed vegetables, covered in ice, not labeled and open to air

Opened bag of pizza crusts, not labeled and open to air

Dish drying rack over by the dishwasher:

baked chocolate chip cookies on a cookie sheet, uncovered

On 10/30/25 at 9:16 A.M., all temperature logs of the food served and dishwasher for 10/1/25-10/29/25, were provided by the Dietary Manager.

The dishwasher log was not completed in the morning or evening from 10/7/25 through 10/29/25.

The following were meals served without temperatures logged:

10/1/25-breakfast, lunch, dinner

10/2/25-breakfast, lunch, dinner

10/3/25-breakfast, lunch, dinner

10/4/25-breakfast, lunch, dinner

10/6/25-dinner

10/7/25-breakfast, lunch, dinner

10/8/25-breakfast, lunch, dinner

10/9/25-breakfast and lunch

10/12/25-dinner

10/13/25-dinner

10/14/25-breakfast and lunch

10/15/25-breakfast and lunch

10/16/25-breakfast and lunch

10/18/25-breakfast, lunch, dinner

10/19/25-breakfast and lunch

10/20/25-breakfast, lunch, dinner

10/21/25-breakfast, lunch, dinner

10/23/25-breakfast, lunch, dinner

10/24/25-dinner

10/25/25-breakfast, lunch, dinner

10/26/25-breakfast, lunch, dinner

2. On 10/30/25 at 9:24 A.M., kitchen staff was observed pushing a food cart from the Main Kitchen past the first floor nurse's station, out the door,

into the parking lot, and into the other building with several food items on the cart. There was a pan of lettuce on top of the cart that was not covered.

3. During an observation of the Main Kitchen on 10/30/25 at 12:16 P.M., the following was observed:

Cook 4 was not wearing a hairnet over his beard and taking the temperatures of the food to be served. He cleaned the thermometer with his apron and the rag from the sanitizing bucket in between the different foods.

Cook 8 carried lettuce out into kitchen and washed it with her bare hands, then made a sandwich with it, and set it on the serving table to be served.

Cook 4 had gloves on. He was touching the utensil handles, eating surface of plates, picking potatoes up, opening the warmer, touching meal tickets, opening the French fry bag, touching fryer handle, and touching the food on plates to move them.

Cook 8 grabbed two slices of bread and put them in the toaster with her bare hands.

4. On 10/30/25 at 8:57 A.M., during the initial tour of the Memory Care Kitchen with Kitchen Aide 17 and the Dietary

Manager, the following was observed:

Kitchen Aide 17's hair was not completely covered with a hair net.

In the resident refrigerator, the following was observed:

1 bottle of relish with no name or open date

1 bottle of mustard with no name or open date

1 bottle of chocolate syrup no name or open date

1 bottle of caramel syrup no name or open date

1 bottle of strawberry syrup with no name or open date

1 bottle of thickener with no open date

1 container of Hawaiian punch with no name or open date

1 container of prune juice with no name or open date

1 container of crescent rolls with no name but had an expiration date of 6/20/25

2 containers of cake icing with no name or open date

1 stick of butter with no open date

In the resident freezer, the

following was observed:

1 package of pancakes with no name or open date

2 breakfast bowls with no name

1 package of pancakes with no name or open date

2 breakfast bowls with no name

1 container of egg sandwiches with no name or open date

The coffee machine in the kitchen had old drippings in the holding area and the dispenser had dried coffee.

The juice dispenser was observed with the following:

Orange juice had dripped in the storage area

Apple juice had dripped in the storage area

Sticky residue above the dispensers and on the metal back splash.

In the reach-in refrigerator, the following was observed:

White debris on the bottle shelf

1 bag of tater-tots with no open date

1 container of burritos with no label, prep date, and lacked covering

The stove was observed with the following:

large streaks of white on the front of the stove

1 large area of yellow substance on the left side on the floor

The following was observed in the Dry Storage area:

1 bunch of over ripe banana with no date

1 box of corn starch with no open date

1 container of granola with prep dated 9/25/24 with no use by date

1 container of candy sprinkles in a bowl with plastic wrap with no open date

1 large container of white powder with no label, no open date, and is covered with plastic wrap

1 container of brown sugar with no date and prep date of 9/9/25

1 container of croutons that had open date of 9/4/25 and use by date of 10/24/25

1 bag of tortillas with no open date

1 large container of chocolate icing with no open date

The floor of the dry storage had

the following:

several pieces of onion debris on the floor

1 package of mayonnaise

1 box of old dishes

The walk-in freezer was observed to have the following:

1 grape on floor

1 red dish on floor

2 containers of yellow fluid with no label, prep date or use by date

2 containers of brown colored fluid with no label, prep date, or use by date

1 container of orange colored fluid with no label, prep dated, or use by date

1 bottle of barbeque sauce with no open date

1 bowl of chicken with no prep date

1 container of sausage patties with no open date.

On 10/30/25 at 10:04 A.M., the Dietary Manager provided a temperature log for the refrigerator that lacked the following days for the month of October:

October 3, October 10-14,

October 10-31.

5. On 10/31/25 at 8:40 A.M., during a random observation of the Memory Care Kitchen the following was observed:

juice dispenser had sticky substance on the back splash

orange juice dispenser with drippings

floor of the dry storage has onion debris

1 box of dishes on the floor

During an interview on 10/30/25 at 9:11 A.M., the Dietary Manager indicated the dishwasher temperatures should be checked and logged twice daily, once in the A.M., and once in the P.M. Food temperatures should be taken and logged prior to every meal.

During an interview on 10/30/25 at 9:15 A.M., Kitchen Aide 17 indicated that the drink dispensers should be cleaned after each meal.

During an interview on 10/30/25 at 9:40 A.M., the Dietary Manager indicated that there should be no debris in the refrigerator, and food should have a label, open date, and use by date.

During an interview on 10/31/25 at 9:35 A.M., the Dietary

Manager indicated all food should be covered, and have a label that indicated date received, date opened or prepped and an expiration date. Leftovers should be kept for three days and then discarded. Staff should not touch food with bare hands or contaminated gloves. Beards should be covered by hairnet. Staff should not use their apron or cleaning rag when cleaning the thermometer and use the appropriate wipes provided.

During an interview on 10/31/25 at 10:25 A.M., the Dietary Manager indicated that containers should be covered.

On 11/3/25 at 11:56 A.M., the Administrator provided a current policy "Food Safety and Sanitation" dated 11/19/19. The policy indicated " ...when a food product is opened make sure to provide an open date when opened .... personal hygiene requires State hair net requirements ...equipment must always be kept clean ...temperature should be taken twice daily ... "

On 11/3/25 at 10:30 A.M., a non-dated current Food Safety and Sanitation Policy was provided by the Administrator and indicated, " ... they must take proper steps to ensure sanitary surroundings and food that is safe to eat ... When a

food product is opened, make sure that you add the date when it was opened ... To prevent food-borne illness, dietary staff must have good personal hygiene and adhere to appropriate work habits, which maintain a sanitary environment ... During food preparation, food items that will not be cooked, before being served to a resident should be handled with utensils or gloved hands. Anything that is ready to eat must be handled with gloves ... During meal service, ALL food items should be handled with utensils or gloved hands ... Avoid handling the eating surface of glasses, dishes ... gloves need to be changed often when working with food ... Wrap, cover, or seal all refrigerated and frozen foods ... all food must have a use-by date ... All leftover prepared foods must be stored in an appropriate container and covered with an airtight lid or cellophane ... "

Based on observation, interview, and record review, the facility failed to ensure proper sanitation and safe food handling for 2 of 2 kitchens observed. Kitchen staff touched food with bare hands and soiled gloves, food was not labeled, food was not covered, temperature logs were not completed, hair was not covered with hairnet, debris was on the

floor, the drink dispencer was dirty, and scoops were stored inside bulk containers. (Main Kitchen, Memory Care Kitchen)

Findings include:

1. On 10/30/25 at 8:54 A.M., the following was observed in the main kitchen:

Reach-in refrigerator:

container of mayonnaise, no open date

container of Italian dressing dated "9/2" on lid

container of pickle relish dated "9-16" on lid

container of maraschino cherries, no open date

liquid in red pitcher, not labeled

lettuce, bacon, tomatoes, shredded cheese, cubed meat, onions, pickles, cherry tomatoes, and sliced cheese all in separate bowls setting in a dishpan, not labeled

container of brown gravy, label indicated prep date "10/21"

container of ham salad, not labeled

container of spaghetti sauce, prep date "10/20"

	container of light brown liquid, label on container was blank Reach-in freezer: four bowls of ice cream, not labeled and open to air brown bag, not labeled four pieces of dessert, not labeled and open to air 32 oz bottle of blue Gatorade Bread cart: nine muffins, not labeled two hamburger bun bags, not labeled two hot dog bun bags, not labeled five full, 2 half loaves of bread, not labeled Bulk containers: container flour, not labeled with scoop inside container of sugar, not labeled with scoop inside container of breadcrumbs, not labeled with uncovered scoop laying on top container of cornmeal, not labeled			

container of brown sugar, not labeled with spoon inside

Reach-in refrigerator in the dry storage area:

queso block of cheese, open to air, not labeled

carton of heavy cream, not labeled

bag of spinach, not labeled

opened bag of white and yellow shredded cheese, not labeled

opened bag of white cheese, not labeled

opened bag of parmesan cheese, not labeled

Dry storage:

opened bottle of orange sauce, manufacturer's best by date: 7/18/25

opened bag of spiral noodles, not labeled

Freezer in dry storage area:

Opened bag of mixed vegetables, covered in ice, not labeled and open to air

Opened bag of pizza crusts, not labeled and open to air

Dish drying rack over by the dishwasher:

baked chocolate chip cookies

on a cookie sheet, uncovered

On 10/30/25 at 9:16 A.M., all temperature logs of the food served and dishwasher for 10/1/25-10/29/25, were provided by the Dietary Manager.

The dishwasher log was not completed in the morning or evening from 10/7/25 through 10/29/25.

The following were meals served without temperatures logged:

10/1/25-breakfast, lunch, dinner

10/2/25-breakfast, lunch, dinner

10/3/25-breakfast, lunch, dinner

10/4/25-breakfast, lunch, dinner

10/6/25-dinner

10/7/25-breakfast, lunch, dinner

10/8/25-breakfast, lunch, dinner

10/9/25-breakfast and lunch

10/12/25-dinner

10/13/25-dinner

10/14/25-breakfast and lunch

10/15/25-breakfast and lunch

10/16/25-breakfast and lunch

10/18/25-breakfast, lunch,

dinner

10/19/25-breakfast and lunch

10/20/25-breakfast, lunch, dinner

10/21/25-breakfast, lunch, dinner

10/23/25-breakfast, lunch, dinner

10/24/25-dinner

10/25/25-breakfast, lunch, dinner

10/26/25-breakfast, lunch, dinner

2. On 10/30/25 at 9:24 A.M., kitchen staff was observed pushing a food cart from the Main Kitchen past the first floor nurse's station, out the door, into the parking lot, and into the other building with several food items on the cart. There was a pan of lettuce on top of the cart that was not covered.

3. During an observation of the Main Kitchen on 10/30/25 at 12:16 P.M., the following was observed:

Cook 4 was not wearing a hairnet over his beard and taking the temperatures of the food to be served. He cleaned the thermometer with his apron and the rag from the sanitizing bucket in between the different

foods.

Cook 8 carried lettuce out into kitchen and washed it with her bare hands, then made a sandwich with it, and set it on the serving table to be served.

Cook 4 had gloves on. He was touching the utensil handles, eating surface of plates, picking potatoes up, opening the warmer, touching meal tickets, opening the French fry bag, touching fryer handle, and touching the food on plates to move them.

Cook 8 grabbed two slices of bread and put them in the toaster with her bare hands.

4. On 10/30/25 at 8:57 A.M., during the initial tour of the Memory Care Kitchen with Kitchen Aide 17 and the Dietary Manager, the following was observed:

Kitchen Aide 17's hair was not completely covered with a hair net.

In the resident refrigerator, the following was observed:

1 bottle of relish with no name or open date

1 bottle of mustard with no name or open date

1 bottle of chocolate syrup no name or open date

1 bottle of caramel syrup no name or open date

1 bottle of strawberry syrup with no name or open date

1 bottle of thickener with no open date

1 container of Hawaiian punch with no name or open date

1 container of prune juice with no name or open date

1 container of crescent rolls with no name but had an expiration date of 6/20/25

2 containers of cake icing with no name or open date

1 stick of butter with no open date

In the resident freezer, the following was observed:

1 package of pancakes with no name or open date

2 breakfast bowls with no name

1 package of pancakes with no name or open date

2 breakfast bowls with no name

1 container of egg sandwiches with no name or open date

The coffee machine in the

kitchen had old drippings in the holding area and the dispenser had dried coffee.

The juice dispenser was observed with the following:

Orange juice had dripped in the storage area

Apple juice had dripped in the storage area

Sticky residue above the dispensers and on the metal back splash.

In the reach-in refrigerator, the following was observed:

White debris on the bottle shelf

1 bag of tater-tots with no open date

1 container of burritos with no label, prep date, and lacked covering

The stove was observed with the following:

large streaks of white on the front of the stove

1 large area of yellow substance on the left side on the floor

The following was observed in the Dry Storage area:

1 bunch of over ripe banana with no date

1 box of corn starch with no

open date

1 container of granola with prep dated 9/25/24 with no use by date

1 container of candy sprinkles in a bowl with plastic wrap with no open date

1 large container of white powder with no label, no open date, and is covered with plastic wrap

1 container of brown sugar with no date and prep date of 9/9/25

1 container of croutons that had open date of 9/4/25 and use by date of 10/24/25

1 bag of tortillas with no open date

1 large container of chocolate icing with no open date

The floor of the dry storage had the following:

several pieces of onion debris on the floor

1 package of mayonnaise

1 box of old dishes

The walk-in freezer was observed to have the following:

1 grape on floor

1 red dish on floor

	2 containers of yellow fluid with no label, prep date or use by date 2 containers of brown colored fluid with no label, prep date, or use by date 1 container of orange colored fluid with no label, prep dated, or use by date 1 bottle of barbeque sauce with no open date 1 bowl of chicken with no prep date 1 container of sausage patties with no open date. On 10/30/25 at 10:04 A.M., the Dietary Manager provided a temperature log for the refrigerator that lacked the following days for the month of October: October 3, October 10-14, October 10-31. 5. On 10/31/25 at 8:40 A.M., during a random observation of the Memory Care Kitchen the following was observed: juice dispenser had sticky substance on the back splash orange juice dispenser with drippings			

floor of the dry storage has onion debris

1 box of dishes on the floor

During an interview on 10/30/25 at 9:11 A.M., the Dietary Manager indicated the dishwasher temperatures should be checked and logged twice daily, once in the A.M., and once in the P.M. Food temperatures should be taken and logged prior to every meal.

During an interview on 10/30/25 at 9:15 A.M., Kitchen Aide 17 indicated that the drink dispensers should be cleaned after each meal.

During an interview on 10/30/25 at 9:40 A.M., the Dietary Manager indicated that there should be no debris in the refrigerator, and food should have a label, open date, and use by date.

During an interview on 10/31/25 at 9:35 A.M., the Dietary Manager indicated all food should be covered, and have a label that indicated date received, date opened or prepped and an expiration date. Leftovers should be kept for three days and then discarded. Staff should not touch food with bare hands or contaminated gloves. Beards should be covered by hairnet. Staff should not use their apron or cleaning rag when cleaning the

thermometer and use the appropriate wipes provided.

During an interview on 10/31/25 at 10:25 A.M., the Dietary Manager indicated that containers should be covered.

On 11/3/25 at 11:56 A.M., the Administrator provided a current policy "Food Safety and Sanitation" dated 11/19/19. The policy indicated " ...when a food product is opened make sure to provide an open date when opened .... personal hygiene requires State hair net requirements ...equipment must always be kept clean ...temperature should be taken twice daily ... "

On 11/3/25 at 10:30 A.M., a non-dated current Food Safety and Sanitation Policy was provided by the Administrator and indicated, " ... they must take proper steps to ensure sanitary surroundings and food that is safe to eat ... When a food product is opened, make sure that you add the date when it was opened ... To prevent food-borne illness, dietary staff must have good personal hygiene and adhere to appropriate work habits, which maintain a sanitary environment ... During food preparation, food items that will not be cooked, before being served to a resident should be handled with utensils or gloved hands.

Anything that is ready to eat must be handled with gloves ... During meal service, ALL food items should be handled with utensils or gloved hands ... Avoid handling the eating surface of glasses, dishes ... gloves need to be changed often when working with food ... Wrap, cover, or seal all refrigerated and frozen foods ... all food must have a use-by date ... All leftover prepared foods must be stored in an appropriate container and covered with an airtight lid or cellophane ... "

Based on observation, interview, and record review, the facility failed to ensure proper sanitation and safe food handling for 2 of 2 kitchens observed. Kitchen staff touched food with bare hands and soiled gloves, food was not labeled, food was not covered, temperature logs were not completed, hair was not covered with hairnet, debris was on the floor, the drink dispencer was dirty, and scoops were stored inside bulk containers. (Main Kitchen, Memory Care Kitchen)

Findings include:

1. On 10/30/25 at 8:54 A.M., the following was observed in the main kitchen:

Reach-in refrigerator:

container of mayonnaise, no

	open date container of Italian dressing dated "9/2" on lid container of pickle relish dated "9-16" on lid container of maraschino cherries, no open date liquid in red pitcher, not labeled lettuce, bacon, tomatoes, shredded cheese, cubed meat, onions, pickles, cherry tomatoes, and sliced cheese all in separate bowls setting in a dishpan, not labeled container of brown gravy, label indicated prep date "10/21" container of ham salad, not labeled container of spaghetti sauce, prep date "10/20" container of light brown liquid, label on container was blank Reach-in freezer: four bowls of ice cream, not labeled and open to air brown bag, not labeled four pieces of dessert, not labeled and open to air 32 oz bottle of blue Gatorade			

Bread cart:

nine muffins, not labeled

two hamburger bun bags, not labeled

two hot dog bun bags, not labeled

five full, 2 half loaves of bread, not labeled

Bulk containers:

container flour, not labeled with scoop inside

container of sugar, not labeled with scoop inside

container of breadcrumbs, not labeled with uncovered scoop laying on top

container of cornmeal, not labeled

container of brown sugar, not labeled with spoon inside

Reach-in refrigerator in the dry storage area:

queso block of cheese, open to air, not labeled

carton of heavy cream, not labeled

bag of spinach, not labeled

opened bag of white and yellow shredded cheese, not labeled

opened bag of white cheese, not labeled

opened bag of parmesan cheese, not labeled

Dry storage:

opened bottle of orange sauce, manufacturer's best by date: 7/18/25

opened bag of spiral noodles, not labeled

Freezer in dry storage area:

Opened bag of mixed vegetables, covered in ice, not labeled and open to air

Opened bag of pizza crusts, not labeled and open to air

Dish drying rack over by the dishwasher:

baked chocolate chip cookies on a cookie sheet, uncovered

On 10/30/25 at 9:16 A.M., all temperature logs of the food served and dishwasher for 10/1/25-10/29/25, were provided by the Dietary Manager.

The dishwasher log was not completed in the morning or evening from 10/7/25 through 10/29/25.

The following were meals served without temperatures

	logged: 10/1/25-breakfast, lunch, dinner 10/2/25-breakfast, lunch, dinner 10/3/25-breakfast, lunch, dinner 10/4/25-breakfast, lunch, dinner 10/6/25-dinner 10/7/25-breakfast, lunch, dinner 10/8/25-breakfast, lunch, dinner 10/9/25-breakfast and lunch 10/12/25-dinner 10/13/25-dinner 10/14/25-breakfast and lunch 10/15/25-breakfast and lunch 10/16/25-breakfast and lunch 10/18/25-breakfast, lunch, dinner 10/19/25-breakfast and lunch 10/20/25-breakfast, lunch, dinner 10/21/25-breakfast, lunch, dinner 10/23/25-breakfast, lunch, dinner 10/24/25-dinner 10/25/25-breakfast, lunch,			

dinner

10/26/25-breakfast, lunch, dinner

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move them.

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1 container of crescent rolls with

	no name but had an expiration date of 6/20/25 2 containers of cake icing with no name or open date 1 stick of butter with no open date In the resident freezer, the following was observed: 1 package of pancakes with no name or open date 2 breakfast bowls with no name 1 package of pancakes with no name or open date 2 breakfast bowls with no name 1 container of egg sandwiches with no name or open date The coffee machine in the kitchen had old drippings in the holding area and the dispenser had dried coffee. The juice dispenser was observed with the following: Orange juice had dripped in the storage area Apple juice had dripped in the storage area Sticky residue above the dispensers and on the metal back splash.			

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1 container of orange colored fluid with no label, prep dated, or use by date

1 bottle of barbeque sauce with no open date

1 bowl of chicken with no prep date

1 container of sausage patties with no open date.

On 10/30/25 at 10:04 A.M., the Dietary Manager provided a temperature log for the refrigerator that lacked the following days for the month of October:

October 3, October 10-14, October 10-31.

5. On 10/31/25 at 8:40 A.M., during a random observation of the Memory Care Kitchen the following was observed:

juice dispenser had sticky substance on the back splash

orange juice dispenser with drippings

floor of the dry storage has onion debris

1 box of dishes on the floor

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	cellophane ... "			

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 SIGNATURECarla Grimwood	TITLEEx Director	(X6) DATE01/08/2026