STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE STAR RESIDENCES OF FORT WAYNE	2601 COVINGTON COMMONS DRIVE, FORT WAYNE, , 46804

(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 Complaint IN00462026, IN00462565 and IN00463272. Complaint IN00462026- No deficiencies related to the allegations are cited. Complaint IN00462566- No deficiencies related to the allegations are cited. Complaint IN00463272- State deficiencies related to the allegations are cited at R245 Survey dates: July 15, and 16, 2025 Facility number: 014017 Residential Census: 71 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality reiew completed July 17,	R 0000		

	2025			
R 0192	Physical Plant Standards - Nonconformance 410 IAC 16.2-5-1.6(p) (p) The facility shall have a janitor's closet conveniently located on each resident occupied floor of the facility. The janitor's closet shall contain a sink or floor receptacle and storage for cleaning supplies. The door to the janitor's closet shall be equipped with a lock and shall be locked when hazardous materials are stored in the closet. Based on observation, interview, and record review the facility failed to have hazardous chemicals locked up and inaccessible to residents for 1 of 12 residents reviewed. (Resident 6) Findings include: During an ongoing observation, on 7/15/25 from 9:06 AM to 9:13 AM a housekeeping cart with multiple hazardous chemicals were unattended. Resident 6 was pacing the hall in his wheelchair. During this time Housekeeper 2 was not in sight of the cart and was behind another closed door. During an observation, on 7/15/25 at 9:10 AM, indicated a housekeeping cart with lockable doors had the following cleaning	R 0192	Housekeeping cart was cleaned out and adjusted on 7/16, to ensure chemical bottles would fit as indicated according to the housekeeping cart standard, to ensure no other residents were effected. Housekeeper was re-educated on Housekeeping Cart standard and Handling Chemicals. All team members will be re-educated on Handling Chemicals policy. Housekeeping cart will be observed and observations documented 5 out of 7 days to ensure chemicals are stored properly, for no less than 30 days. Observations will be reviewed by the QAPI committee, if 95% compliance is achieved in no less than 4 weeks, then observations will drop to 3 out of 7 days for an additional 4 weeks. Upon 95% compliance for those additional 4 weeks, documented	08/13/2025

	supplies on top: multi surface disinfectant Zep-carpet stain remover Febreze aerosol air freshener Old English-furniture polish Windex-window cleaner goo gone A spray bottle labeled bleach spray A container of bleach wipes In an interview, on 7/15/25 at 9:13AM, Housekeeper 2 indicated the items were on top of the cart because the cart was too full of other items. Housekeeper 2 opened locked compartment without a key and showed multiple rags/gloves and other items including other spray bottles. Housekeeper 2 began placing spray bottles from on top of cart into the bottom lockable area of cart. During an observation, on 7/15/25 at 9:47AM, the housekeeper cart that was lockable had the following items on top of cart within reach of residents without staff in eyesight: Windex A spray bottle labeled as bleach		observations will be weekly for no less than a total of 26 weeks.	

	water Multiple surface cleaner Enzyme Plus During an observation, on 7/15/25 at 2:11PM, the Administrator noted the housekeeping cart was unlocked and the previous liquids were exposed as well as soft scrub. Housekeeper 2 was in a resident room sweeping with her back to the cart. In an interview, on 7/15/25 at 2:14PM, the Administrator indicated the cart should be locked. The chemicals should not be unattended. A review of Material Safety Data Sheets provided by the Director of Nursing, on 7/16/25 at 9:28iAM, indicated the following supplies which were left unattended are considered dangerous alkaline cleaner, bleach water, Old English, and Goo Gone. A current policy titled, "Handling Chemicals" provided on 7/16/25 at 9:28 AM was provided by the Director of Nursing indicated ...1.4 How and where to properly store the chemical when it is not in use per Safety Data Sheet ... Based on observation, interview, and record review the facility failed to have hazardous			

chemicals locked up and inaccessible to residents for 1 of 12 residents reviewed. (Resident 6)

Findings include:

During an ongoing observation, on 7/15/25 from 9:06 AM to 9:13 AM a housekeeping cart with multiple hazardous chemicals were unattended. Resident 6 was pacing the hall in his wheelchair. During this time Housekeeper 2 was not in sight of the cart and was behind another closed door.

During an observation, on 7/15/25 at 9:10 AM, indicated a housekeeping cart with lockable doors had the following cleaning supplies on top:

multi surface disinfectant

Zep-carpet stain remover

Febreze aerosol air freshener

Old English-furniture polish

Windex-window cleaner

goo gone

A spray bottle labeled bleach spray

A container of bleach wipes

In an interview, on 7/15/25 at 9:13AM, Housekeeper 2 indicated the items were on top

	of the cart because the cart was too full of other items. Housekeeper 2 opened locked compartment without a key and showed multiple rags/gloves and other items including other spray bottles. Housekeeper 2 began placing spray bottles from on top of cart into the bottom lockable area of cart. During an observation, on 7/15/25 at 9:47AM, the housekeeper cart that was lockable had the following items on top of cart within reach of residents without staff in eyesight: Windex A spray bottle labeled as bleach water Multiple surface cleaner Enzyme Plus During an observation, on 7/15/25 at 2:11PM, the Administrator noted the housekeeping cart was unlocked and the previous liquids were exposed as well as soft scrub. Housekeeper 2 was in a resident room sweeping with her back to the cart. In an interview, on 7/15/25 at 2:14PM, the Administrator indicated the cart should be locked. The chemicals should not be unattended.			

	A review of Material Safety Data Sheets provided by the Director of Nursing, on 7/16/25 at 9:28iAM, indicated the following supplies which were left unattended are considered dangerous alkaline cleaner, bleach water, Old English, and Goo Gone. A current policy titled, "Handling Chemicals" provided on 7/16/25 at 9:28 AM was provided by the Director of Nursing indicated ...1.4 How and where to properly store the chemical when it is not in use per Safety Data Sheet ...			
R 0245	Health Services - Offense 410 IAC 16.2-5-4(e)(5) (5) Injectable medications shall be given only by licensed personnel. Based on interview and record review, the facility failed to ensure licensed/or certified personnel gave injectable medication for 2 of 7 residents reviewed. (Resident E, and Resident G) Findings include: A state report submitted on 7/10/25, indicated Qualified Medication Aides (QMA) were giving insulin without being certified.	R 0245	Resident's PCP will review recorded blood sugars and corresponding insulin given, to ensure amount administered was appropriate. Labs will be requested as needed to verify. Director of Health and Wellness will audit insulin administration from 6/1 to 7/15, to identify any other residents affected, if identified PCP will review recorded blood sugars and corresponding insulin, to ensure amount administered was appropriate. Labs requested as needed.	08/13/2025

	1. On 7/15/25 at 10:15 AM, Resident E's record was reviewed. Diagnoses included type 2 Diabetes Mellitus. Resident E's physician orders indicated to give Humalog KwikPen Subcutaneous solution pen-injector 100 unit/milliliter(ML). Directions, inject as per sliding scale if: 0-200 = 0 units. 201-250=3 units. 251-300=4 units. 301-350=6 units. 351-400=7 units. 401-450=8 units over 450 call Nurse Practitioner (NP). Subcutaneous before meals for diabetes, start date of 5/23/25. Insulin Lispro injection solution 100 unit/ml. Directions: Inject 5 units subcutaneous two times a day for diabetes, give at breakfast and lunch, hold if blood sugar is less than 110, start date of 5/25/25. Insulin Galrgine-aglr subcutaneous solution pen-injector 100 unit/ml. Directions: inject 14 unit units subcutaneous one time a day for Diabetes Mellitus, start date 7/8/25. Insulin Galrgine-aglr		Team member was immediately re-educated during phone call on 7/15, and received final written warning. Re-education for all QMAs completed. Director of Health and Wellness or designee will audit insulin administration daily (as long as community has at least 1 QMA that is not insulin certified) for a period of no less than 30 days. When 100% compliance is achieved for 30 days, auditing will reduce to 3 out of 7 days for a period of no less than 90 days. When 100% is achieved, audits will reduce to weekly for no less than a total of 26 weeks. Audits will be reviewed by the QAPI committee.	

	subcutaneous solution pen-injector 100 unit/ml. Directions: inject 18 unit units subcutaneous at bedtime for Diabetes Mellitus, start date 6/2/25. A review of the Medication Administration Record (MAR), dated July 2025, indicated Insulin Galrgine-aglr subcutaneous solution pen-injector 100 unit/ml were given by QMA 4 on the following dates and times: On 7/2/25 at 8:38 PM, subcutaneous to the left upper quadrant of the abdomen. On 7/6/25 at 7:50 PM, subcutaneous to the left lower quadrant of the abdomen. On 7/10/25 at 7:49 PM, subcutaneous to the right upper quadrant of the abdomen. 2. On 7/15/25 at 11:00 AM, Resident G's record was reviewed. Diagnoses included type 2 Diabetes Mellitus. Resident G's physician orders indicated to give Insulin Aspart injection solution directions: inject 14 units subcutaneous with meals for Diabetes Mellitus, hold if blood sugar less than 120. Notify NP if greater than 400, start date 6/20/25, and Lantus Solostar subcutaneous solution pen-injector 100 unit/ml. Directions: inject 25 units			

	subcutaneous one time a day for Diabetes Mellitus, start date 6/21/25. A review of the MAR, dated July 2025, indicated Lantus solostar subcutaneous solution pen-injector 100 unit/ml was given by QMA 4 on the following dates: On 7/2/25 at 8:09 PM, subcutaneous to the right lower quadrant of the abdomen. On 7/6/25 at 8:02 PM, subcutaneous to the right lower quadrant of the abdomen. On 7/10/25 at 7:54 PM, subcutaneous to the right lower quadrant of the abdomen. A review on 7/15/25 at 1:15 PM, of QMA 4's employee file, indicated the QMA license was active, but QMA 4 did not have a Certificate to administer insulin. On 7/15/25 at 2:03 PM, Director of Wellness, in an interview, indicated QMAs that are not certified to give insulin, should not be administering it. QMA 4, would have worked with someone that could give it. The Director of Wellness was not sure why QMA 4 signed that she gave it. She indicated, she spoke to QMA 4 on the phone, and she has been giving insulin to residents. QMA 4 was educated on, not giving insulin			

since she was not certified to do so.

A current facility policy, titled Medication Management guidelines, dated 4/1/19, was provided by the Director of Wellness. The policy indicated..." This policy provides guidelines for assisting resident with medication management in accordance with applicable state laws and regulations...injectable medications are given only by a licensed nurse...."

This citation is related to complaint IN00463272.

Based on interview and record review, the facility failed to ensure licensed/or certified personnel gave injectable medication for 2 of 7 residents reviewed. (Resident E, and Resident G)

Findings include:

A state report submitted on 7/10/25, indicated Qualified Medication Aides (QMA) were giving insulin without being certified.

1. On 7/15/25 at 10:15 AM, Resident E's record was reviewed. Diagnoses included type 2 Diabetes Mellitus.

Resident E's physician orders indicated to give Humalog

	KwikPen Subcutaneous solution pen-injector 100 unit/milliliter(ML). Directions, inject as per sliding scale if: 0-200 = 0 units. 201-250=3 units. 251-300=4 units. 301-350=6 units. 351-400=7 units. 401-450=8 units over 450 call Nurse Practitioner (NP). Subcutaneous before meals for diabetes, start date of 5/23/25. Insulin Lispro injection solution 100 unit/ml. Directions: Inject 5 units subcutaneous two times a day for diabetes, give at breakfast and lunch, hold if blood sugar is less than 110, start date of 5/25/25. Insulin Galrgine-aglr subcutaneous solution pen-injector 100 unit/ml. Directions: inject 14 unit units subcutaneous one time a day for Diabetes Mellitus, start date 7/8/25. Insulin Galrgine-aglr subcutaneous solution pen-injector 100 unit/ml. Directions: inject 18 unit units subcutaneous at bedtime for Diabetes Mellitus, start date 6/2/25.			

	A review of the Medication Administration Record (MAR), dated July 2025, indicated Insulin Galrgine-aglr subcutaneous solution pen-injector 100 unit/ml were given by QMA 4 on the following dates and times: On 7/2/25 at 8:38 PM, subcutaneous to the left upper quadrant of the abdomen. On 7/6/25 at 7:50 PM, subcutaneous to the left lower quadrant of the abdomen. On 7/10/25 at 7:49 PM, subcutaneous to the right upper quadrant of the abdomen. 2. On 7/15/25 at 11:00 AM, Resident G's record was reviewed. Diagnoses included type 2 Diabetes Mellitus. Resident G's physician orders indicated to give Insulin Aspart injection solution directions: inject 14 units subcutaneous with meals for Diabetes Mellitus, hold if blood sugar less than 120. Notify NP if greater than 400, start date 6/20/25, and Lantus Solostar subcutaneous solution pen-injector 100 unit/ml. Directions: inject 25 units subcutaneous one time a day for Diabetes Mellitus, start date 6/21/25. A review of the MAR, dated July 2025, indicated Lantus solostar subcutaneous solution			

	pen-injector 100 unit/ml was given by QMA 4 on the following dates: On 7/2/25 at 8:09 PM, subcutaneous to the right lower quadrant of the abdomen. On 7/6/25 at 8:02 PM, subcutaneous to the right lower quadrant of the abdomen. On 7/10/25 at 7:54 PM, subcutaneous to the right lower quadrant of the abdomen. A review on 7/15/25 at 1:15 PM, of QMA 4's employee file, indicated the QMA license was active, but QMA 4 did not have a Certificate to administer insulin. On 7/15/25 at 2:03 PM, Director of Wellness, in an interview, indicated QMAs that are not certified to give insulin, should not be administering it. QMA 4, would have worked with someone that could give it. The Director of Wellness was not sure why QMA 4 signed that she gave it. She indicated, she spoke to QMA 4 on the phone, and she has been giving insulin to residents. QMA 4 was educated on, not giving insulin since she was not certified to do so. A current facility policy, titled Medication Management guidelines, dated 4/1/19, was provided by the Director of			

	Wellness. The policy indicated..." This policy provides guidelines for assisting resident with medication management in accordance with applicable state laws and regulations...injectable medications are given only by a licensed nurse...." This citation is related to complaint IN00463272.			
R 0273	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(f) (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview and record review, the facility failed to ensure proper labeling, storage and sanitation were maintained in the kitchen during 2 of 2 observations. This had the potential to affect 71 of 71 residents that resided in the facility and received food from the kitchen. Findings include: 1. During an initial observation of the kitchen on 07/15/25 at 9:15 AM ,the following items were open and undated: 1 bag	R 0273	Director of Dining Services ensured all items were correctly labeled, stored and sanitizer solution dispenser is dispensing at correct concentration. All residents were noted to be affected. Dining Team members were immediately re-educated on procedure for labeling and storing food. Small sanitizer buckets will be tested once end of meal cleaning has been completed, if PPM is less than 200, new solution will be drawn and surfaces re-wiped. Executive Director or designee	08/13/2025

	of peas, 1 bag of spinach, 2 containers of ice cream, 1 bag with 2 submarine buns, 1 bag with 8 submarine buns, 1 bag with 5 submarine buns, 1 bag of tortilla chips, 1 bag with 12 pieces of breaded chicken, 1 bag with 4 pieces of Nann bread, 1 box of butterfly shrimp, 1 bag with 20 pieces of garlic bread, 1 bag with 15 pieces of fish, 1 bag of sweet potato fries, 1 bag of cooked ground beef, 1 bag of cooked chopped bacon, a quarter block of cheese, 1 loaf of bread with approximately 20 slices, 1 package of hotdog buns with 4 buns, 1 package of hotdog buns with 3 buns and 1 loaf of raisin bread with 6 slices. During an interview, on 7/15/2025 at 10 AM, Cook 6 indicated 71 of 71 residents received food from the kitchen. On 7/16/2025 at 9:05AM , during an observation of the kitchen Cook 6 observed 1 bag of peas, 1 bag of spinach, 2 containers of ice cream, 1 bag with 2 submarine buns, 1 bag with 8 submarine buns, 1 bag with 5 submarine buns, 1 bag of tortilla chips, 1 bag with 12 pieces of breaded chicken, 1 bag with 4 pieces of Nann bread, 1 box of butterfly shrimp, 1 bag with 20 pieces of garlic bread, 1 bag with 15 pieces of fish, 1 bag of sweet potato fries, 1 bag of cooked ground beef, 1 bag of cooked chopped bacon,		will audit sanitizer log and observe the kitchen for proper labeling and storage for 5 out of 7 days for no less than 4 weeks. If 95% compliance is achieved then auditing will reduce to 3 out of 7 days for a total of no less than 26 weeks. Audits will be reviewed by the QAPI committee.	

	a quarter block of cheese, 1 loaf of bread with approximately 20 slices, 1 package of hotdog buns with 4 buns, 1 package of hotdog buns with 3 buns and 1 loaf of raisin bread with 6 slices open and undated. On 7/16/2025 at 9:10AM, in an interview, Cook 6 indicated they typically labeled and dated all items when they were opened and the undated items should have been labeled with an open date. During an interview, on 7/16/2025 at 12:00PM, the Food Services Manager indicated he was unaware frozen items needed to be labeled and dated. A current facility policy, Storage of Food and Supplies dated 7/20, was provided by the Facility Administrator, on 7/16/2025 at 11:42 AM. The policy indicated items are dated and labeled when opened. 2. During an observation, on 7/15/2025 at 10AM, Cook 6 tested the concentration of the sanitizer. The results were 100 parts per million (ppm). During an interview, on 7/15/2025 at 10:05AM, Cook 6 indicated the sanitizer amount should be around 100ppm. Cook 6 indicated the sanitizer was currently being used to clean the kitchen.			

	During a second observation on 7/16/2025 at 8:45 AM, Cook 6 tested the concentration of the sanitizer. The results were 100 (ppm). Cook 6 was using the sanitizer to clean the counters. During an interview with the Food Services Manager on 7/16/2025 at 12:00pm he indicated the facility did not have a policy, but the concentration of the sanitizer should be between 200-400 ppm. Based on observation, interview and record review, the facility failed to ensure proper labeling, storage and sanitation were maintained in the kitchen during 2 of 2 observations. This had the potential to affect 71 of 71 residents that resided in the facility and received food from the kitchen. Findings include: 1. During an initial observation of the kitchen on 07/15/25 at 9:15 AM ,the following items were open and undated: 1 bag of peas, 1 bag of spinach, 2 containers of ice cream, 1 bag with 2 submarine buns, 1 bag with 8 submarine buns, 1 bag with 5 submarine buns, 1 bag of tortilla chips, 1 bag with 12 pieces of breaded chicken, 1 bag with 4 pieces of Nann bread, 1 box of butterfly shrimp, 1 bag with 20 pieces of garlic			

	bread, 1 bag with 15 pieces of fish, 1 bag of sweet potato fries, 1 bag of cooked ground beef, 1 bag of cooked chopped bacon, a quarter block of cheese, 1 loaf of bread with approximately 20 slices, 1 package of hotdog buns with 4 buns, 1 package of hotdog buns with 3 buns and 1 loaf of raisin bread with 6 slices. During an interview, on 7/15/2025 at 10 AM, Cook 6 indicated 71 of 71 residents received food from the kitchen. On 7/16/2025 at 9:05AM , during an observation of the kitchen Cook 6 observed 1 bag of peas, 1 bag of spinach, 2 containers of ice cream, 1 bag with 2 submarine buns, 1 bag with 8 submarine buns, 1 bag with 5 submarine buns, 1 bag of tortilla chips, 1 bag with 12 pieces of breaded chicken, 1 bag with 4 pieces of Nann bread, 1 box of butterfly shrimp, 1 bag with 20 pieces of garlic bread, 1 bag with 15 pieces of fish, 1 bag of sweet potato fries, 1 bag of cooked ground beef, 1 bag of cooked chopped bacon, a quarter block of cheese, 1 loaf of bread with approximately 20 slices, 1 package of hotdog buns with 4 buns, 1 package of hotdog buns with 3 buns and 1 loaf of raisin bread with 6 slices open and undated. On 7/16/2025 at 9:10AM, in an interview, Cook 6 indicated they			

typically labeled and dated all items when they were opened and the undated items should have been labeled with an open date.

During an interview, on 7/16/2025 at 12:00PM, the Food Services Manager indicated he was unaware frozen items needed to be labeled and dated.

A current facility policy, Storage of Food and Supplies dated 7/20, was provided by the Facility Administrator, on 7/16/2025 at 11:42 AM. The policy indicated items are dated and labeled when opened.

2. During an observation, on 7/15/2025 at 10AM, Cook 6 tested the concentration of the sanitizer. The results were 100 parts per million (ppm).

During an interview, on 7/15/2025 at 10:05AM, Cook 6 indicated the sanitizer amount should be around 100ppm. Cook 6 indicated the sanitizer was currently being used to clean the kitchen.

During a second observation on 7/16/2025 at 8:45 AM, Cook 6 tested the concentration of the sanitizer. The results were 100 (ppm). Cook 6 was using the sanitizer to clean the counters.

During an interview with the Food Services Manager on 7/16/2025 at 12:00pm he

	indicated the facility did not have a policy, but the concentration of the sanitizer should be between 200-400 ppm.			

R 0356	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(i)(1-8) (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on interview and record review the facility failed to maintain emergency information file for 3 of 5 the residents reviewed. (Resident 5, Resident 6, and Resident 11)	R 0356	Director of Health and Wellness contacted families to get hospital preferences for identified residents. Director of Health and Wellness audited all resident's move in record (facesheet) for hospital preference. Hospital preference was obtained for residents identified in the audit. Policy was updated to reflect required information. Executive Director and Director of Health and Wellness independently verified policy list all required information and all required information can be located on the resident's move-in record (facesheet). Director of Health and Wellness will print all resident's move-in record and to be put in a binder kept at each nurse's station. Director of Health and Wellness or designee will audit binders weekly for 4 weeks, to ensure all residents are included. If 95% compliance is achieved, audit frequency will reduce to every other week for no less than 26 weeks. Audit results will be reviewed by the	08/13/2025

	Findings include: 1) A record review for Resident 5 began on 7/15/25 at 9:39AM, and indicated diagnoses included dementia and anxiety. Resident 5's emergency file/elopement binder did not include hospital preference. There was a section for mobility aids on the facility form. This section was not completed. 2) A record review for Resident 6 began on 7/15/25 at 9:48AM, indicated diagnoses included lymphoma and hypertension. Resident 6 's emergency file/elopement binder did not include hospital preference. There was a section for mobility aid on the facility form. this section was not completed 3) A record review for Resident 11 began on 7/15/25 at 11:21AM, indicated diagnoses including hypertension. Resident 11 did not have a file in the emergency file/elopement book. The Director of Wellness provideda file on 7/16/25 at 9:28AM. This form was missing hospital preference. There was a section for mobility aids on the facility form. This section was not completed In an interview, on 7/15/25 at		QAPI committee.	

1:49PM, the Administrator indicated in an emergency the facility would use the Medication Administration Record computer and the elopement binder would go with the residents.

A current policy titled," Emergency Evacuation", dated 1/1/25 indicated minimum vital information information to be included in an Emergency file included:

Name

Date of Birth

Height

Weight

Mobility

Code Status

Picture

Immediate Care: Care that would need to be provided in a 24-hour period ...

Based on interview and record review the facility failed to maintain emergency information file for 3 of 5 the residents reviewed. (Resident 5, Resident 6, and Resident 11)

Findings include:

1) A record review for Resident 5 began on 7/15/25 at 9:39AM, and indicated diagnoses

included dementia and anxiety.

Resident 5's emergency file/elopement binder did not include hospital preference. There was a section for mobility aids on the facility form. This section was not completed.

2) A record review for Resident 6 began on 7/15/25 at 9:48AM, indicated diagnoses included lymphoma and hypertension.

Resident 6 's emergency file/elopement binder did not include hospital preference. There was a section for mobility aid on the facility form. this section was not completed

3) A record review for Resident 11 began on 7/15/25 at 11:21AM, indicated diagnoses including hypertension.

Resident 11 did not have a file in the emergency file/elopement book.

The Director of Wellness provideda file on 7/16/25 at 9:28AM. This form was missing hospital preference. There was a section for mobility aids on the facility form. This section was not completed

In an interview, on 7/15/25 at 1:49PM, the Administrator indicated in an emergency the facility would use the Medication Administration Record computer and the elopement binder would

	go with the residents. A current policy titled," Emergency Evacuation", dated 1/1/25 indicated minimum vital information information to be included in an Emergency file included: Name Date of Birth Height Weight Mobility Code Status Picture Immediate Care: Care that would need to be provided in a 24-hour period ...			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE