STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GLEN INDEPENDENT & ASSISTED LIVING COMMUNITY	5202 ST JOE ROAD, FORT WAYNE, , 46835

(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 6, 7 and 8, 2025 Facility number: 015503 Residential Census: 107 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed October 9, 2025	R 0000		
R 0048	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(r)(18-24) (18) Prior to any interfacility or involuntary intrafacility relocation, the facility shall prepare a relocation plan to prepare the resident for relocation and to provide continuity of care. In nonemergency relocations, the planning process shall include a relocation planning conference to	R 0048	Arbor Glen Independent & Assisted Living: 015503 10/8/2025 Annual Survey: Plan of Correction The following Plan of Correction	10/10/2025

	which the resident, his or her legal representative, family members, and physician shall be invited. The planning conference may be waived by the resident. (19) At the planning conference the resident ' s medical, psychosocial, and social needs with respect to the relocation shall be considered and a plan devised to meet these needs. (20) The facility shall provide reasonable assistance to the resident to carry out the relocation plan. (21) The facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. (22) If the relocation plan is disputed, a meeting shall be held prior to the relocation with the administrator or his or her designee, the resident, and the resident ' s legal representative. An interested family member, if known, shall be invited. The purpose of the meeting shall be to discuss possible alternatives to the proposed relocation plan. (23) A written report of the content of the discussion at the meeting and the results of the meeting shall be reviewed by: (A) the administrator or his or her designee; (B) the resident; (C) the resident ' s legal representative; and		is prepared and submitted by Arbor Glen Independent & Assisted Living Community, Fort Wayne, as mandated by the Indiana State Department of Health. However, this response does not constitute agreement with the allegations or citations specified on the Statement of Deficiencies. Arbor Glen Independent & Assisted Living Community, Fort Wayne maintains that the alleged deficiencies do not individually or collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by applicable regulations. We respectfully request a paper compliance for the following citations. R 048 Resident Rights Offense 410 IAC 16.2-5-1.2(r)(18-24) Residents' Rights - Deficiency (18) Prior to any interfacility or involuntary intra-facility relocation, the	

	(D) an interested family member, if known; each of whom may make written comments on the report. (24) The written report of the meeting shall be included in the resident ' s permanent record. Based on interview and record review, the facility failed to ensure discharge planning for 1 of 1 resident reviewed (Resident 40). Findings include: Resident 40's record was reviewed on 10/6/25 at 2:15 PM. Diagnoses included bipolar disorder, unspecified asthma, chronic pain disorder, cannabis dependence and history of methicillin resistant staph aureus (MRSA). A physician progress note, dated 5/29/25 at 4:42 PM, indicated Resident 40 was planning to move from the facility to a new apartment. Resident 40 had requested wound care plans related to discharge planning. A physician progress note, dated 6/5/25 at 5:00 PM, indicated Resident 40 was planning to move from the facility to a new apartment. Resident 40 had requested wound care plans related to discharge planning.		facility shall prepare a relocation plan to prepare the resident for relocation and to provide continuity of care. In nonemergency relocations, the planning process shall include a relocation planning conference to which the resident, his or her legal representative, family members, and physician shall be invited. The planning conference may be waived by the resident. (19) At the planning conference the resident ' s medical, psychosocial, and social needs with respect to the relocation shall be considered and a plan devised to meet these needs. (20) The facility shall provide reasonable assistance to the resident to carry out the relocation plan. (21) The facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. (22) If the relocation plan is disputed, a meeting shall be held prior to the relocation with the administrator or his or her designee, the resident, and the resident ' s legal representative. An interested family member, if known, shall be invited. The purpose of the meeting shall be to discuss	

	A physician order, dated 5/27/25, indicated Resident 40 was to be administered hydrophilic wound paste to boils twice daily. A physician order, dated 6/11/25, indicated Resident 40 could discharge to a facility of their choice. A progress note, dated 6/12/25 at 10:55 AM, indicated Resident 40's blood sugar had not been assessed due to the resident having moved out. There were no further notes related to discharge instructions or discharge planning. In an interview, on 10/8/25 at 11:08 AM, the Director of Nursing (DON) indicated Resident 40 had moved out of the facility without the staff's knowledge. The DON indicated they were not aware of where Resident 40 moved to. The DON indicated Resident 40 had been talking about moving to another facility, but there was no definite plan. The DON indicated the Resident 40 had not been provided with official discharge planning as the staff had been unaware the resident was leaving. In an interview, on 10/8/25 at 12:25 PM, the Administrator indicated Resident 40 was planning to move out of the facility. The Administrator		possible alternatives to the proposed relocation plan. (23) A written report of the content of the discussion at the meeting and the results of the meeting shall be reviewed by: (A) the administrator or his or her designee; (B) the resident; (C) the resident ' s legal representative; and (D) an interested family member, if known; each of whom may make written comments on the report. (24) The written report of the meeting shall be included in the resident ' s permanent record. This RULE is not met as evidenced by: Based on interview and record review, the facility failed to ensure discharge planning for 1 of 1 resident reviewed What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: 1 How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:	

	indicated the resident would not say where they were moving to. A current facility policy, dated 10/1/21, indicated in the event of a resident transfer or discharge, documents to ensure continuity of care would be provided by the facility. Based on interview and record review, the facility failed to ensure discharge planning for 1 of 1 resident reviewed (Resident 40). Findings include: Resident 40's record was reviewed on 10/6/25 at 2:15 PM. Diagnoses included bipolar disorder, unspecified asthma, chronic pain disorder, cannabis dependence and history of methicillin resistant staph aureus (MRSA). A physician progress note, dated 5/29/25 at 4:42 PM, indicated Resident 40 was planning to move from the facility to a new apartment. Resident 40 had requested wound care plans related to discharge planning.		This Resident chose to move out without notifying anyone until she was actually leaving the building. We were not told where she was going. Administrator did meet with this Resident several times, informally. She did not give any grievances/concerns, just wanted everything done for her not accepting the responses that were given. Typically, we are notified and we ensure that all residents are given the supports needed as they prepare to move and as they move. Our Team will be following the Regulation and policy set for the to ensure that there isn't any Resident effected negatively. Discharge planning is very important. 2 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: Administrator, DON and/or Nursing Manager will be monitoring Discharges, discharge planning, to	

	A physician progress note, dated 6/5/25 at 5:00 PM, indicated Resident 40 was planning to move from the facility to a new apartment. Resident 40 had requested wound care plans related to discharge planning. A physician order, dated 5/27/25, indicated Resident 40 was to be administered hydrophilic wound paste to boils twice daily. A physician order, dated 6/11/25, indicated Resident 40 could discharge to a facility of their choice. A progress note, dated 6/12/25 at 10:55 AM, indicated Resident 40's blood sugar had not been assessed due to the resident having moved out. There were no further notes related to discharge instructions or discharge planning. In an interview, on 10/8/25 at 11:08 AM, the Director of Nursing (DON) indicated Resident 40 had moved out of the facility without the staff's knowledge. The DON indicated they were not aware of where Resident 40 moved to. The DON indicated Resident 40 had been talking about moving to another facility, but there was no definite plan. The DON indicated the Resident 40 had not been provided with official		ensure that the Residents discharge is positive and successful as well as ensuring that all regulations are followed and our policy is also followed. 3 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: Administrator, DON and/or Nursing Manager will be monitoring Discharges, discharge planning: Audit form will be followed and completed bi-weekly for 2 months, 1 time per month for 2 months, then quarterly thereafter as an ongoing effort to ensure compliance. 4. Compliance date: 10/10/2025	

	discharge planning as the staff had been unaware the resident was leaving. In an interview, on 10/8/25 at 12:25 PM, the Administrator indicated Resident 40 was planning to move out of the facility. The Administrator indicated the resident would not say where they were moving to. A current facility policy, dated 10/1/21, indicated in the event of a resident transfer or discharge, documents to ensure continuity of care would be provided by the facility.			
R 0273	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(f) (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review the facility failed to ensure food items in the kitchen were labeled, dated, and discarded upon expiration. 107 of 107 residents were served food prepared in the facility kitchen. Findings include: In an observation, on 10/6/25 at	R 0273	Arbor Glen Independent & Assisted Living: 015503 10/8/2025 Annual Survey: Plan of Correction The following Plan of Correction is prepared and submitted by Arbor Glen Independent & Assisted Living Community, Fort Wayne, as mandated by the Indiana State Department of Health. However, this response does not constitute agreement with the allegations or citations specified on the Statement of Deficiencies. Arbor Glen Independent & Assisted Living Community, Fort Wayne maintains that the alleged	10/10/2025

	9:51 AM, a tray containing 30 cups of Jello was observed on a cart inside the walk-in cooler. No labels or dates were observed on the tray or any of the individual cups. Another tray on the cart contained 7 Styrofoam boxes dated 10/2/25. The boxes were not labeled. An unlabeled container of red and green food was observed on a shelf in the walk-in cooler. An opened bag of parsley was observed on the shelf in the walk-in cooler with a date of 9/25/25. In an interview, on 10/6/25 at 9:55 AM, the Dietary Manager (DM) indicated he did not know when the Jello cups were made. He indicated the Jello should have been labeled and dated so staff could be aware of when to discard it. The DM indicated the Styrofoam boxes in the walk-in cooler contained leftover desserts. He indicated the desserts should have been labeled and should have been discarded after 3 days. The DM indicated the unlabeled container held roasted peppers and should have been labeled and dated. He indicated the bag of parsley had expired and should have been discarded.		deficiencies do not individually or collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by applicable regulations. We respectfully request a paper compliance for the following citations. R273 410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (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. This RULE is not met as evidenced by: R 273 Based on observation, interview, and record review the facility failed to ensure food items in the kitchen were labeled, dated, and discarded upon expiration. 107 of 107 residents were served food prepared in the facility kitchen. Findings include: In an observation, on 10/6/25 at 9:51 AM, a tray containing 30 cups of Jello was observed on a cart inside the walk-in cooler. No labels or	

	In an observation, on 10/6/25 at 10:02 AM, an open plastic bag, unlabeled, undated containing pastel colored cereal rings was open to air. In an interview, on 10/6/25 at 10:03 AM, the DM indicated cereal bags should be labeled and dated. He indicated the bag should have been closed to prevent contamination. In an observation, on 10/6/25 at 10:04 AM, an opened, undated jar of grape jelly was observed in the reach in cooler. An unlabeled, undated Styrofoam container containing a piece of cake was observed in the reach in cooler. In an interview, on 10/6/25 at 10:07 AM, the DM indicated the box of cake should have been labeled and dated and the jelly jar should have been dated. A current policy, titled Labeling and Dating for Safe Storage of Food, dated 10/1/21, provided by the Administrator on 10/6/25 at 1:34 PM, indicated all food should be labeled with a receive date and use by date. The policy indicated leftover foods should be discarded after a few days.		dates were observed on the tray or any of the individual cups. Another tray on the cart contained 7 Styrofoam boxes dated 10/2/25. The boxes were not labeled. An unlabeled container of red and green food was observed on a shelf in the walk-in cooler. An opened bag of parsley was observed on the shelf in the walk-in cooler with a date of 9/25/25. In an interview, on 10/6/25 at 9:55 AM, the Dietary Manager (DM) indicated he did not know when the Jello cups were made. He indicated the Jello should have been labeled and dated so staff could be aware of when to discard it. The DM indicated the Styrofoam boxes in the walk-in cooler contained leftover desserts. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: All Cooks and Dietary Aids have been trained on proper label, dating and food prep/storage processes and procedures.	

	In an interview, on 10/8/25 at 11:57 AM, the Administrator indicated the facility policy's discarding guideline of "a few days" was defined as 3 days. A current policy titled Cold Storage and Dry Food Storage, dated 10/1/21, provided by the Administrator on 10/8/25 at 11:57 AM indicated food returned to storage after preparation should be covered. Based on observation, interview, and record review the facility failed to ensure food items in the kitchen were labeled, dated, and discarded upon expiration. 107 of 107 residents were served food prepared in the facility kitchen. Findings include: In an observation, on 10/6/25 at 9:51 AM, a tray containing 30 cups of Jello was observed on a cart inside the walk-in cooler. No labels or dates were observed on the tray or any of the individual cups. Another tray on the cart contained 7 Styrofoam boxes dated 10/2/25. The boxes were not labeled. An unlabeled container of red and green food was observed on a shelf in the walk-in cooler. An opened bag of parsley was observed on the shelf in the walk-in cooler with a date of 9/25/25. In an interview, on 10/6/25 at		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: Residents could be effected by this – the potential for bacteria to be on the items. All Dietary staff have been re-trained on label, dating and food prep/storage processes and procedures.	

	9:55 AM, the Dietary Manager (DM) indicated he did not know when the Jello cups were made. He indicated the Jello should have been labeled and dated so staff could be aware of when to discard it. The DM indicated the Styrofoam boxes in the walk-in cooler contained leftover desserts. He indicated the desserts should have been labeled and should have been discarded after 3 days. The DM indicated the unlabeled container held roasted peppers and should have been labeled and dated. He indicated the bag of parsley had expired and should have been discarded. In an observation, on 10/6/25 at 10:02 AM, an open plastic bag, unlabeled, undated containing pastel colored cereal rings was open to air. In an interview, on 10/6/25 at 10:03 AM, the DM indicated cereal bags should be labeled and dated. He indicated the bag should have been closed to prevent contamination. In an observation, on 10/6/25 at 10:04 AM, an opened, undated jar of grape jelly was observed in the reach in cooler. An unlabeled, undated Styrofoam container containing a piece of cake was observed in the reach in cooler. In an interview, on 10/6/25 at		What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; Administrator trained with 2 Dietary Director and Assistant Director who then trained with Cooks, Dietary aids & Servers about label/dating and food prep/storage processes and procedures. Both Dietary Manager & Assistant Manager are walking the kitchen each day checking all food items for labels/dates. ED is also checking 1 times a week, checking all food storage areas & monitoring forms -that this is being completed. How the corrective action(s) will be monitored to ensure the deficient practice will not recur? Both Dietary Managers are walking the kitchen daily, 3 months, checking all food items for labels/dates. 3 times per week, for 2 months, then 2 times per week ongoing.	

	10:07 AM, the DM indicated the box of cake should have been labeled and dated and the jelly jar should have been dated. A current policy, titled Labeling and Dating for Safe Storage of Food, dated 10/1/21, provided by the Administrator on 10/6/25 at 1:34 PM, indicated all food should be labeled with a receive date and use by date. The policy indicated leftover foods should be discarded after a few days. In an interview, on 10/8/25 at 11:57 AM, the Administrator indicated the facility policy's discarding guideline of "a few days" was defined as 3 days. A current policy titled Cold Storage and Dry Food Storage, dated 10/1/21, provided by the Administrator on 10/8/25 at 11:57 AM indicated food returned to storage after preparation should be covered.		Administrator is also - 1 time a week, 3 months, checking all food storage areas & monitoring forms -that this is being completed. Dietary Managers will doing this as an ongoing effort to stay in compliance. By what date the systemic changes will be completed. 10/10/2025	
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	R 0414	Arbor Glen Independent & Assisted Living: 015503 10/8/2025 Annual Survey: Plan of Correction The following Plan of Correction	10/10/2025

	hygiene was performed and gloves were used in all opportunities during medication administration for 4 of 5 residents reviewed (Resident 80, Resident 90, Resident 100, and Resident 110). Findings include: During a med pass observation, on 10/7/25 at 11:00 AM, Qualified Medicine Aide (QMA) 2 was observed administering insulin lispro, 6 units, to Resident 80. QMA 2 was not wearing gloves for the procedure and did not wash her hands before or after the procedure. QMA 2 prepared 2 Tums 500 mg tablets for Resident 90. No hand hygiene was performed before or after preparing and administering the medication. QMA 2 opened Resident 100's walker compartment and obtained her FreeStyle Libre reader that had been stored below stacks of papers and other personal items. No hand hygiene was performed before or after touching Resident 100's personal items. QMA 2 returned to the cart, reviewed the physician's order and prepared the correct 3 units of humalog insulin in an insulin multidose pen. QMA 2 returned to Resident 100's room, wiped her lower abdomen with an alcohol wipe and administered the insulin. QMA 2 did not don any		is prepared and submitted by Arbor Glen Independent & Assisted Living Community, Fort Wayne, as mandated by the Indiana State Department of Health. However, this response does not constitute agreement with the allegations or citations specified on the Statement of Deficiencies. Arbor Glen Independent & Assisted Living Community, Fort Wayne maintains that the alleged deficiencies do not individually or collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by applicable regulations. We respectfully request a paper compliance for the following citations. R414 410 IAC 16.2-5-12(k) Infection Control - Deficiency (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. This RULE is not met as evidenced by: R 414 Based on observation, interview, and record review the facility failed to ensure hand	

	gloves or perform any hand hygiene before or after the insulin administration. QMA 2 then prepared 10 units of humalog insulin for Resident 110 and went to her room. QMA 2 performed a blood glucose check by pricking Resident 110's finger and obtaining a drop of blood. After obtaining the blood sample, QMA 2 wiped Resident 110's finger with an alcohol swab. After obtaining a reading of 179, QMA 2 administered the insulin to resident 110. No gloves were used for the procedure and no hand hygiene was performed before or after the blood glucose check, insulin preparation, or insulin administration. In an interview, on 10/7/25 at 11:17 AM, QMA 2 indicated she should have performed hand hygiene between each resident medication administration. She indicated gloves should have been donned before performing a blood sugar check and before insulin administration. 1) Resident 80's record was reviewed on 10/7/25 at 11:54 AM. Diagnoses included type 2 diabetes with chronic kidney disease. A review of physician orders, dated 4/8/25, indicated Resident 80 should receive insulin lispro 6 units subcutaneously before		hygiene was performed and gloves were used in all opportunities during medication administration for 4 of 5 residents reviewed (Resident 80, Resident 90, Resident 100, and Resident 110) 1 What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Retraining of all staff on handwashing. Monitoring staff on duty to ensure that they are following this practice/policy/regulation. Ongoing trainings to ensure that this practice is being followed. 2 How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: In order to ensure that no other Residents will be affected, we have re-trained with staff, monitoring staff while on duty and also providing ongoing trainings for handwashing/use of hand sanitizer. 3 What measures will be put into	

meals.

2) Resident 90's record was reviewed on 10/7/25 at 11:58 AM. Diagnoses included gastrointestinal reflux disease and heartburn.

A review of physician orders, dated 12/26/2,3 indicated Resident 90 should receive Tums chewable oral tablets, 500 milligrams every 2 hours as needed for heartburn.

3) Resident 100's record was reviewed on 10/7/25 at 12:10 PM. Diagnoses included type 2 diabetes mellitus with hyperglycemia.

A review of physician's orders, dated 5/23/25, indicated Resident 100's FreeStyle Libre continuous glucose system receiver device should be used to obtain a glucose reading before meals. A physician's order dated 1/2/25 indicated Resident 100 should receive Humalog insulin subcutaneously according to sliding scale directions before meals as follows:

If the blood glucose reading was 141 - 180 = 2 units;

181 - 220 = 3 units;

221 - 260 = 4 units;

261 - 300 = 6 units:

place or what
systemic changes you will make to ensure that the deficient practice does not
recur: Staff have been re-trained. Staff are being monitored while on duty and ongoing training is being followed. Administrator, DON and/or Nurse Manager are doing this monitoring.

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: Audits – Training and monitoring of staff for
proper handwashing/use of hand sanitizer.
This is being completed 3 times per week for 2 months, 2 times per week
for 2 months, 2 times per week for 2 months then 1 time per week ongoing.

4. Compliance date: 10/10/2025

If the blood glucose reading was greater than 300 give 8 units and call the physician.

4) Resident 110's record was reviewed on 10/7/25 at 12:25 PM. Diagnoses included type 2 diabetes with diabetic peripheral angiopathy.

A review of physician orders, dated 9/16/25, indicated blood glucose checks should be obtained, and Humalog insulin, 10 units, should be administered subcutaneously before meals.

In an interview, on 10/7/25 at 12:10 PM, the Director of Nursing indicated hand hygiene should be performed before and after interactions with residents and gloves should be worn to obtain blood glucose checks and for insulin administration.

A current policy titled Infection Control, dated 10/1/21, provided by the Administrator on 10/7/25 at 1:04 PM indicated hands should be washed after direct contact with a resident and any other contact with potential to spread infection. The policy indicated gloves should be worn for any contact with blood or body fluids.

Based on observation, interview, and record review the facility failed to ensure hand hygiene was performed and gloves were used in all opportunities during medication

administration for 4 of 5 residents reviewed (Resident 80, Resident 90, Resident 100, and Resident 110).

Findings include:

During a med pass observation, on 10/7/25 at 11:00 AM, Qualified Medicine Aide (QMA) 2 was observed administering insulin lispro, 6 units, to Resident 80. QMA 2 was not wearing gloves for the procedure and did not wash her hands before or after the procedure. QMA 2 prepared 2 Tums 500 mg tablets for Resident 90. No hand hygiene was performed before or after preparing and administering the medication. QMA 2 opened Resident 100's walker compartment and obtained her FreeStyle Libre reader that had been stored below stacks of papers and other personal items. No hand hygiene was performed before or after touching Resident 100's personal items. QMA 2 returned to the cart, reviewed the physician's order and prepared the correct 3 units of humalog insulin in an insulin multidose pen. QMA 2 returned to Resident 100's room, wiped her lower abdomen with an alcohol wipe and administered the insulin. QMA 2 did not don any gloves or perform any hand hygiene before or after the insulin administration. QMA 2

then prepared 10 units of humalog insulin for Resident 110 and went to her room. QMA 2 performed a blood glucose check by pricking Resident 110's finger and obtaining a drop of blood. After obtaining the blood sample, QMA 2 wiped Resident 110's finger with an alcohol swab. After obtaining a reading of 179, QMA 2 administered the insulin to resident 110. No gloves were used for the procedure and no hand hygiene was performed before or after the blood glucose check, insulin preparation, or insulin administration.

In an interview, on 10/7/25 at 11:17 AM, QMA 2 indicated she should have performed hand hygiene between each resident medication administration. She indicated gloves should have been donned before performing a blood sugar check and before insulin administration.

1) Resident 80's record was reviewed on 10/7/25 at 11:54 AM. Diagnoses included type 2 diabetes with chronic kidney disease.

A review of physician orders, dated 4/8/25, indicated Resident 80 should receive insulin lispro 6 units subcutaneously before meals.

2) Resident 90's record was

reviewed on 10/7/25 at 11:58 AM. Diagnoses included gastrointestinal reflux disease and heartburn.

A review of physician orders, dated 12/26/2,3 indicated Resident 90 should receive Tums chewable oral tablets, 500 milligrams every 2 hours as needed for heartburn.

3) Resident 100's record was reviewed on 10/7/25 at 12:10 PM. Diagnoses included type 2 diabetes mellitus with hyperglycemia.

A review of physician's orders, dated 5/23/25, indicated Resident 100's FreeStyle Libre continuous glucose system receiver device should be used to obtain a glucose reading before meals. A physician's order dated 1/2/25 indicated Resident 100 should receive Humalog insulin subcutaneously according to sliding scale directions before meals as follows:

If the blood glucose reading was 141 - 180 = 2 units;

181 - 220 = 3 units;

221 - 260 = 4 units;

261 - 300 = 6 units:

If the blood glucose reading was greater than 300 give 8 units and call the physician.

4) Resident 110's record was reviewed on 10/7/25 at 12:25 PM. Diagnoses included type 2 diabetes with diabetic peripheral angiopathy.

A review of physician orders, dated 9/16/25, indicated blood glucose checks should be obtained, and Humalog insulin, 10 units, should be administered subcutaneously before meals.

In an interview, on 10/7/25 at 12:10 PM, the Director of Nursing indicated hand hygiene should be performed before and after interactions with residents and gloves should be worn to obtain blood glucose checks and for insulin administration.

A current policy titled Infection Control, dated 10/1/21, provided by the Administrator on 10/7/25 at 1:04 PM indicated hands should be washed after direct contact with a resident and any other contact with potential to spread infection. The policy indicated gloves should be worn for any contact with blood or body fluids.

SIGNATUREKathy (Mary K) Bolling		