STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUGAR FORK CROSSING	1745 EAST 67TH STREET, ANDERSON, , 46013

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Intakes 470495 and 470617. Intake 470495 - State deficiencies related to the allegations are cited at R052. Intake 470617 - State deficiencies related to the allegations are cited at R117. Survey date: July 6, 7, and 8, 2026 Facility number: 014080 Residential Census: 80 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed July 16, 2026.	R 0000	This Plan of Correction is submitted under regulations applicable to long-term care providers. This Plan of Correction is not to be construed as an admission or agreement with the findings and conclusions in the Statement of Deficiencies. The preparation/ submission and/or execution of this Plan does not constitute agreement by the facility that the surveyor’s findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any deficiencies are correctly applied. Submission of this Plan is evidence of compliance.	
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6)	R 0052	The service plan for Resident B was updated with behavior	08/15/2026

	(v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on observation, interview, and record review, the facility failed to protect a resident's right to be free from resident-to-resident physical abuse when the facility failed to supervise and develop and implement interventions for a resident with known aggressive behavior towards a peer and failed to provide supervision for a resident with a known behavior expression of wandering for 2 of 6 residents reviewed for abuse. (Resident B and Resident C) This deficient practice resulted in Resident C sustaining multiple contusions and lacerations to his face and head requiring hospitalization and rehabilitation services following an assault by Resident B with a wheelchair foot pedal. Findings include: Review of an anonymous intake filed with the Indiana		interventions on 7/1/2026 by the community's Director of Health and Wellness. Resident B has had no new resident-to-resident incidents noted since the resident-to-resident incident with resident C on 06/26/2026. Resident C moved out of community. The community's Director of Health and Wellness, or their designee, shall audit current community resident behavior notes and incident reports within the last 30 days by 8/5/2026 to identify any potential patterns or behaviors that could or have resulted in a resident-to-resident incident. Identified resident(s) shall have their service plan updated with interventions to provide staff guidance and behavior management and will be reviewed and updated as needed for 4 weeks following the initial audit completion. The community's Director of Health and Wellness, or their designee, shall complete an in-service utilizing the community's Abuse and Neglect Reporting guideline with current community Team Members no later than 08/15/2026. Team Members for which the in-service has not been completed shall be removed from the community's work schedule until training has been completed satisfactorily. An	

	Department of Health (IDOH), indicated Resident C was admitted to the hospital with multiple facial and skull injuries following an assault by another resident (Resident B). Review of facility reported incidents for the previous 90 days, provided by the Administrator on 7/6/26 at 10:29 a.m., included the following: On 4/17/26 at 1:10 p.m., Resident C was standing over Resident B, they were punching at each other, and they had a hold of each other's shirts. No injuries were noted. They were placed on 15-minute checks for two hours and then hourly checks for 24 hours. On 5/27/26 at 9:45 a.m., Resident C lifted the edge of the dining room table where Resident B sat. Resident B began hitting Resident C. No injuries were noted. They were placed on 15-minute checks for two hours and then hourly checks for 24 hours. On 6/7/26 at 10:17 a.m., Resident B and Resident C were in the dining room. Resident B hit Resident C on the hand with a fork. No injuries were noted. They were placed on 15-minute checks for two hours and then hourly checks for 24 hours.		Inservice Attendance Log shall be used as evidence of completion of such training and shall be maintained with the community's training files. New community Team Members shall be oriented to the community's Abuse and Neglect Reporting guideline at the time of hire. The community's Director of Health and Wellness, or their designee, shall complete an in-service utilizing the community's Preventing, Recognizing and Reporting Abuse guideline with current community Team Members no later than 08/15/2026. Team Members for which the in-service has not been completed shall be removed from the community's work schedule until training has been completed satisfactorily. An Inservice Attendance Log shall be used as evidence of completion of such training and shall be maintained with the community's training files. New community Team Members shall be oriented to the community's Preventing, Recognizing, and Reporting Abuse guideline at the time of hire. The community's Executive Director shall deploy"Abuse: Preventing, Recognizing and Reporting" training within Relias	

	On 7/6/26 at 12:19 p.m., Resident B was observed sitting alone in a wheelchair at a table in the dining room. On 7/8/26 at 9:13 a.m., Resident B was sitting in wheelchair in the dining room, eating. A female resident sat across from him in a wheelchair. On 7/8/26 at 2:00 p.m., Resident B was sitting in his wheelchair in the dining room, holding hands with a female resident sitting beside him in a wheelchair. Resident B's clinical record was reviewed on 7/6/26 at 9:40 a.m. Diagnoses included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, and vascular dementia, moderate, with anxiety. His medications included hydrocodone/acetaminophen (treats pain) 5/325 milligram (mg) twice daily, levetiracetam (treats myoclonus (jerking)) 250 mg daily, and memantine (treats dementia) 5 mg twice daily. A 5/18/26 Brief Interview for Mental Status (BIMS) assessment indicated he was severely cognitive impaired. An incident note, dated 6/26/26 at 6:52 p.m., indicated a QMA		LMS to the community's current Team Members for completion no later than 8/15/2026. Team Members for which the Relias training has not been completed shall be removed from the community's work schedule until training has been completed satisfactorily. New community Team Members shall have the "Abuse: Preventing, Recognizing, and Reporting" module shall be deployed within Relias LMS for completion at the time of hire. The Community's Executive Director shall deploy "Dementia Care: Challenging Behaviors and Direct Care Staff" training within Relias LMS to the community's /current Team Members for completion no later than 8/15/2026. Team Members for which the Relias training has not been completed shall be removed from the community's work schedule until training has been completed satisfactorily. New community Team Members shall have the "Dementia Care: Challenging Behaviors and Direct Care Staff" module shall be deployed within Relias LMS for completion at the time of hire. All in-service monitoring will be reviewed weekly by the Community's Executive Director or their designee to ensure compliance is met by 8/15/2026	

	requested assistance in Resident B's room. Resident B was found on his back on the floor with blood on his arm, hands, and right hip area. Another resident was in Resident B's room and was receiving first aid from a hospice nurse, who walked by the room and observed the residents fighting. The hospice nurse and facility staff intervened to get Resident B to stop hitting the other resident with a foot pedal from Resident B's wheelchair. The foot pedal caused multiple lacerations with heavy bleeding. Resident B indicated he was defending himself from the other resident. Resident B was reluctant to hand over the foot pedal and swung the foot pedal like he was going to hit the CNA as she attempted to retrieve the foot pedal. Resident B's family member indicated that the video camera located in the apartment showed that Resident B had slid from his recliner to the floor, the other resident was on top of Resident B, and that was when Resident B grabbed the footrest and swung, hitting the other resident multiple times in the head causing a lot of head trauma. Resident C's clinical record was reviewed on 7/6/26 at 10:01 a.m. Diagnoses included Alzheimer's disease with late		or employee corrective action of removal from schedule will occur with employees that have not completed each in-service by 08/15/2026.	

	onset, degenerative disease of nervous system, peripheral vascular disease, anxiety disorder, patient's other noncompliance with medication regimen for other reasons, visual hallucinations, altered mental status, and thrombocytopenia. His medications included buspirone (treats anxiety) 5 mg twice daily, risperidone (antipsychotic) 0.25 mg daily, and trazodone (for insomnia)150 mg daily. A 1/21/26 BIMS assessment indicated he was unable to complete the interview. A 1/20/26 behavior service plan indicated that factors/interventions would be identified to prevent/minimize inappropriate behaviors. Interventions included notifying the psychiatric nurse practitioner (4/16/26) and the resident was unable to follow directions (1/20/26). A 1/21/26 wandering risk assessment indicated he was at a moderate risk for wandering. An incident note, dated 6/26/26 at 9:33 p.m., indicated a QMA requested assistance in Resident B's room. Resident C was observed on the floor with a hospice nurse providing first aid to several lacerations to			

	Resident C's head as his face and head were covered in blood and he was actively bleeding. The hospice nurse had a towel over the areas on his head, and he had several bruises on both arms. He was alert and oriented to self, according to his baseline. He responded verbally to the hospice nurse, and he was unable to explain what had happened. From interviews with staff and the hospice nurse, it appeared that Resident B was on the floor on his back and Resident C was on top of him. The hospice nurse and a CNA removed the foot pedal from Resident B's hands and removed Resident C from the top of Resident B and provided first aid to his head. Two ambulances were called and both residents were transferred to the emergency room. A nurses note, dated 6/26/26 at 11:12 p.m., indicated the emergency room reported that Resident B was admitted to the hospital. On 6/26/26 at 6:10 p.m., a hospice provider entered Resident B's apartment to find Resident B and Resident C on the floor. Resident B was hitting Resident C with a foot pedal from his wheelchair. Resident B had skin tears to his hands and hip. Resident C was bleeding from his head. Resident B was			

	evaluated by a local hospital emergency room physician and psychiatric provider and released back to the facility. He was placed on 30-minute checks for 48 hours. Resident C was admitted to a local hospital for a skull fracture and released to a rehabilitation facility for therapy. During an interview, on 7/6/26 at 11:47 a.m., Resident C's family member indicated that Resident C could not walk at this time. He had been in the hospital for four to five days, and he was currently in a rehabilitation facility. He sustained seven lacerations to his head, with two of the lacerations requiring staples. There were no fractures. He had bruising to the right side of his face and arms. During an interview, on 7/6/26 at 12:19 p.m., QMA 21 indicated Resident B's demeanor was okay until someone came within five feet of his female friend at the facility, who he thought was his wife. He would yell and smack at the residents to go away. Sometimes, he was easily redirectable. They tried to keep residents away from him, especially those residents who aggravated him. They kept his door closed so no one went into his room. It seemed they had a whole unit of residents who wandered. Resident C was			

	pleasantly confused, and QMA 21 could not see him being aggressive unless Resident B upset him. During an interview, on 7/6/26 at 12:33 p.m., CNA 44 indicated she arrived at work a little early on 6/26/26, and someone yelled "Come here and call an ambulance!" Resident B was on the floor in his room with a wheelchair foot pedal in his hand that he would not let go of and the hospice nurse was holding onto Resident C. Resident B and Resident C had a few previous altercations. Resident B targeted Resident C. Resident B would get aggressive if anyone came near his female friend in the unit. Resident C wandered and was not cognitively present. He tried to fix things. He was fixated on chairs and picking things up from the floor. During an interview, on 7/6/26 at 2:25 p.m., Housekeeper 2 indicated she had previously separated Resident B and Resident C during an altercation. Resident B was sitting in his wheelchair, and Resident C was standing over him and they were fist fighting. The staff were so busy and tried to keep an eye on the residents, they did the best they could. During an interview with the			

	interim DON present, on 7/7/26 at 9:23 a.m., the Administrator indicated Resident B could be aggressive towards people. There was an incident where someone touched the table, and he did not like people in his space. Resident C was a "sweetheart." He picked things up from the floor and wandered. During an interview, on 7/7/26 at 1:54 p.m., QMA 12 indicated Resident B was very difficult and felt that he was more alert and oriented than he "put on." He had numerous incidents of physical aggression, several sexually-toned instances, and he had "creative language." Resident C had progressed in the dementia disease process, had tunnel vision, and was not aggressive. He was a "textbook dementia resident. " He accepted redirection well, and wandered, picking garbage from the floor. Resident B would get mad due to Resident C being "fidgety," or if Resident C would try to fix a table leg. Resident B "sun downed" and they had to be vigilant when he was out and about on the unit. During an interview, on 7/7/26 at 2:54 p.m., CNA 9 indicated she witnessed Resident B smack Resident C with a fork and told her that he hated Resident C. Resident B was friendly with everyone else, but not with			

	Resident C. Resident C was not aggressive and wandered a lot. Interventions included talking and walking with the residents, and after a couple of laps around the unit, they were usually okay. A current facility policy, revised 9/28/23 and titled "Abuse & Neglect Reporting Policy," provided by the Administrator on 7/8/26 at 11:24 a.m., indicated the following: "Policy Statement...Experience Senior Living (ESL) strives to provide a safe environment for all residents...Resident-to-resident incidents...The community shall identify opportunities for intervention for residents involved, as applicable. Interventions shall be documented within resident's electronic medical record...." This citation relates to Intake 470495.			
R 0117	Personnel - Deficiency 410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on	R 0117	The community's Director of Health and Wellness contacted the community's house pharmacy on July 6, 2026 to ensure update of the practice to only accepting pre-filled narcotic medications, refusing pre-filled multi-dose narcotic medications. The community's Director of Health and Wellness, or their designee will complete a med	08/27/2026

	skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review, the facility failed to ensure staff received training and orientation to prevent medication errors when a narcotic medication was not administered according to physicians orders for 1 of 3 residents reviewed for medication errors. (Resident F) This deficient practice resulted in Resident F experiencing an overdose requiring hospitalization when he experienced difficulty breathing. Findings include: Resident F's clinical record was		cart audit to identify any non pre-filled narcotic medications and contact the provider for corrections by 08/05/2026. The community's Director of Health and Wellness, or their designee, shall complete an in-service to the community's Medication Management policy with the community's current Qualified Medication Aides and Licensed Practical Nurses has been initiated on 07/09/2026 and will be completed 08/05/2026. Qualified Medication Aides and Licensed Practical Nurses who do not complete this in-service by 08/05/2026 shall be removed from the community's work schedule until training has been completed satisfactorily. An Inservice Attendance Log shall be used as evidence of completion of such training and shall be maintained with the community's training files. New community Qualified Medication Aides and Licensed Practical Nurses shall be oriented to the community's Medication Management Policy during their new hire onboarding and be verified by a skills check to each specific med assignments by our Director of Health and Wellness, or their designee. The community's Director of Health and Wellness, or their designee, shall complete an in-service on the community's Controlled Medication Policy	

	reviewed on 7/7/26 at 8:53 a.m. Medication orders included methadone (narcotic to treat pain) concentrate 8.5 milliliter (ml) (85 milligram (mg)) daily for chronic pain. A move-in facility care evaluation and service plan, dated 6/14/26, indicated he was oriented to person, place, time, and situation. He was able to communicate needs, ideas, and/or wishes. A medication management service plan, dated 6/20/26, indicated he required assistance for medication administration, ordering of medications, communication with pharmacy, and lab appointments. A nurse's note, dated 7/5/26 at 2:20 p.m., indicated a CNA reported she thought something was going on with Resident F due to him falling asleep at the table while eating breakfast. Staff tried to awaken him to check his vital signs but he did not respond. His vital signs were within normal range; however, his oxygen level ranged from 43% to 83% and was unstable. His lips were purple and his hands were becoming discolored. He snored loudly with his head tilted backward. A sternum rub was performed with no response, and he was breathing. No code status was found for him. 911 was called,		with the community's current Qualified Medication Aides and Licensed Practical Nurses no later than 08/15/2026. Qualified Medication Aides and Licensed Practical Nurses who do not complete this in-service by 08/15/2026 shall be removed from the community's work schedule until training has been completed satisfactorily. An Inservice Attendance Log shall be used as evidence of completion of such training and shall be maintained with the community's training files. New community Qualified Medication Aides and Licensed Practical Nurses shall be oriented to the community's Controlled Medication Policy during their New Hire Onboarding. The community's Director of Health and Wellness, or their designee, shall complete an in-service on the community's Medication Program Audit Policy with the community's current Qualified Medication Aides and Licensed Practical Nurses no later than 08/15/2026. Qualified Medication Aides and Licensed Practical Nurses who do not complete this in-service by 08/15/2026 shall be removed from the community's work schedule until training has been completed satisfactorily. An Inservice Attendance Log shall be used as evidence of	

	and he was transferred to the hospital for an evaluation. A nurse's note, dated 7/5/26 at 3:53 p.m., indicated he was admitted into the Intensive Care Unit (ICU) at a local hospital for further evaluation. A nurses note, dated 7/6/26 at 11:19 a.m., indicated the local hospital reported the resident was alert, oriented, talkative, and consuming meals. He had some delay in answering questions. He attended therapy for strengthening and was no longer on an intravenous Narcan (a drug used to counteract the effects of narcotic drugs) drip. During an interview with the interim DON present, on 7/7/26 at 9:23 a.m., the Administrator indicated Resident F was in the hospital (due to an overdose of methadone). The facility leadership were unsure what dosage of methadone he had received. QMA 15 was coming to the facility to be interviewed. The interim DON indicated QMA 15 reported a medication error, and the new DON came into the facility to determine what occurred. They were not certain what dosage the resident had actually been given and that was why QMA 15 was coming in to complete an interview. During an interview, on 7/7/26 at		completion of such training and shall be maintained with the community's training files. New community Qualified Medication Aides and Licensed Practical Nurses shall be oriented to the community's Medication Program Audits Policy during their New Hire Onboarding. The community's Director of Health and Wellness, or their designee, shall complete an in-service on the community's Incident Reporting Policy with the community's current Qualified Medication Aides and Licensed Practical Nurses no later than 08/15/2026. Qualified Medication Aides and Licensed Practical Nurses who do not complete this in-service by 08/15/2026 shall be removed from the community's work schedule until training has been completed satisfactorily. An Inservice Attendance Log shall be used as evidence of completion of such training and shall be maintained with the community's training files. New community Qualified Medication Aides and Licensed Practical Nurses shall be oriented to the community's Incident Reporting Policy during their New Hire Onboarding. The community's Director of Health and Wellness, or their designee, shall complete an in-service on the QMA Role and	

	10:28 a.m., QMA 15 indicated she felt that she did not get the proper training at the facility. On 7/5/26, the day of a medication error affecting Resident F, it was her first time working day shift by herself on Medication Cart 1. QMA 15 looked at the electronic Medication Administration Record (eMAR) and thought she read an order for 85 ml of methadone and thought it was a lot of medication. QMA 24 indicated to QMA 15 that the resident was "an addict" so QMA 15 thought that was part of his treatment. QMA 24 double-checked the amount of medication with QMA 15, and they both signed the narcotic count sheet. QMA 15 thought the order was for 85 ml but the order was actually for 8.5 ml. She administered Resident F's medications to him at approximately 8:00 a.m. At approximately 8:20 a.m., staff noticed something was wrong with Resident F. QMA 15 checked the eMAR and realized she mistakenly gave Resident F 85 ml rather than 8.5 ml and immediately sent Resident F to the hospital. When preparing the methadone, she used a multidose bottle. There were single dose bottles available, but she had not seen them in the medication cart. She provided a written statement to the facility on 7/5/26 and they asked her to return to the		Scope of Practice with the community's current Qualified Medication Aides and Licensed Practical Nurses no later than 08/15/2026. Qualified Medication Aides and Licensed Practical Nurses who do not complete this in-service by 08/15/2026 shall be removed from the community's work schedule until training has been completed satisfactorily. An Inservice Attendance Log shall be used as evidence of completion of such training and shall be maintained with the community's training files. New community Qualified Medication Aides and Licensed Practical Nurses shall be oriented to the QMA Role and Scope of Practice during their New Hire Onboarding. The community's Director of Health and Wellness, or their designee, shall complete an in-service on Controlled Medication-delivery, documentation, administration and shift-to-shift Narcotic Count with the community's current Qualified Medication Aides and Licensed Practical Nurse no later than 08/15/2026. Qualified Medication Aides and Licensed Practical Nurses who do not complete this in-service by 08/15/2026 shall be removed from the community's work schedule until training has been completed satisfactorily. An	

	facility. During an interview, on 7/7/26 at 11:04 a.m., QMA 24 indicated, on 7/5/26, she was walking down the hall when a CNA asked her to check Resident F, as he could not be awakened. As she approached him in the dining room, he became limp and fell backward into his wheelchair. QMA 24 obtained his vital signs, and his blood pressure was normal, but his oxygen level fluctuated between 40% and 83%. She assisted in repositioning him upright in his wheelchair. Staff were unable to locate a code status for him, and his hands and lips were turning purple. QMA 15 asked what was going on and indicated that she didn't do anything wrong, then indicated she thought she may have given him too much medication. When administering methadone, two QMAs or a nurse were required to sign the narcotic count sheet. QMA 15 had already administered the methadone, but QMA 24 verified with QMA 15 that she filled the medication cup up to the 8.5 ml line or between the 8 ml and the 10 ml line, then QMA 24 signed the narcotic count sheet. The narcotic count sheet was blank, the date, time, amount given or the amount left in the bottle had not been documented. Resident F was the only resident on a		Inservice Attendance Log shall be used as evidence of completion of such training and shall be maintained with the community's training files. New community Qualified Medication Aides and Licensed Practical Nurses shall be oriented to Controlled Medication-delivery, documentation, administration and shift-to-shift Narcotic Count during their New Hire Onboarding. The community's Director of Health and Wellness, or their designee, shall complete QMA/Nurse Skills Checklist and be orientated to each assignment with the community's current Qualified Medication Aides and Licensed Practical Nurses to verify knowledge after training no later than 08/27/2026. Qualified Medication Aides and Licensed Practical Nurses who do not complete this in-service by 08/27//2026 shall be removed from the community's work schedule until training has been completed satisfactorily. An Inservice Attendance Log shall be used as evidence of completion of such training and shall be maintained with the community's training files. New community Qualified Medication Aides and Licensed Practical Nurses shall be oriented to QMA/Nurse Skills Checklist and be orientated to each	

	maintenance dose of methadone. During an observation of Medication Cart 1 and the medication room, accompanied by LPN 34 on 7/7/26 at 1:36 p.m., three single dose bottles of methadone for Resident F were in the narcotic box, and the narcotic count sheet reflected the amount of single dose bottles. In the medication room, LPN 34 retrieved the multidose methadone bottle from the refrigerator. The multidose bottle contained approximately 170 ml and the label indicated a quantity of 255 ml, filled on 6/25/26. The methadone multidose narcotic count sheet with the facility's logo was dated 7/5/26 at 11:00 p.m. with 170 ml remaining. LPN 34 indicated that she did not know where the original narcotic count sheet had gone. On 7/7/26 at 2:20 p.m., LPN 34 provided the original methadone multidose narcotic count sheet and indicated it had been in the DON's office. The narcotic count sheet with the pharmacy's logo, indicated 255 ml was received on 6/26/26 by QMA 55. On 7/5/26 at 7:30 a.m., 85 mg was documented as given and 170 ml remained with the initials of QMA 15 and QMA 24. On 7/8/26 at 11:08 a.m., the Administrator provided QMA		assignment during their New Hire Onboarding. The community's Director of Health and Wellness, or their designee, shall conduct at least 3 random weekly medication pass observations sampling across all shifts for current community residents for the next 2 weeks, followed by monthly observations for 3 months. Findings shall be reported to the community's Executive Director, and any non-compliance shall result in corrective action with the Qualified Medication Aide and/or Licensed Practical Nurse. If non-compliance continues during the specified observation time, continued observation shall occur weekly for an additional month, and monthly for an additional three months. The community's Director of Health and Wellness, or their designee, shall conduct random weekly narcotic log reviews and observation for the next 2 weeks, followed by monthly narcotic log reviews for 3 months. Findings shall be reported to the community's Executive Director, and any non-compliance shall result in corrective action with the Qualified Medication Aide and/or Licensed Practical Nurse. If non-compliance	

	15's Medication Assistant Skills Checklist. The checklist indicated the required skills were met, were signed by the observer, and dated 6/28/26. The checklist did not include QMA 15's signature. During an interview, on 7/8/26 at 1:28 p.m., the interim DON indicated QMA 15 was asked to come in to sign her skills checklist, but QMA 15 indicated she lived too far away to come into the facility to sign it. A current facility policy, revised 8/11/23, titled "Medication Management," provided by the Administrator, on 7/8/26 at 11:24 a.m., indicated the following: "Guideline Interpretation and Implementation...3. Staff assisting with or administering medications will follow the 7 rights of medication administration to include: right resident, right dose, right drug, right route, right time, right reason, right documentation...." This citation relates to Intake 470617.		continues during the specified observation time, continued observation shall occur weekly for an additional month, and monthly for an additional three months.	

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 SIGNATURELorena Glover	TITLEESL Executive Director	(X6) DATE07/27/2026