STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDEPENDENCE VILLAGE OF FISHERS EAST	12950 TALBLICK STREET, FISHERS, , 46037

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. This visit included the Investigation of Intake IN00464993 and Intake IN00464954. Intake IN00464993 - No deficiencies related to the allegations are cited. Intake IN00464954 - State deficiencies related to the allegations are cited at R0240. Survey dates: October 16, 17, and 20, 2025 Facility number: 013945 Residential Census: 72 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on October 24, 2025.	R 0000		

R 0036	Residents' Rights- Deficiency 410 IAC 16.2-5-1.2(k)(1-2) (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on interview and record review, the facility failed to timely notify the physician and resident representative of a resident's significant weight loss for 1 of 5 resident records reviewed. (Resident E) Findings include: The clinical record for Resident E was reviewed on 10/16/25 at 2:20 p.m. The diagnoses included, but were not limited to, dementia with behavioral disturbance. A service plan, last revised on 7/17/25, indicated Resident E required assistance with dining. The goal was for his dining needs to be met with assistance. The intervention included, but were not limited to,	R 0036	Updating the Resident Weight Change and Notification procedure to require a repeat weight within 24 hours for any change; to trigger an automatic PCC alert for weight loss within 30 days; and to mandate a standardized notification workflow to the attending physician and the resident’s responsible party, using a templated notification note placed in the chart. Hospice communications regarding weight changes must also be documented in the medical record. •Implementing a “Weight Loss Alert Form” to be completed, signed, and uploaded to the resident chart anytime a weight-loss threshold is exceeded. •All nursing staff who perform resident weights (LPNs, QMAs, CNAs) completing training on the revised weight-monitoring protocol, repeat-weight procedure, notification timeframes, and documentation requirements by [date within 7 days]. The DON delivering targeted coaching to nursing leadership on audit expectations. •Conducting weekly weight audits for 8 weeks, then monthly for 6 months. Each weekly audit will review 10 randomly selected resident charts to confirm	01/08/2026

	requiring reminders for mealtimes and assistance to the dining room. A service plan, last revised on 7/23/25, indicated Resident E was receiving hospice services. The goal was for him to be made comfortable and his end of life journey would be dignified. The interventions included hospice services would be provided. Resident E's weight was recorded, on 8/5/25, as 160.2 pounds. On 9/30/25, his weight was recorded as 137 pounds. Resident E had experienced a 23-pound weight loss in 12 weeks. The clinical record did not indicate the physician, or the resident representative had been notified of Resident E's weight loss. During an interview on 10/20/25 at 1:17 p.m., the Assistant Director of Nursing indicated the Nurse Practitioner had been verbally notified. She was unsure if there was any documentation of the notification of weight loss. The staff fed Resident E all his meals. She was unsure if the resident's representative had been notified. On 10/20/25 at 4:11 p.m., the Executive Director provided the Resident Weights Policy, last		accurate weights, appropriate repeat weights when indicated, and that physician and responsible-party notifications were completed and documented within 24 hours of identification. WD is responsible implementation and oversite.	

	updated 10/17/22, that indicated "...The purpose of the Resident Weight Policy is to recognize and respond to resident's weight related to nutritional needs...Each resident will be routinely weighted upon move-in, monthly, and when returning from an alternate healthcare setting unless otherwise directed by the resident's Healthcare provider...If the resident has gained/lost three pounds or more from the prior recorded weight, the weight should be repeated...If the re-weigh continues to reflect a gain/loss of three pounds or more, the findings should be reported to the Healthcare provider and Wellness Leader ..." Based on interview and record review, the facility failed to timely notify the physician and resident representative of a resident's significant weight loss for 1 of 5 resident records reviewed. (Resident E) Findings include: The clinical record for Resident E was reviewed on 10/16/25 at 2:20 p.m. The diagnoses included, but were not limited to, dementia with behavioral disturbance. A service plan, last revised on 7/17/25, indicated Resident E required assistance with dining.			

	The goal was for his dining needs to be met with assistance. The intervention included, but were not limited to, requiring reminders for mealtimes and assistance to the dining room. A service plan, last revised on 7/23/25, indicated Resident E was receiving hospice services. The goal was for him to be made comfortable and his end of life journey would be dignified. The interventions included hospice services would be provided. Resident E's weight was recorded, on 8/5/25, as 160.2 pounds. On 9/30/25, his weight was recorded as 137 pounds. Resident E had experienced a 23-pound weight loss in 12 weeks. The clinical record did not indicate the physician, or the resident representative had been notified of Resident E's weight loss. During an interview on 10/20/25 at 1:17 p.m., the Assistant Director of Nursing indicated the Nurse Practitioner had been verbally notified. She was unsure if there was any documentation of the notification of weight loss. The staff fed Resident E all his meals. She was unsure if the resident's representative had			

	been notified. On 10/20/25 at 4:11 p.m., the Executive Director provided the Resident Weights Policy, last updated 10/17/22, that indicated "...The purpose of the Resident Weight Policy is to recognize and respond to resident's weight related to nutritional needs...Each resident will be routinely weighted upon move-in, monthly, and when returning from an alternate healthcare setting unless otherwise directed by the resident's Healthcare provider...If the resident has gained/lost three pounds or more from the prior recorded weight, the weight should be repeated...If the re-weigh continues to reflect a gain/loss of three pounds or more, the findings should be reported to the Healthcare provider and Wellness Leader ..."			

R 0041	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(o)(4) (4) The facility shall develop and implement policies for investigating and responding to complaints when made known and grievances made by: (A) an individual resident; (B) a resident council or family council, or both; (C) a family member; (D) family groups; or (E) other individuals. Based on interview and record review, the facility failed to document, and timely address concerns and grievances brought by individual residents', family members, Resident Council, and Family Council for 3 of 3 residents reviewed for grievances with the potential to affect 72 of 72 residents residing at the facility (Resident D, Resident C, and Resident F) Findings include: 1. The clinical record for Resident D was reviewed on 10/17/25 at 1:15 p.m. The diagnoses included, but were not limited to, dementia and anxiety. She was admitted to the facility's assisted living on 5/13/25. She was moved to the facility's dementia care unit on	R 0041	Require all grievances — whether submitted in writing or voiced verbally — to be recorded in the Grievance Log (electronic or paper) within 24 hours of receipt. •Designate a Department Leader to investigate each grievance, implement corrective actions, and provide a written response within seven (7) business days, or sooner when a safety concern is identified. •Provide documented follow-up to the Resident Council and Family Council within 30 days of issues raised; meeting minutes must reflect the disposition and actions taken. •Retain grievance records for a minimum of one year in the Executive Director’s office. •Train all supervisory staff, the Life Enrichment Director, and the WD on the revised grievance process, documentation requirements, timelines, and Council follow-up •Educate Resident and Family Council chairs on how to submit formal grievances and on expected response timelines. •Implement ED review of the open Grievance Log weekly for 12 weeks, then incorporate the log into the monthly review. Track and report: initial logging within 24 hours, investigation	01/08/2026

	5/31/25. A service plan, created 5/27/25, indicated Resident D required assistance with medications. The goal was for her medication needs to be met with assistance. The interventions were that Resident D required assistance with medication administration and used an outside pharmacy for medications. A physician's order, dated 5/9/25, indicated she was to receive quetiapine (anti-psychotic medication) 25 milligram (mg); one half tablet by mouth twice a day. The July 2025 Medication Administration Record (MAR) indicated she did not receive her scheduled dosage of quetiapine on 7/19/25, 7/20/25, 7/21/25, 7/22/25, 7/24/25, 7/25/25, 7/26/25, 7/27/25, 7/28/25, 7/29/25, 7/30/25, and 7/31/25. During an interview on 10/20/25 at 9:49 a.m., Family Member (FM) 10 indicated she had concerns about where Resident D's medications were going. The facility would contact her to refill medication. When she attempted to refill the prescription at the pharmacy, the medication refills were being requested too soon. She had brought this to the attention of the staff at the facility and had		completion within 7 days, and documented response within 7 days. •Conduct a quarterly satisfaction survey of Resident and Family Council members to assess perceived improvements and identify remaining concerns. ED is responsible implementation and oversite.	

	not received any follow-up on her concern. During an interview on 10/20/25 at 2:10 p.m., the Director of Nursing indicated the facility rarely used grievance forms. Concerns that were voiced by the residents or families were addressed immediately so there was no reason to complete a grievance form. During an interview on 10/20/25 at 4:10 p.m., the Assistant Director of Nursing (ADON) indicated there were no grievances for Resident D. The family had voiced some concerns, but none that were turned into grievances. 2. The clinical record for Resident C was reviewed on 10/17/25 at 10:11 a.m. The diagnoses included, but were not limited to, dementia and diabetes. An interview was conducted with FM 11 on 10/20/25 at 3:36 p.m. FM 11 indicated she had voiced many concerns about Resident C's care. She had voiced concerns to the staff on the memory care unit and to the management staff. FM 11 had voiced concerns about fall interventions not being followed, incontinent care not being provided, and safety checks not being provided. The staff had not been able to inform her how			

	often safety checks should be provided. Resident C had resided in the memory care unit for approximately six weeks. FM 11 did not feel he was receiving the level of care that they pay for. She had requested a form to write down her concerns and was told there were no forms to use. 3. The clinical record for Resident F was reviewed on 10/20/25 at 1:50 p.m. The diagnoses included, but were not limited to, depression and weakness. An interview was conducted with FM 12 on 10/20/25 at 1:47 p.m. FM 12 indicated she regularly attended Family Council meetings. The facility did not follow-up on grievances voiced during the Family Council. The Family Council would provide a report of the meeting to the Executive Director (ED). Since the current ED was new to her role, the council had not provided reports to her yet, but the previous EDs had not followed-up with concerns the family council took to them. FM 12 provided notes from past Family Council meetings. The Family Council Meeting Notes for the Executive Director, dated 5/21/25, indicated areas of concern as: communication and providing an update to			

	family members and residents on which staff phone numbers were no longer valid, providing new residents with information for requesting meal substitutions, transportation services being canceled after being booked for weeks, staffing issues, security of front doors, and staff dress code. The Family Council Meeting Notes, dated 6/18/25, indicated areas of concerns as: communication and providing an update to family members and residents on which staff phone numbers were no longer valid, who to contact for pharmacy concerns and how to contact them, staffing issues on the night shift, security at the front door, problems with contacting someone at the facility after hours, lack of communications, and concern that the Town Hall Meeting (resident council) concerns not being followed-up with. The Family Council Meeting shared with the E.D. notes, dated 7/16/25, indicated areas of concern as: communication was always the number one concern, pest control issues, care conferences were not being held for every resident, levels of care and cost points were not transparent, safety concerns with the front door, housekeeping issues, concerns about lack of response from the			

ED, staffing on the night shift, and carpet outside the memory unit doors and security of the memory unit doors.

A confidential interview was conducted during the survey. The confidential interview indicated they were concerned about the lack of follow-up to residents and family concerns. The management staff did not follow-up with residents and families when concerns were voiced. They had concerns brought to them frequently because of the lack of follow-up to grievances.

4. On 10/20/25 at 5:18 p.m., the Assistant Director of Nursing provided the Resident Council Notes from July, August, and September 2025.

The Resident Council note, dated 7/9/25, indicated concerns with facility doors not being locked and grounds maintenance.

The Resident Council note, dated 8/13/25, indicated concerns about the reflooring of the second floor, and dining room temperatures being too cold.

The Resident Council note, dated 9/3/25, indicated concerns with security pendants not functioning during power outages. This was a concern first raised six to eight months

	ago. Land line telephones were not operable during power outages. There were concerns about the overnight emergency procedures and requests for clear, written guidance regarding emergency procedures that occur overnight. A concern over emergency responders have access to the building during off hours. During an interview on 10/20/25 at 5:42 p.m., the Life Enrichment Director (LED) indicated she attended the monthly Resident Council meetings and took minutes. She would follow-up on the concerns brought to the resident council and report back to the council at the next meeting. She was not involved with the Family Council and was unaware of any concerns the Family Council had. She did not use grievance forms to address Resident Council concerns. The minute notes for Resident Council did not address follow-up to previous meeting concerns. On 10/20/25 at 9:21 a.m., the ED provided the current Grievance Procedure that indicated "...It is the Community's desire to try to accommodate and respond timely to resident requests, need, complaints and concerns...2) Without fear of reprisal or interference, residents or individuals on			

	behalf of the resident are encourage to submit grievances directly to the Community through the following: a. Directly to the Executive Director [either verbally or in writing] b. during care conferences c. At Resident or Family Forum Meetings or Grievance Committee. 3) Community staff are to bring all resident requests, concerns, and/or complaints to the attention of his/her immediate supervisor or the Executive Director. 4) The Executive Director or Designee investigates all complaints and discusses his/her findings with the resident and responsible party..." On 10/20/25 at 5:27 p.m., the DON provided the Resident Council for Licensed AL (Assisted Living) & MC (Memory Care), implemented 7/22/25, that indicated "...The purpose of Resident Council is to provide residents an opportunity to form and voluntarily participate in a meeting to discuss alleged grievances, community operations, resident rights, or other items of interest without fear of restraint, interference, coercion, discrimination, or reprisal...LED initiates the Resident Council Concern Form for each department leader with any identified resident concerns for the department. Department Leaders: Addresses the resident concern[s]. Completes the			

	Resident Council Concern form and submits to the ED. Executive Director: Reviews the department response and follows up with residents in the residents' desired format. Follows up with departments as appropriate. Maintains Resident Council Concern forms for one [1] year in ED office..." Based on interview and record review, the facility failed to document, and timely address concerns and grievances brought by individual residents', family members, Resident Council, and Family Council for 3 of 3 residents reviewed for grievances with the potential to affect 72 of 72 residents residing at the facility (Resident D, Resident C, and Resident F) Findings include: 1. The clinical record for Resident D was reviewed on 10/17/25 at 1:15 p.m. The diagnoses included, but were not limited to, dementia and anxiety. She was admitted to the facility's assisted living on 5/13/25. She was moved to the facility's dementia care unit on 5/31/25. A service plan, created 5/27/25, indicated Resident D required assistance with medications. The goal was for her medication needs to be met with assistance. The interventions			

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	was told there were no forms to use. 3. The clinical record for Resident F was reviewed on 10/20/25 at 1:50 p.m. The diagnoses included, but were not limited to, depression and weakness. An interview was conducted with FM 12 on 10/20/25 at 1:47 p.m. FM 12 indicated she regularly attended Family Council meetings. The facility did not follow-up on grievances voiced during the Family Council. The Family Council would provide a report of the meeting to the Executive Director (ED). Since the current ED was new to her role, the council had not provided reports to her yet, but the previous EDs had not followed-up with concerns the family council took to them. FM 12 provided notes from past Family Council meetings. The Family Council Meeting Notes for the Executive Director, dated 5/21/25, indicated areas of concern as: communication and providing an update to family members and residents on which staff phone numbers were no longer valid, providing new residents with information for requesting meal substitutions, transportation services being canceled after being booked for weeks, staffing			

	issues, security of front doors, and staff dress code. The Family Council Meeting Notes, dated 6/18/25, indicated areas of concerns as: communication and providing an update to family members and residents on which staff phone numbers were no longer valid, who to contact for pharmacy concerns and how to contact them, staffing issues on the night shift, security at the front door, problems with contacting someone at the facility after hours, lack of communications, and concern that the Town Hall Meeting (resident council) concerns not being followed-up with. The Family Council Meeting shared with the E.D. notes, dated 7/16/25, indicated areas of concern as: communication was always the number one concern, pest control issues, care conferences were not being held for every resident, levels of care and cost points were not transparent, safety concerns with the front door, housekeeping issues, concerns about lack of response from the ED, staffing on the night shift, and carpet outside the memory unit doors and security of the memory unit doors. A confidential interview was conducted during the survey. The confidential interview			

	indicated they were concerned about the lack of follow-up to residents and family concerns. The management staff did not follow-up with residents and families when concerns were voiced. They had concerns brought to them frequently because of the lack of follow-up to grievances. 4. On 10/20/25 at 5:18 p.m., the Assistant Director of Nursing provided the Resident Council Notes from July, August, and September 2025. The Resident Council note, dated 7/9/25, indicated concerns with facility doors not being locked and grounds maintenance. The Resident Council note, dated 8/13/25, indicated concerns about the reflooring of the second floor, and dining room temperatures being too cold. The Resident Council note, dated 9/3/25, indicated concerns with security pendants not functioning during power outages. This was a concern first raised six to eight months ago. Land line telephones were not operable during power outages. There were concerns about the overnight emergency procedures and requests for clear, written guidance regarding emergency			

	procedures that occur overnight. A concern over emergency responders have access to the building during off hours. During an interview on 10/20/25 at 5:42 p.m., the Life Enrichment Director (LED) indicated she attended the monthly Resident Council meetings and took minutes. She would follow-up on the concerns brought to the resident council and report back to the council at the next meeting. She was not involved with the Family Council and was unaware of any concerns the Family Council had. She did not use grievance forms to address Resident Council concerns. The minute notes for Resident Council did not address follow-up to previous meeting concerns. On 10/20/25 at 9:21 a.m., the ED provided the current Grievance Procedure that indicated "...It is the Community's desire to try to accommodate and respond timely to resident requests, need, complaints and concerns...2) Without fear of reprisal or interference, residents or individuals on behalf of the resident are encourage to submit grievances directly to the Community through the following: a. Directly to the Executive Director [either verbally or in writing] b. during care conferences c. At Resident			

	or Family Forum Meetings or Grievance Committee. 3) Community staff are to bring all resident requests, concerns, and/or complaints to the attention of his/her immediate supervisor or the Executive Director. 4) The Executive Director or Designee investigates all complaints and discusses his/her findings with the resident and responsible party..." On 10/20/25 at 5:27 p.m., the DON provided the Resident Council for Licensed AL (Assisted Living) & MC (Memory Care), implemented 7/22/25, that indicated "...The purpose of Resident Council is to provide residents an opportunity to form and voluntarily participate in a meeting to discuss alleged grievances, community operations, resident rights, or other items of interest without fear of restraint, interference, coercion, discrimination, or reprisal...LED initiates the Resident Council Concern Form for each department leader with any identified resident concerns for the department. Department Leaders: Addresses the resident concern[s]. Completes the Resident Council Concern form and submits to the ED. Executive Director: Reviews the department response and follows up with residents in the residents' desired format. Follows up with departments as			

	appropriate. Maintains Resident Council Concern forms for one [1] year in ED office..."			
R 0042	Residents' Rights - Noncompliance 410 IAC 16.2-5-1.2(p) (p) Residents have the right to the examination of the results of the most recent annual survey of the facility conducted by the state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. Based on observation and interview, the facility failed to have a posting of the location of the Indiana Department of Health survey reports binder. This had the potential to affect 72 of 72 residents that reside in the facility. Findings include: During an environmental tour with the Maintenance Supervisor (MS) on 10/20/25 at 10:40 a.m., the MS indicated the Indiana Department of Health survey reports binder was located up front at the receptionist desk. At that time, an observation was made of the receptionist desk area. Receptionist 10 indicated she had the survey reports binder behind the desk. The MS and Receptionist 10 was unable to locate the posting of the location of the survey report binder for	R 0042	•Immediate correction (completed): 1.A clear notice was posted at the reception desk indicating the location of the Indiana Department of Health survey reports binder, and the binder was placed in the designated public viewing area. ED is responsible implementation and oversite.	01/08/2026

visitors and residents to review.

An interview was conducted with the Director of Nursing (DON) and Receptionist 10 on 10/20/25 at 11:10 a.m. The DON indicated the posting was normally on a columned wall at the receptionist desk. She was unable to locate the posting. Receptionist 10 indicated she would place a posting on the columned wall the DON had indicated.

Based on observation and interview, the facility failed to have a posting of the location of the Indiana Department of Health survey reports binder. This had the potential to affect 72 of 72 residents that reside in the facility.

Findings include:

During an environmental tour with the Maintenance Supervisor (MS) on 10/20/25 at 10:40 a.m., the MS indicated the Indiana Department of Health survey reports binder was located up front at the receptionist desk. At that time, an observation was made of the receptionist desk area. Receptionist 10 indicated she had the survey reports binder behind the desk. The MS and Receptionist 10 was unable to locate the posting of the location of the survey report binder for

	visitors and residents to review. An interview was conducted with the Director of Nursing (DON) and Receptionist 10 on 10/20/25 at 11:10 a.m. The DON indicated the posting was normally on a columned wall at the receptionist desk. She was unable to locate the posting. Receptionist 10 indicated she would place a posting on the columned wall the DON had indicated.			
R 0216	Evaluation - Noncompliance 410 IAC 16.2-5-2(c)(1-4)(d) (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility.	R 0216	•Immediate correction (completed): 1.Obtained the physician's order authorizing Resident 6 to self-administer inhalers, scanned the order into the medical record, updated the resident's service plan, and revised the medication list. •Require a completed Self Administration Evaluation, a signed physician order, and an updated service plan within 48 hours of determination that a resident may self administer medications.	01/08/2026

	Based on interview and record review, the facility failed to timely receive a physician's order for a resident to self-administer inhalers for 1 of 5 residents records reviewed. (Resident 6) Findings include: The clinical record for Resident 6 was reviewed on 10/16/25 at 2:00 p.m. The diagnoses included, but were not limited to, asthma and restless leg syndrome. A Saint Louis University Mental Status (SLUMS) Assessment, dated 6/26/25, indicated Resident 6 was cognitively intact. A service plan, dated 7/15/25, indicated Resident 6 required staff assistance with her medication administration. A service plan, dated 7/15/25, indicated Resident 6 "...requires assistance with scheduled treatments: monthly vitals, topical patch, eye drops, nasal sprays, lotions, creams, ointments, daily BS [blood sugar] checks, insulin per MD [medical doctor] orders." A service plan, dated 7/15/25, indicated Resident 6 "...requires assistance with respiratory treatments: inhalers per MD		•Require scanning of the signed physician order into the medical record within 24 hours of receipt. •Implementing a daily WD/AWD review workflow to verify new Self Administration Evaluations, confirm physician orders have been received, and ensure orders are scanned into the chart. •Training nursing staff on the new workflow, documentation requirements, and time frames. •Conduct weekly audits of new Self Administration Evaluations and corresponding physician orders for eight (8) weeks; any deficiencies will be corrected immediately. WD is responsible implementation and oversite.	

orders..."

A physician's order, dated 7/24/25, indicated Resident 6 was to receive two puffs of albuterol inhaler as needed every six hours.

A physician's order, dated 6/9/25, indicated Resident 6 was to receive one puff of Trelegy inhaler daily.

The resident's clinical record did not include orders by a medical provider she was able to self-administer her inhalers.

An interview was conducted with Resident 6 on 10/16/25 at 2:15 p.m. She indicated she self-administered some of her medications. She administers her creams, powders, and inhalers.

A list of residents that self-administer their medications was provided by the Director of Nursing (DON) on 10/16/25 at 2:30 p.m. Resident 6 was not included on the list that she self-administered her medications.

A Medication Self-Administration Evaluation for Resident 6, dated 6/26/25, was provided by the Director of Nursing on 10/17/25 at 2:00 p.m. It indicated Resident 6 was able to self-administer an inhaler.

	An interview was conducted with the DON on 10/17/25 at 2:03 p.m. She indicated the Assistant Director of Nursing (ADON) had conducted a self-medication assessment for Resident 6, on 6/26/25, but had not yet scanned in the resident's electronic medical record. The resident's service plan should reflect the resident was able to self-administer medications, and the medical provider should have an order for the resident to self-administer inhalers. An interview was conducted with the ADON on 10/20/25 at 5:45 p.m. She indicated she had received a physician's order that indicated Resident 6 was able to self-administer the inhalers. A resident self-administration policy was provided by the DON on 10/17/25 at 1:00 p.m. It indicated "...In additional to the completion of the Self-Administration Evaluation, a current signed order from the healthcare provider indicating the resident may self-administer specific or all medications must be in the medical record..." Based on interview and record review, the facility failed to timely receive a physician's order for a resident to self-administer inhalers for 1 of 5 residents records reviewed. (Resident 6)			

Findings include:

The clinical record for Resident 6 was reviewed on 10/16/25 at 2:00 p.m. The diagnoses included, but were not limited to, asthma and restless leg syndrome.

A Saint Louis University Mental Status (SLUMS) Assessment, dated 6/26/25, indicated Resident 6 was cognitively intact.

A service plan, dated 7/15/25, indicated Resident 6 required staff assistance with her medication administration.

A service plan, dated 7/15/25, indicated Resident 6 "...requires assistance with scheduled treatments: monthly vitals, topical patch, eye drops, nasal sprays, lotions, creams, ointments, daily BS [blood sugar] checks, insulin per MD [medical doctor] orders."

A service plan, dated 7/15/25, indicated Resident 6 "...requires assistance with respiratory treatments: inhalers per MD orders..."

A physician's order, dated 7/24/25, indicated Resident 6 was to receive two puffs of albuterol inhaler as needed every six hours.

A physician's order, dated 6/9/25, indicated Resident 6

was to receive one puff of Trelegy inhaler daily.

The resident's clinical record did not include orders by a medical provider she was able to self-administer her inhalers.

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A Medication Self-Administration Evaluation for Resident 6, dated 6/26/25, was provided by the Director of Nursing on 10/17/25 at 2:00 p.m. It indicated Resident 6 was able to self-administer an inhaler.

An interview was conducted with the DON on 10/17/25 at 2:03 p.m. She indicated the Assistant Director of Nursing (ADON) had conducted a self-medication assessment for Resident 6, on 6/26/25, but had not yet scanned in the resident's electronic medical record. The resident's service plan should

	reflect the resident was able to self-administer medications, and the medical provider should have an order for the resident to self-administer inhalers. An interview was conducted with the ADON on 10/20/25 at 5:45 p.m. She indicated she had received a physician's order that indicated Resident 6 was able to self-administer the inhalers. A resident self-administration policy was provided by the DON on 10/17/25 at 1:00 p.m. It indicated "...In additional to the completion of the Self-Administration Evaluation, a current signed order from the healthcare provider indicating the resident may self-administer specific or all medications must be in the medical record..."			
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency;	R 0217	•Immediate correction (completed): 1.Performed immediate service plan reviews for Residents E, D, and 6; updated each plan to accurately reflect current ADL assistance needs, transfer requirements (mechanical lift), toileting and dining assistance, behavior interventions, and inhaler self administration. Updated plan copies were provided to family and hospice as applicable. •Require staff to submit a Care	01/08/2026

	(C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. 3. The clinical record for Resident 6 was reviewed on 10/16/25 at 2:00 p.m. The diagnoses included, but were not limited to, asthma and restless leg syndrome. A Saint Louis University Mental Status (SLUMS) Assessment, dated 6/26/25, indicated Resident 6 was cognitively		Plan Review Referral within 24 hours whenever they observe a significant change (e.g., weight loss, increased ADL dependence, behavior changes, falls, hospital transfer, refusal of care, or changes in self administration ability). •Implement a weekly interdisciplinary Care Huddle (Nursing, Life Enrichment, and Therapy as indicated) to identify residents who require service plan updates. •Train all direct care staff on change triggers and the Care Plan Review Referral process. Train the interdisciplinary team on timelines and expectations for completing plan revisions. •Conduct random chart reviews (10 charts weekly for 8 weeks, then monthly for 6 months) to verify that service plans reflect current resident needs and that referrals resulted in documented plan updates within 48 hours. WD is responsible implementation and oversite.	

intact.

A service plan, dated 7/15/25, indicated Resident 6 required staff assistance with medication administration.

A service plan, dated 7/15/25, indicated Resident 6 "...requires assistance with scheduled treatments: monthly vitals, topical patch, eye drops, nasal sprays, lotions, creams, ointments, daily BS [blood sugar] checks, insulin per MD [medical doctor] orders."

A service plan, dated 7/15/25, indicated Resident 6 "...requires assistance with respiratory treatments: inhalers per MD orders..."

A physician's order, dated 7/24/25, indicated Resident 6 was to receive two puffs of albuterol inhaler as needed every six hours.

A physician's order, dated 6/9/25, indicated Resident 6 was to receive one puff of Trelegy inhaler daily.

The resident's clinical record did not include orders by a medical provider, indicating she was able to self-administer her inhalers.

An interview was conducted with Resident 6 on 10/16/25 at 2:15 p.m. She indicated she self-administers some of her

	medications. She administers her creams, powders, and inhalers. A Medication Self-Administration Evaluation for Resident 6, dated 6/26/25, was provided by the Director of Nursing on 10/17/25 at 2:00 p.m. It indicated Resident 6 was able to self-administer an inhaler. An interview was conducted with the Director of Nursing (DON) on 10/17/25 at 2:03 p.m. She indicated Resident 6's service plan should be updated and that included Resident 6 self-administering some of her medications. On 10/17/25 at 1:00 p.m., the DON provided the Resident Evaluation and Service plan, last reviewed/ updated 9/15/25, that indicated "...The purpose of the Resident Evaluation and Service Plan is to establish a process to evaluate and plan for the Resident's needs. The purpose of the service plan is to provide a description of the services that will be provided to the resident based on their individual needs and preferences...The Service Plan will address, but is not limited to, the following:...Medication management...When to complete: The service plan is reviewed and updated at least annually and when a resident's			

	needs or preferences changes..." Based on observation, interview, and record review, the facility failed to timely update resident service plans with increased need for assistance with activities of daily living, behavior concerns, and self-administration of inhaler medications for 3 of 6 residents reviewed for service plans. (Resident E, Resident D, and Resident 6) Findings include: 1. The clinical record for Resident E was reviewed on 10/16/25 at 2:20 p.m. The diagnoses included, but were not limited to, dementia with behavioral disturbance. A service plan, last revised on 7/17/25, indicated Resident E required assistance with dining. The goal was that his dining needs would be met with assistance. The intervention was that he required reminders for mealtimes and assistance to the dining room.			

	A service plan, last revised on 7/17/25, indicated he required assistance with toileting. The goal was for toileting needs to be met with assistance. The interventions were the assistive device of grab bars and care staff would report any changes in the ability to toilet. A service plan, last revised on 7/17/25, indicated transfers. The goal was Resident E would be able to transfer safely. The intervention was care staff will report any changes in ability to transfer. A service plan, last revised on 7/23/25, indicated Resident E was receiving hospice services. The goal was for him to be made comfortable and his end of life journey would be dignified. The interventions included hospice services would be provided. On 10/16/25 at 11:15 a.m., Resident E was observed with the Director of Nursing (DON). He was in the common area of the dementia care unit. He was sitting in a Broda (reclining chair) chair with a mechanical lift pad underneath him. The DON indicated he required a mechanical lift to assist with transfers. On 10/16/25 at 2:17 p.m., Resident E was observed being transported in his Broda chair by			

	Certified Nurse Aide (CNA) 4. CNA 4 indicated he required total assistance with Activities of Daily Living (ADL) care. He could feed himself some things, but staff assisted him with eating. He required a mechanical lift for transfers and was dependent on staff for toileting. During an interview on 10/20/25 at 1:17 p.m., the Assistant Director of Nursing indicated Resident E required total care and was receiving hospice services to assist with his care. He required staff to feed him meals. 2. The clinical record for Resident D was reviewed on 10/17/25 at 1:15 p.m. The diagnoses included, but were not limited to, dementia and anxiety. She was admitted to the facility assisted living on 5/13/25. She was moved to the facility dementia care unit on 5/31/25. A service plan, dated 5/13/25, indicated bathing. Resident D would remain independent with bathing/showers. The interventions included she was independent for all tasks related to bathing without reminders from staff. A service plan, dated 5/13/25, indicated dressing. Resident D will maintain independence with			

dressing. Resident D was independent with all tasks related to dressing without reminders from staff.

Resident D's service plan did not include a service plan addressing behavioral concerns.

During an interview on 10/20/25 at 10:40 a.m., CNA 5 indicated Resident D needed staff assistance with getting dressed and with showers. Resident D also required reminders to attend meals and activities on the unit. Resident D did display behaviors, but the behaviors were mostly in the evenings.

During an interview on 10/20/25 at 11:27 a.m., CNA 6 indicated he had worked with Resident D often. Resident D could be aggressive at times, hitting staff during care. Resident D often refused showers. The staff would offer a different staff member and attempt to redirect her to accept showers. If Resident D refused to be showered, CNA 6 would inform the nurse or Qualified Medication Aide (QMA) so that the family could be contacted.

3. The clinical record for Resident 6 was reviewed on 10/16/25 at 2:00 p.m. The diagnoses included, but were not limited to, asthma and restless leg syndrome.

A Saint Louis University Mental

Status (SLUMS) Assessment, dated 6/26/25, indicated Resident 6 was cognitively intact.

A service plan, dated 7/15/25, indicated Resident 6 required staff assistance with medication administration.

A service plan, dated 7/15/25, indicated Resident 6 "...requires assistance with scheduled treatments: monthly vitals, topical patch, eye drops, nasal sprays, lotions, creams, ointments, daily BS [blood sugar] checks, insulin per MD [medical doctor] orders."

A service plan, dated 7/15/25, indicated Resident 6 "...requires assistance with respiratory treatments: inhalers per MD orders..."

A physician's order, dated 7/24/25, indicated Resident 6 was to receive two puffs of albuterol inhaler as needed every six hours.

A physician's order, dated 6/9/25, indicated Resident 6 was to receive one puff of Trelegy inhaler daily.

The resident's clinical record did not include orders by a medical provider, indicating she was able to self-administer her inhalers.

An interview was conducted

	with Resident 6 on 10/16/25 at 2:15 p.m. She indicated she self-administers some of her medications. She administers her creams, powders, and inhalers. A Medication Self-Administration Evaluation for Resident 6, dated 6/26/25, was provided by the Director of Nursing on 10/17/25 at 2:00 p.m. It indicated Resident 6 was able to self-administer an inhaler. An interview was conducted with the Director of Nursing (DON) on 10/17/25 at 2:03 p.m. She indicated Resident 6's service plan should be updated and that included Resident 6 self-administering some of her medications. On 10/17/25 at 1:00 p.m., the DON provided the Resident Evaluation and Service plan, last reviewed/ updated 9/15/25, that indicated "...The purpose of the Resident Evaluation and Service Plan is to establish a process to evaluate and plan for the Resident's needs. The purpose of the service plan is to provide a description of the services that will be provided to the resident based on their individual needs and preferences...The Service Plan will address, but is not limited to, the following:...Medication management...When to			

	complete: The service plan is reviewed and updated at least annually and when a resident's needs or preferences changes..." Based on observation, interview, and record review, the facility failed to timely update resident service plans with increased need for assistance with activities of daily living, behavior concerns, and self-administration of inhaler medications for 3 of 6 residents reviewed for service plans. (Resident E, Resident D, and Resident 6) Findings include: 1. The clinical record for Resident E was reviewed on 10/16/25 at 2:20 p.m. The diagnoses included, but were not limited to, dementia with behavioral disturbance. A service plan, last revised on 7/17/25, indicated Resident E required assistance with dining. The goal was that his dining needs would be met with assistance. The intervention was that he required reminders for mealtimes and assistance to the dining room. A service plan, last revised on 7/17/25, indicated he required assistance with toileting. The goal was for toileting needs to be met with assistance. The interventions were the assistive			

	device of grab bars and care staff would report any changes in the ability to toilet. A service plan, last revised on 7/17/25, indicated transfers. The goal was Resident E would be able to transfer safely. The intervention was care staff will report any changes in ability to transfer. A service plan, last revised on 7/23/25, indicated Resident E was receiving hospice services. The goal was for him to be made comfortable and his end of life journey would be dignified. The interventions included hospice services would be provided. On 10/16/25 at 11:15 a.m., Resident E was observed with the Director of Nursing (DON). He was in the common area of the dementia care unit. He was sitting in a Broda (reclining chair) chair with a mechanical lift pad underneath him. The DON indicated he required a mechanical lift to assist with transfers. On 10/16/25 at 2:17 p.m., Resident E was observed being transported in his Broda chair by Certified Nurse Aide (CNA) 4. CNA 4 indicated he required total assistance with Activities of Daily Living (ADL) care. He could feed himself some things, but staff assisted him with			

eating. He required a mechanical lift for transfers and was dependent on staff for toileting.

During an interview on 10/20/25 at 1:17 p.m., the Assistant Director of Nursing indicated Resident E required total care and was receiving hospice services to assist with his care. He required staff to feed him meals.

2. The clinical record for Resident D was reviewed on 10/17/25 at 1:15 p.m. The diagnoses included, but were not limited to, dementia and anxiety. She was admitted to the facility assisted living on 5/13/25. She was moved to the facility dementia care unit on 5/31/25.

A service plan, dated 5/13/25, indicated bathing. Resident D would remain independent with bathing/showers. The interventions included she was independent for all tasks related to bathing without reminders from staff.

A service plan, dated 5/13/25, indicated dressing. Resident D will maintain independence with dressing. Resident D was independent with all tasks related to dressing without reminders from staff.

Resident D's service plan did not include a service plan

addressing behavioral concerns.

During an interview on 10/20/25 at 10:40 a.m., CNA 5 indicated Resident D needed staff assistance with getting dressed and with showers. Resident D also required reminders to attend meals and activities on the unit. Resident D did display behaviors, but the behaviors were mostly in the evenings.

During an interview on 10/20/25 at 11:27 a.m., CNA 6 indicated he had worked with Resident D often. Resident D could be aggressive at times, hitting staff during care. Resident D often refused showers. The staff would offer a different staff member and attempt to redirect her to accept showers. If Resident D refused to be showered, CNA 6 would inform the nurse or Qualified Medication Aide (QMA) so that the family could be contacted.

3. The clinical record for Resident 6 was reviewed on 10/16/25 at 2:00 p.m. The diagnoses included, but were not limited to, asthma and restless leg syndrome.

A Saint Louis University Mental Status (SLUMS) Assessment, dated 6/26/25, indicated Resident 6 was cognitively intact.

A service plan, dated 7/15/25, indicated Resident 6 required

staff assistance with medication administration.

A service plan, dated 7/15/25, indicated Resident 6 "...requires assistance with scheduled treatments: monthly vitals, topical patch, eye drops, nasal sprays, lotions, creams, ointments, daily BS [blood sugar] checks, insulin per MD [medical doctor] orders."

A service plan, dated 7/15/25, indicated Resident 6 "...requires assistance with respiratory treatments: inhalers per MD orders..."

A physician's order, dated 7/24/25, indicated Resident 6 was to receive two puffs of albuterol inhaler as needed every six hours.

A physician's order, dated 6/9/25, indicated Resident 6 was to receive one puff of Trelegy inhaler daily.

The resident's clinical record did not include orders by a medical provider, indicating she was able to self-administer her inhalers.

An interview was conducted with Resident 6 on 10/16/25 at 2:15 p.m. She indicated she self-administers some of her medications. She administers her creams, powders, and inhalers.

	A Medication Self-Administration Evaluation for Resident 6, dated 6/26/25, was provided by the Director of Nursing on 10/17/25 at 2:00 p.m. It indicated Resident 6 was able to self-administer an inhaler. An interview was conducted with the Director of Nursing (DON) on 10/17/25 at 2:03 p.m. She indicated Resident 6's service plan should be updated and that included Resident 6 self-administering some of her medications. On 10/17/25 at 1:00 p.m., the DON provided the Resident Evaluation and Service plan, last reviewed/ updated 9/15/25, that indicated "...The purpose of the Resident Evaluation and Service Plan is to establish a process to evaluate and plan for the Resident's needs. The purpose of the service plan is to provide a description of the services that will be provided to the resident based on their individual needs and preferences...The Service Plan will address, but is not limited to, the following:...Medication management...When to complete: The service plan is reviewed and updated at least annually and when a resident's needs or preferences changes..." Based on observation,			

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3. The clinical record for Resident 6 was reviewed on 10/16/25 at 2:00 p.m. The diagnoses included, but were not limited to, asthma and restless leg syndrome.

A Saint Louis University Mental Status (SLUMS) Assessment, dated 6/26/25, indicated Resident 6 was cognitively intact.

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The resident's clinical record did not include orders by a medical provider, indicating she was able to self-administer her inhalers.

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medications for 3 of 6 residents reviewed for service plans. (Resident E, Resident D, and Resident 6)

Findings include:

1. The clinical record for Resident E was reviewed on 10/16/25 at 2:20 p.m. The diagnoses included, but were not limited to, dementia with behavioral disturbance.

A service plan, last revised on 7/17/25, indicated Resident E required assistance with dining. The goal was that his dining needs would be met with assistance. The intervention was that he required reminders for mealtimes and assistance to the dining room.

A service plan, last revised on 7/17/25, indicated he required assistance with toileting. The goal was for toileting needs to be met with assistance. The interventions were the assistive device of grab bars and care staff would report any changes in the ability to toilet.

A service plan, last revised on 7/17/25, indicated transfers. The goal was Resident E would be able to transfer safely. The intervention was care staff will report any changes in ability to transfer.

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	was receiving hospice services. The goal was for him to be made comfortable and his end of life journey would be dignified. The interventions included hospice services would be provided. On 10/16/25 at 11:15 a.m., Resident E was observed with the Director of Nursing (DON). He was in the common area of the dementia care unit. He was sitting in a Broda (reclining chair) chair with a mechanical lift pad underneath him. The DON indicated he required a mechanical lift to assist with transfers. On 10/16/25 at 2:17 p.m., Resident E was observed being transported in his Broda chair by Certified Nurse Aide (CNA) 4. CNA 4 indicated he required total assistance with Activities of Daily Living (ADL) care. He could feed himself some things, but staff assisted him with eating. He required a mechanical lift for transfers and was dependent on staff for toileting. During an interview on 10/20/25 at 1:17 p.m., the Assistant Director of Nursing indicated Resident E required total care and was receiving hospice services to assist with his care. He required staff to feed him meals.			

	2. The clinical record for Resident D was reviewed on 10/17/25 at 1:15 p.m. The diagnoses included, but were not limited to, dementia and anxiety. She was admitted to the facility assisted living on 5/13/25. She was moved to the facility dementia care unit on 5/31/25. A service plan, dated 5/13/25, indicated bathing. Resident D would remain independent with bathing/showers. The interventions included she was independent for all tasks related to bathing without reminders from staff. A service plan, dated 5/13/25, indicated dressing. Resident D will maintain independence with dressing. Resident D was independent with all tasks related to dressing without reminders from staff. Resident D's service plan did not include a service plan addressing behavioral concerns. During an interview on 10/20/25 at 10:40 a.m., CNA 5 indicated Resident D needed staff assistance with getting dressed and with showers. Resident D also required reminders to attend meals and activities on the unit. Resident D did display behaviors, but the behaviors were mostly in the evenings. During an interview on 10/20/25			

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R 0240	Health Services - Deficiency 410 IAC 16.2-5-4(d) (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. 3. The clinical record for Resident 34 was reviewed on 10/17/25 at 10:57 a.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus. A physician's order, dated 7/7/25, indicated Resident 34 was to receive a sliding scale of lispro insulin utilizing a flex pen three times a day. The sliding scale was the following: 125 blood sugar reading - 150 blood sugar reading = 2 units of insulin,	R 0240	•Shower schedule: Reviewed Resident D's shower schedule with family; staff began documenting shower refusals and initiated the family/clinical notification process. All refusal attempts and notification attempts are now recorded. •Assurance checks: Following investigation of Resident F's fall, assurance rounds were increased immediately. Staff were ensured access to keys and trained on entry procedures for locked apartments. Resident F's plan now requires visual checks every shift with documentation of each round. •Insulin priming and administration: Retrained the QMA on priming FlexPens and observed a return demonstration. Corrected prior insulin administrations for Residents 29 and 34 and	01/08/2026

	151 blood sugar reading - 180 blood sugar reading = 4 units of insulin, 181 blood sugar reading - 210 blood sugar reading = 6 units of insulin, 211 blood sugar reading - 250 blood sugar reading = 8 units of insulin, 251 blood sugar reading - 280 blood sugar reading = 10 units of insulin, 281 blood sugar reading - 310 blood sugar reading = 12 units of insulin, 311 blood sugar reading - 350 blood sugar reading = 14 units of insulin, 351 blood sugar reading - 380 blood sugar reading = 16 units of insulin, 381 blood sugar reading - 410 blood sugar reading = 18 units of insulin, 411 blood sugar reading - 450 blood sugar reading = 20 units of insulin and staff was to call the medical provider if the resident's blood sugar was less than 80 or greater than 450. An observation was conducted of an insulin medication administration with QMA 1 on		documented the education provided. •Shower/Personal Care protocol: Require documentation of each shower attempt and the reason for non completion (refusal, clinical contraindication, off site). If a resident refuses two showers in one week, the nurse and family (per family preference) must be notified. All entries must be recorded in the shower log. •Assurance Check Procedure: Updated to specify frequency per service plan, keys availability, staff responsibilities for locked doors, and immediate reporting of missed checks with required corrective actions. An assurance check audit sheet and electronic reminders were implemented. •Insulin Administration Procedure: Revised to require priming the pen with 2 units before each injection, competency verification for all staff who administer insulin, and posting pharmacy/manufacturer instructions at medication carts. •Trainings: All CNAs, QMAs, and LPNs trained on updated shower documentation and refusal reporting, assurance check procedures (including keys and entry protocols), and correct insulin pen priming technique.	

	10/17/25 at 10:58 a.m. QMA 1 entered Resident 34's room and obtained the resident's blood sugar reading of 145. She then returned to the cart and prepared the resident's lispro insulin flex pen. QMA 1 was observed donning on gloves, wiping the rubber seal, and placing the needle on the seal. She then dialed two units of lispro insulin. After, she entered the resident's room and administered two units of lispro insulin in Resident 34's abdomen. QMA 1 did not prime the resident's flex pen with two units of insulin prior to dialing up the insulin dosage. 4. The clinical record for Resident 29 was reviewed on 10/17/25 at 11:10 a.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus. A physician's order, dated 7/21/25, indicated Resident 29 was to receive four units of Humalog insulin three times a day. An observation was conducted of an insulin medication administration with QMA 1 for Resident 29 on 10/17/25 at 11:10 a.m. QMA 1 was observed at the medication cart preparing the insulin flexpen. She indicated at that time, the resident's blood sugar reading was 87. She pulled a flexpen		•Competency checks: All medication administration staff were observed for insulin pen use and documented for competency. •Audits: (1)Shower logs: weekly audits for accuracy and completeness for 8 weeks. (2)Assurance checks: daily audits for 14 days, then weekly for 8 weeks. (3)Medication pass: direct observation of insulin administration — 5 random observations weekly for 8 weeks, then monthly thereafter. WD is responsible implementation and oversite.	

	from the medication cart and donned gloves. During that time, QMA 1 wiped the rubber seal with an alcohol wipe and placed a needle on the rubber seal. She then dialed up four units of Humalog insulin. After, she doffed her gloves and entered the resident's room. QMA 1 was observed donning a new set of gloves and administered the four units of Humalog insulin to Resident 29. There was no observation of QMA 1 priming the resident's insulin flexpen of two units prior to dialing up the insulin dosage. An interview was conducted with the Director of Nursing on 10/17/25 at 1:47 p.m. She indicated the staff should be priming the insulin flexpens of two units prior to dialing up the insulin dosage. A Humalog/lispro manufacture instructions document was provided by the Director of Nursing on 10/17/25 at 3:10 p.m. It indicated "...Priming your Pen. Prime before each injection. Priming your pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. Step 6: To prime your pen, turn the dose knob to select 2 units. Step 7: Hold your pen with the			

	needle pointing up. Tap the cartridge holder gently to collect air bubbles at the top. Step 8: Continue holding your pen with needle pointing up. Push the dose knob in until it stops, and '0' is seen in the dose window. Hold the dose knob in and count to 5 slowly. You should see insulin at the tip of the needle..." On 10/17/25 at 1:00 p.m., the DON provided the Resident Evaluation and Service plan, last reviewed/ updated 9/15/25, that indicated "...The purpose of the Resident Evaluation and Service Plan is to establish a process to evaluate and plan for the Resident's needs. The purpose of the service plan is to provide a description of the services that will be provided to the resident based on their individual needs and preferences..." This citation relates to Intake IN00464954. Based on interview and record review, the facility failed to ensure a resident received showers as scheduled, ensure residents received assurance checks to maintain safety, and to ensure an insulin flex pen was primed with two units of insulin prior to administration of an insulin dosage for 2 of 6 residents reviewed for service plans and 2 of 2 residents observed for insulin			

	administration. (Resident D, Resident F, Resident 34, and Resident 29) Findings include: 1. The clinical record for Resident D was reviewed on 10/17/25 at 1:15 p.m. The diagnoses included, but were not limited to, dementia and anxiety. She was admitted to the facility assisted living on 5/13/25. She was moved to the facility dementia care unit on 5/31/25. A service plan, dated 5/13/25, indicated bathing. Resident D would remain independent with bathing/showers. The interventions indicated she was independent for all tasks related to bathing without reminders from staff. The care staff would report any changes in the ability to bathe. A service plan, dated 5/13/25, indicated dressing. Resident D will maintain independence with dressing. Resident D was independent with all tasks related to dressing without reminders from staff. The staff would report any changes in ability to dress. A service plan, dated 5/13/25, indicated assurance checks. The goal was that safety would be maintained while living in the community. Assurance checks to be provided each shift for			

	safety. A Health Status Note, dated 9/7/2025 at 5:25 p.m., indicated Resident D had returned from a leave of absence with her family. The family stated Resident D had diarrhea twice while she was out of the facility. Family had noted dried diarrhea in Resident D's bathroom area. Staff cleaned the bathroom. During an interview on 10/20/25 at 9:49 a.m., Family Member (FM) 10 indicated Resident D had not received showers twice weekly while she was on the dementia care unit. FM 10 offered to come to the facility and assist Resident D with showers if she refused to let staff shower her. The facility had not made her aware that Resident D was refusing showers. On 9/7/25, FM 10 took Resident D out of the facility for a few hours. After FM 10 returned Resident D to the facility, on 9/7/25, FM 10 had gone to Resident D's apartment to check for something and had found Resident D's bathroom "covered in" dried feces. The feces were on the walls and floor and appeared as if Resident D had attempted to clean the feces up by herself. There was a used incontinence brief in the sink that was full of dried feces, and the incontinence brief had dried and become stuck to the sink. There			

	were footprints of dried feces on the floor coming into the bedroom of the apartment. FM 10 had informed the facility staff, and the staff came to clean the bathroom. During an interview on 10/20/25 at 11:27 a.m., Certified Nurse Aide (CNA) 6 indicated he had worked with Resident D often. Resident D could be aggressive at times, hitting staff during care. Resident D often refused showers. The staff would offer a different staff member and attempt to redirect her to accept showers. If Resident D refused to be showered, CNA 6 would inform the nurse or Qualified Medication Aide (QMA) so the family could be contacted. CNA 6 was on duty in the evening on 9/7/25 and had assisted with cleaning the feces in Resident D's bathroom. The feces had been smeared and were dried. During an interview on 10/20/25 at 11:35 a.m., Licensed Practical Nurse (LPN) 3 indicated she had worked the evening of 9/7/25 and had assisted with cleaning Resident D's bathroom. The bathroom had been "a mess". There were feces everywhere and it looked like Resident D had attempted to clean it herself. There had been a used incontinent brief that contained dried feces and was dried to the sink. When Resident D refused care or			

	medications, LPN 3 would contact the family to assist with care. On 10/20/25 at 4:17 p.m., the Executive Director (ED) provided the July, August, and September 2025 shower records for Resident D. The shower records indicated Resident D had received a shower on the following days: 8/4/25, 8/21/25, and 9/4/25. During an interview on 10/20/25 at 5:06 p.m., the Director of Nursing (DON) indicated residents should receive showers twice weekly. There were no other shower records for Resident D. The staff had not filled out shower records if the resident refused her shower. The DON was not aware that the family had requested to be called if Resident D refused her shower. 2. The clinical record for Resident F was reviewed on 10/20/25 at 1:50 p.m. The diagnoses included, but were not limited to, depression and weakness. A service plan, last revised on 7/15/25, indicated she required assurance checks. The goal was to maintain safety while living in the community. The intervention was to provide frequent assurance checks for safety and ensure that needs			

	were met. A service plan, last revised 7/15/25, indicated she was at risk for falls. The goal was the chance of falls would be reduced within the community. The intervention was to keep pathways free from clutter including clothes baskets. She was at risk for falls due to weakness and safety unawareness. A service plan, created 9/8/25, indicated Post Fall. The goal was for her to participate with fall prevention measures to reduce the risk of fall occurrence. The intervention was to assist her with toileting in the morning, before meals, and at bedtime. A Post Fall service plan, created 4/26/25 and last revised on 10/19/25, indicated the goal of Resident F participating with prevention measures to reduce risk of falls. The interventions were to encourage Resident F to utilize her call pendant for assistance. During an interview on 10/20/25 at 1:47 p.m., Family Member (FM) 12 indicated Resident F slid from her bed and onto the floor just after 7:00 a.m. FM 12 was aware of the time of the fall from the camera the family installed in her room. Resident F sat on the floor after the fall for			

	an hour before someone came in to check on her. The door was locked, and Resident F did not have on her alert bracelet to push. The staff did not have keys to get into the room. Resident F had a facility provided safety monitoring camera present in her room, but it had not picked up the fall. FM 12 had not been able to contact anyone at the facility to inform them of Resident F's fall. During an interview on 10/20/25 at 2:32 p.m., LPN 3 indicated she was on duty when Resident F was found on 10/19/25. The CNAs should have visually checked Resident F during walking rounds at shift change. If the door was locked, the CNA's and QMA's had keys to enter apartments. Each resident should be visually checked during walking rounds to ensure they are safe. During an interview on 10/20/25 at 5:11 p.m., the DON indicated Resident F had slipped off the bed the morning of 10/19/25. The CNAs had knocked on the door during walking rounds and Resident F had answered. The CNAs had not gone into the room since she had answered them. There was a key available for the CNAs to use if they needed to enter an apartment. 3. The clinical record for Resident 34 was reviewed on			

	10/17/25 at 10:57 a.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus. A physician's order, dated 7/7/25, indicated Resident 34 was to receive a sliding scale of lispro insulin utilizing a flex pen three times a day. The sliding scale was the following: 125 blood sugar reading - 150 blood sugar reading = 2 units of insulin, 151 blood sugar reading - 180 blood sugar reading = 4 units of insulin, 181 blood sugar reading - 210 blood sugar reading = 6 units of insulin, 211 blood sugar reading - 250 blood sugar reading = 8 units of insulin, 251 blood sugar reading - 280 blood sugar reading = 10 units of insulin, 281 blood sugar reading - 310 blood sugar reading = 12 units of insulin, 311 blood sugar reading - 350 blood sugar reading = 14 units of insulin, 351 blood sugar reading - 380 blood sugar reading = 16 units of insulin,			

381 blood sugar reading - 410 blood sugar reading = 18 units of insulin,

411 blood sugar reading - 450 blood sugar reading = 20 units of insulin and

staff was to call the medical provider if the resident's blood sugar was less than 80 or greater than 450.

An observation was conducted of an insulin medication administration with QMA 1 on 10/17/25 at 10:58 a.m. QMA 1 entered Resident 34's room and obtained the resident's blood sugar reading of 145. She then returned to the cart and prepared the resident's lispro insulin flex pen. QMA 1 was observed donning on gloves, wiping the rubber seal, and placing the needle on the seal. She then dialed two units of lispro insulin. After, she entered the resident's room and administered two units of lispro insulin in Resident 34's abdomen. QMA 1 did not prime the resident's flex pen with two units of insulin prior to dialing up the insulin dosage.

4. The clinical record for Resident 29 was reviewed on 10/17/25 at 11:10 a.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus.

A physician's order, dated

	7/21/25, indicated Resident 29 was to receive four units of Humalog insulin three times a day. An observation was conducted of an insulin medication administration with QMA 1 for Resident 29 on 10/17/25 at 11:10 a.m. QMA 1 was observed at the medication cart preparing the insulin flexpen. She indicated at that time, the resident's blood sugar reading was 87. She pulled a flexpen from the medication cart and donned gloves. During that time, QMA 1 wiped the rubber seal with an alcohol wipe and placed a needle on the rubber seal. She then dialed up four units of Humalog insulin. After, she doffed her gloves and entered the resident's room. QMA 1 was observed donning a new set of gloves and administered the four units of Humalog insulin to Resident 29. There was no observation of QMA 1 priming the resident's insulin flexpen of two units prior to dialing up the insulin dosage. An interview was conducted with the Director of Nursing on 10/17/25 at 1:47 p.m. She indicated the staff should be priming the insulin flexpens of two units prior to dialing up the insulin dosage. A Humalog/lispro manufacture instructions document was			

	provided by the Director of Nursing on 10/17/25 at 3:10 p.m. It indicated "...Priming your Pen. Prime before each injection. Priming your pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. Step 6: To prime your pen, turn the dose knob to select 2 units. Step 7: Hold your pen with the needle pointing up. Tap the cartridge holder gently to collect air bubbles at the top. Step 8: Continue holding your pen with needle pointing up. Push the dose knob in until it stops, and '0' is seen in the dose window. Hold the dose knob in and count to 5 slowly. You should see insulin at the tip of the needle..." On 10/17/25 at 1:00 p.m., the DON provided the Resident Evaluation and Service plan, last reviewed/ updated 9/15/25, that indicated "...The purpose of the Resident Evaluation and Service Plan is to establish a process to evaluate and plan for the Resident's needs. The purpose of the service plan is to provide a description of the services that will be provided to the resident based on their individual needs and preferences..." This citation relates to Intake			

IN00464954.

Based on interview and record review, the facility failed to ensure a resident received showers as scheduled, ensure residents received assurance checks to maintain safety, and to ensure an insulin flex pen was primed with two units of insulin prior to administration of an insulin dosage for 2 of 6 residents reviewed for service plans and 2 of 2 residents observed for insulin administration. (Resident D, Resident F, Resident 34, and Resident 29)

Findings include:

1. The clinical record for Resident D was reviewed on 10/17/25 at 1:15 p.m. The diagnoses included, but were not limited to, dementia and anxiety. She was admitted to the facility assisted living on 5/13/25. She was moved to the facility dementia care unit on 5/31/25.

A service plan, dated 5/13/25, indicated bathing. Resident D would remain independent with bathing/showers. The interventions indicated she was independent for all tasks related to bathing without reminders from staff. The care staff would report any changes in the ability to bathe.

A service plan, dated 5/13/25,

	indicated dressing. Resident D will maintain independence with dressing. Resident D was independent with all tasks related to dressing without reminders from staff. The staff would report any changes in ability to dress. A service plan, dated 5/13/25, indicated assurance checks. The goal was that safety would be maintained while living in the community. Assurance checks to be provided each shift for safety. A Health Status Note, dated 9/7/2025 at 5:25 p.m., indicated Resident D had returned from a leave of absence with her family. The family stated Resident D had diarrhea twice while she was out of the facility. Family had noted dried diarrhea in Resident D's bathroom area. Staff cleaned the bathroom. During an interview on 10/20/25 at 9:49 a.m., Family Member (FM) 10 indicated Resident D had not received showers twice weekly while she was on the dementia care unit. FM 10 offered to come to the facility and assist Resident D with showers if she refused to let staff shower her. The facility had not made her aware that Resident D was refusing showers. On 9/7/25, FM 10 took Resident D out of the facility for a few hours. After FM 10			

returned Resident D to the facility, on 9/7/25, FM 10 had gone to Resident D's apartment to check for something and had found Resident D's bathroom "covered in" dried feces. The feces were on the walls and floor and appeared as if Resident D had attempted to clean the feces up by herself. There was a used incontinence brief in the sink that was full of dried feces, and the incontinence brief had dried and become stuck to the sink. There were footprints of dried feces on the floor coming into the bedroom of the apartment. FM 10 had informed the facility staff, and the staff came to clean the bathroom.

During an interview on 10/20/25 at 11:27 a.m., Certified Nurse Aide (CNA) 6 indicated he had worked with Resident D often. Resident D could be aggressive at times, hitting staff during care. Resident D often refused showers. The staff would offer a different staff member and attempt to redirect her to accept showers. If Resident D refused to be showered, CNA 6 would inform the nurse or Qualified Medication Aide (QMA) so the family could be contacted. CNA 6 was on duty in the evening on 9/7/25 and had assisted with cleaning the feces in Resident D's bathroom. The feces had been smeared and were dried.

	During an interview on 10/20/25 at 11:35 a.m., Licensed Practical Nurse (LPN) 3 indicated she had worked the evening of 9/7/25 and had assisted with cleaning Resident D's bathroom. The bathroom had been "a mess". There were feces everywhere and it looked like Resident D had attempted to clean it herself. There had been a used incontinent brief that contained dried feces and was dried to the sink. When Resident D refused care or medications, LPN 3 would contact the family to assist with care. On 10/20/25 at 4:17 p.m., the Executive Director (ED) provided the July, August, and September 2025 shower records for Resident D. The shower records indicated Resident D had received a shower on the following days: 8/4/25, 8/21/25, and 9/4/25. During an interview on 10/20/25 at 5:06 p.m., the Director of Nursing (DON) indicated residents should receive showers twice weekly. There were no other shower records for Resident D. The staff had not filled out shower records if the resident refused her shower. The DON was not aware that the family had requested to be called if Resident D refused her shower.			

	2. The clinical record for Resident F was reviewed on 10/20/25 at 1:50 p.m. The diagnoses included, but were not limited to, depression and weakness. A service plan, last revised on 7/15/25, indicated she required assurance checks. The goal was to maintain safety while living in the community. The intervention was to provide frequent assurance checks for safety and ensure that needs were met. A service plan, last revised 7/15/25, indicated she was at risk for falls. The goal was the chance of falls would be reduced within the community. The intervention was to keep pathways free from clutter including clothes baskets. She was at risk for falls due to weakness and safety unawareness. A service plan, created 9/8/25, indicated Post Fall. The goal was for her to participate with fall prevention measures to reduce the risk of fall occurrence. The intervention was to assist her with toileting in the morning, before meals, and at bedtime. A Post Fall service plan, created 4/26/25 and last revised on 10/19/25, indicated the goal of Resident F participating with			

	prevention measures to reduce risk of falls. The interventions were to encourage Resident F to utilize her call pendant for assistance. During an interview on 10/20/25 at 1:47 p.m., Family Member (FM) 12 indicated Resident F slid from her bed and onto the floor just after 7:00 a.m. FM 12 was aware of the time of the fall from the camera the family installed in her room. Resident F sat on the floor after the fall for an hour before someone came in to check on her. The door was locked, and Resident F did not have on her alert bracelet to push. The staff did not have keys to get into the room. Resident F had a facility provided safety monitoring camera present in her room, but it had not picked up the fall. FM 12 had not been able to contact anyone at the facility to inform them of Resident F's fall. During an interview on 10/20/25 at 2:32 p.m., LPN 3 indicated she was on duty when Resident F was found on 10/19/25. The CNAs should have visually checked Resident F during walking rounds at shift change. If the door was locked, the CNA's and QMA's had keys to enter apartments. Each resident should be visually checked during walking rounds to ensure they are safe.			

During an interview on 10/20/25 at 5:11 p.m., the DON indicated Resident F had slipped off the bed the morning of 10/19/25. The CNAs had knocked on the door during walking rounds and Resident F had answered. The CNAs had not gone into the room since she had answered them. There was a key available for the CNAs to use if they needed to enter an apartment.

3. The clinical record for Resident 34 was reviewed on 10/17/25 at 10:57 a.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus.

A physician's order, dated 7/7/25, indicated Resident 34 was to receive a sliding scale of lispro insulin utilizing a flex pen three times a day. The sliding scale was the following:

125 blood sugar reading - 150 blood sugar reading = 2 units of insulin,

151 blood sugar reading - 180 blood sugar reading = 4 units of insulin,

181 blood sugar reading - 210 blood sugar reading = 6 units of insulin,

211 blood sugar reading - 250 blood sugar reading = 8 units of insulin,

251 blood sugar reading - 280

	blood sugar reading = 10 units of insulin, 281 blood sugar reading - 310 blood sugar reading = 12 units of insulin, 311 blood sugar reading - 350 blood sugar reading = 14 units of insulin, 351 blood sugar reading - 380 blood sugar reading = 16 units of insulin, 381 blood sugar reading - 410 blood sugar reading = 18 units of insulin, 411 blood sugar reading - 450 blood sugar reading = 20 units of insulin and staff was to call the medical provider if the resident's blood sugar was less than 80 or greater than 450. An observation was conducted of an insulin medication administration with QMA 1 on 10/17/25 at 10:58 a.m. QMA 1 entered Resident 34's room and obtained the resident's blood sugar reading of 145. She then returned to the cart and prepared the resident's lispro insulin flex pen. QMA 1 was observed donning on gloves, wiping the rubber seal, and placing the needle on the seal. She then dialed two units of lispro insulin. After, she entered the resident's room and			

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A Humalog/lispro manufacture instructions document was provided by the Director of Nursing on 10/17/25 at 3:10 p.m. It indicated "...Priming your Pen. Prime before each injection. Priming your pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. Step 6: To prime your pen, turn the dose knob to select 2 units. Step 7: Hold your pen with the needle pointing up. Tap the cartridge holder gently to collect air bubbles at the top. Step 8: Continue holding your pen with needle pointing up. Push the dose knob in until it stops, and '0' is seen in the dose window. Hold the dose knob in and count to 5 slowly. You should see insulin at the tip of the needle..."

On 10/17/25 at 1:00 p.m., the DON provided the Resident

	Evaluation and Service plan, last reviewed/ updated 9/15/25, that indicated "...The purpose of the Resident Evaluation and Service Plan is to establish a process to evaluate and plan for the Resident's needs. The purpose of the service plan is to provide a description of the services that will be provided to the resident based on their individual needs and preferences..." This citation relates to Intake IN00464954. Based on interview and record review, the facility failed to ensure a resident received showers as scheduled, ensure residents received assurance checks to maintain safety, and to ensure an insulin flex pen was primed with two units of insulin prior to administration of an insulin dosage for 2 of 6 residents reviewed for service plans and 2 of 2 residents observed for insulin administration. (Resident D, Resident F, Resident 34, and Resident 29) Findings include: 1. The clinical record for Resident D was reviewed on 10/17/25 at 1:15 p.m. The diagnoses included, but were not limited to, dementia and anxiety. She was admitted to the facility assisted living on			

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	push. The staff did not have keys to get into the room. Resident F had a facility provided safety monitoring camera present in her room, but it had not picked up the fall. FM 12 had not been able to contact anyone at the facility to inform them of Resident F's fall. During an interview on 10/20/25 at 2:32 p.m., LPN 3 indicated she was on duty when Resident F was found on 10/19/25. The CNAs should have visually checked Resident F during walking rounds at shift change. If the door was locked, the CNA's and QMA's had keys to enter apartments. Each resident should be visually checked during walking rounds to ensure they are safe. During an interview on 10/20/25 at 5:11 p.m., the DON indicated Resident F had slipped off the bed the morning of 10/19/25. The CNAs had knocked on the door during walking rounds and Resident F had answered. The CNAs had not gone into the room since she had answered them. There was a key available for the CNAs to use if they needed to enter an apartment.			

	3. The clinical record for Resident 34 was reviewed on 10/17/25 at 10:57 a.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus. A physician's order, dated 7/7/25, indicated Resident 34 was to receive a sliding scale of lispro insulin utilizing a flex pen three times a day. The sliding scale was the following: 125 blood sugar reading - 150 blood sugar reading = 2 units of insulin, 151 blood sugar reading - 180 blood sugar reading = 4 units of insulin, 181 blood sugar reading - 210 blood sugar reading = 6 units of insulin, 211 blood sugar reading - 250 blood sugar reading = 8 units of insulin, 251 blood sugar reading - 280 blood sugar reading = 10 units of insulin, 281 blood sugar reading - 310 blood sugar reading = 12 units of insulin, 311 blood sugar reading - 350 blood sugar reading = 14 units of insulin, 351 blood sugar reading - 380 blood sugar reading = 16 units			

	of insulin, 381 blood sugar reading - 410 blood sugar reading = 18 units of insulin, 411 blood sugar reading - 450 blood sugar reading = 20 units of insulin and staff was to call the medical provider if the resident's blood sugar was less than 80 or greater than 450. An observation was conducted of an insulin medication administration with QMA 1 on 10/17/25 at 10:58 a.m. QMA 1 entered Resident 34's room and obtained the resident's blood sugar reading of 145. She then returned to the cart and prepared the resident's lispro insulin flex pen. QMA 1 was observed donning on gloves, wiping the rubber seal, and placing the needle on the seal. She then dialed two units of lispro insulin. After, she entered the resident's room and administered two units of lispro insulin in Resident 34's abdomen. QMA 1 did not prime the resident's flex pen with two units of insulin prior to dialing up the insulin dosage.			

	4. The clinical record for Resident 29 was reviewed on 10/17/25 at 11:10 a.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus. A physician's order, dated 7/21/25, indicated Resident 29 was to receive four units of Humalog insulin three times a day. An observation was conducted of an insulin medication administration with QMA 1 for Resident 29 on 10/17/25 at 11:10 a.m. QMA 1 was observed at the medication cart preparing the insulin flexpen. She indicated at that time, the resident's blood sugar reading was 87. She pulled a flexpen from the medication cart and donned gloves. During that time, QMA 1 wiped the rubber seal with an alcohol wipe and placed a needle on the rubber seal. She then dialed up four units of Humalog insulin. After, she doffed her gloves and entered the resident's room. QMA 1 was observed donning a new set of gloves and administered the four units of Humalog insulin to Resident 29. There was no observation of QMA 1 priming the resident's insulin flexpen of two units prior to dialing up the insulin dosage. An interview was conducted with the Director of Nursing on			

	10/17/25 at 1:47 p.m. She indicated the staff should be priming the insulin flexpens of two units prior to dialing up the insulin dosage. A Humalog/lispro manufacture instructions document was provided by the Director of Nursing on 10/17/25 at 3:10 p.m. It indicated "...Priming your Pen. Prime before each injection. Priming your pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. Step 6: To prime your pen, turn the dose knob to select 2 units. Step 7: Hold your pen with the needle pointing up. Tap the cartridge holder gently to collect air bubbles at the top. Step 8: Continue holding your pen with needle pointing up. Push the dose knob in until it stops, and '0' is seen in the dose window. Hold the dose knob in and count to 5 slowly. You should see insulin at the tip of the needle..." On 10/17/25 at 1:00 p.m., the DON provided the Resident Evaluation and Service plan, last reviewed/ updated 9/15/25, that indicated "...The purpose of the Resident Evaluation and Service Plan is to establish a process to evaluate and plan for the Resident's needs. The			

purpose of the service plan is to provide a description of the services that will be provided to the resident based on their individual needs and preferences..."

This citation relates to Intake IN00464954.

Based on interview and record review, the facility failed to ensure a resident received showers as scheduled, ensure residents received assurance checks to maintain safety, and to ensure an insulin flex pen was primed with two units of insulin prior to administration of an insulin dosage for 2 of 6 residents reviewed for service plans and 2 of 2 residents observed for insulin administration. (Resident D, Resident F, Resident 34, and Resident 29)

Findings include:

1. The clinical record for Resident D was reviewed on 10/17/25 at 1:15 p.m. The diagnoses included, but were not limited to, dementia and anxiety. She was admitted to the facility assisted living on 5/13/25. She was moved to the facility dementia care unit on 5/31/25.

A service plan, dated 5/13/25, indicated bathing. Resident D would remain independent with bathing/showers. The

	interventions indicated she was independent for all tasks related to bathing without reminders from staff. The care staff would report any changes in the ability to bathe. A service plan, dated 5/13/25, indicated dressing. Resident D will maintain independence with dressing. Resident D was independent with all tasks related to dressing without reminders from staff. The staff would report any changes in ability to dress. A service plan, dated 5/13/25, indicated assurance checks. The goal was that safety would be maintained while living in the community. Assurance checks to be provided each shift for safety. A Health Status Note, dated 9/7/2025 at 5:25 p.m., indicated Resident D had returned from a leave of absence with her family. The family stated Resident D had diarrhea twice while she was out of the facility. Family had noted dried diarrhea in Resident D's bathroom area. Staff cleaned the bathroom. During an interview on 10/20/25 at 9:49 a.m., Family Member (FM) 10 indicated Resident D had not received showers twice weekly while she was on the dementia care unit. FM 10 offered to come to the facility			

	and assist Resident D with showers if she refused to let staff shower her. The facility had not made her aware that Resident D was refusing showers. On 9/7/25, FM 10 took Resident D out of the facility for a few hours. After FM 10 returned Resident D to the facility, on 9/7/25, FM 10 had gone to Resident D's apartment to check for something and had found Resident D's bathroom "covered in" dried feces. The feces were on the walls and floor and appeared as if Resident D had attempted to clean the feces up by herself. There was a used incontinence brief in the sink that was full of dried feces, and the incontinence brief had dried and become stuck to the sink. There were footprints of dried feces on the floor coming into the bedroom of the apartment. FM 10 had informed the facility staff, and the staff came to clean the bathroom. During an interview on 10/20/25 at 11:27 a.m., Certified Nurse Aide (CNA) 6 indicated he had worked with Resident D often. Resident D could be aggressive at times, hitting staff during care. Resident D often refused showers. The staff would offer a different staff member and attempt to redirect her to accept showers. If Resident D refused to be showered, CNA 6 would inform the nurse or Qualified			

	Medication Aide (QMA) so the family could be contacted. CNA 6 was on duty in the evening on 9/7/25 and had assisted with cleaning the feces in Resident D's bathroom. The feces had been smeared and were dried. During an interview on 10/20/25 at 11:35 a.m., Licensed Practical Nurse (LPN) 3 indicated she had worked the evening of 9/7/25 and had assisted with cleaning Resident D's bathroom. The bathroom had been "a mess". There were feces everywhere and it looked like Resident D had attempted to clean it herself. There had been a used incontinent brief that contained dried feces and was dried to the sink. When Resident D refused care or medications, LPN 3 would contact the family to assist with care. On 10/20/25 at 4:17 p.m., the Executive Director (ED) provided the July, August, and September 2025 shower records for Resident D. The shower records indicated Resident D had received a shower on the following days: 8/4/25, 8/21/25, and 9/4/25. During an interview on 10/20/25 at 5:06 p.m., the Director of Nursing (DON) indicated residents should receive showers twice weekly. There were no other shower records			

	for Resident D. The staff had not filled out shower records if the resident refused her shower. The DON was not aware that the family had requested to be called if Resident D refused her shower. 2. The clinical record for Resident F was reviewed on 10/20/25 at 1:50 p.m. The diagnoses included, but were not limited to, depression and weakness. A service plan, last revised on 7/15/25, indicated she required assurance checks. The goal was to maintain safety while living in the community. The intervention was to provide frequent assurance checks for safety and ensure that needs were met. A service plan, last revised 7/15/25, indicated she was at risk for falls. The goal was the chance of falls would be reduced within the community. The intervention was to keep pathways free from clutter including clothes baskets. She was at risk for falls due to weakness and safety unawareness. A service plan, created 9/8/25, indicated Post Fall. The goal was for her to participate with fall prevention measures to reduce the risk of fall occurrence. The intervention			

	was to assist her with toileting in the morning, before meals, and at bedtime. A Post Fall service plan, created 4/26/25 and last revised on 10/19/25, indicated the goal of Resident F participating with prevention measures to reduce risk of falls. The interventions were to encourage Resident F to utilize her call pendant for assistance. During an interview on 10/20/25 at 1:47 p.m., Family Member (FM) 12 indicated Resident F slid from her bed and onto the floor just after 7:00 a.m. FM 12 was aware of the time of the fall from the camera the family installed in her room. Resident F sat on the floor after the fall for an hour before someone came in to check on her. The door was locked, and Resident F did not have on her alert bracelet to push. The staff did not have keys to get into the room. Resident F had a facility provided safety monitoring camera present in her room, but it had not picked up the fall. FM 12 had not been able to contact anyone at the facility to inform them of Resident F's fall. During an interview on 10/20/25 at 2:32 p.m., LPN 3 indicated she was on duty when Resident F was found on 10/19/25. The CNAs should have visually checked Resident F during			

	walking rounds at shift change. If the door was locked, the CNA's and QMA's had keys to enter apartments. Each resident should be visually checked during walking rounds to ensure they are safe. During an interview on 10/20/25 at 5:11 p.m., the DON indicated Resident F had slipped off the bed the morning of 10/19/25. The CNAs had knocked on the door during walking rounds and Resident F had answered. The CNAs had not gone into the room since she had answered them. There was a key available for the CNAs to use if they needed to enter an apartment.			
R 0297	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(c)(1) (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on observation, interview, and record review, the facility failed to ensure the availability of medications for 2 of 8 residents observed for	R 0297	•Obtained missing medications immediately during the survey by placing STAT orders or securing supplies from the backup pharmacy as needed. Nursing staff reordered out of stock medications at the time and documented each occurrence •Reorder thresholds: Established automated reorder triggers so medications are reordered when a 5 day supply remains (or earlier when required by manufacturer or insurance guidance). Critical medications (e.g., seizure medications, psychotropics) are set to reorder earlier than the 5	01/08/2026

	medication administration and 1 of 5 residents records reviewed. (Residents' 6, 19, and G) Findings include: 1. The clinical record for Resident 19 was reviewed on 10/17/25 at 8:50 a.m. The diagnoses included, but were not limited to, hypertension. A physician's order, dated 7/2/25, indicated Resident 19 was to receive 5 milligrams (mg) of memantine daily. An observation was conducted of a medication administration with Qualified Medication Aide (QMA) 2 on 10/17/25 at 8:51 a.m. QMA 2 was observed at the medication cart pulling Resident 19's medications from the cart. During that time, QMA 2 indicated she was unable to administer the resident's 5 mg of memantine. The medication was not available to administer. An interview was conducted with QMA 2 on 10/17/25 at 9:13 a.m. She indicated medications were often unavailable due to the delay of receiving medications from the pharmacy. A progress note, dated 10/17/25, indicated the medical provider was notified to send a new order to pharmacy for the 5 milligrams of memantine. 2. The clinical record for		day threshold. •Backup pharmacy protocol: If the contracted pharmacy cannot supply essential medications within 24 hours, the facility will obtain the medication from a designated backup pharmacy. •Pharmacy communication: Implemented a weekly Pharmacy Communication Log to record orders, expected delivery dates, substitutions, and authorization issues. •Trained nursing and medication staff on the new reorder thresholds, the process for using the backup pharmacy, documentation requirements for unavailable medications, and timely notification to providers and families. •Weekly medication inventory logs will be audited by the WD for 8 weeks, then monthly for 6 months. •Track and report any missed doses due to medication unavailability; the facility’s target is zero missed doses attributable to pharmacy supply issues. •Pharmacy performance: Review pharmacy turnaround times with the contracted pharmacy monthly and implement corrective actions if delays persist.	

	Resident G was reviewed on 10/17/25 at 9:35 a.m. The diagnoses included, but were not limited to, hypertension. The resident was admitted to the assisted living on 10/14/25. A physician's order, dated 10/14/25, indicated Resident G was to receive 360 milligrams of diltiazem daily. The order was "pending confirmation." A physician's order, dated 10/14/25, indicated Resident G was to receive 50 micrograms of fluticasone nasal spray daily. The order was "pending confirmation." During a medication administration with QMA 1 for Resident G on 10/17/25 at 9:36 a.m., QMA 1 indicated she was unable to administer all morning medications to Resident G because they were not available to administer. The resident was a new admission and still waiting for pharmacy to send all of his medications. She was unable to give the fluticasone nasal spray and 360 milligrams of diltiazem. An interview was conducted with QMA 1 on 10/17/25 at 10:00 a.m. She indicated there were times when the medications were not available due to the delay of pharmacy sending the medication supply. She reordered residents'		WD is responsible implementation and oversite.	

	medications when there were a few left to ensure the medications would arrive without running out. 3. The clinical record for Resident 6 was reviewed on 10/16/25 at 2:00 p.m. The diagnoses included, but were not limited to, asthma and restless leg syndrome. A Saint Louis University Mental Status (SLUMS) Assessment, dated 6/26/25, indicated Resident 6 was cognitively intact. A service plan, dated 7/15/25, indicated Resident 6 required staff assistance with medication administration. A physician's order, dated 12/31/24, indicated Resident 6 was to receive 200 milligrams of pregabalin twice a day. The medication order was rewritten. A physician's order, dated 7/15/25, indicated Resident 6 was to receive 200 milligrams of pregabalin twice a day. A physician's order, dated 5/25/25, indicated Resident 6 was to receive 1.5 tablets of 60 milligrams of pyridostigmine three times a day. The July 2025 Medication Administration Record (MAR) indicated the following days and times the resident did not			

	receive the 200 milligrams of pregabalin twice a day due to it being unavailable: 7/15/25 at 8:00 p.m., 7/16/25 at 8:00 a.m., and 8:00 p.m., 7/17/25 at 8:00 a.m., and 8:00 p.m., and 7/18/25 at 8:00 a.m. The October 2025 MAR indicated the following days and times the resident did not receive the 1.5 tablets of 60 milligrams of pyridostigmine three times a day due to it being unavailable: 10/7/25 at 2:00 p.m., 10/10/25 at 8:00 a.m., and 2:00 p.m., and 10/11/25 at 8:00 a.m. An interview was conducted with Resident 6 on 10/16/25 at 2:15 p.m. She indicated the facility's pharmacy they use was "awful." She runs out of medications all the time. If you have a urine sample, it could take up to 10 days to find out if you have an infection. The pharmacy and lab services were "very slow." In July, she started having weird nightmares and spoke to nursing about it. The nurse had informed her she had run out of her pregabalin			

	medication and had not been getting it during medication administrations. The facility had run out of the medication and didn't tell her. By that time, she had gone without the medication for three days. She believed by stopping the pregabalin medication "cold turkey", it caused her to have nightmares. She had missed six dosages before the facility finally received the medication. The month of October, she had gone without her pyridostigmine medication for a few days due to the facility running out of that medication. It happened all the time. An interview was conducted with the Director of Nursing on 10/17/25 at 10:14 a.m. She indicated there was a problem with the availability of medications at times. If staff put new orders in by 3:00 p.m., they should receive the medications the next day. If staff were running low, they were to reorder. Currently, the nurses on Tuesdays and Fridays were auditing residents' medications to ensure the medications were available to administer. It had improved. If the medication was needed STAT (as soon as possible), the facility staff would use a backup pharmacy to ensure the arrival of the medication. Resident G was a new resident in the assisted living. He previously lived in the			

	independent living side of the building. She was not sure why all Resident G's medications had not arrived yet. She would look into the reason why Resident 6 went without her pregabalin medication in July. An interview was conducted with the Assistant Director of Nursing on 10/20/25 at 3:27 p.m. She indicated she was unaware Resident 6 had gone without her pregabalin medication in July. The staff had not made her or the DON aware. On 10/17/25 at 1:00 p.m., the Executive Director provided the Medication Order Fill Policy, last reviewed 5/2/22, that indicated "...The purpose of the Medication Order Fill policy is to maintain an adequate supply of medications as ordered by the Resident's Healthcare Provider...Medication Order Refill Process 1. All meds are to be fully inventoried minimally once per week per individual community schedule by designated/ authorized staff member[s]. 2.To Determine which medications need to be re-ordered: a. remove all resident meds from the cart and then compare to the MAR entries. This will ensure that no currently ordered meds are missed and determine if any medications that have been			

discontinued need to be destroyed...3. Time frame for reorder: a. Meds that need to refilled through contracted/ local retail pharmacy shall be reordered when a 5 day or less quantity remains. Re-ordering before then will result in a 'refill too soon notification' and create additional workload for both Community and pharmacy. This time frame is established based on when insurance plans will authorize a refill...c. Schedule II controlled medications shall be reordered when a 7-day supply remains. The physician/ prescriber must write a new original hard copy script first..."

Based on observation, interview, and record review, the facility failed to ensure the availability of medications for 2 of 8 residents observed for medication administration and 1 of 5 residents records reviewed. (Residents' 6, 19, and G)

Findings include:

1. The clinical record for Resident 19 was reviewed on 10/17/25 at 8:50 a.m. The diagnoses included, but were not limited to, hypertension.

A physician's order, dated 7/2/25, indicated Resident 19 was to receive 5 milligrams (mg) of memantine daily.

An observation was conducted of a medication administration

	with Qualified Medication Aide (QMA) 2 on 10/17/25 at 8:51 a.m. QMA 2 was observed at the medication cart pulling Resident 19's medications from the cart. During that time, QMA 2 indicated she was unable to administer the resident's 5 mg of memantine. The medication was not available to administer. An interview was conducted with QMA 2 on 10/17/25 at 9:13 a.m. She indicated medications were often unavailable due to the delay of receiving medications from the pharmacy. A progress note, dated 10/17/25, indicated the medical provider was notified to send a new order to pharmacy for the 5 milligrams of memantine. 2. The clinical record for Resident G was reviewed on 10/17/25 at 9:35 a.m. The diagnoses included, but were not limited to, hypertension. The resident was admitted to the assisted living on 10/14/25. A physician's order, dated 10/14/25, indicated Resident G was to receive 360 milligrams of diltiazem daily. The order was "pending confirmation."			

	A physician's order, dated 10/14/25, indicated Resident G was to receive 50 micrograms of fluticasone nasal spray daily. The order was "pending confirmation." During a medication administration with QMA 1 for Resident G on 10/17/25 at 9:36 a.m., QMA 1 indicated she was unable to administer all morning medications to Resident G because they were not available to administer. The resident was a new admission and still waiting for pharmacy to send all of his medications. She was unable to give the fluticasone nasal spray and 360 milligrams of diltiazem. An interview was conducted with QMA 1 on 10/17/25 at 10:00 a.m. She indicated there were times when the medications were not available due to the delay of pharmacy sending the medication supply. She reordered residents' medications when there were a few left to ensure the medications would arrive without running out. 3. The clinical record for Resident 6 was reviewed on 10/16/25 at 2:00 p.m. The diagnoses included, but were not limited to, asthma and restless leg syndrome. A Saint Louis University Mental			

	Status (SLUMS) Assessment, dated 6/26/25, indicated Resident 6 was cognitively intact. A service plan, dated 7/15/25, indicated Resident 6 required staff assistance with medication administration. A physician's order, dated 12/31/24, indicated Resident 6 was to receive 200 milligrams of pregabalin twice a day. The medication order was rewritten. A physician's order, dated 7/15/25, indicated Resident 6 was to receive 200 milligrams of pregabalin twice a day. A physician's order, dated 5/25/25, indicated Resident 6 was to receive 1.5 tablets of 60 milligrams of pyridostigmine three times a day. The July 2025 Medication Administration Record (MAR) indicated the following days and times the resident did not receive the 200 milligrams of pregabalin twice a day due to it being unavailable: 7/15/25 at 8:00 p.m., 7/16/25 at 8:00 a.m., and 8:00 p.m., 7/17/25 at 8:00 a.m., and 8:00 p.m., and			

7/18/25 at 8:00 a.m.

The October 2025 MAR indicated the following days and times the resident did not receive the 1.5 tablets of 60 milligrams of pyridostigmine three times a day due to it being unavailable:

10/7/25 at 2:00 p.m.,

10/10/25 at 8:00 a.m., and 2:00 p.m., and

10/11/25 at 8:00 a.m.

An interview was conducted with Resident 6 on 10/16/25 at 2:15 p.m. She indicated the facility's pharmacy they use was "awful." She runs out of medications all the time. If you have a urine sample, it could take up to 10 days to find out if you have an infection. The pharmacy and lab services were "very slow." In July, she started having weird nightmares and spoke to nursing about it. The nurse had informed her she had run out of her pregabalin medication and had not been getting it during medication administrations. The facility had run out of the medication and didn't tell her. By that time, she had gone without the medication for three days. She believed by stopping the pregabalin medication "cold turkey", it caused her to have nightmares. She had missed six dosages before the facility

	finally received the medication. The month of October, she had gone without her pyridostigmine medication for a few days due to the facility running out of that medication. It happened all the time. An interview was conducted with the Director of Nursing on 10/17/25 at 10:14 a.m. She indicated there was a problem with the availability of medications at times. If staff put new orders in by 3:00 p.m., they should receive the medications the next day. If staff were running low, they were to reorder. Currently, the nurses on Tuesdays and Fridays were auditing residents' medications to ensure the medications were available to administer. It had improved. If the medication was needed STAT (as soon as possible), the facility staff would use a backup pharmacy to ensure the arrival of the medication. Resident G was a new resident in the assisted living. He previously lived in the independent living side of the building. She was not sure why all Resident G's medications had not arrived yet. She would look into the reason why Resident 6 went without her pregabalin medication in July. An interview was conducted with the Assistant Director of Nursing on 10/20/25 at 3:27			

	p.m. She indicated she was unaware Resident 6 had gone without her pregabalin medication in July. The staff had not made her or the DON aware. On 10/17/25 at 1:00 p.m., the Executive Director provided the Medication Order Fill Policy, last reviewed 5/2/22, that indicated "...The purpose of the Medication Order Fill policy is to maintain an adequate supply of medications as ordered by the Resident's Healthcare Provider...Medication Order Refill Process 1. All meds are to be fully inventoried minimally once per week per individual community schedule by designated/ authorized staff member[s]. 2.To Determine which medications need to be re-ordered: a. remove all resident meds from the cart and then compare to the MAR entries. This will ensure that no currently ordered meds are missed and determine if any medications that have been discontinued need to be destroyed...3. Time frame for reorder: a. Meds that need to refilled through contracted/ local retail pharmacy shall be reordered when a 5 day or less quantity remains. Re-ordering before then will result in a 'refill too soon notification' and create additional workload for both Community and pharmacy. This time frame is established based			

	on when insurance plans will authorize a refill...c. Schedule II controlled medications shall be reordered when a 7-day supply remains. The physician/ prescriber must write a new original hard copy script first..."			
R 0298	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(2) (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. Based on interview and record review, the facility failed to ensure pharmacy reviews were conducted timely for 1 of 5	R 0298	•Immediate correction (completed) 1.Requested and received a medication regimen review for Resident F and documented the pharmacist's recommendations. •Working with the consultant pharmacist to ensure medication regimen reviews occur at least every 60 days, per regulatory requirement. •Implemented an internal tracking calendar that lists pharmacist review due dates by resident and includes automated notifications to the pharmacy 7 days before a review is due. •Training nursing leadership and the pharmacy liaison on the 60 day review requirement and the new tracking/notification process. •Conduct monthly audits of pharmacist review dates for 6 months to confirm reviews are completed every 60 days and to address any gaps.	01/08/2026

	residents reviewed for pharmacy reviews (Resident F). Findings include: The clinical record for Resident F was reviewed on 10/20/25 at 1:50 p.m. The diagnoses included, but were not limited to, depression and weakness. On 10/20/25 at 10:30 a.m., the Director of Nursing provided the list of Medication Regimen Review activity for the resident. Resident F had a medication regimen review conducted in May 2025 and August 2025. During an interview on 10/20/25 at 3:26 p.m., the Assistant Director of Nursing indicated the pharmacy conducted medication reviews every three months, not every 60 days. Based on interview and record review, the facility failed to ensure pharmacy reviews were conducted timely for 1 of 5 residents reviewed for pharmacy reviews (Resident F). Findings include: The clinical record for Resident F was reviewed on 10/20/25 at 1:50 p.m. The diagnoses included, but were not limited to, depression and weakness. On 10/20/25 at 10:30 a.m., the Director of Nursing provided the list of Medication Regimen		WD is responsible implementation and oversite.	

	Review activity for the resident. Resident F had a medication regimen review conducted in May 2025 and August 2025. During an interview on 10/20/25 at 3:26 p.m., the Assistant Director of Nursing indicated the pharmacy conducted medication reviews every three months, not every 60 days.			
R 0299	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(c)(3) (3) The medication review, recommendations, and notification of the physician, if necessary, shall be documented in accordance with the facility ' s policy. 2. The clinical record for Resident E was reviewed on 10/16/25 at 2:20 p.m. The diagnoses included, but were not limited to, dementia with behavioral disturbance. A pharmacy recommendation, dated 6/20/25, indicated Resident E was receiving two orders for Risperdal (anti-psychotic medication) at bedtime (3 mg and 1.5 mg). Please consider reviewing due to possible duplicate therapy. A physician's order, dated 8/12/25, indicated risperidone taper day 1-3 give 4.5 mg, day 4-6 give 3 mg, day 7-9 give 1	R 0299	Immediate correction (completed) 1.Notified medical providers of outstanding pharmacy recommendations, documented provider responses or orders, and implemented changes as appropriate (for example, resolved duplicate risperidone orders and requested a review for calcium management). 2.Implemented a Pharmacy Recommendation Tracking Log. All pharmacy recommendations must be entered into the log upon receipt, assigned to the DON or designee, communicated to the prescriber within 48 hours, and closed only after the provider’s response and any related orders are documented in the resident’s chart. •Require provider responses to pharmacy recommendations to be documented within 7 business days, or sooner when	01/08/2026

	mg, and day 10 discontinue risperidone. An interview was conducted with the Director of Nursing on 10/20/25 at 5:00 p.m. She indicated she was unable to provide documentation the medical provider had addressed Resident B's recommendation regarding the Fosamax. There was no documentation that the medical provider had addressed the pharmacy recommendation for Resident E's Risperdal bedtime dose. Based on interview and record review, the facility failed to timely follow up on pharmacy recommendations for 2 of 5 residents reviewed for pharmacy recommendations. (Resident B and Resident E) Findings include: 1. The clinical record for Resident B was reviewed on 10/16/25 at 11:00 a.m. The diagnoses included, but were not limited to, osteoarthritis. A physician's order, dated 7/11/23, indicated Resident B received 70 milligrams of alendronate/Fosamax once a week. A pharmacy recommendation, dated 5/2/25, indicated "...This resident is receiving Fosamax. To improve efficacy and give it a substrate to work on, please		clinically indicated. •Training the WD AWD, and nursing staff on tracking, communication, and escalation processes. •Institute weekly reviews of the Pharmacy Recommendation Log for 12 weeks and will track the percentage of recommendations addressed and documented within the 7 day target. WD is responsible implementation and oversite.	

consider adding calcium 600 mg [milligrams] BID [twice a day] to this resident's regimen (as resident already on Vitamin D)..."

2. The clinical record for Resident E was reviewed on 10/16/25 at 2:20 p.m. The diagnoses included, but were not limited to, dementia with behavioral disturbance.

A pharmacy recommendation, dated 6/20/25, indicated Resident E was receiving two orders for Risperdal (anti-psychotic medication) at bedtime (3 mg and 1.5 mg). Please consider reviewing due to possible duplicate therapy.

A physician's order, dated 8/12/25, indicated risperidone taper day 1-3 give 4.5 mg, day 4-6 give 3 mg, day 7-9 give 1 mg, and day 10 discontinue risperidone.

An interview was conducted with the Director of Nursing on 10/20/25 at 5:00 p.m. She indicated she was unable to provide documentation the medical provider had addressed Resident B's recommendation regarding the Fosamax. There was no documentation that the medical provider had addressed the pharmacy recommendation for Resident E's Risperdal bedtime dose.

Based on interview and record

review, the facility failed to timely follow up on pharmacy recommendations for 2 of 5 residents reviewed for pharmacy recommendations. (Resident B and Resident E)

Findings include:

1. The clinical record for Resident B was reviewed on 10/16/25 at 11:00 a.m. The diagnoses included, but were not limited to, osteoarthritis.

A physician's order, dated 7/11/23, indicated Resident B received 70 milligrams of alendronate/Fosamax once a week.

A pharmacy recommendation, dated 5/2/25, indicated "...This resident is receiving Fosamax. To improve efficacy and give it a substrate to work on, please consider adding calcium 600 mg [milligrams] BID [twice a day] to this resident's regimen (as resident already on Vitamin D)..."

2. The clinical record for Resident E was reviewed on 10/16/25 at 2:20 p.m. The diagnoses included, but were not limited to, dementia with behavioral disturbance.

A pharmacy recommendation, dated 6/20/25, indicated Resident E was receiving two orders for Risperdal (anti-psychotic medication) at

bedtime (3 mg and 1.5 mg). Please consider reviewing due to possible duplicate therapy.

A physician's order, dated 8/12/25, indicated risperidone taper day 1-3 give 4.5 mg, day 4-6 give 3 mg, day 7-9 give 1 mg, and day 10 discontinue risperidone.

An interview was conducted with the Director of Nursing on 10/20/25 at 5:00 p.m. She indicated she was unable to provide documentation the medical provider had addressed Resident B's recommendation regarding the Fosamax. There was no documentation that the medical provider had addressed the pharmacy recommendation for Resident E's Risperdal bedtime dose.

Based on interview and record review, the facility failed to timely follow up on pharmacy recommendations for 2 of 5 residents reviewed for pharmacy recommendations. (Resident B and Resident E)

Findings include:

1. The clinical record for Resident B was reviewed on 10/16/25 at 11:00 a.m. The diagnoses included, but were not limited to, osteoarthritis.

A physician's order, dated 7/11/23, indicated Resident B received 70 milligrams of

alendronate/Fosamax once a week.

A pharmacy recommendation, dated 5/2/25, indicated "...This resident is receiving Fosamax. To improve efficacy and give it a substrate to work on, please consider adding calcium 600 mg [milligrams] BID [twice a day] to this resident's regimen (as resident already on Vitamin D)..."

2. The clinical record for Resident E was reviewed on 10/16/25 at 2:20 p.m. The diagnoses included, but were not limited to, dementia with behavioral disturbance.

A pharmacy recommendation, dated 6/20/25, indicated Resident E was receiving two orders for Risperdal (anti-psychotic medication) at bedtime (3 mg and 1.5 mg). Please consider reviewing due to possible duplicate therapy.

A physician's order, dated 8/12/25, indicated risperidone taper day 1-3 give 4.5 mg, day 4-6 give 3 mg, day 7-9 give 1 mg, and day 10 discontinue risperidone.

An interview was conducted with the Director of Nursing on 10/20/25 at 5:00 p.m. She indicated she was unable to provide documentation the medical provider had addressed Resident B's recommendation

	regarding the Fosamax. There was no documentation that the medical provider had addressed the pharmacy recommendation for Resident E's Risperdal bedtime dose. Based on interview and record review, the facility failed to timely follow up on pharmacy recommendations for 2 of 5 residents reviewed for pharmacy recommendations. (Resident B and Resident E) Findings include: 1. The clinical record for Resident B was reviewed on 10/16/25 at 11:00 a.m. The diagnoses included, but were not limited to, osteoarthritis. A physician's order, dated 7/11/23, indicated Resident B received 70 milligrams of alendronate/Fosamax once a week. A pharmacy recommendation, dated 5/2/25, indicated "...This resident is receiving Fosamax. To improve efficacy and give it a substrate to work on, please consider adding calcium 600 mg [milligrams] BID [twice a day] to this resident's regimen (as resident already on Vitamin D)..."			

R 0354	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(g)(1-7) (g) A transfer form shall include the following: (1) Identification data. (2) Name of the transferring institution. (3) Name of the receiving institution and date of transfer. (4) Resident ' s personal property when transferred to an acute care facility. (5) Nurses ' notes relating to the resident ' s: (A) functional abilities and physical limitations; (B) nursing care; (C) medications; (D) treatment; and (E) current diet and condition on transfer. (6) Diagnosis. (7) Date of chest x-ray and skin test for tuberculosis. Based on interview and record review, the facility failed to document the transfer of a resident to an acute care hospital and to ensure transfer forms were provided to the receiving provider for 1 of 1 resident reviewed for transfer	R 0354	•Immediate Correction (completed): 1.Contacted the receiving hospital to confirm transfer documentation was sent, obtained the required transfer paperwork, and scanned it into the resident's medical record. Provided immediate staff education reinforcing documentation for all transfers. •Transfer documentation requirement: Implemented mandatory completion of a Transfer Form for all transfers. The form must include: 1.Resident identification data 2.Transferring and receiving facility names and dates/time of transfer 3.nventory of personal property 4.Nurses' notes on functional status and nursing care provided 5.Current medication list and treatments 6.Current diet and diagnoses 7.TB testing status (when applicable) •For planned transfers, the Transfer Form must be completed before the resident leaves the facility. For emergency transfers, the form	01/08/2026

	and discharge rights. (Resident D) Findings include: The clinical record for Resident D was reviewed on 10/17/25 at 1:15 p.m. The diagnoses included, but were not limited to, dementia and anxiety. A Behavior Expression Note, dated 9/8/25 at 9:56 p.m., indicated the nurse had been called to assist with Resident D. Resident D was actively having behaviors. Resident D and the Connection Points Director were sitting on a bench beside an exit door. Resident D was visibly agitated and wringing her hands. The resident census in Resident D's clinical record indicated, on 9/8/25, she was placed on hospital leave. The clinical record did not contain information about Resident D being sent to a hospital, which hospital she went to, or the information that was sent with her to the hospital. During an interview on 10/20/25 at 4:30 p.m., the Assistant Director of Nursing indicated the clinical record should have documentation of Resident D being sent to the hospital. Based on interview and record		must be completed and entered the chart within 24 hours. A copy of the completed Transfer Form will be provided to the receiving facility at the time of transfer. •Transfer Checklist: Being created a Transfer Checklist to be signed by the nurse managing the transfer to confirm completion of required items and transmission of records. •Training nursing and on call staff on the Transfer Form, checklist, and timelines for completion and transmission. WD is responsible implementation and oversite.	

review, the facility failed to document the transfer of a resident to an acute care hospital and to ensure transfer forms were provided to the receiving provider for 1 of 1 resident reviewed for transfer and discharge rights. (Resident D)

Findings include:

The clinical record for Resident D was reviewed on 10/17/25 at 1:15 p.m. The diagnoses included, but were not limited to, dementia and anxiety.

A Behavior Expression Note, dated 9/8/25 at 9:56 p.m., indicated the nurse had been called to assist with Resident D. Resident D was actively having behaviors. Resident D and the Connection Points Director were sitting on a bench beside an exit door. Resident D was visibly agitated and wringing her hands.

The resident census in Resident D's clinical record indicated, on 9/8/25, she was placed on hospital leave.

The clinical record did not contain information about Resident D being sent to a hospital, which hospital she went to, or the information that was sent with her to the hospital.

During an interview on 10/20/25

	at 4:30 p.m., the Assistant Director of Nursing indicated the clinical record should have documentation of Resident D being sent to the hospital.			
R 0357	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(j)(1-3) (j) If a death occurs, information concerning the resident ' s death shall include the following: (1) Notification of the physician, family, responsible person, and legal representative. (2) The disposition of the body, personal possessions, and medications. (3) A complete and accurate notation of the resident ' s condition and most recent vital signs and symptoms preceding death. Based on interview and record review, the facility failed to document information pertaining to a resident's death in the clinical record for 1 of 2 closed records reviewed. (Resident 68) Findings include: The clinical record for Resident 68 was reviewed on 10/17/25 at 1:00 p.m. The diagnoses included, but were not limited to, anxiety. The resident's clinical record indicated the resident was	R 0357	mmediate correction (completed) 1.Nursing staff completed and filed required post mortem documentation in the resident’s chart, including time of death, notification of the physician and responsible party, disposition of the body and personal possessions, and a narrative describing the condition preceding death. •Revised the Post Mortem/Death Documentation procedure to mandate timely, complete documentation of: 1.Notification of physician, family, and legal representative 2.Disposition of body, personal possessions, and medications 3.Final vital signs and a concise clinical summary of events prior to death. •Implementing a standardized Death Documentation Checklist that must be completed and scanned into the resident’s chart for every death. •Training all nursing supervisory	01/08/2026

	discharged on 9/16/25. It did not include the reason why the resident had discharged. A staff email document was provided by the Director of Nursing on 10/20/25 at 1:58 p.m. It indicated Resident 68 was deceased on 9/16/25 at 3:50 a.m. The resident's family was at bedside. An interview was conducted with the Director of Nursing on 10/20/25 at 2:00 p.m. She indicated Resident 68 had passed away on 9/16/25. There should be nursing documentation in the resident's medical chart indicating he had passed away with the required documentation. Based on interview and record review, the facility failed to document information pertaining to a resident's death in the clinical record for 1 of 2 closed records reviewed. (Resident 68) Findings include: The clinical record for Resident 68 was reviewed on 10/17/25 at 1:00 p.m. The diagnoses included, but were not limited to, anxiety. The resident's clinical record indicated the resident was discharged on 9/16/25. It did not include the reason why the resident had discharged.		staff on the updated policy and the Death Documentation Checklist. •Conduct audits of all closed records for deaths monthly for 12 months to verify checklist completion and documentation accuracy. WD is responsible implementation and oversite.	

	A staff email document was provided by the Director of Nursing on 10/20/25 at 1:58 p.m. It indicated Resident 68 was deceased on 9/16/25 at 3:50 a.m. The resident's family was at bedside. An interview was conducted with the Director of Nursing on 10/20/25 at 2:00 p.m. She indicated Resident 68 had passed away on 9/16/25. There should be nursing documentation in the resident's medical chart indicating he had passed away with the required documentation.			
R 0414	Infection Control - Deficiency 410 IAC 16.2-5-12(k) (k) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Based on observation, interview, and record review, the facility failed to ensure hand hygiene was utilized during medication administrations for 5 of 8 residents observed during medication administration. (Residents' 19, 29, 34, 51 and 67) Findings include: 1. The clinical record for Resident 19 was reviewed on	R 0414	•Immediate correction (completed) 1.Addressed the observed staff immediately and provided on the spot re education. 2.Checked and replenished hand sanitizer on all medication carts; restocked alcohol hand gel where containers were empty. •Reinforced the Hand Hygiene Policy: hand hygiene is required before and after direct resident contact, before and after glove use, and between residents during medication administration. •Inspected all medication carts and ensured hand sanitizer	01/08/2026

	10/17/25 at 8:50 a.m. The diagnoses included, but were not limited to, hypertension. An observation was conducted of a medication administration with Qualified Medication Aide (QMA) 2 on 10/17/25 at 8:51 a.m. QMA 2 was observed at the medication cart pulling Resident 19's medications from the cart. She had placed the resident's medications utilizing medication cards in a medication cup. QMA 2 then removed a blood pressure cuff from the cart and entered the resident's room. Utilizing the resident's left arm, she had obtained the resident's blood pressure. After, she returned to the medication cart. During that time, QMA 2 requested for another blood pressure cuff from QMA 1. After, she returned back to the resident's room and obtained the resident's blood pressure again. She then returned back to the medication cart and reviewed the resident's medical record utilizing the electronic Medication Administration Record. After, she went back to the resident's room and administered the medications that were in the medication cup to the resident. QMA 2 did not utilize hand hygiene before or after obtaining the resident's blood pressure, preparing the medication administration, or after the completion of the		availability; daily checks put in place. •Implemented a “Medication Pass Hand Hygiene” checklist for QMA/LPN staff to initial at each medication pass for the first 30 days following training. • Required infection control training for all medication administrators (QMA, , LPN), covering hand hygiene technique and indications. •WD to perform competency observations: direct observation of 100% of medication pass staff within 7 days, then quarterly thereafter. •Administration Nurse to perform daily spot checks for 14 days, then weekly checks for 2 months to confirm hand hygiene compliance during medication passes. •Initiated monthly hand hygiene compliance audits using random direct observation; results to be tracked and reported for continuous improvement. WD is responsible implementation and oversite.	

medication administration.

2. The clinical record for Resident 34 was reviewed on 10/17/25 at 10:57 a.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus.

An observation was conducted of an insulin administration with QMA 1 on 10/17/25 at 10:58 a.m. QMA 1 was observed at the medication cart preparing an insulin flexpen for Resident 34. She donned gloves and wiped the rubber seal utilizing an alcohol wipe. She then placed the needle on the seal and dialed up the dosage. After, she doffed her gloves and entered the resident's room. QMA 1 donned new set of gloves and administered the insulin in Resident 34's abdomen. There was no hand hygiene before or after donning or doffing the gloves.

3. The clinical record for Resident 29 was reviewed on 10/17/25 at 11:10 a.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus.

An observation was conducted of an insulin administration with QMA 1 for Resident 29 on 10/17/25 at 11:10 a.m. QMA 1 was observed at the medication cart preparing the insulin flexpen for Resident 29. She

pulled a flexpen from the medication cart and donned gloves. During that time, QMA 1 wiped the rubber seal with an alcohol wipe and placed a needle on the rubber seal. She then dialed up the insulin medication dosage. After, she doffed her gloves and entered the resident's room. QMA 1 was observed donning a new set of gloves and administered the insulin to Resident 29. There was no observation of QMA 1 utilizing hand hygiene before or after donning and doffing gloves.

4. The clinical record for Resident 51 was reviewed on 10/17/25 at 9:20 a.m. The diagnoses included, but were not limited to, dementia and hypertension.

An observation was conducted of medication administration with QMA 7 for Resident 51 on 10/17/25 at 9:20 a.m. QMA 7 was observed at a memory care unit medication cart. The alcohol hand gel on the medication cart was empty. QMA 7 obtained a blood pressure cuff from the medication cart and entered Resident 51's apartment. She obtained Resident 51's blood pressure and returned to the medication cart. She prepared Resident 51's medications, poured a glass of water, and locked the medication cart. She then returned to Resident 51's

apartment and administered the medications. She returned to the medication cart, signed off the medications, and began pushing the medication cart down the hallway. She did not perform hand hygiene after finishing the medication pass for Resident 51.

5. The clinical record for Resident 67 was reviewed on 10/17/25 at 9:27 a.m. The diagnoses included, but were not limited to, dementia and depression.

An observation was conducted of medication administration with QMA 7 for Resident 67 on 10/17/25 at 9:27 a.m. QMA 7 entered Resident 67's apartment. She did not perform hand hygiene prior to entering the apartment. She touched Resident 67's back and adjusted his blanket. QMA 7 then adjusted the thermostat in the apartment. She exited the apartment and opened the medication cart and began preparing Resident 67's medications. She did not perform hand hygiene prior to preparing the medications. She obtained a tube of Bio-freeze (topical pain cream) and a bottle of ammonium lactate (lotion for dry skin) and returned to Resident 67's apartment. She administered the medications and then donned the disposable gloves. She did not perform

hand hygiene prior to donning gloves. She applied the Bio-freeze to Resident 67's shoulders and lower back. She doffed her disposable gloves and donned a new pair of gloves. She did not perform hand hygiene prior to donning the new gloves. She then applied the ammonium lactate lotion to Resident 67's arms and doffed her gloves. She did not perform hand hygiene after doffing the gloves. She assisted Resident 67 with putting on a sweatshirt and a belt and handed him a hat to wear. She exited the apartment and began pushing the medication cart down the hallway.

During an interview on 10/17/25 at 9:45 a.m., QMA 7 indicated hand hygiene should be completed between each resident and after removing disposable gloves.

An interview was conducted with the Director of Nursing on 10/17/25 at 1:47 p.m. She indicated the staff should be utilizing hand hygiene in between residents and before and after utilizing gloves.

On 10/17/25 at 1:00 p.m., the Director of Nursing provided the Hand Hygiene Policy, last reviewed 8/10/22, that indicated "...To prevent transfer of germs and transmission of infections to patients and caregivers and to

implement a hand hygiene compliance program. Indications for hand hygiene are: Before and after direct patient care. Before and after each procedure.... Before re-entering nursing bag or patient's clean supplies ...Gloves are not a substitute for hand hygiene..."

Based on observation, interview, and record review, the facility failed to ensure hand hygiene was utilized during medication administrations for 5 of 8 residents observed during medication administration. (Residents' 19, 29, 34, 51 and 67)

Findings include:

1. The clinical record for Resident 19 was reviewed on 10/17/25 at 8:50 a.m. The diagnoses included, but were not limited to, hypertension.

An observation was conducted of a medication administration with Qualified Medication Aide (QMA) 2 on 10/17/25 at 8:51 a.m. QMA 2 was observed at the medication cart pulling Resident 19's medications from the cart. She had placed the resident's medications utilizing medication cards in a medication cup. QMA 2 then removed a blood pressure cuff from the cart and entered the resident's room. Utilizing the resident's left arm, she had

obtained the resident's blood pressure. After, she returned to the medication cart. During that time, QMA 2 requested for another blood pressure cuff from QMA 1. After, she returned back to the resident's room and obtained the resident's blood pressure again. She then returned back to the medication cart and reviewed the resident's medical record utilizing the electronic Medication Administration Record. After, she went back to the resident's room and administered the medications that were in the medication cup to the resident. QMA 2 did not utilize hand hygiene before or after obtaining the resident's blood pressure, preparing the medication administration, or after the completion of the medication administration.

2. The clinical record for Resident 34 was reviewed on 10/17/25 at 10:57 a.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus.

An observation was conducted of an insulin administration with QMA 1 on 10/17/25 at 10:58 a.m. QMA 1 was observed at the medication cart preparing an insulin flexpen for Resident 34. She donned gloves and wiped the rubber seal utilizing an alcohol wipe. She then placed the needle on the seal and

dialed up the dosage. After, she doffed her gloves and entered the resident's room. QMA 1 donned new set of gloves and administered the insulin in Resident 34's abdomen. There was no hand hygiene before or after donning or doffing the gloves.

3. The clinical record for Resident 29 was reviewed on 10/17/25 at 11:10 a.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus.

An observation was conducted of an insulin administration with QMA 1 for Resident 29 on 10/17/25 at 11:10 a.m. QMA 1 was observed at the medication cart preparing the insulin flexpen for Resident 29. She pulled a flexpen from the medication cart and donned gloves. During that time, QMA 1 wiped the rubber seal with an alcohol wipe and placed a needle on the rubber seal. She then dialed up the insulin medication dosage. After, she doffed her gloves and entered the resident's room. QMA 1 was observed donning a new set of gloves and administered the insulin to Resident 29. There was no observation of QMA 1 utilizing hand hygiene before or after donning and doffing gloves.

4. The clinical record for

Resident 51 was reviewed on 10/17/25 at 9:20 a.m. The diagnoses included, but were not limited to, dementia and hypertension.

An observation was conducted of medication administration with QMA 7 for Resident 51 on 10/17/25 at 9:20 a.m. QMA 7 was observed at a memory care unit medication cart. The alcohol hand gel on the medication cart was empty. QMA 7 obtained a blood pressure cuff from the medication cart and entered Resident 51's apartment. She obtained Resident 51's blood pressure and returned to the medication cart. She prepared Resident 51's medications, poured a glass of water, and locked the medication cart. She then returned to Resident 51's apartment and administered the medications. She returned to the medication cart, signed off the medications, and began pushing the medication cart down the hallway. She did not perform hand hygiene after finishing the medication pass for Resident 51.

5. The clinical record for Resident 67 was reviewed on 10/17/25 at 9:27 a.m. The diagnoses included, but were not limited to, dementia and depression.

An observation was conducted of medication administration

with QMA 7 for Resident 67 on 10/17/25 at 9:27 a.m. QMA 7 entered Resident 67's apartment. She did not perform hand hygiene prior to entering the apartment. She touched Resident 67's back and adjusted his blanket. QMA 7 then adjusted the thermostat in the apartment. She exited the apartment and opened the medication cart and began preparing Resident 67's medications. She did not perform hand hygiene prior to preparing the medications. She obtained a tube of Bio-freeze (topical pain cream) and a bottle of ammonium lactate (lotion for dry skin) and returned to Resident 67's apartment. She administered the medications and then donned the disposable gloves. She did not perform hand hygiene prior to donning gloves. She applied the Bio-freeze to Resident 67's shoulders and lower back. She doffed her disposable gloves and donned a new pair of gloves. She did not perform hand hygiene prior to donning the new gloves. She then applied the ammonium lactate lotion to Resident 67's arms and doffed her gloves. She did not perform hand hygiene after doffing the gloves. She assisted Resident 67 with putting on a sweatshirt and a belt and handed him a hat to wear. She exited the apartment and began pushing the medication cart

down the hallway.

During an interview on 10/17/25 at 9:45 a.m., QMA 7 indicated hand hygiene should be completed between each resident and after removing disposable gloves.

An interview was conducted with the Director of Nursing on 10/17/25 at 1:47 p.m. She indicated the staff should be utilizing hand hygiene in between residents and before and after utilizing gloves.

On 10/17/25 at 1:00 p.m., the Director of Nursing provided the Hand Hygiene Policy, last reviewed 8/10/22, that indicated "...To prevent transfer of germs and transmission of infections to patients and caregivers and to implement a hand hygiene compliance program. Indications for hand hygiene are: Before and after direct patient care. Before and after each procedure.... Before re-entering nursing bag or patient's clean supplies ...Gloves are not a substitute for hand hygiene..."

Based on observation, interview, and record review, the facility failed to ensure hand hygiene was utilized during medication administrations for 5 of 8 residents observed during medication administration. (Residents' 19, 29, 34, 51 and 67)

Findings include:

1. The clinical record for Resident 19 was reviewed on 10/17/25 at 8:50 a.m. The diagnoses included, but were not limited to, hypertension.

An observation was conducted of a medication administration with Qualified Medication Aide (QMA) 2 on 10/17/25 at 8:51 a.m. QMA 2 was observed at the medication cart pulling Resident 19's medications from the cart. She had placed the resident's medications utilizing medication cards in a medication cup. QMA 2 then removed a blood pressure cuff from the cart and entered the resident's room. Utilizing the resident's left arm, she had obtained the resident's blood pressure. After, she returned to the medication cart. During that time, QMA 2 requested for another blood pressure cuff from QMA 1. After, she returned back to the resident's room and obtained the resident's blood pressure again. She then returned back to the medication cart and reviewed the resident's medical record utilizing the electronic Medication Administration Record. After, she went back to the resident's room and administered the medications that were in the medication cup to the resident. QMA 2 did not utilize hand hygiene before or after

obtaining the resident's blood pressure, preparing the medication administration, or after the completion of the medication administration.

2. The clinical record for Resident 34 was reviewed on 10/17/25 at 10:57 a.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus.

An observation was conducted of an insulin administration with QMA 1 on 10/17/25 at 10:58 a.m. QMA 1 was observed at the medication cart preparing an insulin flexpen for Resident 34. She donned gloves and wiped the rubber seal utilizing an alcohol wipe. She then placed the needle on the seal and dialed up the dosage. After, she doffed her gloves and entered the resident's room. QMA 1 donned new set of gloves and administered the insulin in Resident 34's abdomen. There was no hand hygiene before or after donning or doffing the gloves.

3. The clinical record for Resident 29 was reviewed on 10/17/25 at 11:10 a.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus.

An observation was conducted of an insulin administration with QMA 1 for Resident 29 on

10/17/25 at 11:10 a.m. QMA 1 was observed at the medication cart preparing the insulin flexpen for Resident 29. She pulled a flexpen from the medication cart and donned gloves. During that time, QMA 1 wiped the rubber seal with an alcohol wipe and placed a needle on the rubber seal. She then dialed up the insulin medication dosage. After, she doffed her gloves and entered the resident's room. QMA 1 was observed donning a new set of gloves and administered the insulin to Resident 29. There was no observation of QMA 1 utilizing hand hygiene before or after donning and doffing gloves.

4. The clinical record for Resident 51 was reviewed on 10/17/25 at 9:20 a.m. The diagnoses included, but were not limited to, dementia and hypertension.

An observation was conducted of medication administration with QMA 7 for Resident 51 on 10/17/25 at 9:20 a.m. QMA 7 was observed at a memory care unit medication cart. The alcohol hand gel on the medication cart was empty. QMA 7 obtained a blood pressure cuff from the medication cart and entered Resident 51's apartment. She obtained Resident 51's blood pressure and returned to the medication cart. She prepared

Resident 51's medications, poured a glass of water, and locked the medication cart. She then returned to Resident 51's apartment and administered the medications. She returned to the medication cart, signed off the medications, and began pushing the medication cart down the hallway. She did not perform hand hygiene after finishing the medication pass for Resident 51.

5. The clinical record for Resident 67 was reviewed on 10/17/25 at 9:27 a.m. The diagnoses included, but were not limited to, dementia and depression.

An observation was conducted of medication administration with QMA 7 for Resident 67 on 10/17/25 at 9:27 a.m. QMA 7 entered Resident 67's apartment. She did not perform hand hygiene prior to entering the apartment. She touched Resident 67's back and adjusted his blanket. QMA 7 then adjusted the thermostat in the apartment. She exited the apartment and opened the medication cart and began preparing Resident 67's medications. She did not perform hand hygiene prior to preparing the medications. She obtained a tube of Bio-freeze (topical pain cream) and a bottle of ammonium lactate (lotion for dry skin) and returned to

Resident 67's apartment. She administered the medications and then donned the disposable gloves. She did not perform hand hygiene prior to donning gloves. She applied the Bio-freeze to Resident 67's shoulders and lower back. She doffed her disposable gloves and donned a new pair of gloves. She did not perform hand hygiene prior to donning the new gloves. She then applied the ammonium lactate lotion to Resident 67's arms and doffed her gloves. She did not perform hand hygiene after doffing the gloves. She assisted Resident 67 with putting on a sweatshirt and a belt and handed him a hat to wear. She exited the apartment and began pushing the medication cart down the hallway.

During an interview on 10/17/25 at 9:45 a.m., QMA 7 indicated hand hygiene should be completed between each resident and after removing disposable gloves.

An interview was conducted with the Director of Nursing on 10/17/25 at 1:47 p.m. She indicated the staff should be utilizing hand hygiene in between residents and before and after utilizing gloves.

On 10/17/25 at 1:00 p.m., the Director of Nursing provided the Hand Hygiene Policy, last

reviewed 8/10/22, that indicated "...To prevent transfer of germs and transmission of infections to patients and caregivers and to implement a hand hygiene compliance program. Indications for hand hygiene are: Before and after direct patient care. Before and after each procedure.... Before re-entering nursing bag or patient's clean supplies ...Gloves are not a substitute for hand hygiene..."

Based on observation, interview, and record review, the facility failed to ensure hand hygiene was utilized during medication administrations for 5 of 8 residents observed during medication administration. (Residents' 19, 29, 34, 51 and 67)

Findings include:

1. The clinical record for Resident 19 was reviewed on 10/17/25 at 8:50 a.m. The diagnoses included, but were not limited to, hypertension.

An observation was conducted of a medication administration with Qualified Medication Aide (QMA) 2 on 10/17/25 at 8:51 a.m. QMA 2 was observed at the medication cart pulling Resident 19's medications from the cart. She had placed the resident's medications utilizing medication cards in a medication cup. QMA 2 then

removed a blood pressure cuff from the cart and entered the resident's room. Utilizing the resident's left arm, she had obtained the resident's blood pressure. After, she returned to the medication cart. During that time, QMA 2 requested for another blood pressure cuff from QMA 1. After, she returned back to the resident's room and obtained the resident's blood pressure again. She then returned back to the medication cart and reviewed the resident's medical record utilizing the electronic Medication Administration Record. After, she went back to the resident's room and administered the medications that were in the medication cup to the resident. QMA 2 did not utilize hand hygiene before or after obtaining the resident's blood pressure, preparing the medication administration, or after the completion of the medication administration.

2. The clinical record for Resident 34 was reviewed on 10/17/25 at 10:57 a.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus.

An observation was conducted of an insulin administration with QMA 1 on 10/17/25 at 10:58 a.m. QMA 1 was observed at the medication cart preparing an insulin flexpen for Resident 34.

She donned gloves and wiped the rubber seal utilizing an alcohol wipe. She then placed the needle on the seal and dialed up the dosage. After, she doffed her gloves and entered the resident's room. QMA 1 donned new set of gloves and administered the insulin in Resident 34's abdomen. There was no hand hygiene before or after donning or doffing the gloves.

3. The clinical record for Resident 29 was reviewed on 10/17/25 at 11:10 a.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus.

An observation was conducted of an insulin administration with QMA 1 for Resident 29 on 10/17/25 at 11:10 a.m. QMA 1 was observed at the medication cart preparing the insulin flexpen for Resident 29. She pulled a flexpen from the medication cart and donned gloves. During that time, QMA 1 wiped the rubber seal with an alcohol wipe and placed a needle on the rubber seal. She then dialed up the insulin medication dosage. After, she doffed her gloves and entered the resident's room. QMA 1 was observed donning a new set of gloves and administered the insulin to Resident 29. There was no observation of QMA 1 utilizing hand hygiene before or

after donning and doffing gloves.

4. The clinical record for Resident 51 was reviewed on 10/17/25 at 9:20 a.m. The diagnoses included, but were not limited to, dementia and hypertension.

An observation was conducted of medication administration with QMA 7 for Resident 51 on 10/17/25 at 9:20 a.m. QMA 7 was observed at a memory care unit medication cart. The alcohol hand gel on the medication cart was empty. QMA 7 obtained a blood pressure cuff from the medication cart and entered Resident 51's apartment. She obtained Resident 51's blood pressure and returned to the medication cart. She prepared Resident 51's medications, poured a glass of water, and locked the medication cart. She then returned to Resident 51's apartment and administered the medications. She returned to the medication cart, signed off the medications, and began pushing the medication cart down the hallway. She did not perform hand hygiene after finishing the medication pass for Resident 51.

5. The clinical record for Resident 67 was reviewed on 10/17/25 at 9:27 a.m. The diagnoses included, but were not limited to, dementia and

depression.

An observation was conducted of medication administration with QMA 7 for Resident 67 on 10/17/25 at 9:27 a.m. QMA 7 entered Resident 67's apartment. She did not perform hand hygiene prior to entering the apartment. She touched Resident 67's back and adjusted his blanket. QMA 7 then adjusted the thermostat in the apartment. She exited the apartment and opened the medication cart and began preparing Resident 67's medications. She did not perform hand hygiene prior to preparing the medications. She obtained a tube of Bio-freeze (topical pain cream) and a bottle of ammonium lactate (lotion for dry skin) and returned to Resident 67's apartment. She administered the medications and then donned the disposable gloves. She did not perform hand hygiene prior to donning gloves. She applied the Bio-freeze to Resident 67's shoulders and lower back. She doffed her disposable gloves and donned a new pair of gloves. She did not perform hand hygiene prior to donning the new gloves. She then applied the ammonium lactate lotion to Resident 67's arms and doffed her gloves. She did not perform hand hygiene after doffing the gloves. She assisted Resident 67 with putting on a

sweatshirt and a belt and handed him a hat to wear. She exited the apartment and began pushing the medication cart down the hallway.

During an interview on 10/17/25 at 9:45 a.m., QMA 7 indicated hand hygiene should be completed between each resident and after removing disposable gloves.

An interview was conducted with the Director of Nursing on 10/17/25 at 1:47 p.m. She indicated the staff should be utilizing hand hygiene in between residents and before and after utilizing gloves.

On 10/17/25 at 1:00 p.m., the Director of Nursing provided the Hand Hygiene Policy, last reviewed 8/10/22, that indicated "...To prevent transfer of germs and transmission of infections to patients and caregivers and to implement a hand hygiene compliance program. Indications for hand hygiene are: Before and after direct patient care. Before and after each procedure.... Before re-entering nursing bag or patient's clean supplies ...Gloves are not a substitute for hand hygiene..."

SIGNATUREAndrea Lake		