| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | | A. BUILDING<br>B. WING | 04/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| VITA OF GREENFIELD | 1683 COMMUNITY WAY, GREENFIELD, , 46140 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES... | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION... | (X5) COMPLETION DATE |
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| R 0000 | INITIAL COMMENTS<br><br>This visit was for the Investigation of Complaints IN00457774 and IN00458171.<br><br>Complaint IN00457774 -- No deficiencies related to the allegations are cited.<br><br>Complaint IN00458171 -- Residential deficiencies related to the allegations are cited at R0241, R0301, R0302 and R0406.<br><br>Unrelated deficiencies are cited.<br><br>Survey dates: April 24 and 25, 2025<br><br>Facility number: 016063<br><br>Residential Census: 33<br><br>These Residential findings are cited in accordance with 410 IAC 16.2-5.<br><br>Quality review completed on April 30, 2025. | R 0000 | | |

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| R 0096 | Administration and Management - Deficiency<br><br>410 IAC 16.2-5-1.3(m)(1-2)(A-B)(i-iii)<br><br>(m) The director of the Alzheimer's and dementia special care unit shall do the following:<br><br>(1) Oversee the operation of the unit.<br><br>(2) Ensure that:<br><br>(A) personnel assigned to the unit receive required in-service training; and<br><br>(B) care provided to Alzheimer's and dementia care unit residents is consistent with:<br><br>(i) in-service training;<br><br>(ii) current Alzheimer's and dementia care practices; and<br><br>(iii) regulatory standards.<br><br>Based on interview and record review, the facility failed to ensure a contracted nursing employee working on the facility's secured dementia/memory care unit (MCU) was able to provide the facility with documentation of current training on abuse prohibition, resident rights, and dementia education for 1 of 1 resident reviewed for an allegation of abuse. (Resident C and Qualified Medication Aide | R 0096 | All MC Residents were potentially affected. The DON or designee will provide abuse training to all current staff. Moving forward, any clinical contracted must provide proof of abuse and dementia training before providing any clinical care to residents. BOM will conduct audit of employee records weekly x 4 weeks, then monthly thereafter. | 05/25/2025 |

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| | 5)<br><br>Findings include:<br><br>The clinical record of Resident C was reviewed on 4-24-25 at 1:33 p.m. Her diagnoses included, but were not limited to, dementia with behavioral disturbances. It indicated she was admitted to the secured MCU within the last month, related to increased confusion, agitation, wandering and combativeness at home, including at night. Nursing notes since admission reflected similar episodes. A nursing note, dated 4-24-25 at 12:41 a.m., indicated Resident C had attempted to follow a staff member out the door of the secured MCU. "When staff attempted to redirect her back into the unit, she became physically resistive. During the interaction, the patient sustained a skin tear to her left forearm....expressed mild pain...no other injuries noted."<br><br>In an interview with the Director of Nursing on 4-24-25 at 9:35 a.m., during the entrance process, she identified herself as the Director of the secured MCU.<br><br>In an interview with the Corporate Nurse on 4-25-25 at 2:41 p.m., she indicated the facility became aware of the skin tear of Resident C on | | | |

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| | 4-24-25. She indicated their investigation indicated Qualified Medication Aide (QMA) 5 had worked with Resident C on the night shift of 4-23-25, into 4-24-25. She indicated the facility was able to speak with QMA 5, by phone late in the day on 4-24-25. The facility had learned from other staff interviews and hall camera footage this resident had been up late into the night of 4-23-25, and into the early morning hours of 4-24-25, wandering the halls and being aggressive towards staff with her cane.<br><br>On 4-25-25 at 3:30 p.m., the Corporate Director of Operations and the Director of Nursing demonstrated the hall camera footage from the overnight of 4-23-25, to early morning of 4-24-25, for the secured MCU. The footage demonstrated Resident C was wandering up and down the halls and into the activity room area, ambulating with her cane multiple times, from 4-23-25 at 10:28 p.m., through 4-24-25 at 2:47 a.m. There was no audio available for the camera footage. It demonstrated Resident C did not have a dressing to her left arm until 12:43 a.m. The camera footage did not demonstrate the exact time or situation which caused the skin tear to her arm.<br><br>During the investigation, it was | | | |

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| | learned QMA 5 was providing care for Resident C during this time. The facility indicated QMA 5 was not a facility-employed person, but was hired with the assistance of a contracted agency. When the facility was requested to provide documentation regarding QMA 5's most current abuse prohibition, resident rights, and dementia education, they indicated they were unable to do so.<br><br>The Corporate Nurse indicated, on 4-25-25 at 4:04 p.m., upon review of the contract with the contracted agency, the individual employees of the contracted agency were actually independent contractors and were responsible for ensuring their own educational trainings were kept current. She indicated the facility had not encountered such issues previously. She indicated the facility follows all state regulations regarding employee records requirements, including requirements for abuse prohibition, resident rights and dementia education. On 4-25-25 at 1:50 p.m., the Director of Nursing provided a copy of a document which indicated, on 4-25-25, the facility had verified QMA 5's certification as being current and had reached out to the contracted agency's management staff and they were "unaware of any dementia | | | |

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| | and/or resident rights training," for QMA 5. | | | |

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| | On 4-25-25 at 4:32 p.m., the Director of Nursing provided a copy of the contract of the staffing agency with the facility. The contract, signed on 12-16-24, by both parties, indicated, the contracted agency, "operates a technology platform that allows independent freelance health professionals to match with and provide healthcare services to facility...that will allow the facility to match and engage with one or more licensed healthcare providers (i.e., LPN's, QMA's, RN's, CNA's, HHA's) as specified by facility...[Name of company] will connect facility with Healthcare Professionals...provide evidence of the following to facility upon written request: 1) Possess active state license/registration and/or certification with no findings of abuse. 2) Possess proof of pre-activation screen to include: a. a TB skin test or chest xray...c. Attempt to obtain two (2) professional references, d. criminal background [check]...CPR certification...Healthcare Professionals provided to facility are independent contractors of [name of company]...Facility will promptly provide [name of company] Professionals with an adequate and timely orientation to the facility."<br><br>On 4-25-25 at 1:50 p.m., the Director of Nursing provided an | | | |

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| | undated copy of a document entitled, "Statement of Residents' Rights." This document indicated, "Each resident shall have the right to: A dignified existence, self-determination...Be treated at all times with consideration, respect, and recognition of their dignity and individuality..."<br><br>Based on interview and record review, the facility failed to ensure a contracted nursing employee working on the facility's secured dementia/memory care unit (MCU) was able to provide the facility with documentation of current training on abuse prohibition, resident rights, and dementia education for 1 of 1 resident reviewed for an allegation of abuse. (Resident C and Qualified Medication Aide 5)<br><br>Findings include:<br><br>The clinical record of Resident C was reviewed on 4-24-25 at 1:33 p.m. Her diagnoses included, but were not limited to, dementia with behavioral disturbances. It indicated she was admitted to the secured MCU within the last month, related to increased confusion, agitation, wandering and combativeness at home, including at night. Nursing notes since admission reflected similar episodes. A nursing note, dated | | | |

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| | On 4-25-25 at 3:30 p.m., the Corporate Director of Operations and the Director of Nursing demonstrated the hall camera footage from the overnight of 4-23-25, to early morning of 4-24-25, for the secured MCU. The footage demonstrated Resident C was wandering up and down the halls and into the activity room area, ambulating with her cane multiple times, from 4-23-25 at 10:28 p.m., through 4-24-25 at 2:47 a.m. There was no audio available for the camera footage. It demonstrated Resident C did not have a dressing to her left arm until 12:43 a.m. The camera footage did not demonstrate the exact time or situation which caused the skin tear to her arm.<br><br>During the investigation, it was learned QMA 5 was providing care for Resident C during this time. The facility indicated QMA 5 was not a facility-employed person, but was hired with the assistance of a contracted agency. When the facility was requested to provide documentation regarding QMA 5's most current abuse prohibition, resident rights, and dementia education, they indicated they were unable to do so.<br><br>The Corporate Nurse indicated, on 4-25-25 at 4:04 p.m., upon review of the contract with the | | | |

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| | providers (i.e., LPN's, QMA's, RN's, CNA's, HHA's) as specified by facility...[Name of company] will connect facility with Healthcare Professionals...provide evidence of the following to facility upon written request: 1) Possess active state license/registration and/or certification with no findings of abuse. 2) Possess proof of pre-activation screen to include: a. a TB skin test or chest xray...c. Attempt to obtain two (2) professional references, d. criminal background [check]...CPR certification...Healthcare Professionals provided to facility are independent contractors of [name of company]...Facility will promptly provide [name of company] Professionals with an adequate and timely orientation to the facility."<br><br>On 4-25-25 at 1:50 p.m., the Director of Nursing provided an undated copy of a document entitled, "Statement of Residents' Rights." This document indicated, "Each resident shall have the right to: A dignified existence, self-determination...Be treated at all times with consideration, respect, and recognition of their dignity and individuality..." | | | |
| R 0119 | Personnel - Noncompliance<br><br>410 IAC | R 0119 | All MC Residents were potentially affected. DON will provide abuse and dementia education to all | 05/25/2025 |

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| | 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3-<br><br>(d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following:<br><br>(1) Instructions on the needs of the specialized populations:<br><br>(A) aged;<br><br>(B) developmentally disabled;<br><br>(C) mentally ill;<br><br>(D) dementia; or<br><br>(E) children;<br><br>served in the facility.<br><br>(2) A review of the facility's policy manual and applicable procedures, including:<br><br>(A) organization chart;<br><br>(B) personnel policies;<br><br>(C) appearance and grooming policies for employees; and<br><br>(D) residents' rights.<br><br>(3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures.<br><br>(4) Review of ethical considerations and confidentiality in resident care and records. | | current staff. Contracted staff will be required to show proof of dementia and abuse training before providing care to residents. BOM will audit employee records weekly x 4 weeks, then monthly thereafter. | |

(5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care.

(6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation.

Based on interview and record review, the facility failed to ensure a contracted nursing employee working on the facility's secured dementia/memory care unit (MCU) was able to provide the facility with documentation of current training on abuse prohibition, resident rights, and dementia education for 1 of 1 resident reviewed for an allegation of abuse. (Resident C and QMA 5)

Findings include:

The clinical record of Resident C was reviewed on 4-24-25 at 1:33 p.m. Her diagnoses included, but were not limited to dementia with behavioral disturbances. It indicated she was admitted to the secured MCU within the last month, related to increased confusion, agitation, wandering and combativeness at home, including at night. Nursing notes since admission reflected similar episodes. A nursing note, dated 4-24-25 at 12:41 a.m., indicated Resident C had attempted to

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| R 0241 | Health Services - Offense<br><br>410 IAC 16.2-5-4(e)(1)<br><br>(e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows:<br><br>(1) Medication shall be administered by licensed nursing personnel or qualified medication aides.<br><br>Based on observation, interview, and record review, the facility failed to ensure medications were administered as ordered by the attending practitioner during 1 of 2 medication pass observations with 1 of 2 staff members for 1 of 5 residents observed for | R 0241 | All current residents were potentially affected. The DON or ED will provide education on medication administration. DON or designee will perform EMAR and medication cart audits weekly x 4 weeks, then monthly thereafter. Documentation of education and audits will be uploaded upon completion. | 05/25/2025 |

medication pass observations. (Resident F)

Findings include:

During a medication pass observation with Licensed Practical Nurse (LPN) 3, on 4-25-25 at 8:40 a.m., she was observed to prepare and administer medications for Resident F which included, but were not limited to the following medications:

- Vitamin D3, 2000 IU (international units)/50 mcg (micrograms), 1 tablet. During reconciliation of the attending practitioner's orders for Resident F, the order indicated she was to receive Vitamin D3, 5000 IU by mouth once daily. This order had an effective start date of 8-13-24.

- Zinc Gummies 15 mg (milligrams), 2 gummies, for a total of 30 mg. During reconciliation of the attending practitioner's orders for Resident F, the order indicated she was to receive zinc 220 mg daily, with an effective start date of 11-12-24.

- Women's Probiotic, 1 tablet, strength unknown. During reconciliation of the attending practitioner's orders for Resident F, the order indicated she was to receive, "Animi-3 w/ for vitamin deficiency D 1000-1-500-200-12.4-0.5: give 1

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| | capsule by mouth once daily for vitamin deficiency not carried by vendors." This order had an effective start date of 11-6-24.<br><br>An over-the-counter medication of, "Fiber Adult Gummies, give 1 tablet by mouth three times daily," was located on the attending practitioner's orders, but was not observed to have been prepared for Resident F, upon reconciliation of the medication pass observation. This order had an effective start date of 11-7-24.<br><br>A copy of an undated policy entitled, "Medication Administration Policy," was provided by the Corporate Operations staff on 4-25-25 at 2:45 p.m. This policy indicated, "Medication Administration shall be conducted by appropriately trained by authorized personnel in accordance with state laws and the resident's individualized service plans...Medication Orders: All medications, including over the counter medications, must include resident name, medication name, dosage, route, frequency, and special instructions...The "Five Rights," must be followed: Right resident, Right medication, Right dose, Right route, Right time." | | | |

This Residential tag relates to Complaint IN00458171.

Based on observation, interview, and record review, the facility failed to ensure medications were administered as ordered by the attending practitioner during 1 of 2 medication pass observations with 1 of 2 staff members for 1 of 5 residents observed for medication pass observations. (Resident F)

Findings include:

During a medication pass observation with Licensed Practical Nurse (LPN) 3, on 4-25-25 at 8:40 a.m., she was observed to prepare and administer medications for Resident F which included, but were not limited to the following medications:

- Vitamin D3, 2000 IU (international units)/50 mcg (micrograms), 1 tablet. During reconciliation of the attending practitioner's orders for Resident F, the order indicated she was to receive Vitamin D3, 5000 IU by mouth once daily. This order had an effective start date of 8-13-24.

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| | medications, must include resident name, medication name, dosage, route, frequency, and special instructions...The "Five Rights," must be followed: Right resident, Right medication, Right dose, Right route, Right time."<br><br>This Residential tag relates to Complaint IN00458171. | | | |
| R 0301 | Pharmaceutical Services - Deficiency<br><br>410 IAC 16.2-5-6(c)(5)<br><br>(5) Labeling of prescription drugs shall include the following:<br><br>(A) Resident ' s full name.<br><br>(B) Physician ' s name.<br><br>(C) Prescription number.<br><br>(D) Name and strength of the drug.<br><br>(E) Directions for use.<br><br>(F) Date of issue and expiration date (when applicable).<br><br>(G) Name and address of the pharmacy that filled the prescription.<br><br>If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted.<br><br>Based on observation, | R 0301 | All current residents currently affected. The DON or designee will provide education to all clinical staff on medication administration. The DON or designee will perform an audit of EMAR and medication cart weekly x 4 weeks, then monthly thereafter. Documentation of education and audit log to be uploaded upon completion. | 05/25/2025 |

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| | interview, and record review, the facility failed to ensure prescription medications were appropriately labeled during 1 of 2 medication pass observations with 1 of 2 staff members for 1 of 5 residents observed for medication pass observations. (Resident G)<br><br>Findings include:<br><br>During a medication pass observation with Licensed Practical Nurse (LPN) 3 on 4-25-25 at 8:25 a.m., she was observed to prepare medications for Resident G, including, but not limited to, one tablet of Rexulti 2 mg (milligrams), a prescription medication. The bottle label did not have a resident name, a physician name, a name or address of the pharmacy that filled the prescription, a prescription number, date of issue or any directions for use. LPN 3 indicated the family must have brought this medication in for the resident's use.<br><br>A copy of an undated policy entitled, "Medication Administration Policy," was provided by the Corporate Operations staff on 4-25-25 at 2:45 p.m. This policy indicated, "Medication Administration shall be conducted by appropriately trained by authorized personnel in accordance with state laws and the resident's individualized | | | |

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| | service plans...Medication Orders: All medications, including over the counter medications, must include resident name, medication name, dosage, route, frequency, and special instructions...The "Five Rights," must be followed: Right resident, Right medication, Right dose, Right route, Right time."<br><br>This Residential tag relates to Complaint IN00458171.<br><br>Based on observation, interview, and record review, the facility failed to ensure prescription medications were appropriately labeled during 1 of 2 medication pass observations with 1 of 2 staff members for 1 of 5 residents observed for medication pass observations. (Resident G)<br><br>Findings include:<br><br>During a medication pass observation with Licensed Practical Nurse (LPN) 3 on 4-25-25 at 8:25 a.m., she was observed to prepare medications for Resident G, including, but not limited to, one tablet of Rexulti 2 mg (milligrams), a prescription medication. The bottle label did not have a resident name, a physician name, a name or address of the pharmacy that filled the prescription, a | | | |

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| R 0302 | Pharmaceutical Services - Deficiency<br><br>410 IAC 16.2-5-6(c)(6)<br><br>(6) Over-the-counter medications must be identified with the following:<br><br>(A) Resident name.<br><br>(B) Physician name.<br><br>(C) Expiration date.<br><br>(D) Name of drug.<br><br>(E) Strength.<br><br>Based on observation, interview, and record review, the facility failed to ensure over-the-counter (OTC) medications were appropriately labeled during 1 of 2 medication pass observations with 1 of 2 staff members for 2 of 5 residents observed for medication pass observations. (Residents F and Resident G)<br><br>Findings include:<br><br>1. During a medication pass observation with Licensed Practical Nurse (LPN) 3 on 4-25-25 at 8:40 a.m., she was observed to prepare five OTC medications for Resident F. Each of the OTC medications had incomplete or missing labeling information on the bottle as follows:<br><br>-iron 65 mg (milligrams)/325 mg, | R 0302 | All current residents were potentially affected. DON or designee will provide education on medication administration and labeling. The DON or designee will audit the medication carts weekly x 4 weeks, then monthly thereafter. Documentation of education and audit log will be uploaded upon completion. | 05/25/2025 |

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| | one tablet, had no resident name or physician name present.<br><br>-acetaminophen 650 mg, one tablet, a typed label indicated to refer to the medication administration record (MAR) for administration instructions, but the space for the physician's name was blank.<br><br>-D-Mannos 500 mg, one tablet, was missing labeling information to indicate the resident's or physician's name or the correct administration orders, as based on the physician's orders, as the manufacturer's directions differed from the physician's order.<br><br>-Zinc Gummies 15 mg, two gummies, for a total of 30 mg, were missing labelling information to indicate the resident's or physician's name, the correct medication name or the correct administration orders, as based on the physician's orders, as the manufacturer's directions differed from the physician's order.<br><br>-Women's Probiotic, one tablet, strength unknown, was missing labelling information to indicate the resident's or physician's name or the correct administration orders, as based on the physician's orders, as the manufacturer's directions | | | |

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| | differed from the physician's order.<br><br>2. During a medication pass observation with LPN 3 on 4-25-25 at 8:25 a.m., she was observed to prepare two OTC medications for Resident G, one tablet of Vitamin D3, 2000 IU (international units) or 50 mcg (micrograms) and one tablet of Vitamin B12, 1000 mcg A typed label on each bottle indicated to refer to the medication administration record (MAR) for administration instructions. The typed labels had a space for the name of the physician, but each were blank. | | | |

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| | A copy of an undated policy entitled, "Medication Administration Policy," was provided by the Corporate Operations staff on 4-25-25 at 2:45 p.m. This policy indicated, "Medication Administration shall be conducted by appropriately trained by authorized personnel in accordance with state laws and the resident's individualized service plans...Medication Orders: All medications, including over the counter medications, must include resident name, medication name, dosage, route, frequency, and special instructions...The "Five Rights," must be followed: Right resident, Right medication, Right dose, Right route, Right time."<br><br>This Residential tag relates to Complaint IN00458171.<br><br>Based on observation, interview, and record review, the facility failed to ensure over-the-counter (OTC) medications were appropriately labeled during 1 of 2 medication pass observations with 1 of 2 staff members for 2 of 5 residents observed for medication pass observations. (Residents F and Resident G)<br><br>Findings include:<br><br>1. During a medication pass observation with Licensed | | | |

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| | Practical Nurse (LPN) 3 on 4-25-25 at 8:40 a.m., she was observed to prepare five OTC medications for Resident F. Each of the OTC medications had incomplete or missing labeling information on the bottle as follows:<br><br>-iron 65 mg (milligrams)/325 mg, one tablet, had no resident name or physician name present.<br><br>-acetaminophen 650 mg, one tablet, a typed label indicated to refer to the medication administration record (MAR) for administration instructions, but the space for the physician's name was blank.<br><br>-D-Mannos 500 mg, one tablet, was missing labeling information to indicate the resident's or physician's name or the correct administration orders, as based on the physician's orders, as the manufacturer's directions differed from the physician's order.<br><br>-Zinc Gummies 15 mg, two gummies, for a total of 30 mg, were missing labelling information to indicate the resident's or physician's name, the correct medication name or the correct administration orders, as based on the physician's orders, as the manufacturer's directions differed from the physician's | | | |

order.

-Women's Probiotic, one tablet, strength unknown, was missing labelling information to indicate the resident's or physician's name or the correct administration orders, as based on the physician's orders, as the manufacturer's directions differed from the physician's order.

2. During a medication pass observation with LPN 3 on 4-25-25 at 8:25 a.m., she was observed to prepare two OTC medications for Resident G, one tablet of Vitamin D3, 2000 IU (international units) or 50 mcg (micrograms) and one tablet of Vitamin B12, 1000 mcg A typed label on each bottle indicated to refer to the medication administration record (MAR) for administration instructions. The typed labels had a space for the name of the physician, but each were blank.

A copy of an undated policy entitled, "Medication Administration Policy," was provided by the Corporate Operations staff on 4-25-25 at 2:45 p.m. This policy indicated, "Medication Administration shall be conducted by appropriately trained by authorized personnel in accordance with state laws and the resident's individualized service plans...Medication Orders: All medications,

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| | including over the counter medications, must include resident name, medication name, dosage, route, frequency, and special instructions...The "Five Rights," must be followed: Right resident, Right medication, Right dose, Right route, Right time."<br><br>This Residential tag relates to Complaint IN00458171. | | | |
| R 0406 | Infection Control - Offense<br><br>410 IAC 16.2-5-12(a)<br><br>(a) The facility must establish and maintain an infection control practice designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of diseases and infection.<br><br>Based on observation, interview and record review, the facility failed to ensure medications were provided in a safe and sanitary manner and the staff's hands did not come in direct contact with the medication during 1 of 2 medication pass observations with 1 of 2 staff members for 1 of 5 residents observed for medication pass observations. (Resident G)<br><br>Findings include:<br><br>During a medication pass observation with Licensed | R 0406 | All current residents were potentially affected. The DON or designee will ensure that clinical staff will be provided with an in service on infection control and medication administration. The DON or designee will watch one med pass per shift per week x 4 weeks then periodically thereafter. Documentation of in service and med pass audit will be uploaded upon completion. | 05/25/2025 |

Practical Nurse (LPN) 3 on 4-25-25 at 8:25 a.m., she was observed to prepare memantine 10 milligrams (mg) for Resident G. She was observed to take the tablet with her bare hand and place it in a pill cutter, touching it several times to adjust its positioning within the cutting device. She was able to successfully cut it in half to achieve the dosage of memantine 5 mg for the morning dose.

Upon completion of the medication administration, LPN 3 was queried as to how this action could have been changed or improved. She indicated she should not have touched the medication with her bare hands and could have worn gloves to achieve this.

A copy of an undated policy entitled, "Medication Administration Policy," was provided by the Corporate Operations staff on 4-25-25 at 2:45 p.m. This policy indicated, "Medication Administration shall be conducted by appropriately trained by authorized personnel in accordance with state laws and the resident's individualized service plans...Medication Orders: All medications, including over the counter medications, must include resident name, medication name, dosage, route, frequency, and special

instructions...The "Five Rights," must be followed: Right resident, Right medication, Right dose, Right route, Right time."

This Residential tag relates to Complaint IN00458171.

Based on observation, interview and record review, the facility failed to ensure medications were provided in a safe and sanitary manner and the staff's hands did not come in direct contact with the medication during 1 of 2 medication pass observations with 1 of 2 staff members for 1 of 5 residents observed for medication pass observations. (Resident G)

Findings include:

During a medication pass observation with Licensed Practical Nurse (LPN) 3 on 4-25-25 at 8:25 a.m., she was observed to prepare memantine 10 milligrams (mg) for Resident G. She was observed to take the tablet with her bare hand and place it in a pill cutter, touching it several times to adjust its positioning within the cutting device. She was able to successfully cut it in half to achieve the dosage of memantine 5 mg for the morning dose.

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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