STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BIRCH OF MISHAWAKA	3630 HICKORY ROAD, MISHAWAKA, , 46545

(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. Survey dates: October 22, 23 and 24, 2025. Facility number: 014260 Residential Census: 104 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review completed on 11/7/2025	R 0000		
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	R 0144	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: **Immediate Correction:**	12/13/2025

	ensure the residential environment was free from carpet stains and damaged walls for 3 of 3 hallways observed. (1st floor hallway, 2nd floor hallway and 3rd floor hallway) Finding includes: During an initial facility tour, on 10/22/2025, beginning at 9:10 A.M. through 9:30 A.M., the following was observed on the first-floor hallway: - a dark gray stain in front of Room 131, approximately the size of a large pizza, - 2 areas with carpet removed, located near the South elevator, at the threshhold between the carpeted and non carpeted floor. The left side had missing carpet approximately 10 inches long by 2 inches wide and the right side had an area devoid of carpet approvimately 18 inches long by 2 inches wide, - a 2 feet by 2 feet round area of carpet with a dark gray stain directly in front of Room 141, - directly in front of Room 143, the carpet had a dark, gray stain twice as wide as the doorway, - the carpet had a discolored,dark gray stain, beginning from Room 145 until 2 feet before the door of Room 146 that extended to the middle		· The affected areas will be **cleaned and sanitized** professionally. · Any **tripping hazards or loose edges** were temporarily repaired or secured until full replacement could occur in December 2025. · Maintenance staff inspected all resident and common areas for similar concerns and documented findings. 2. How the facility will identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken: · The **Maintenance Director** completed a full **facility flooring and carpet condition assessment** to identify additional areas in need of repair or replacement. · A **preventative maintenance schedule** was established to include regular flooring inspections and prompt work orders for damage or	

	of the hallway. During an initial facility tour, on 10/22/2025, beginning at 9:30 A.M. through 9:50 A.M., the following was observed on the second-floor hallway: - a light black linear streak stain in the carpet, the streak began in front of Room 251 and was several feet in length, - several spots on the carpet, in front of Room 231, approximately the size of a ping pong ball, with black substance stuck to the carpet. During an initial facility tour, on 10/22/2025, beginning at 9:50 A.M. through 10:00 A.M., the following was observed on the third-floor hallway: - a cantaloupe-sized gray stain located between Room 306 and Room 308, on the carpeting in the hallway, - directly in front of Room 310, a large watermelon-sized dark gray stain on the carpet,		deterioration. · The facility established a **priority repair plan** for high-traffic and resident areas to ensure safety and appearance are consistently maintained. · **Housekeeping leadership** re-educated staff on proper carpet cleaning and stain-removal procedures to preserve flooring integrity. Flooring on second and third floors will be completely renovated in December 2025. First floor including all common areas (library, theatre, etc) will be professionally cleaned the first week of December of 2025. 3. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur. · The **Maintenance Director or designee** will conduct **weekly rounds for 30 days**, ensuring all flooring and carpeted areas remain in safe and sanitary condition. · After the initial 30 days, **monthly environmental rounds** will be completed and reviewed until	

	- a damaged and missing area of drywall with 3 baseball-sized holes near the floor, located between Room 310 and Room 312. In addition, there was a liner black stain with a large, black streak parallel to the floor and above the missing drywall, approximately 1 to 2 feet in length, - the carpeting outside the trash room was discolored and appeared heavily soiled , - the south lounge carpeting had gray stains ranging in size from quarter-sized to baseball-sized on the carpeting. During an interview, on 10/22/2025 at 10:20 A.M., the Maintenance/Environmental Services (EVS) Director indicated he had not scheduled routine carpet cleaning for the hallways because the facility had been scheduled to have the carpets replaced with hard floors but there was no scheduled date for the replacement . The Maintenance/EVS Director indicated the facility had purchased a new carpet cleaner upon his hire two months ago. During an interview, on 10/22/2025 at 3:45 P.M., the Director of Nursing (DON) indicated the facility was supposed to have all the carpets removed and flooring		compliance is sustained. · Any identified flooring issues will result in immediate corrective action and follow-up documentation. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: • Maintenance and Housekeeping staff are re-educated, regarding environmental standards per 410 IAC 16.2-5-1.4(e) and procedures for identifying and reporting flooring issues. Ongoing training will occur during new-hire orientation.	

changed to a hard floor but she was unable to locate documentation indicating when the replacement had been scheduled.

During an interview, on 10/22/2025 at 4:00 P.M. The Maintenance/EVS Manager indicated there had not been any carpet cleaning schedule prior to his hiring two months ago.

On 10/22/2025 at 2:20 P.M., the DON provided a policy titled, "Common Areas," dated 5/1/2018 and indicated the policy was the one currently used by the facility. The policy indicated " ...assures the highest standards of sanitation for resident apartments ...common areas are to receive the same attention to detail as resident apartments ...Other cleaning ...Spot clean carpets ..."

Based on observation and interview, the facility failed to ensure the residential environment was free from carpet stains and damaged walls for 3 of 3 hallways observed. (1st floor hallway, 2nd floor hallway and 3rd floor hallway)

Finding includes:

During an initial facility tour, on 10/22/2025, beginning at 9:10 A.M. through 9:30 A.M., the

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R 0145	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(b) (b) The facility shall maintain equipment and supplies in a safe and operational condition and in sufficient quantity to meet the needs of the residents. Based on observation and interview, the facility failed to maintain the walk-in freezer and walk-in refrigerator in good working order. This had the potential to affect 104 of 104 residents who consumed food prepared in the facility kitchen. Finding includes: During an observation on 10/22/2025 at 9:07 A.M., the walk-in freezer had a large amount of ice build up on the floor and on a box of frozen food that could not be identified due to the ice build up. The Culinary Manager (CM) indicated the ice build up was due to the door not sealing properly when it was closed because of a damaged gasket. The gasket on the door also had areas of black smears and black	R 0145	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: **Immediate Correction:** • The broken freezer seal was immediately replaced**.** • All ice and water were removed from the affected area, and the floor was cleaned**,** sanitized, and dried to eliminate slip hazards. • All food items stored in the affected freezer were inspected; any items with improper temperature exposure were discarded. • The Culinary Manager	12/13/2025

	spots. The CM indicated it was "probably mold." During an observation on 10/22/2025 at 9:12 A.M., the walk-in refrigerator's door gasket had areas of black dots. The CM indicated it was "probably mold." During an interview on 10/22/2025 at 9:12 A.M., the CM indicated the gasket for the walk-in freezer was going to be replaced and provided the invoice for the order. She also indicated the gaskets should have been clean and in good condition. On 10/23/2025 at 3:30 P.M., the CM indicated there was not a policy that specifically addressed the gaskets for the walk-in freezer and walk-in refrigerator. Based on observation and interview, the facility failed to maintain the walk-in freezer and walk-in refrigerator in good working order. This had the potential to affect 104 of 104 residents who consumed food prepared in the facility kitchen. Finding includes: During an observation on 10/22/2025 at 9:07 A.M., the walk-in freezer had a large amount of ice build up on the floor and on a box of frozen food that could not be identified		verified that the freezer was functioning at the correct temperature following repair. 2. How the facility will identify other residents who have the potential to be affected by the same deficient practice, and what corrective action will be taken: · A **preventative maintenance schedule** for all kitchen equipment, including freezers, refrigerators, and coolers, was reviewed and updated to ensure seals, gaskets, and temperature controls are routinely inspected. · A **Daily Temperature and Equipment Condition Log** was implemented for dietary staff to record freezer and refrigerator temperatures, as well as visual checks for damage or frost buildup.	

	due to the ice build up. The Culinary Manager (CM) indicated the ice build up was due to the door not sealing properly when it was closed because of a damaged gasket. The gasket on the door also had areas of black smears and black spots. The CM indicated it was "probably mold." During an observation on 10/22/2025 at 9:12 A.M., the walk-in refrigerator's door gasket had areas of black dots. The CM indicated it was "probably mold." During an interview on 10/22/2025 at 9:12 A.M., the CM indicated the gasket for the walk-in freezer was going to be replaced and provided the invoice for the order. She also indicated the gaskets should have been clean and in good condition. On 10/23/2025 at 3:30 P.M., the CM indicated there was not a policy that specifically addressed the gaskets for the walk-in freezer and walk-in refrigerator.		·Culinary staff were re-educated on the procedure for **reporting equipment issues immediately** to maintenance and the Culinary Manager. 3. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur. · The **Culinary Manager or designee** will complete **daily equipment inspections** for 30 days to ensure all food storage units are clean, sealed properly, and maintaining appropriate temperature. · After 30 days, inspections will continue **weekly for three months**, or until 100% compliance is sustained. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: · All **Culinary and**	

			maintenance staff are re-educated 410 IAC 16.2-5-5.1(e) equipment maintenance requirements Proper food storage and temperature monitoring Reporting processes for damaged or malfunctioning kitchen equipment · This education will be included in **new employee orientation** for dietary and maintenance staff moving forward.	
R 0241	Health Services - Offense 410 IAC 16.2-5-4(e)(1) (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on observation, record	R 0241	. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: **Immediate Correction:** The discontinued medication was **immediately removed** from the resident’s	12/13/2025

	review and interview, the facility failed to ensure a resident received only physician-ordered medications for 1 of 5 residents reviewed for medication administration. Finding includes: During an observation of the medication pass, on 10/24/2025 at 9:05 A.M., the Qualified Medication Aide (QMA) 2 administered Spironolactone (a diuretic) 25 mg (milligrams) 1 tablet to Resident 9. The clinical record of Resident 9 was reviewed on 10/24/2025 at 10:30 A.M. The resident's diagnoses included, but were not limited to: hypertension, depression, anxiety, chronic obstructive pulmonary disease, atrial fibrillation and malignant neoplasm of breast. The October 2025 Medication Administration Record (MAR) indicated the Spironolactone 25 mg had been discontinued on 10/21/2025. During an interview, on 10/24/2025 at 11:30 A.M., the Director of Nursing (DON) indicated the facility's process to discontinue a medication was staff would have first faxed the physician order to the pharmacy. The DON indicated the pharmacy would have changed the order in the Electronic Medical Record		medication supply. The **resident's physician was notified** promptly of the error. The QMA involved received **immediate re-education** on verifying active orders prior to administration. 2. How the facility will identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken : An audit was completed for all residents on cycle fill medication to ensure no discontinued medications were present in most recent cycle fill packets 3. What measures will be put into place or what systemic changes the facility will make to	

	(EMR). The DON indicated Resident 9's MAR would have had a red flag if the medication had been discontinued. The DON indicated the facility staff should have pulled the discontinued Spironolactone from the pre-packaged pouch. The DON indicated the administering staff should have known which pill to remove from the pre-packaged pouch because each pre-packaged pill pouch contained a brief description of each pill's physical descriptionl. The rolls of pre-packaged medications were sent by the pharmacy every two weeks. During an interview, on 10/24/2025 at 1:20 P.M., an (name of pharmacy utilized by the facility) pharmacy technician indicated the process to discontinue a medication was, first, the pharmacy would have received the discontinuation order from the physician or facility. The pharmacy technician indicated the pharmacy would have discontinued the medication in the EMR. The pharmacy technician indicated they did not send a new roll of pre-packaged pills to the facility when a physician order changed or discontinued a resident's medication. On 10/24/2025 at 11:39 A.M., the Director of Nursing (DON)		ensure that the deficient practice does not recur; The **Medication Administration Core Practices** was reviewed with all licensed nurses and QMAs emphasizing: Verification of current orders prior to each administration. Immediate removal of discontinued medications upon receipt of discontinuation orders. Documentation of discontinuation confirmation in PCC. The **pharmacy communication practice** was reviewed with Extended Living Pharmacy to ensure all discontinued orders are promptly updated and reflected in packaging.	

	provided a policy titled, "Core Process: Medication Administration," dated 1/2024 and indicated the policy was the one currently used by the facility. The policy indicated, " ...it is the duty and responsibility of all applicable team members to adhere to the Rights of Medication Administration without exception. The Rights of Medication Administration include ...Right Medication ...Verify that the medication to be administered matches the MAR ..." Based on observation, record review and interview, the facility failed to ensure a resident received only physician-ordered medications for 1 of 5 residents reviewed for medication administration. Finding includes: During an observation of the medication pass, on 10/24/2025 at 9:05 A.M., the Qualified Medication Aide (QMA) 2 administered Spironolactone (a diuretic) 25 mg (milligrams) 1 tablet to Resident 9. The clinical record of Resident 9 was reviewed on 10/24/2025 at 10:30 A.M. The resident's diagnoses included, but were not limited to: hypertension, depression, anxiety, chronic obstructive pulmonary disease, atrial fibrillation and malignant		4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: · The **DON or designee** will perform **weekly random medication audits** for four consecutive weeks to ensure discontinued medications are properly removed and not available for administration. · After the initial four weeks, **monthly audits** will continue for three months with results being forwarded to QAPI committee for any further recommendations and/or resolution	

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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 store, prepare and serve food under sanitary conditions for 1 of 1 kitchen areas observed. These issues had the potential to affect 104 of 104 residents who consumed food from the kitchen and/or ate in the dining room. Findings include: During an observation of the kitchen, with the Culinary Manager (CM) on 10/22/2025 at 8:59 P.M., the following was noted: -a bag of breadcrumbs was not dated -6 packages of gelatin mix were not dated. -a large box of lasagna noodles was not dated. -2 bottles of white vinegar were not dated. -2 jars of beef base were not	R 0273	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: **Immediate Correction:** The identified unsanitary conditions were immediately corrected at the time of the survey. • All food-contact surfaces were cleaned and sanitized according to 410 IAC 7-24 guidelines. • Any improperly stored or uncovered food items were discarded. • Kitchen staff involved received verbal re-education on proper sanitation and food safety standards. 2. How the facility will identify other residents who have the potential to be affected by the	11/14/2025

	dated. -a box of Idaho instant potatoes was not dated. -4 cans of tomato soup were not dated. -several boxes of styrofoam containers were being stored on the floor. -the flour bin scoop was laying on top of the flour instide the bin - the lid to the flour bin was dirty with a brown colored dried matter During an interview on 10/22/2025 at 9:15 A.M. the CM indicated the flour bin lid should have been cleaned , the scoop should not have been stored in the bin, and food items should have been dated. On 10/23/2025 at 3:32 P.M. the CM provided a current, undated policy titled, "Dry Storage." The policy indicated, "...Label and date all storage containers or bins. Keep free of scoops...." and "...Clean and sanitize the outside of food bins daily...." Based on observation and interview, the facility failed to store, prepare and serve food under sanitary conditions for 1 of 1 kitchen areas observed. These issues had the potential to affect 104 of 104 residents who consumed food from the		same deficient practice and what corrective action will be taken : · The **Culinary Manager** reviewed the community's Core Practices with all dietary staff. · A **daily kitchen sanitation checklist** was implemented to ensure all food preparation and storage areas meet state and local standards. · The **maintenance department** inspected and corrected any environmental concerns (e.g., flooring, shelving, refrigeration gaskets, or storage conditions) contributing to the deficiency. · All **Culinary staff** were re-educated on: Proper food storage temperatures Cleanliness of food preparation areas and equipment Cross-contamination prevention 3. What measures will be put into place or what	

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R 0304	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(e) (e) Medicine or treatment cabinets or rooms shall be appropriately locked at all times except when authorized personnel are present. All Schedule II drugs administered by the facility shall be kept in individual containers under double lock and stored in a substantially constructed box, cabinet, or mobile drug storage unit. Based on observation and interview, the facility failed to ensure the medication cart was locked when not in use for 1 of 3 medication carts reviewed. Finding includes: During an observation, on 10/24/2025 at 8:38 A.M., Qualified Medication Aide	R 0304	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: **Immediate Correction:** · The medication cart was **immediately secured and locked** at the time of discovery. Computer screen was closed.	12/13/2025

	(QMA) 3 left the medication cart unlocked with a laptop opened to resident information when she entered Room 139. She shut the aparment door for Room 139 and left the medication cart in the hallway out of view. During an interview, on 10/24/2025 at 8:38 A.M., QMA 3 indicated she should have locked the unattended cart and closed the facility laptop when she had walked away from the medication cart. On 10/24/2025 at 11:39 A.M., the Director of Nursing (DON) provided a policy titled, "Core Process: Medication Administration," dated 1/2024 and indicated the policy was the one currently used by the facility. The policy indicated, "Keys (apartments, medication drawers, etc.) laptops ...and other devices shall be accounted for at all times by a team member ...Do not place medications in pockets and/or any unauthorized location ..." Based on observation and interview, the facility failed to ensure the medication cart was locked when not in use for 1 of 3 medication carts reviewed. Finding includes: During an observation, on 10/24/2025 at 8:38 A.M., Qualified Medication Aide		· The nurse responsible was **re-educated** on medication security policy & HIPPA compliance 2. How the facility will identify other residents who have the potential to be affected by the same deficient practice, and what corrective action will be taken: · All medication storage areas were inspected by the **Director of Nursing** to ensure proper security and locking mechanisms were functioning 3. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur. All nurses and QMAs were re-educated regarding: • Core practice on	

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R 0383	Mental Health Screening - Deficiency 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:	R 0383	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:	12/13/2025

	(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 record review and interview the facility failed to develop a care plan in coordination with a mental health provider for 1 of 5 residents reviewed for mental health care. (Resident 4) Finding includes: A record review for Resident 4 was completed on 10/22/2025 at 1:30 P.M. Diagnoses included, but were not limited to, major depressive disorder. The current Service Plan, dated 8/26/2025, did not address Resident 4's major depressive disorder. During an interview on 10/23/2025 at 1:35 P.M., the DON indicated Resident 4's		**Immediate Correction:**· Resident #4's **Service Plan has been updated** to include all identified **Major Mental Health Diagnoses**, appropriate interventions, and monitoring requirements. 2. How the facility will identify other residents who have the potential to be affected by the same deficient practice, and what corrective action will be taken: An audit has been initiated for all residents receiving mental health services, and Service Plans updated to reflect the residents current status 3. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur. • Nurses were re-educated, regarding:	

	care plan should have addressed her major depressive disorder. On 10/23/2025 at 2:40 P.M. the DON provided a current, undated policy titled, "Core Process: Service Plans." The policy indicated, "...For residents living with 'major mental illness:' The residential care facility, in cooperation with the mental health service providers, shall develop the comprehensive care plan for the resident...." Based on record review and interview the facility failed to develop a care plan in coordination with a mental health provider for 1 of 5 residents reviewed for mental health care. (Resident 4) Finding includes: A record review for Resident 4 was completed on 10/22/2025 at 1:30 P.M. Diagnoses included, but were not limited to, major depressive disorder. The current Service Plan, dated 8/26/2025, did not address Resident 4's major depressive disorder.		• Inclusion of all medical and mental health diagnoses in service plans • Appropriate behavioral and environmental interventions for residents with major mental health conditions • Documentation expectations and communication 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: DON/Designee will audit 3 service plans a week for 30 days, then 5 service plans monthly to ensure mental health services are present. Results will be forwarded to QAPI committee for any further recommendations and/or	

	During an interview on 10/23/2025 at 1:35 P.M., the DON indicated Resident 4's care plan should have addressed her major depressive disorder. On 10/23/2025 at 2:40 P.M. the DON provided a current, undated policy titled, "Core Process: Service Plans." The policy indicated, "...For residents living with 'major mental illness:' The residential care facility, in cooperation with the mental health service providers, shall develop the comprehensive care plan for the resident...."		resolution.	
R 0406	Infection Control - Offense 410 IAC 16.2-5-12(a) (a) The facility must establish and maintain an infection control practice designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of diseases and infection. Based on observation, interview and record review, the facility failed to ensure standard precautions (a set of infection control practices used in healthcare settings to prevent the transmission of diseases from both recognized and unrecognized sources) were implemented for 1 of 3 residents	R 0406	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: **Immediate Correction:** The resident had no negative outcome 2. How the facility will identify other residents who have the potential to be affected by the same deficient practice, and what	12/13/2025

observed for blood sugar monitoring. (Resident 10)

Finding includes:

During an observation, on 10/24/2025 at 8:38 A.M., Qualified Medication Aide (QMA) 3 entered Resident 10's apartment with a clean glucometer (a device used to measure how much blood glucose was present in the bloodstream at a given moment in time) already prepared with a blood glucose strip in place. QMA 3 stood by Resident 10's bed and utilized a lancet device to prick the reisdent's finger tip and obtained a drop of blood to access Resident 4's blood glucose level with the glucometer. QMA 3 performed these procedures without having applied gloves to her hands.

During an interview, on 10/24/2025 at 8:38 A.M., QMA 3 indicated she knew she should have worn gloves when she had assessed Resident 10's blood sugar.

On 10/22/2025 at 10:15 A.M., the Director of Nursing (DON) provided a policy titled, "Infection Prevention and Control Program," dated 9/15/2023 and indicated the policy was the one currently used by the facility. The policy indicated, " ...All employees are required to utilize Standard

corrective action will be taken:

The QMA
received immediate education on appropriate infection control practices when
checking blood sugars. 3. What measures will be put into place or what systemic
changes will the facility make to

ensure that the deficient practice does not recur.

Licensed Nurses and Insulin Certified QMA’s have been re-educated on core practices related to infection
prevention when taking a blood sugar.

4. How the corrective action(s) will be monitored to ensure the deficient practice will not

recur, i.e., what quality assurance program will be put into place:

	Precautions. Standard Precautions ...make use of common sense practices and personal protective equipment that protect healthcare providers from infection and prevent the spread of infection from one individual to another ...Use of personal protective equipment whenever there is an expectation of possible exposure to infectious material ..." Based on observation, interview and record review, the facility failed to ensure standard precautions (a set of infection control practices used in healthcare settings to prevent the transmission of diseases from both recognized and unrecognized sources) were implemented for 1 of 3 residents observed for blood sugar monitoring. (Resident 10) Finding includes: During an observation, on 10/24/2025 at 8:38 A.M., Qualified Medication Aide (QMA) 3 entered Resident 10's apartment with a clean glucometer (a device used to measure how much blood glucose was present in the bloodstream at a given moment in time) already prepared with a blood glucose strip in place. QMA 3 stood by Resident 10's bed and utilized a lancet device to prick the reisdent's finger tip		DON/Designee will complete weekly blood glucose monitoring audits Three times a week focusing on infection control for one month, then 5 monthly for 3 months.	

and obtained a drop of blood to access Resident 4's blood glucose level with the glucometer. QMA 3 performed these procedures without having applied gloves to her hands.

During an interview, on 10/24/2025 at 8:38 A.M., QMA 3 indicated she knew she should have worn gloves when she had assessed Resident 10's blood sugar.

On 10/22/2025 at 10:15 A.M., the Director of Nursing (DON) provided a policy titled, "Infection Prevention and Control Program," dated 9/15/2023 and indicated the policy was the one currently used by the facility. The policy indicated, " ...All employees are required to utilize Standard Precautions. Standard Precautions ...make use of common sense practices and personal protective equipment that protect healthcare providers from infection and prevent the spread of infection from one individual to another ...Use of personal protective equipment whenever there is an expectation of possible exposure to infectious material ..."

SIGNATURENicole Whalen		