STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE MEADOWS SENIOR ASSISTED LIVING	11570 E 126TH STREET, FISHERS, , 46037

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. This visit included the Investigation of Intake IN00463320. Intake IN00463320 - No deficiencies related to the allegations are cited. Survey dates: September 29 and 30, 2025 Facility number: 014910 Residential Census: 99 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on October 6, 2025.	R 0000	In lieu of revisit, the community would like to request a desk review	
R 0091	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(h)(1-4) (h) The facility shall establish and	R 0091	· What corrective action(s) will be accomplished for those residents found to have been affected by the	10/18/2025

	implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request. Based on interview and record review, the facility failed to ensure the policy was followed regarding following a resident's choice for advanced directives for 1 of 5 residents reviewed for resident rights. (Resident 224) Findings include: The clinical record for Resident 224 was reviewed on 9/30/25 at 10:55 a.m. The diagnoses included, but were not limited to, hypertension, chronic obstructive pulmonary disease, anxiety disorder, and chronic pain. The July 2025 medication administration record (MAR) indicated Resident 224's advanced directives were DNR (do not resuscitate) and do not hospitalize (DNH). An Indiana Physician Orders for		deficient practice; **Resident 224 is no longer a resident of the community** . How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; **All residents have the potential to be affected by this alleged deficient practice. The DON/designee will audit the advanced directives for each resident in the community to ensure accuracy. The DON/designee will ensure that all nursing personnel are trained/educated on where to find the advanced directives for each resident in the community.** . What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not	

	Scope of Treatment (POST) form, dated and signed by Resident 224, on 11/25/23, indicated "Do Not Attempt Resuscitation/DNR" and indicated Resident 224 was capable of making such decision. Resident 224's service plan, last revised 6/17/25, did not reflect advanced directives. A health status note, dated 8/3/25 at 12:54 p.m., indicated the following, "...On duty QMA [qualified medication aide] notify this writer regarding resident was found unresponsive laying down on the bed around 8:35 in the morning during morning med-pass...This writer and on duty QMA start giving CPR [cardiopulmonary resuscitation] and Call 911 and family at the same time. This writer find out resident's code status in was DNR, so we stop giving CPR. EMS [emergency medical services] team came and declare resident deceased sometimes [sic] at night time...." An interview conducted with the Clinical Director, on 9/30/25 at 2:30 p.m., indicated once a staff member started CPR, you would continue with CPR until EMS stated otherwise. The emergency binders must be kept up to date to reflect the residents' current code status.		recur; **All nursing staff were in-served by the DON/designee regarding where to find the advanced directives for each resident. Advanced directives binders have been placed at the nurses' stations and receptionist area for staff to use for reference.** . 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; and **The DON/designee will review the community's advanced directives policy with the nursing department once a month x 6 months to ensure compliance and report any findings to the executive director or designee. Any findings will be corrected immediately. Results will be reviewed at QA, and logged on the QA concern form.** · By what date the systemic	

	A policy entitled "Living Will/Advance Directives", undated, was provided by the Administrator on 9/30/25 at 12:05 p.m. The policy indicated the following, "...Advance Directives allows the resident to ask for no life saving measures without the need for a terminal diagnosis. The Living Will or Advance Directives will then be noted on the resident's assistance plan...." Based on interview and record review, the facility failed to ensure the policy was followed regarding following a resident's choice for advanced directives for 1 of 5 residents reviewed for resident rights. (Resident 224) Findings include: The clinical record for Resident 224 was reviewed on 9/30/25 at 10:55 a.m. The diagnoses included, but were not limited to, hypertension, chronic obstructive pulmonary disease, anxiety disorder, and chronic pain. The July 2025 medication administration record (MAR) indicated Resident 224's advanced directives were DNR (do not resuscitate) and do not hospitalize (DNH). An Indiana Physician Orders for Scope of Treatment (POST) form, dated and signed by Resident 224, on 11/25/23,		changes will be completed. **10/18/2025**	

	indicated "Do Not Attempt Resuscitation/DNR" and indicated Resident 224 was capable of making such decision. Resident 224's service plan, last revised 6/17/25, did not reflect advanced directives. A health status note, dated 8/3/25 at 12:54 p.m., indicated the following, "...On duty QMA [qualified medication aide] notify this writer regarding resident was found unresponsive laying down on the bed around 8:35 in the morning during morning med-pass...This writer and on duty QMA start giving CPR [cardiopulmonary resuscitation] and Call 911 and family at the same time. This writer find out resident's code status in was DNR, so we stop giving CPR. EMS [emergency medical services] team came and declare resident deceased sometimes [sic] at night time...." An interview conducted with the Clinical Director, on 9/30/25 at 2:30 p.m., indicated once a staff member started CPR, you would continue with CPR until EMS stated otherwise. The emergency binders must be kept up to date to reflect the residents' current code status. A policy entitled "Living Will/Advance Directives", undated, was provided by the			

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R 0214	Evaluation - Deficiency 410 IAC 16.2-5-2(a) (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on interview and record review, the facility failed to ensure a resident's service plan was updated/reviewed semi-annually for 1 of 5 residents records reviewed. (Resident 32) Findings include: The clinical record for Resident 32 was reviewed on 9/29/25 at 1:25 p.m. The resident's diagnoses included, but were not limited to, hypertension. Resident 32's service plan was	R 0214	. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **A new service plan was completed for Resident 32 by a licensed nurse before 10/18/25.** . How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;	10/18/2025

	provided by the Assistant Director of Nursing on 9/30/25 at 11:27 a.m. The service plan was signed and dated 9/6/24. During an interview with the Administrator on 9/30/25 12:46 p.m., she indicated she provided the most current service plan. The resident's service plan was overdue for an evaluation. Based on interview and record review, the facility failed to ensure a resident's service plan was updated/reviewed semi-annually for 1 of 5 residents records reviewed. (Resident 32) Findings include: The clinical record for Resident 32 was reviewed on 9/29/25 at 1:25 p.m. The resident's diagnoses included, but were not limited to, hypertension. Resident 32's service plan was provided by the Assistant Director of Nursing on 9/30/25 at 11:27 a.m. The service plan was signed and dated 9/6/24. During an interview with the Administrator on 9/30/25 12:46 p.m., she indicated she provided the most current service plan. The resident's service plan was overdue for an evaluation.		**All residents have the potential to be affected.** **An audit was completed for all current residents; no other residents were identified as being affected.** . What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; **Education was provided to the DON and ADON regarding the requirements for updating resident service plans quarterly and when a change of condition occurs** . 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; and **The DON/designee will complete monthly audits for the residents that are identified for a change in status/condition and for those identified as needing a**	

			quarterly assessment to ensure compliance x 6 months. any findings to the executive director or designee. Results will be reviewed at QA, and any violations will be addressed immediately. · By what date the systemic changes will be completed. **10/18/2025**	
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	R 0216	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **A reassessment for medication self-administration was completed by a licensed nurse to determine if resident 32 and 224 should continue to self-administer medication.** How the facility will identify other residents having the potential to be affected	10/18/2025

	documented in writing and kept in the facility. 2. The clinical record for Resident 224 was reviewed on 9/30/25 at 10:55 a.m. The diagnoses included, but were not limited to, hypertension, chronic obstructive pulmonary disease, anxiety disorder, and chronic pain. A medication self-administration safety screen, dated 11/24/21, indicated Resident 224 was able to self-administer medications unsupervised. This was not applicable to suppositories. A physician's order, dated 5/19/25, indicated the staff may leave medications at bedside after being set up by nursing staff. A service plan, last revised 6/17/25, indicated staff were to administer all scheduled medication and required daily supervision of medication. A level of care document, dated 7/15/25, indicated caregiver administration and/or observation of medications requiring judgement for necessity, dosage, and/or effect. This was "round the clock need". The July 2025 medication administration record (MAR) indicated the following		by the same deficient practice and what corrective action will be taken; **All residents have the potential to be affected by this alleged deficient practice. An audit was completed for all current residents that self-administer medication; no other residents were identified as being affected.** What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; **Education was provided to the DON regarding the requirements for residents that do self-medication administration and ensuring that a medication self-administration assessment is completed every 30 days for residents.** How the corrective action(s) will be monitored to ensure the deficient practice	

	medications were documented as "U-SA [unsupervised self-administration]": Albuterol inhaler every four hours, diclofenac sodium gel 1% to bilateral knees as needed, fluticasone propionate nasal spray twice daily, polyethylene glycol powder daily, and Trelegy inhaler daily. The following date(s) indicated a bisacodyl suppository was not administered by nursing staff due to Resident 224 self-administering such: 7/29/25, 7/26/25, 7/22/25, 7/21/25, 7/15/25, 7/14/25, and 7/1/25. There was no recent assessment to determine if Resident 224 was capable of self-administering inhalers, topical gel, nasal spray, and/or suppositories. The most recent self-administration assessment		will not recur, i.e., what quality assurance program will be put into place; and **The DON/designee will complete monthly audits x 6 months for the residents that are identified as able to self-administer medication. Those identified as needing a new assessment will be reassessed immediately to ensure compliance. Any findings will be reported to the executive director or designee. Results will be reviewed at QA, and any violations will be addressed immediately.** By what date the systemic changes will be completed. **10/18/2025**	

was completed on 11/24/21.

An interview conducted with the Clinical Director, on 9/30/25 at 2:30 p.m., indicated the self-administration assessments were expected to be conducted monthly along with having a physician's order for the resident to self-administer medications.

Based on interview and record review, the facility failed to ensure a resident was deemed appropriate and capable of self-administering medications for 2 of 7 records reviewed. (Resident 32 and Resident 224)

Findings include:

1. The clinical record for Resident 32 was reviewed on 9/29/25 at 1:25 p.m. The resident's diagnoses included, but were not limited to, hypertension.

A self-medication assessment, dated 4/24/25, indicated the resident can safely self-administer his medications.

A physician's order, dated 3/15/25, indicated Resident 32 was to self-administer 10-325 milligrams of hydrocodone-acetaminophen every four hours for pain.

A nursing progress note, dated 7/1/25, indicated "This writer went to check on resident [sic]

	was sitting down on the chair. This writer ask resident if he need help to take his medication. Resident deny and he have a empty bottle of medication on the floor. Res [resident] also have a used injections on the floor. Res stuff and medication all over the place..." A nursing progress note for Resident 32, dated 7/11/25 indicated, "Writer spoke with this resident by phone. He stated he was at [name of hospital] Reported that he had Rabdo as a diagnosis and tests are being ran. Stated that he will be discharging today. Stated that he does not want to come back to building because of the rules that he has tried to understand. He said he is trying to find another place to live but needs money. Writer explained that he has not followed our regs [regulations] or rules at all. Reminded resident of his behavior as he drinks walking around drunk many days each week. Drinking has been witnessed and when staff entered room after a fall staff saw liquor bottles in kitchenette area. Res often smells of booze. Slurred speech and loud voice as well. Res disrupts the assisted living environment and causes scenes in the building that makes the other residents uncomfortable. His behavior has gone on a long time with no			

	change despite warnings of consequences. Resident stated that he does not know what he does wrong. Writer explained that he is to keep his room free of garbage collected and free of loose food all over and on floor. Explained that he has been told that he cannot smoke in his room, yet staff found several cigarettes half smoked in room, and it was laying on papers which was a huge fire hazard. ED took pictures to remind res of his behavior. This res disregards fire safety after many reminders that he cannot smoke in the building especially when drunk. Many residents have witnessed his behavior over a period of months." A nursing progress note, dated 7/25/25, indicated "...Ambulance transfer to hospital after he informed staff that he self-overdosed on meds." A nursing progress note, dated 8/21/25, indicated "...The resident contacted the police department to report his fall. The police department then notified the facility staff. The CNA [certified nurse aide] who received the call informed the QMA [qualified medication aide], who in turn notified the writer about the resident fall near the lake. Resident could not explain what he was doing around the lake by that time of the night or what cause his fall. Upon arrival,			

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	chronic obstructive pulmonary disease, anxiety disorder, and chronic pain. A medication self-administration safety screen, dated 11/24/21, indicated Resident 224 was able to self-administer medications unsupervised. This was not applicable to suppositories. A physician's order, dated 5/19/25, indicated the staff may leave medications at bedside after being set up by nursing staff. A service plan, last revised 6/17/25, indicated staff were to administer all scheduled medication and required daily supervision of medication. A level of care document, dated 7/15/25, indicated caregiver administration and/or observation of medications requiring judgement for necessity, dosage, and/or effect. This was "round the clock need". The July 2025 medication administration record (MAR) indicated the following medications were documented as "U-SA [unsupervised self-administration]": Albuterol inhaler every four hours,			

	diclofenac sodium gel 1% to bilateral knees as needed, fluticasone propionate nasal spray twice daily, polyethylene glycol powder daily, and Trelegy inhaler daily. The following date(s) indicated a bisacodyl suppository was not administered by nursing staff due to Resident 224 self-administering such: 7/29/25, 7/26/25, 7/22/25, 7/21/25, 7/15/25, 7/14/25, and 7/1/25. There was no recent assessment to determine if Resident 224 was capable of self-administering inhalers, topical gel, nasal spray, and/or suppositories. The most recent self-administration assessment was completed on 11/24/21. An interview conducted with the Clinical Director, on 9/30/25 at 2:30 p.m., indicated the self-administration assessments			

were expected to be conducted monthly along with having a physician's order for the resident to self-administer medications.

Based on interview and record review, the facility failed to ensure a resident was deemed appropriate and capable of self-administering medications for 2 of 7 records reviewed. (Resident 32 and Resident 224)

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1. The clinical record for Resident 32 was reviewed on 9/29/25 at 1:25 p.m. The resident's diagnoses included, but were not limited to, hypertension.

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A physician's order, dated 3/15/25, indicated Resident 32 was to self-administer 10-325 milligrams of hydrocodone-acetaminophen every four hours for pain.

A nursing progress note, dated 7/1/25, indicated "This writer went to check on resident [sic] was sitting down on the chair. This writer ask resident if he need help to take his medication. Resident deny and he have a empty bottle of medication on the floor. Res

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	resident can safely self-administer his medications. A physician's order, dated 3/15/25, indicated Resident 32 was to self-administer 10-325 milligrams of hydrocodone-acetaminophen every four hours for pain. A nursing progress note, dated 7/1/25, indicated "This writer went to check on resident [sic] was sitting down on the chair. This writer ask resident if he need help to take his medication. Resident deny and he have a empty bottle of medication on the floor. Res [resident] also have a used injections on the floor. Res stuff and medication all over the place..." A nursing progress note for Resident 32, dated 7/11/25 indicated, "Writer spoke with this resident by phone. He stated he was at [name of hospital] Reported that he had Rabdo as a diagnosis and tests are being ran. Stated that he will be discharging today. Stated that he does not want to come back to building because of the rules that he has tried to understand. He said he is trying to find another place to live but needs money. Writer explained that he has not followed our regs [regulations] or rules at all. Reminded resident of his behavior as he drinks walking			

	around drunk many days each week. Drinking has been witnessed and when staff entered room after a fall staff saw liquor bottles in kitchenette area. Res often smells of booze. Slurred speech and loud voice as well. Res disrupts the assisted living environment and causes scenes in the building that makes the other residents uncomfortable. His behavior has gone on a long time with no change despite warnings of consequences. Resident stated that he does not know what he does wrong. Writer explained that he is to keep his room free of garbage collected and free of loose food all over and on floor. Explained that he has been told that he cannot smoke in his room, yet staff found several cigarettes half smoked in room, and it was laying on papers which was a huge fire hazard. ED took pictures to remind res of his behavior. This res disregards fire safety after many reminders that he cannot smoke in the building especially when drunk. Many residents have witnessed his behavior over a period of months." A nursing progress note, dated 7/25/25, indicated "...Ambulance transfer to hospital after he informed staff that he self-overdosed on meds." A nursing progress note, dated 8/21/25, indicated "...The			

	resident contacted the police department to report his fall. The police department then notified the facility staff. The CNA [certified nurse aide] who received the call informed the QMA [qualified medication aide], who in turn notified the writer about the resident fall near the lake. Resident could not explain what he was doing around the lake by that time of the night or what cause his fall. Upon arrival, the fire department was already on the scene. They assisted the resident off the ground and out of the lake area. The writer and the other QMA on duty then escorted him back to his room." A nursing progress note, dated 8/22/25, indicated "...This nurse went and assessed resident PT [patient] stated he wasn't himself and in connection with falls his condition is lethargic, mumbling slurred speech all vitals WNLs [within normal limits]. Sent the resident out 911 via ambulance..." A nursing note, dated 8/23/25, indicated "Called [name of hospital] to s/w [social worker] nurse in care of Resident. Nurse stated that [Resident 32] is back to his baseline. The hospital was concern resident may have taken to much warfarin. Informed the nurse that resident is self-medicated at this time." A nursing progress note, dated			

	9/16/25, indicated the resident had contacted the police reporting he was suicidal. The resident's clinical record did not include any self-medication assessments that were conducted after 4/24/25.			
R 0246	Health Services - Deficiency 410 IAC 16.2-5-4(e)(6) (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on observation, interview, and record review, the facility failed to obtain a nurse's authorization prior to the administration of an as needed (PRN) medication for 1 of 5 residents observed for medication administration. (Resident 35) Findings include: The clinical record for Resident 35 was reviewed on 9/30/25 at 10:40 a.m. The resident's	R 0246	· What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Resident 35** **was assessed by a licensed nurse and had no negative outcome related to this alleged deficient practice. The QMA involved was immediately re-educated on the requirement to** **obtain nurse authorization before administering any PRN medication.** · How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;	10/18/2025

	diagnoses included, but were not limited to, stroke. A physician's order, dated 8/19/25, indicated Resident 35 was to receive 4 milligrams of ondansetron/Zofran (medication for nausea) every 6 hours as needed. An observation was conducted of a medication administration for Resident 35 with Qualified Medication Aide (QMA) 1 on 9/30/25 at 9:35 a.m. Resident 35 had approached the medication cart requesting for her medications. At that time, QMA 1 was observed preparing Resident 35's medications at the medication cart. The resident had requested for an as needed Zofran. QMA 1 was observed pulling the Zofran from the medication cart and administered the medication to the resident. There was no observation of QMA 1 notifying the nurse to receive prior authorization to administer the as needed medication. An interview was conducted with Assistant Director of Nursing on 9/30/25 at 11:04 a.m. She indicated QMA 1 should receive prior authorization from a nurse to give an as needed medication. Based on observation, interview, and record review, the facility failed to obtain a nurse's		**All residents in the facility have the potential to be affected by this alleged deficient practice.** **Education was completed with all nursing personnel relating to the process for administrating PRN medication in accordance to the rules and regulations of Indiana state department of health.** · What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; **The DON/Designee in-serviced the nurses and QMA’s regarding the procedure for administrating PRN medication on 10/16/2025. The nurse must document in the progress notes that approval was granted to give the medication or nurse must sign off with the QMA on the Medication Administration record. Staff that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated.**	

	authorization prior to the administration of an as needed (PRN) medication for 1 of 5 residents observed for medication administration. (Resident 35) Findings include: The clinical record for Resident 35 was reviewed on 9/30/25 at 10:40 a.m. The resident's diagnoses included, but were not limited to, stroke. A physician's order, dated 8/19/25, indicated Resident 35 was to receive 4 milligrams of ondansetron/Zofran (medication for nausea) every 6 hours as needed. An observation was conducted of a medication administration for Resident 35 with Qualified Medication Aide (QMA) 1 on 9/30/25 at 9:35 a.m. Resident 35 had approached the medication cart requesting for her medications. At that time, QMA 1 was observed preparing Resident 35's medications at the medication cart. The resident had requested for an as needed Zofran. QMA 1 was observed pulling the Zofran from the medication cart and administered the medication to the resident. There was no observation of QMA 1 notifying the nurse to receive prior authorization to administer the as needed medication.		· 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; and **Director of nursing or designee will conduct weekly PRN medication audits for four weeks then monthly for three months to ensure compliance. Any non-compliance will result in immediate retraining and/or disciplinary action. Results of all audits will be discussed during monthly QA meetings to determine if further monitoring is required.** · By what date the systemic changes will be completed. 10/18/25	

	An interview was conducted with Assistant Director of Nursing on 9/30/25 at 11:04 a.m. She indicated QMA 1 should receive prior authorization from a nurse to give an as needed medication.			
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 ensure the dish machine temperatures were being monitored to ensure proper functioning and ensure proper food storage in the main kitchen and freezer. This had the potential to affect 99 of 99 residents who received food from the kitchen. (Facility) Findings include: An initial kitchen tour was conducted with the Culinary Director (CD) on 9/29/25 from 9:40 a.m. to 10:10 a.m. The oven was noted with three boxes containing cooking liners that were stacked on top of the oven. The CD indicated she had been in the process of	R 0273	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **A** **new dish machine has been for been ordered for the community. Kitchen and freezer** **areas were cleaned and reorganized to ensure proper food** **separation and labeling. No residents were identified as being adversely** **affected.** How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;	10/18/2025

	organizing items in the kitchen and believed she would place the box of liners underneath the counter space/food preparation area. One box had debris to the top of the box. In the cabinet space underneath the countertop, there was a box containing pears. The pears had brown spots and were indented. The CD indicated the pears, as a whole, would not be served to residents but utilized in a dessert such as a cobbler. The main freezer was observed to have six large bags containing ice that were placed on the floor of the freezer. The CD indicated the ice machine was broken and the bags of ice were meant for resident use until the ice machine was fixed. During the initial kitchen tour, the dish machine was observed. The CD indicated it was a low temperature dish machine. The was cycle was noted at 140 degrees Fahrenheit, and the rinse cycle was noted at 160 degrees Fahrenheit (F). The CD indicated an outside company came twice within the past two weeks and stated the machine was working okay for the time being, but a new machine was in the process of being ordered. The CD indicated they did not test the dish machine for sanitation since the outside provider deemed the machine was okay to use. The dish machine log, dated September		**All residents have the potential to be affected by improper sanitation or food storage. All dietary staff were re-educated on safe food storage and dishwashing temperature monitoring procedures.** What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; **As a measure of ongoing compliance, the dietary manager/designee will check the kitchen and freezer for safe food storage to ensure compliance. Any non-compliance identified will result in immediate re-education and corrective action.** 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; and	

	2025, indicated temperatures were recording ranging from 130 to 152 degrees F for 29 out of the 30 days of September 2025. There was no documentation of the chemical sanitation concentration for the dish machine. An invoice, dated 6/5/25, indicated the dish machine was not reaching proper temperature. The document indicated "Will quote customer new machine before ordering any repair parts...." A service report, dated 9/5/25, indicated the current dish machine was a high temperature dish machine. An interview was conducted with the CD on 9/30/25 at 3:35 p.m. She indicated she put a work order in for an outside company to come in, on 10/1/25, for the dish machine. The CD attempted to check the chemical sanitation with strips, but the strips did not work for the type of sanitation solution utilized. So, when the outside provider comes out to service the dish machine, the CD would obtain the right test strips for the dish machine. There was the intention to order a new dish machine, but the CD was unsure when that would occur. A policy entitled "Storage of Refrigerated and Dry Foods",		**The Dietary Manager/designee will review the dishwasher and food storage temperature logs daily for four weeks, then weekly for three months. The Administrator and Director of Nursing (DON) will review audit logs monthly in QA Committee meetings for six months. Any non-compliance identified will result in immediate re-education and corrective action.** By what date the systemic changes will be completed. **10/18/2025**	

	undated, was provided by the Administrator on 9/30/25 at 12:05 p.m. The policy indicated fresh fruits will be stored in refrigeration of 41 degrees Fahrenheit or lower. A policy entitled "Dish Machine Policy", undated, was provided by the Administrator on 9/30/25 at 12:05 p.m. The policy indicated high-temperature dish machines were to have operating temperatures of 150 degrees F and 165 degrees F for the wash cycle and 165 degrees F to 180 degrees F for the rinse cycle. Low-temperature dish machines were to reach at least 120 degrees F and use approved chemical sanitizers at manufacturer-recommended concentrations. The documentation should consist of daily sanitizer concentration tests and cycle temperatures on the dish machine log for each meal period. Based on observation and interview, the facility failed to ensure the dish machine temperatures were being monitored to ensure proper functioning and ensure proper food storage in the main kitchen and freezer. This had the potential to affect 99 of 99 residents who received food from the kitchen. (Facility)			

	Findings include: An initial kitchen tour was conducted with the Culinary Director (CD) on 9/29/25 from 9:40 a.m. to 10:10 a.m. The oven was noted with three boxes containing cooking liners that were stacked on top of the oven. The CD indicated she had been in the process of organizing items in the kitchen and believed she would place the box of liners underneath the counter space/food preparation area. One box had debris to the top of the box. In the cabinet space underneath the countertop, there was a box containing pears. The pears had brown spots and were indented. The CD indicated the pears, as a whole, would not be served to residents but utilized in a dessert such as a cobbler. The main freezer was observed to have six large bags containing ice that were placed on the floor of the freezer. The CD indicated the ice machine was broken and the bags of ice were meant for resident use until the ice machine was fixed. During the initial kitchen tour, the dish machine was observed. The CD indicated it was a low temperature dish machine. The was cycle was noted at 140 degrees Fahrenheit, and the rinse cycle was noted at 160 degrees Fahrenheit (F). The CD indicated an outside company			

	came twice within the past two weeks and stated the machine was working okay for the time being, but a new machine was in the process of being ordered. The CD indicated they did not test the dish machine for sanitation since the outside provider deemed the machine was okay to use. The dish machine log, dated September 2025, indicated temperatures were recording ranging from 130 to 152 degrees F for 29 out of the 30 days of September 2025. There was no documentation of the chemical sanitation concentration for the dish machine. An invoice, dated 6/5/25, indicated the dish machine was not reaching proper temperature. The document indicated "Will quote customer new machine before ordering any repair parts...." A service report, dated 9/5/25, indicated the current dish machine was a high temperature dish machine. An interview was conducted with the CD on 9/30/25 at 3:35 p.m. She indicated she put a work order in for an outside company to come in, on 10/1/25, for the dish machine. The CD attempted to check the chemical sanitation with strips, but the strips did not work for the type of sanitation solution			

	utilized. So, when the outside provider comes out to service the dish machine, the CD would obtain the right test strips for the dish machine. There was the intention to order a new dish machine, but the CD was unsure when that would occur. A policy entitled "Storage of Refrigerated and Dry Foods", undated, was provided by the Administrator on 9/30/25 at 12:05 p.m. The policy indicated fresh fruits will be stored in refrigeration of 41 degrees Fahrenheit or lower. A policy entitled "Dish Machine Policy", undated, was provided by the Administrator on 9/30/25 at 12:05 p.m. The policy indicated high-temperature dish machines were to have operating temperatures of 150 degrees F and 165 degrees F for the wash cycle and 165 degrees F to 180 degrees F for the rinse cycle. Low-temperature dish machines were to reach at least 120 degrees F and use approved chemical sanitizers at manufacturer-recommended concentrations. The documentation should consist of daily sanitizer concentration tests and cycle temperatures on the dish machine log for each meal period.			
R 0296	Pharmaceutical Services -	R 0296	What	10/18/2025

	Noncompliance 410 IAC 16.2-5-6(b) (b) The facility shall maintain clear written policies and procedures on medication assistance. The facility shall provide for ongoing training to ensure competence of medication staff. Based on observation, interview, and record review, the facility failed to notify a nurse that a resident's blood pressure medications would be held for 1 of 5 residents observed during medication administration. (Resident 34) Findings include: The clinical record for Resident 34 was reviewed on 9/30/25 at 10:15 a.m. The resident's diagnoses included, but were not limited to, hypertension. A physician's order, dated 6/5/24, indicated the resident was to receive 5 milligrams of amlodipine daily for hypertension. A physician's order, dated 1/26/24, indicated the resident was to receive 25 milligrams of metoprolol daily for hypertension. An observation was conducted of a medication administration for Resident 34 with Qualified Medication Aide (QMA) 1 on		corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Resident 34 did not experience any negative outcomes related to this alleged deficient practice.** How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; **All residents in the facility have the potential to be affected by this alleged deficient practice. Education was completed with all nursing personnel regarding the process for holding any medication for any resident.** What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; **As a measure of**	

	9/30/25 at 9:14 a.m. QMA 1 was observed at the medication cart. QMA 1 entered Resident 34's room and obtained the resident's blood pressure utilizing a blood pressure wrist cuff on her right wrist. The blood pressure reading was 94/64. She then utilized the resident's left wrist to obtain the resident's blood pressure. The blood pressure reading was 104/65. She then left the resident's room and went to the medication cart. After review of the physician's order, she stated the resident had parameters ordered to hold the 5 milligrams of amlodipine and 25 milligrams of metoprolol if the resident's systolic blood pressure (the top number of the blood pressure reading) was less than 110. After, she pulled the resident's medications and administered the resident's other medications and held the amlodipine and metoprolol. She notified the resident she would not be receiving her blood pressure medications due to her blood pressure being too low. There was no observation of QMA 1 notifying the nurse for clarification to hold the medications. Resident 34's clinical record did not have parameters to hold the metoprolol nor amlodipine medications if the resident's systolic blood pressure was less than 110.		**ongoing compliance, the DON/designee will review any medication being held for any resident to ensure compliance with documentation of proper notification to the nurse and physician. The nurse must document in the progress notes that consent was granted to hold the medication. Staff that fail to comply with the points of this in-service will be further educated and/or disciplined as indicated.** 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; and **DON/Designee will review any medication being held to ensure compliance five times a week x 4 weeks, then 3 times a week x 4 weeks, the once-a-week x 4 months.** **DON/Designee will check for a corresponding progress note. Any findings will be reported to the executive director/designee.** **Results will be reviewed at**	

	An interview was conducted with the Assistant Director of Nursing on 9/30/25 at 3:00 p.m. She indicated QMA 1 should have notified the nurse prior to holding the amlodipine and metoprolol. She was unable to locate any parameters to hold the medications. Based on observation, interview, and record review, the facility failed to notify a nurse that a resident's blood pressure medications would be held for 1 of 5 residents observed during medication administration. (Resident 34) Findings include: The clinical record for Resident 34 was reviewed on 9/30/25 at 10:15 a.m. The resident's diagnoses included, but were not limited to, hypertension. A physician's order, dated 6/5/24, indicated the resident was to receive 5 milligrams of amlodipine daily for hypertension. A physician's order, dated 1/26/24, indicated the resident was to receive 25 milligrams of metoprolol daily for hypertension. An observation was conducted of a medication administration for Resident 34 with Qualified Medication Aide (QMA) 1 on 9/30/25 at 9:14 a.m. QMA 1 was		**QA, and any violations will be addressed immediately.** By what date the systemic changes will be completed. **10/18/2025**	

	observed at the medication cart. QMA 1 entered Resident 34's room and obtained the resident's blood pressure utilizing a blood pressure wrist cuff on her right wrist. The blood pressure reading was 94/64. She then utilized the resident's left wrist to obtain the resident's blood pressure. The blood pressure reading was 104/65. She then left the resident's room and went to the medication cart. After review of the physician's order, she stated the resident had parameters ordered to hold the 5 milligrams of amlodipine and 25 milligrams of metoprolol if the resident's systolic blood pressure (the top number of the blood pressure reading) was less than 110. After, she pulled the resident's medications and administered the resident's other medications and held the amlodipine and metoprolol. She notified the resident she would not be receiving her blood pressure medications due to her blood pressure being too low. There was no observation of QMA 1 notifying the nurse for clarification to hold the medications. Resident 34's clinical record did not have parameters to hold the metoprolol nor amlodipine medications if the resident's systolic blood pressure was less than 110. An interview was conducted			

	with the Assistant Director of Nursing on 9/30/25 at 3:00 p.m. She indicated QMA 1 should have notified the nurse prior to holding the amlodipine and metoprolol. She was unable to locate any parameters to hold the medications.			
R 0298	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(2) (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. Based on interview and record review, the facility failed to timely follow-up with pharmacy	R 0298	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Resident C did not experience any negative outcomes related to this alleged deficient practice.** How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; **All residents in the facility have the potential to be affected by this alleged deficient practice. Education was completed with all nursing personnel regarding the process for clarifying physician orders with the**	10/18/2025

	for a medication delivery and to clarify orders for eye drops to be administered routine or as needed (PRN) for 1 of 5 residents' records reviewed. (Resident C) Findings include: The clinical record for Resident C was reviewed on 9/29/25 at 11:40 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease. A physician's order, dated 6/21/25, indicated the resident was to receive 50 milligrams primidone at bedtime. A physician's order, dated 1/26/24, indicated the resident was to receive Visine dry eyes every 8 hours as needed. The order was entered twice in the resident's medical record. A physician's order, dated 1/26/24, indicated the resident was to receive artificial eye drops every 8 hours as needed. The September 2025 Medication Administration Record (MAR) indicated the following days the 50 milligrams of primidone was not available to administer: 9/5/25, 9/6/25, 9/7/25, 9/8/25, 9/9/25, 9/11/25, 9/12/25, and 9/13/25. On 9/11/25, the record indicated a script was needed by the		**pharmacy.** What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; **As a measure of ongoing compliance, the DON/designee will review any new physician orders ensure compliance. Any physician orders that are found to be needing clarifying will be addressed immediately.** 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; and **The DON/Designee will audit physician orders for 5 residents a week x 4 weeks to ensure compliance, then 3 residents weekly x4 weeks. If the facility is in compliance at the end of the 6 months, the monitoring will be stopped. At the monthly QA**	

	pharmacy to fill the order. The September 2025 MAR indicated one order entered for the Visine dry eye drops was ordered as needed (PRN), but scheduled to be administered at 7:00 a.m., 12:00 p.m., and 4:00 p.m. The other order entered for the Visine dry eye drops was entered to be given PRN. The MAR included another order for artificial tears. The record indicated the staff was administering the eye drops scheduled three times a day and not PRN as ordered. The September 2025 pharmacy recommendation indicated "There are 3 orders for Visine on the MAR. All of them have directions which indicate 'prn'. 2 of these are prn and 1 is on the MAR as routine. Please delete all except for correct order." An interview was conducted with the Clinical Director on 9/30/25 at 2:10 p.m. She indicated the pharmacy handled all data entry of the physician's orders onto the residents' MARs. The facility staff cannot enter or delete orders on the MARs. It has to be handled through the pharmacy. The Visine eye drops were incorrectly entered in the system. She would call and clarify with the pharmacy. The staff should have been calling the pharmacy to address the		**meeting, the monitoring will be reviewed. Any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee.** By what date the systemic changes will be completed. **10/18/2025**	

unavailability of the primidone medication sooner. The medication did arrive to the facility on 9/13/25.

Based on interview and record review, the facility failed to timely follow-up with pharmacy for a medication delivery and to clarify orders for eye drops to be administered routine or as needed (PRN) for 1 of 5 residents' records reviewed. (Resident C)

Findings include:

The clinical record for Resident C was reviewed on 9/29/25 at 11:40 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease.

A physician's order, dated 6/21/25, indicated the resident was to receive 50 milligrams primidone at bedtime.

A physician's order, dated 1/26/24, indicated the resident was to receive Visine dry eyes every 8 hours as needed.

The order was entered twice in the resident's medical record.

A physician's order, dated 1/26/24, indicated the resident was to receive artificial eye drops every 8 hours as needed.

The September 2025 Medication Administration

	Record (MAR) indicated the following days the 50 milligrams of primidone was not available to administer: 9/5/25, 9/6/25, 9/7/25, 9/8/25, 9/9/25, 9/11/25, 9/12/25, and 9/13/25. On 9/11/25, the record indicated a script was needed by the pharmacy to fill the order. The September 2025 MAR indicated one order entered for the Visine dry eye drops was ordered as needed (PRN), but scheduled to be administered at 7:00 a.m., 12:00 p.m., and 4:00 p.m. The other order entered for the Visine dry eye drops was entered to be given PRN. The MAR included another order for artificial tears. The record indicated the staff was administering the eye drops scheduled three times a day and not PRN as ordered. The September 2025 pharmacy recommendation indicated "There are 3 orders for Visine on the MAR. All of them have directions which indicate 'prn'. 2 of these are prn and 1 is on the MAR as routine. Please delete all except for correct order." An interview was conducted with the Clinical Director on 9/30/25 at 2:10 p.m. She indicated the pharmacy handled all data entry of the physician's orders onto the residents' MARs. The facility staff cannot enter or delete orders on the			

	MARs. It has to be handled through the pharmacy. The Visine eye drops were incorrectly entered in the system. She would call and clarify with the pharmacy. The staff should have been calling the pharmacy to address the unavailability of the primidone medication sooner. The medication did arrive to the facility on 9/13/25.			
R 0414	Infection Control - Deficiency 410 IAC 16.2-5-12(k) (k) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Based on observation, interview, and record review, the facility failed to ensure hand hygiene was performed during medication administration for 5 of 5 residents observed during medication administration. (Residents' 28, 30, 34, 35 and 54) Findings include: 1. The clinical record for Resident 54 was reviewed on 9/30/25 at 10:00 a.m. The resident's diagnoses included, but were not limited to, heart failure and type 2 diabetes mellitus.	R 0414	1 Immediate corrective action taken: TheQMA observed that did not perform proper hand hygiene during medication administration was immediately re-educated on correct hand washing procedure and the facility’s policies regarding handwashing and infection control practices All medications administered to affected residents were reviewed; no adverse effects were identified. 2How other residents identified at risk- All residents were considered potentially at risk due to possible cross	10/18/2025

	An observation was conducted of medication administration for Resident 54 with Qualified Medication Aide (QMA) 1 on 9/30/25 at 8:29 a.m. QMA 1 was observed preparing and administering the resident's medications at the medication cart. During the medication administration, QMA 1 had not utilized hand hygiene prior to preparing the medication. She was observed touching elevator buttons, blood pressure wrist cuff, glucometer, supply room doors, baskets, computer mouse, medication cards, keys, and another resident's hands that had stopped at the medication cart. QMA 1 was observed donning on gloves and administering insulin to Resident 54. There was no hand hygiene prior to the administration of insulin. During that time, she was observed touching keys, the resident's door, the resident's arm, wrist and abdomen. After, QMA 1 doffed gloves and then utilized hand hygiene. 2. The clinical record for Resident 34 was reviewed on 9/30/25 at 10:15 a.m. The resident's diagnoses included, but were not limited to, hypertension. An observation was conducted of medication administration for Resident 34 with QMA 1 on 9/30/25 at 9:14 a.m. QMA 1 was		contamination during medication administration. Observations of medication administration practices for nursing staff were completed to ensure compliance with hand hygiene. Measures & systemic changes to ensure def does not recur All nurses and QMA's were educated on hand hygiene with emphasis on handwashing prior to preparing or administering medications, between residents, after glove removal, and after touching contaminated surfaces. New hires will receive this training during orientation and during annual infection control Inservices. Hand sanitizer dispensers were also checked and replenished in all med carts and nurses' stations. DON or designee will conduct hand hygiene observations during medication administration weekly x4 weeks, then monthly for 3 months to ensure sustained compliance.	

	observed preparing and administering the resident's medications. During that time, QMA 1 touched the computer mouse, medication cards, medication drawers, keys, door badge, medication cups, and blood pressure wrist cuff. QMA 1 obtained the resident's blood pressure utilizing the blood pressure cuff and administered the medications to the resident. There was no hand hygiene prior or after Resident 34's medication administration. 3. The clinical record for Resident 30 was reviewed on 9/30/25 at 10:25 a.m. The resident's diagnoses included, but were not limited to, kidney failure. An observation was conducted of a medication administration for Resident 30 with QMA 1 on 9/30/25 at 9:28 a.m. QMA 1 was observed at the medication cart preparing the resident's medications. QMA 1 had touched the computer mouse, medication cards, keys, medication drawers, narcotic box and medication cups. She then administered the medication to the resident. There was no observation of hand hygiene before or after the medication administration. 4. The clinical record for Resident 28 was reviewed on 9/30/25 at 10:30 a.m. The		Any identified instance of non-compliance will result in immediate retraining, and documentation of the retraining will be maintained in the employee's personnel file. All observation results will be reviewed monthly during QA meetings to identify trends, assess ongoing compliance, and determine whether continued monitoring or corrective measures are necessary.	

resident's diagnoses included, but were not limited to, type 2 diabetes mellitus and Parkinson's disease.

5. The clinical record for Resident 35 was reviewed on 9/30/25 at 10:40 a.m. The resident's diagnoses included, but were not limited to, stroke.

An observation was conducted of a medication administration for Resident 28 and Resident 35 with QMA 1 on 9/30/25 at 9:30 a.m. QMA 1 was observed entering the resident's room and obtaining Resident 28's blood pressure utilizing the blood pressure wrist cuff. She then donned on gloves and obtained the resident's blood sugar reading. After, she returned to the medication cart to prepare the resident's medications. During that time, Resident 35 had approached the medication cart requesting her medications. At that time, QMA 1 was observed preparing Resident 35's medications at the medication cart. After, she administered the medications to Resident 35. There was no observation of hand hygiene prior or after obtaining Resident 28's blood pressure and/or blood sugar reading. There was no observation of hand hygiene prior to preparing Resident 35's medications or after the administration. QMA 1 then prepared Resident 28's

medication at the medication cart. After, she administered Resident 28's medications. There was no observation of hand hygiene prior and/or after the administration of medications to Resident 28.

An interview was conducted with the Assistant Director of Nursing on 9/30/25 at 11:04 a.m. She indicated QMA 1 should have utilized hand hygiene in between residents.

An infection control policy was provided by Assistant Director of Nursing on 9/30/25 at 12:25 p.m. It indicated, "...Purpose. To prevent the spread of infections from one resident to another. To protect staff from infections...Handwashing is the most important method of infection control. Hands must be washed between direct contact with any residents..."

A Standard Precautions policy was provided by Assistant Director of Nursing on 9/30/25 at 12:25 p.m. It indicated, "...1. Hands must be washed between any task which has possibility of transferring bacteria from resident to resident..."

An injection medication administration procedures policy was provided by Assistant Director of Nursing on 9/30/25 at 12:25 p.m. It indicated, "...2.

Hands are to be washed before preparing injectable. 3. Gloves are to be used during administration...8. Gloves disposed of in a waste receptacle. 9. Hands are to be washed."

Based on observation, interview, and record review, the facility failed to ensure hand hygiene was performed during medication administration for 5 of 5 residents observed during medication administration. (Residents' 28, 30, 34, 35 and 54)

Findings include:

1. The clinical record for Resident 54 was reviewed on 9/30/25 at 10:00 a.m. The resident's diagnoses included, but were not limited to, heart failure and type 2 diabetes mellitus.

An observation was conducted of medication administration for Resident 54 with Qualified Medication Aide (QMA) 1 on 9/30/25 at 8:29 a.m. QMA 1 was observed preparing and administering the resident's medications at the medication cart. During the medication administration, QMA 1 had not utilized hand hygiene prior to preparing the medication. She was observed touching elevator buttons, blood pressure wrist cuff, glucometer, supply room

	doors, baskets, computer mouse, medication cards, keys, and another resident's hands that had stopped at the medication cart. QMA 1 was observed donning on gloves and administering insulin to Resident 54. There was no hand hygiene prior to the administration of insulin. During that time, she was observed touching keys, the resident's door, the resident's arm, wrist and abdomen. After, QMA 1 doffed gloves and then utilized hand hygiene. 2. The clinical record for Resident 34 was reviewed on 9/30/25 at 10:15 a.m. The resident's diagnoses included, but were not limited to, hypertension.			

	An observation was conducted of medication administration for Resident 34 with QMA 1 on 9/30/25 at 9:14 a.m. QMA 1 was observed preparing and administering the resident's medications. During that time, QMA 1 touched the computer mouse, medication cards, medication drawers, keys, door badge, medication cups, and blood pressure wrist cuff. QMA 1 obtained the resident's blood pressure utilizing the blood pressure cuff and administered the medications to the resident. There was no hand hygiene prior or after Resident 34's medication administration. 3. The clinical record for Resident 30 was reviewed on 9/30/25 at 10:25 a.m. The resident's diagnoses included, but were not limited to, kidney failure.			

An observation was conducted of a medication administration for Resident 30 with QMA 1 on 9/30/25 at 9:28 a.m. QMA 1 was observed at the medication cart preparing the resident's medications. QMA 1 had touched the computer mouse, medication cards, keys, medication drawers, narcotic box and medication cups. She then administered the medication to the resident. There was no observation of hand hygiene before or after the medication administration.

4. The clinical record for Resident 28 was reviewed on 9/30/25 at 10:30 a.m. The resident's diagnoses included, but were not limited to, type 2 diabetes mellitus and Parkinson's disease.

5. The clinical record for Resident 35 was reviewed on 9/30/25 at 10:40 a.m. The resident's diagnoses included, but were not limited to, stroke.

An observation was conducted of a medication administration for Resident 28 and Resident 35 with QMA 1 on 9/30/25 at 9:30 a.m. QMA 1 was observed entering the resident's room and obtaining Resident 28's blood pressure utilizing the blood pressure wrist cuff. She then donned on gloves and obtained the resident's blood sugar reading. After, she returned to

the medication cart to prepare the resident's medications. During that time, Resident 35 had approached the medication cart requesting her medications. At that time, QMA 1 was observed preparing Resident 35's medications at the medication cart. After, she administered the medications to Resident 35. There was no observation of hand hygiene prior or after obtaining Resident 28's blood pressure and/or blood sugar reading. There was no observation of hand hygiene prior to preparing Resident 35's medications or after the administration. QMA 1 then prepared Resident 28's medication at the medication cart. After, she administered Resident 28's medications. There was no observation of hand hygiene prior and/or after the administration of medications to Resident 28.

An interview was conducted with the Assistant Director of Nursing on 9/30/25 at 11:04 a.m. She indicated QMA 1 should have utilized hand hygiene in between residents.

An infection control policy was provided by Assistant Director of Nursing on 9/30/25 at 12:25 p.m. It indicated, "...Purpose. To prevent the spread of infections from one resident to another. To protect staff from infections...Handwashing is the

	most important method of infection control. Hands must be washed between direct contact with any residents..." A Standard Precautions policy was provided by Assistant Director of Nursing on 9/30/25 at 12:25 p.m. It indicated, "...1. Hands must be washed between any task which has possibility of transferring bacteria from resident to resident..." An injection medication administration procedures policy was provided by Assistant Director of Nursing on 9/30/25 at 12:25 p.m. It indicated, "...2. Hands are to be washed before preparing injectable. 3. Gloves are to be used during administration...8. Gloves disposed of in a waste receptacle. 9. Hands are to be washed."			

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 SIGNATUREGoodwell Chavunduka	TITLEExecutive Director	(X6) DATE10/18/2025