STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELLENIC SENIOR LIVING OF MISHAWAKA	1540 SOUTH LOGAN STREET, MISHAWAKA, , 46544

(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 IN00449170, IN00451454 & IN00452967. Complaint IN00449170 - No deficiencies related to the allegations are cited. Complaint IN00451454 - No deficiencies related to the allegations are cited. Complaint IN00452967 - No deficiencies related to the allegations are cited. Survey dates: March 17, 18 and 19, 2025. Facility number: 014224 Census Bed Type: Residential: 112 Census Payor Type:	R 0000		

	Medicaid: 102 Other: 10 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review completed on 3/25/2025			
R 0144	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(a) (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation and interview, the facility failed to maintain a clean environment on 3 of 3 floors. (Floors 1, 2 and 3) Findings include: During an observation of the facility on 3/17/2025 at 2:50 P.M. the following was noted: On the first floor: -Room 112 the door was scuffed with black marks. -Room 108 the door and wall aroung the door were very scuffed up and dirty.	R 0144	1. Corrections from previous time frames cannot be made. No residents were affected by this alleged deficient practice. 2. All residents could have been affected, however in this case no residents were affected. 3. Resident doors have been cleaned/re-painted for 112, 209, 233, 243, 311, 312, 321, 325, 329, 330 and 333. Wall around 108 has been repaired and re-painted. Stained carpet has been shampooed outside of rooms 116, 117 and 127. Debris and dead bugs were removed throughout the hallway of 229-236.	04/30/2025

	-The carpet outside rooms 116, 117 and 127 was stained. On the second floor: -Debris and dead bugs were noted in light fixtures throughout the hallway from rooms 229-236. -Rooms 209, 233 and 243, the doors were dirty. On the third floor: -The doors to rooms 311, 312, 321, 325, 329, 330, and 333 were very dirty and scuffed. During an interview on 3/19/2025 at 9:02 A.M. the Maintenance Director indicated he needed corporate approval to paint the doors. He indicated they cleaned and painted resident rooms when a resident moved out, but there was no routine maintenance schedule for cleaning or painting room doors. He indicated there was no facility policy related to building maintenance. Based on observation and interview, the facility failed to maintain a clean environment on 3 of 3 floors. (Floors 1, 2 and 3) Findings include:		4. Maintenance Director/Designee will monitor for cleanliness during rounds daily 5 times per week. Any areas found to be deficient will logged on our work ticket system and corrected promptly. This will continue on-going.	

	During an observation of the facility on 3/17/2025 at 2:50 P.M. the following was noted: On the first floor: -Room 112 the door was scuffed with black marks. -Room 108 the door and wall aroung the door were very scuffed up and dirty. -The carpet outside rooms 116, 117 and 127 was stained. On the second floor: -Debris and dead bugs were noted in light fixtures throughout the hallway from rooms 229-236. -Rooms 209, 233 and 243, the doors were dirty. On the third floor: -The doors to rooms 311, 312, 321, 325, 329, 330, and 333 were very dirty and scuffed. During an interview on 3/19/2025 at 9:02 A.M. the Maintenance Director indicated he needed corporate approval to paint the doors. He indicated they cleaned and painted resident rooms when a resident moved out, but there was no routine maintenance schedule for cleaning or painting room doors. He indicated there was no facility policy related to			

	building maintenance.			
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. Based on record review and interview the facility failed to obtain semi-annual weights for 2 of 7 residents reviewed for weights. (Residents 5 and C) Findings include: 1. During a record review, completed on 3/18/2025 at 10:00 A.M., Resident 5's record lacked a semi-annual weight that should have been	R 0216	1.Corrections from previous time frames cannot be made. No residents were affected by this alleged deficient practice. 2. All residents could have been affected, however in this case no residents were affected. 3. Sited residents without semi-annual weights have been obtained and recorded in PCC. - Monthly vital sign and weights will be completed the second week of each month (Tuesday's) via health clinic. - Room to room vital signs/weights for those who missed the clinic, will be obtained on Wednesday through Friday. 4) DON/Designee will monitor PCC charting to ensure the Vital signs and weights are obtained and entered into PCC during the second week of each month	04/30/2025

	completed in October of 2024.The last weight was completed in April 2024. 2. During a record review, completed on 3/17/2025 at 2:15 P.M.,Resident C's record lacked a semi-annual weight that should have been done in October of 2024. During an interview on 3/19/2025 at 10:24 A.M., the DON indicated the facility had a monthly vital sign fair and the residents were expected to attend so staff could record weights and vital signs. If a resident did not attend, staff did not seek them out to ensure their weight or vital signs were obtained. The DON indicated the facility did not have a policy specifically for obtaining resident weights every six months. Based on record review and interview the facility failed to obtain semi-annual weights for 2 of 7 residents reviewed for weights. (Residents 5 and C) Findings include: 1. During a record review, completed on 3/18/2025 at 10:00 A.M., Resident 5's record lacked a semi-annual weight that should have been completed in October of 2024.The last weight was completed in April 2024.		on-going	

	2. During a record review, completed on 3/17/2025 at 2:15 P.M.,Resident C's record lacked a semi-annual weight that should have been done in October of 2024. During an interview on 3/19/2025 at 10:24 A.M., the DON indicated the facility had a monthly vital sign fair and the residents were expected to attend so staff could record weights and vital signs. If a resident did not attend, staff did not seek them out to ensure their weight or vital signs were obtained. The DON indicated the facility did not have a policy specifically for obtaining resident weights every six months.			
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 and interview, the facility failed to maintain sanitary conditions in the kitchen. This had the potential to affect 112 of 112 residents who consumed food prepared in the kitchen.	R 0273	1. Corrections from previous timeframes cannot be made. No resident were affected by this alleged deficient practice. 2. All residents could have been affected, however in this case, no residents were affected. 3. For the kitchen observation, the following are the measure that have been implemented to correct any deficiencies. a.) The walk in cooler thermometer has been replaced. b.) The boxes of food stored in the walk in freezer floor has been	04/30/2025

	Findings include: During an observation of the kitchen on 3/17/2025 at 9:55 A.M. with Cook 4, the following was noted: -The thermometer instide the walk-in cooler was broken. The outside temperature indicated the cooler was 36 degrees Fahrenheit. -The walk-in freezer had opened and closed boxes of food stored on the floor. During an observation of the kitchen on 3/18/2025 at 9:10 A.M. with the Culinary Director (CD), the following was noted: -The thermometer had not been replaced inside the walk-in cooler. -The walk-in freezer still had opened and closed boxes of food on the floor. -The daily temperature logs for the walk-in cooler, freezer and the reach-in cooler were incomplete for the month of March. During an interview on 3/18/2025 at 9:25 A.M., the CD indicated the blanks in incomplete temperature logs were mostly for weekend days. In addition, the CD indicated the thermometer should have been replaced in the walk-in cooler		discarded. c.) Temperature logs have been replaced and are completed to date. Staff was rein-serviced on proper storage of food, temperature logs 7 days per week. 4. Culinary Director/Designee will check/monitor storage and temperature logs daily 5 times per week for one month, weekly for one month, bi-monthly for one month and then monthly thereafter to ensure proper documentation and storage. Broken or misplaced thermometers will replaced immediately on-going.	

	immediately and boxes of food should not have been be stored on the floor. An undated policy titled "Dry Food Storage Policy and Procedure" was provided on 3/18/2025 at 11:45 A.M. by the CD. The policy indicated, "...Containers of food shall be stored a minimum of six inches above the floor...." A policy for maintaining temperature logs was not provided before the exit. Based on observation and interview, the facility failed to maintain sanitary conditions in the kitchen. This had the potential to affect 112 of 112 residents who consumed food prepared in the kitchen. Findings include: During an observation of the kitchen on 3/17/2025 at 9:55 A.M. with Cook 4, the following was noted: -The thermometer instide the walk-in cooler was broken. The outside temperature indicated the cooler was 36 degrees Fahrenheit. -The walk-in freezer had opened and closed boxes of food stored on the floor. During an observation of the kitchen on 3/18/2025 at 9:10 A.M. with the Culinary Director			

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R 0379	Mental Health Screening - Deficiency	R 0379		04/30/2025

	410 IAC 16.2-5-11.1(c) (c) If a person is a recipient of Medicaid or federal SSI and has a major mental illness as defined by the individual needs assessment, the person will be referred to the mental health service provider for a consultation on needed treatment services. All residents who participate in Medicaid or SSI admitted after April 1, 1997, shall have a completed individual needs assessment in their clinical record. All persons admitted after April 1, 1997, shall have the assessment completed prior to the admission, and, if a mental health center consultation is needed, the consultation shall be completed prior to the admission and a copy maintained in the clinical record. 2. A a record review was completed on 3/17/2025 at 2:05 P.M. for Resident B. Diagnoses included but were not limited to major depressive disorder. A Brief Interview for Mental Status assessment indicated the resident had moderate cognitive impairment. There was no documentation Resident B had a mental health screening and needs assessment completed by a mental health services provider. During an interview on 3/19/2025 at 11:02 A.M., the DON indicated the resident did not have a mental health services provider.		1. Corrections from previous time frames cannot be made. No residents were affected by this alleged deficient practice. 1. All residents could have been affected, however in this case no residents were affected. 3.Completing a thorough audit of all current residents in building to determine residents that have major mental illness as defined by their individual needs assessment and ensure mental health screening has been completed. Mental health assessments are being completed perprotocol to ensure mental health services are met. The Service Plan Coordinator has been educated in this process. 4.DON/Designee will audit service plans quarterly after completion for any	

	During an interview on 3/19/2025 at 11:02 A.M., the DON indicated the faciity did not have a specific policy regarding provding mental health services for residents with major mental health diagnosis. Based on observation, interview and record review, the facility failed to ensure a mental health screening and assessment was completed for 2 of 5 residents reviewed for mental health needs. (Resident 2 & B) Finding includes: 1. A record review was completed on 3/18/2025 at 2 P.M., for Resident 2. Diagnoses included, but were not limited to: major depressive disorder and anxiety disorder. There was no doumentation located in the electronic or paper medical record which indiated Resident 2 had a mental health screening and needs assessment, from any mental health service provider, completed. During an interview on 3/19/2025 at 9:32 A.M., the DON indicated the Nurse Practitioner that came to the building would have suggested wether a resident needed to see mental health services. She indicated Resident 2 had his own PCP in the community that he visited. She indicated the facility probably should have		residents with major psych diagnosis for six months and on-going	

	offered him mental health screening. 2. A a record review was completed on 3/17/2025 at 2:05 P.M. for Resident B. Diagnoses included but were not limited to major depressive disorder. A Brief Interview for Mental Status assessment indicated the resident had moderate cognitive impairment. There was no documentation Resident B had a mental health screening and needs assessment completed by a mental health services provider. During an interview on 3/19/2025 at 11:02 A.M., the DON indicated the resident did not have a mental health services provider. During an interview on 3/19/2025 at 11:02 A.M., the DON indicated the faciity did not have a specific policy regarding provding mental health services for residents with major mental health diagnosis. Based on observation, interview and record review, the facility failed to ensure a mental health screening and assessment was completed for 2 of 5 residents reviewed for mental health needs. (Resident 2 & B)			

Finding includes:

1. A record review was completed on 3/18/2025 at 2 P.M., for Resident 2. Diagnoses included, but were not limited to: major depressive disorder and anxiety disorder. There was no doumentation located in the electronic or paper medical record which indiated Resident 2 had a mental health screening and needs assessment, from any mental health service provider, completed.

During an interview on 3/19/2025 at 9:32 A.M., the DON indicated the Nurse Practitioner that came to the building would have suggested wether a resident needed to see mental health services. She indicated Resident 2 had his own PCP in the community that he visited. She indicated the facility probably should have offered him mental health screening.

2. A a record review was completed on 3/17/2025 at 2:05 P.M. for Resident B. Diagnoses included but were not limited to major depressive disorder. A Brief Interview for Mental Status assessment indicated the resident had moderate cognitive impairment.

There was no documentation Resident B had a mental health

screening and needs assessment completed by a mental health services provider.

During an interview on 3/19/2025 at 11:02 A.M., the DON indicated the resident did not have a mental health services provider.

During an interview on 3/19/2025 at 11:02 A.M., the DON indicated the faciity did not have a specific policy regarding provding mental health services for residents with major mental health diagnosis.

Based on observation, interview and record review, the facility failed to ensure a mental health screening and assessment was completed for 2 of 5 residents reviewed for mental health needs. (Resident 2 & B)

Finding includes:

1. A record review was completed on 3/18/2025 at 2 P.M., for Resident 2. Diagnoses included, but were not limited to: major depressive disorder and anxiety disorder. There was no doumentation located in the electronic or paper medical record which indiated Resident 2 had a mental health screening and needs assessment, from any mental health service provider, completed.

During an interview on 3/19/2025 at 9:32 A.M., the

DON indicated the Nurse Practitioner that came to the building would have suggested wether a resident needed to see mental health services. She indicated Resident 2 had his own PCP in the community that he visited. She indicated the facility probably should have offered him mental health screening.

2. A a record review was completed on 3/17/2025 at 2:05 P.M. for Resident B. Diagnoses included but were not limited to major depressive disorder. A Brief Interview for Mental Status assessment indicated the resident had moderate cognitive impairment.

There was no documentation Resident B had a mental health screening and needs assessment completed by a mental health services provider.

During an interview on 3/19/2025 at 11:02 A.M., the DON indicated the resident did not have a mental health services provider.

During an interview on 3/19/2025 at 11:02 A.M., the DON indicated the faciity did not have a specific policy regarding provding mental health services for residents with major mental health diagnosis.

	Based on observation, interview and record review, the facility failed to ensure a mental health screening and assessment was completed for 2 of 5 residents reviewed for mental health needs. (Resident 2 & B) Finding includes: 1. A record review was completed on 3/18/2025 at 2 P.M., for Resident 2. Diagnoses included, but were not limited to: major depressive disorder and anxiety disorder. There was no doumentation located in the electronic or paper medical record which indiated Resident 2 had a mental health screening and needs assessment, from any mental health service provider, completed. During an interview on 3/19/2025 at 9:32 A.M., the DON indicated the Nurse Practitioner that came to the building would have suggested wether a resident needed to see mental health services. She indicated Resident 2 had his own PCP in the community that he visited. She indicated the facility probably should have offered him mental health screening.			
R 0383	Mental Health Screening - Deficiency	R 0383	1. Corrections from previous time frames cannot be made.	04/30/2025

	410 IAC 16.2-5-11.1(g)(1-2) (g) The residential care facility, in cooperation with the mental health service providers, shall develop the comprehensive careplan for the resident that includes the following: (1) Psychosocial rehabilitation services that are to be provided within the community. (2) A comprehensive range of activities to meet multiple levels of need, including the following: (A) Recreational and socialization activities. (B) Social skills. (C) Training, occupational, and work programs. (D) Opportunities for progression into less restrictive and more independent living arrangements. Based on observation, interview and record review, the facility failed to ensure a care plan was developed in cooperation with a mental health provider for 2 out of 5 resident reviewed for mental health needs. (Resident 2 & B) Finding includes: 1. A record review was completed on 3/18/2025 at 2 P.M., for Resident 2. Diagnoses included, but were not limited to: major depressive disorder, and anxiety disorder. There was no		No residents were affected by this alleged deficient practice. 2 All residents could have been affected, however in this case no residents were affected. 3. Completing a thorough audit of all current residents in building to determine residents that have major mental illness as defined by their individual needs assessment and ensure mental health care plans are developed in cooperation with a mental health provider for mental health needs. Mental health care plans are being completed per protocol to ensure mental health services are met. The service plan coordinator has been educated in this process. 4.DON/Designee will audit care plans quarterly after completion for any residents with major psych diagnosis for six months and ongoing.	

	plan of care reagarding mental health needs on the service plan for Resident 2, which was completed on 12/31/2024. During an interview on 3/19/2025 at 9:32 A.M., the DON indicated that Resident 2 did not have a care plan for mental health in his service plan and did not have a mental health service provider. 2. A a reecord review was completed on 3/17/2025 at 2:05 P.M. for Resident B. Diagnoses included but were not limited to major depressive disorder. A Brief Interview for Mental Status assessment indicated the resident had moderate cognitive impairment. A review of the service plan indicated there was not a comprehensive care plan developed in cooperation with a mental health service provider that addressed Resident B's major depressive disorder or anxiety diagnosis. During an interview on 3/19/2025 at 11:02 A.M., the DON indicated the resident did not have mental health services or a mental health care plan.			

During an interview on 3/19/2025 at 11:02 A.M., the DON indicated the facility did not have a specific policy regarding mental health services or care plans.

Based on observation, interview and record review, the facility failed to ensure a care plan was developed in cooperation with a mental health provider for 2 out of 5 resident reviewed for mental health needs. (Resident 2 & B)

Finding includes:

1. A record review was completed on 3/18/2025 at 2 P.M., for Resident 2. Diagnoses included, but were not limited to: major depressive disorder, and anxiety disorder. There was no plan of care reagarding mental health needs on the service plan for Resident 2, which was completed on 12/31/2024.

During an interview on 3/19/2025 at 9:32 A.M., the DON indicated that Resident 2 did not have a care plan for mental health in his service plan and did not have a mental health service provider.

2. A a reecord review was completed on 3/17/2025 at 2:05 P.M. for Resident B. Diagnoses included but were not limited to major depressive disorder. A Brief Interview for Mental Status assessment indicated the

resident had moderate cognitive impairment.

A review of the service plan indicated there was not a comprehensive care plan developed in cooperation with a mental health service provider that addressed Resident B's major depressive disorder or anxiety diagnosis.

During an interview on 3/19/2025 at 11:02 A.M., the DON indicated the resident did not have mental health services or a mental health care plan.

During an interview on 3/19/2025 at 11:02 A.M., the DON indicated the facility did not have a specific policy regarding mental health services or care plans.

Based on observation, interview and record review, the facility failed to ensure a care plan was developed in cooperation with a mental health provider for 2 out of 5 resident reviewed for mental health needs. (Resident 2 & B)

Finding includes:

1. A record review was completed on 3/18/2025 at 2 P.M., for Resident 2. Diagnoses included, but were not limited to: major depressive disorder, and anxiety disorder. There was no plan of care reagarding mental health needs on the service

plan for Resident 2, which was completed on 12/31/2024.

During an interview on 3/19/2025 at 9:32 A.M., the DON indicated that Resident 2 did not have a care plan for mental health in his service plan and did not have a mental health service provider.

2. A a reecord review was completed on 3/17/2025 at 2:05 P.M. for Resident B. Diagnoses included but were not limited to major depressive disorder. A Brief Interview for Mental Status assessment indicated the resident had moderate cognitive impairment.

A review of the service plan indicated there was not a comprehensive care plan developed in cooperation with a mental health service provider that addressed Resident B's major depressive disorder or anxiety diagnosis.

During an interview on 3/19/2025 at 11:02 A.M., the DON indicated the resident did not have mental health services or a mental health care plan.

During an interview on 3/19/2025 at 11:02 A.M., the DON indicated the facility did not have a specific policy regarding mental health services or care plans.

Based on observation, interview

	and record review, the facility failed to ensure a care plan was developed in cooperation with a mental health provider for 2 out of 5 resident reviewed for mental health needs. (Resident 2 & B) Finding includes: 1. A record review was completed on 3/18/2025 at 2 P.M., for Resident 2. Diagnoses included, but were not limited to: major depressive disorder, and anxiety disorder. There was no plan of care reagarding mental health needs on the service plan for Resident 2, which was completed on 12/31/2024. During an interview on 3/19/2025 at 9:32 A.M., the DON indicated that Resident 2 did not have a care plan for mental health in his service plan and did not have a mental health service provider. 2. A a reecord review was completed on 3/17/2025 at 2:05 P.M. for Resident B. Diagnoses included but were not limited to major depressive disorder. A Brief Interview for Mental Status assessment indicated the resident had moderate cognitive impairment. A review of the service plan indicated there was not a comprehensive care plan developed in cooperation with a mental health service provider			

	that addressed Resident B's major depressive disorder or anxiety diagnosis. During an interview on 3/19/2025 at 11:02 A.M., the DON indicated the resident did not have mental health services or a mental health care plan. During an interview on 3/19/2025 at 11:02 A.M., the DON indicated the facility did not have a specific policy regarding mental health services or care plans.			
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 and interview, the staff failed to perform hand hygiene before and after the administration of eye drops and insulin per the standard of practice for 2 of 5 residents reviewed during medication administration. (Resident 6 & 7) Finding includes: 1. During an observation on 3/18/2025 at 10:09 A.M., QMA 3 administered dorzol/timol one drop to both eyes for Resident	R 0414	1. Corrections from previous time frames cannot be made. No residents were affected by this alleged deficient practice. 2. All residents could have been affected, however in this case no residents were affected. 3. The staff member has been reeducated on direct resident care hand hygiene before and after the administration of eye	04/30/2025

	7. She donned gloves and provided the drop to each eye. She removed the gloves and proceeded to sign off and prepare the next resident's medication. QMA 3 did not wash her hands after removing her gloves. During an interview on 3/18/2025 at 10:12 A.M., QMA 3 indicated that she should have washed her hands before and after administering the medication. 2. During an observation on 3/18/2025 at 11:45 A.M., QMA 3 prepared admelog 14 units via an insulin pen for Resident 6. She gathered the supplies, donned gloves and administered the medication, removed her gloves and signed off the medication. QMA 3 did not wash her hands after removing her gloves. During an interview on 3/18/2025 at 11:53 A.M., QMA 3 indicated she should have washed her hands before and after the administration of the insulin. On 3/18/2025 at 2:25 P.M., the DON provided a policy titled, "Insulin Administration QMA," dated 9/22/2022, and indicated the policy was the one currently used by the facility. The policy indicated "...Procedure: 11. Wash and dry hands thoroughly		drops and insulin administration. • All new employees will be educated during the New Employee Orientation and on-going on the importance of Hand Hygiene during medication administration. • Hand hygiene, eye drop, and insulin administration will be covered at all clinical staff in-service. • An all-clinical staff in-service will be held prior to April 30th, 2025 1. The DON/Designee will observe staff members daily x5 days/week for two months, daily x3 days/week for two months then daily x 1 day/week for two months on various shifts to ensure proper procedure of Handwashing is	

	or use alcohol-based hand rub. 12. Put on gloves. 18. Dispose of supplies. Remove gloves. Wash hands with soap and water or alcohol-based hand rub....." On 3/19/2025 at 10:30 A.M., the ED provided a policy titled, "Hand Hygiene," dated 9/30/2022, and indicated the policy was the one currently used by the facility. The policy indicated "...3. Staff must always wash their hands when assisting a resident, including: a) Before and after putting on disposable gloves. b) Before and after resident contact involving personal care. e) Before assisting a resident with medication. g) After hand contact with any body fluids. 5. The use of gloves does not replace handwashing or the use of alcohol-based hand sanitizer....." Based on observation and interview, the staff failed to perform hand hygiene before and after the administration of eye drops and insulin per the standard of practice for 2 of 5 residents reviewed during medication administration. (Resident 6 & 7) Finding includes: 1. During an observation on 3/18/2025 at 10:09 A.M., QMA 3 administered dorzol/timol one		followed in medication administration.	

drop to both eyes for Resident 7. She donned gloves and provided the drop to each eye. She removed the gloves and proceeded to sign off and prepare the next resident's medication. QMA 3 did not wash her hands after removing her gloves.

During an interview on 3/18/2025 at 10:12 A.M., QMA 3 indicated that she should have washed her hands before and after administering the medication.

2. During an observation on 3/18/2025 at 11:45 A.M., QMA 3 prepared admelog 14 units via an insulin pen for Resident 6. She gathered the supplies, donned gloves and administered the medication, removed her gloves and signed off the medication. QMA 3 did not wash her hands after removing her gloves.

During an interview on 3/18/2025 at 11:53 A.M., QMA 3 indicated she should have washed her hands before and after the administration of the insulin.

On 3/18/2025 at 2:25 P.M., the DON provided a policy titled, "Insulin Administration QMA," dated 9/22/2022, and indicated the policy was the one currently used by the facility. The policy indicated "...Procedure: 11.

	Wash and dry hands thoroughly or use alcohol-based hand rub. 12. Put on gloves. 18. Dispose of supplies. Remove gloves. Wash hands with soap and water or alcohol-based hand rub....." On 3/19/2025 at 10:30 A.M., the ED provided a policy titled, "Hand Hygiene," dated 9/30/2022, and indicated the policy was the one currently used by the facility. The policy indicated "...3. Staff must always wash their hands when assisting a resident, including: a) Before and after putting on disposable gloves. b) Before and after resident contact involving personal care. e) Before assisting a resident with medication. g) After hand contact with any body fluids. 5. The use of gloves does not replace handwashing or the use of alcohol-based hand sanitizer....."			

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