STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155824	A. BUILDING 00 B. WING	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WELLBROOKE OF SOUTH BEND	52565 STATE ROAD 933 SOUTH BEND, IN 46637

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: 2/13, 2/14, 2/15, 2/16, 2/19 & 2/20/2024 Facility number: 013302 Provider number: 155824 AIM number: 201281730 Census Bed Type: SNF/NF: 14 SNF: 33 Residential: 37 Total: 84 Census Payor Type: Medicare: 19 Medicaid: 14 Other: 14 Total: 47 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 2/21/24.	F 0000	The submission of this plan of correction does not indicate an admission by Wellbrooke of South Bend that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Wellbrooke of South Bend. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Karl Steinhaus	ED HFA	03/01/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	§483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to ensure medications were kept in a locked cart when unattended, failed to ensure a medication cart was clean and free from loose medications, failed to put an opened-on date on opened medications, and failed to ensure over the counter medications had resident identifiers, for 2 of 2 medication carts observed. (110 & 100 Hall Medication Carts) Findings include: 1. During a random observation, on 02/15/2024 at 8:27 A.M., the medication cart on the 110 hall was unlocked and unattended. An interview was completed, on 02/15/24 at 8:31 A.M. LPN 3 indicated the medication cart should be locked when unattended.	F 0761	1 All residents have the potential to be affected. No adverse effects were noted for any residents due to the medication cart being unlocked, loose pills, dirty drawers, undated/opened meds, and over-the-counter medications being unlabeled. 2 All nursing carts have been cleaned of loose pills, and sticky substances from drawers. All medications have been labeled and dated as open, and all over-the-counter medications have been labeled per facility policy. Nursing staff educated on dating opened medications, cleaning of the carts, removing loose pills, and policy on over-the-counter medications brought into the	03/08/2024

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	2. During a medication storage observation of the 110-hall medication cart with LPN 3, on 2/15/2024 at 9:22 A.M., the following was observed: a. A drawer containing resident medications had a large amount of a sticky solution spilled on the sides and bottom of the drawer. b. Five loose pills were sitting on the bottom of a medication drawer. c. The following medications were open but did not contain an opened-on date: one bottle of Tums (antacid), one bottle of Milk of Magnesia (laxative), one bottle of Alive Women's Gummies (supplement), one bottle of Pro-Stat (supplement), and one bottle of Peg 3350 (laxative). d. The following over the counter medications were unopened and did not contain any resident identifiers: one box of extra strength acetaminophen/diphenhydramine, one box of aspirin, one box of caffeine tablets, and one box of ibuprofen tablets. An interview was completed, on 2/15/2024 at 9:38 A.M. LPN 3 indicated the drawer containing residents' medications should not have sticky solution on the sides and bottom of the drawer and the medication cart should not contain loose pills. LPN 3 indicated residents' over the counter medications should have an opened on date, and contain a label with the resident's name, drug name and dosage amount. 3. During a medication storage observation of the 100-hall medication cart with LPN 2, on 2/15/2024 at 9:42 A.M., the following was observed: a. One opened box of Tylenol with no opened-on		facility. 3 As a measure of ongoing compliance, the Director of Health Services (DHS) and/or designee will audit medication carts twice weekly X 4 weeks, every other week X 4 weeks, and then monthly for 4 months. 4 As a quality measure, the DHS and/or designee will review the findings with QAPI monthly X 6 months. The plan will be reviewed and updated as warranted.	

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	date. b. Two unopened boxes of Lidocaine patches with no resident identifiers. c. One opened box of Afrin (nasal spray) with no resident identifiers and no opened-on date. An interview was completed, on 2/15/2024 at 9:48 A.M. LPN 2 indicated the resident's over the counter medication should have an opened on date, and a label containing resident's name, dosage amounts and dosage times. On 2/15/2024 at 10:15 A.M., the DON (Director of Nursing) provided a policy titled, "Medication Ordering And Receiving From Pharmacy", and dated January 2018. The DON indicated the policy was the current policy used by the facility. The policy indicated, "...A. Use of medications brought to the facility by a resident or responsible party is allowed only when the following conditions are met... 3) The medication container is clearly labeled in accordance with facility procedures for medication labeling and packaged in a manner consistent with facility guidelines for medications...." On 2/15/2024 at 2:45 P.M., the Corporate Nurse provided a policy titled, "Medication Storage in The Facility", and dated January 2018. The Corporate Nurse indicated the policy was the current policy used by the facility. The policy indicated, "...Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access... Medication storage areas are kept clean...When the original seal of a manufacturer's container or vial is initially broken, the container or vial with be dated. 1) A "dated opened" sticker shall be placed on the			

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	medication...." 3.1-25(j) 3.1-25(l) 3.1-25(m)			
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, record review, and interview, the facility failed to store food under sanitary conditions, related to foods not tightly sealed, outdated foods, and dirty kitchen equipment, for 1 of 1 kitchen observed. This had the potential to affect all residents who resided in the facility and received food from this dietary kitchen.	F 0812	1 All residents have the potential to be affected. No adverse effects were noted for any residents related to improper food storage, outdated foods, storage of food above the 18-inch line, scratched Teflon coating on pans, and soiled kitchen equipment. 2 All dietary deficiencies were	03/08/2024

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	Findings include: On 2/13/2023 at 9:45 A.M., a kitchen tour was conducted with the Dietary Manager (DM). The following was observed in the walk-in cooler: - A bag of carrots in the walk-in cooler with a use by date of 2/9/2024. - A bag of chopped onions with a use by date of 2/11/2024. - A block of cream cheese not sealed tightly. - A bag of mashed sweet potatoes not sealed tightly. - A tray of salad bar items: olives, eggs, onions, cheese, tomatoes, and bacon not sealed appropriately. The following was observed in the walk-in freezer: - A bag of diced meat unlabeled and not sealed. - An opened bag of sliced pepperoni not sealed appropriately. - An opened box of bread sticks not sealed appropriately. - 2 Boxes on the floor. In the dry storage area, the following was observed: - Numerous boxes and items not 18 inches below the ceiling. - An opened bag of cookie pieces not sealed or dated. - Two (2) large and 10 small skillets with the Teflon coating completely off and or chipped. A microwave on a shelf was observed with splattered food on the inside of the door and a reddish stain on the glass tray. During an interview, on 2/13/2024 at 9:55 A.M., the DM indicated the food should have been		corrected immediately upon identification. All outdated items were thrown away, all items not sealed appropriately were thrown away, the storage of items above the 18-inch line were removed and placed in an appropriate area. Teflon pans were purchased, and the old pans were thrown away. Kitchen equipment that was soiled was cleaned immediately after identification. Dietary staff educated on proper food labeling and dating, sanitation and safety. 3 As an ongoing measure of compliance, the Director of Food Services (DFS) and/or designee will audit food storage dates, appropriate sealing, and labeling of foods, and check the cleanliness of kitchen equipment 2 times weekly X 8 weeks, every other week X 4 weeks, and then monthly for 3 months. 4 As a quality measure, the DFS and/or designee will review the findings with QAPI monthly X 6 months. The plan will be reviewed and updated as warranted.	

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	thrown out, sealed appropriately and labeled. The items in the dry storage were not 18 inches below the ceiling and should have been. The skillets should have not been used and the microwave should have been cleaned. On 2/15/2024 at 9:20 A.M., the Corporate Nurse provided the policy titled, "Storage Procedures", dated 5/31/2016, and indicated the policy was the one currently used by the facility. The policy indicated...."Dry Storage of Food...4. Items are stored at least 18 inches from the ceiling on clean racks or other clean surfaces and away from sprinkler heads and pipes... 4. Open packages are labeled, dated and stored in closed containers... Refrigerated Storage: ...5. Food is covered, dated and stored loosely to permit air circulation... 7. Prepared perishables such as salads, puddings, milk, etc., are stored in a refrigerator and covered, labeled, and dated until used... Frozen Storage: ...3. All foods in the freezer are wrapped in moisture proof wrapping or placed in suitable containers, to prevent freezer burn. Items are labeled and dated... Storage of Non-Food Supplies: ... 2. Items are stored at least six (6) inches off the floor and 18 inches from the ceiling...." On 2/15/2024 at 9:20 A.M., the Corporate Nurse, provided the policy titled,"Food Labeling and Dating Policy", dated 1/2023, and indicated the policy was the one currently used by the facility. The policy indicated," Any food product removed from its original container, has a broken seal, has been processed in any way must have a label that contains the following: 1. Item name 2. Date and Time the food was labeled. 3. Use by date. 4. Initials of the person labeling the item. 5 Securely cover the food item...."			

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	On 2/15/2024 at 9:20 A.M., the Corporate Nurse provided the policy titled," Food Production Guidelines: Sanitation and Safety", dated 5/31/2016, and indicated the policy was the one currently use by the facility. The policy indicated"... 15. All preparation and serving equipment and surfaces that have been in contact with raw meat and other raw foods, especially poultry, will be cleaned and sanitized to avoid cross contamination .... pots pans, ...etc...." 3.1-21(i)(3)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;			

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	§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.			

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	§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation and interview, the facility failed to ensure proper infection control practices were implemented, related to lack of changing gloves and handwashing during peri-care for 1 of 1 resident observed for peri-care and failed to ensure that a blood glucose was completed in a sanitary manner for 1 of 1 resident observed for glucometer use. (Residents 31 and 30) Findings include: 1. On 2/16/2024 at 10:46 A.M., a peri care observation for Resident 31 was conducted with CNA 4 and CNA 6. Resident 31 was observed on the toilet. Both CNA 4 and CNA 6 were properly gloved during care. CNA 4 wiped the resident after having a bowel movement, and pulled up his brief. CNA 4 preceded to position the resident in his wheelchair and fix his clothing, all while still wearing the same gloves. CNA 4 removed her gloves and disposed of them in the bathroom trash and wheeled the resident out of his room to the common area. During an interview, on 2/26/2024 at 10:56 A.M., CNA 4 indicated she should have removed her gloves and washed her hands before interacting with the resident.2. During an observation on 2/15/2024 at 10:57 A.M., LPN 3 completed a blood glucose check on Resident 30. LPN 3 applied gloves, placed the glucometer device on a barrier and cleansed the finger with an alcohol pad. With an opened hand, LPN 3 fanned the area she had just cleansed.	F 0880	1 Resident #31, 30 were affected by alleged deficient practice of hand hygiene/handwashing and improper blood glucose check. The residents were assessed with no adverse events noted. 2 Nursing staff were immediately educated and then re-educated on proper hand hygiene during peri-care and proper cleansing of the blood glucose site. 3 As a measure of ongoing compliance, the DHS and/or designee will audit peri-care for 2 like residents weekly X 4 weeks, then 2 like residents every other week x 4 weeks, then monthly X 4 months. 2 like residents who require blood glucose checks will be reviewed weekly X 4 weeks, every other week X 4 weeks, and then monthly X 4 months. 4 As a quality measure, the DHS and/or designee will review the findings with QAPI monthly X 6 months. The plan will be reviewed and updated as warranted.	03/08/2024

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	During an interview, on 2/15/2024 at 10:58 A.M., LPN 3 indicated she should not have fanned the area. On 2/16/2024 at 11:30 A.M., the Director of Nursing provided the policy titled,"Guideline for Handwashing/Hand Hygiene", dated 12/31/2023, and indicated the policy was the one currently used by the facility. The policy indicated"... 1. All health care workers shall utilize hand hygiene frequently and appropriately...3. Health Care Workers (HCW) shall uses hand hygiene at times such as:...c. Before/after having direct physical contact with residents. d. After removing gloves, worn per Standard Precautions for direct contact with excretions or secretions, mucous membranes...." On 2/15/2024 at 1:46 P.M., the Corporate Clinical Nurse provided the policy titled,"Guidelines for performance of blood glucose monitoring and glucometer maintenance", dated 12/31/2023, and indicated the policy was the one currently used by the facility. The policy indicated"... 2. Appropriate infection control technique shall be followed during testing procedures...." 3.1-18(a)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: 2/13, 2/14, 2/15, 2/16, 2/19 & 2/20/2024	R 0000	The submission of this plan of correction does not indicate an admission by Wellbrooke of South Bend that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and	

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	Facility number: 013302 Residential Census: 37 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 2/21/24.		the living environment provided to the residents of Wellbrooke of South Bend. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	
R 0214 Bldg. 00	410 IAC 16.2-5-2(a) Evaluation - Deficiency (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 record review and interview, the facility failed to ensure semi-annual evaluations were completed for 2 of 7 residents reviewed. (Residents 8 & 4) Findings include: 1. A closed record review was completed on 2/29/24 at 1:49 PM. Resident 8's diagnoses included, but were not limited to, Parkinson's disease, osteoarthritis and hypertension.	R 0214	1 Resident #8, 4 were affected by this alleged deficient practice of lacking evaluation/service plans. The residents have had no concerns related to this deficient practice. 2 The Director of Assisted Living was educated on the policy of evaluations and service plan guidelines. All like residents have been reviewed and semi-annual service plans have been	03/08/2024

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	The clinical record lacked any semi evaluations/service plans for the year 2023. The last completed service plan was dated 12/7/2022. During an interview, on 2/19/2024 at 2:40 P.M., the Director of Nursing indicated she should have had evaluations completed in 2023.2) A clinical record review, on 2/19/2024 at 11:45 A.M., indicated Resident 4 was admitted to the facility on 2/6/2023. Diagnoses included, but were not limited to: hypertension, encephalopathy, and congestive heart failure. An Admission Service Plan Evaluation, dated 2/6/2023, was in the chart, and the facility provided a semi-annual evaluation dated 2/19/2024. During an interview, on 2/19/2024 at 3:00 P.M., the DON indicated Resident 4 did not have any other semi-annual evaluations completed for 2023. The resident should have had one completed at least every six months and did not. On 2/19/2024 at 3:15 P.M., the DON provided a policy titled "Assisted Living Evaluation and Service Plan Guidelines" with a review date of 12/31/2023 and indicated this was the policy currently used by the facility. The policy indicated, " ...To provide documentation of nursing and ancillary care needs to develop a service plan. To determine acuity level based on the amount of assistance provided with both activities of daily living (ADL) and nursing care. 1). Upon admission, semi-annually and with significant change in health status or functioning, the acquired or worsened wound, or deterioration of health status ...."		completed. Nursing IDT educated on the policy for evaluations and service plan guidelines. 3 As a measure of ongoing compliance, the DHS and/or designee will audit assisted living residents semi-annual service plans monthly X 6 months to ensure ongoing compliance. 4 As a quality measure, the DHS and/or designee will review the findings of the audits with QAPI monthly X 6 months. The plan will be reviewed and updated as warranted.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155824	A. BUILDING 00 B. WING	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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R 0273 Bldg. 00	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. Based on observation, interview, and record review, the facility failed to ensure appliances were free from food debris, failed to ensure dishes were dry before storing, and failed to ensure the dishwasher was at the appropriate temperature in 1 of 1 kitchenette observed. This had the potential to affect all 37 residents residing in Assisted Living. Findings include: During a kitchenette observation, on 2/19/2024 at 11:08 A.M., with the Dietary Manager, the following was observed: a. An ice cream cooler had food debris along the edges of the cooler. b. The plate warmer had dinner plates with water droplets on them. c. A drawer had bowls and saucers with water droplets on them. d. A toaster was filled will a large amount of dried bread crumbs. e. A microwave with food crumbs and a greasy substance on the inside of the door. f. The mechanical dishwasher temperature during the wash cycle indicated 110 degrees.	R 0273	1 All residents have the potential to be affected by the alleged deficient practice of soiled appliances, inappropriate dishwasher temperature, soiled cooler, or improper storage of dishes. No adverse effects have been noted for any residents. 2 All dietary deficiencies were corrected after identification. The dietary staff were educated on proper cleaning of kitchen appliances, storage of dishes, dishwasher temp, and debris noted in the cooler. 3 As a measure of ongoing compliance, the Director of Food Services (DFS) and/or designee will audit the assisted living kitchen 2 x weekly X 8 weeks, every other week X 4 weeks, and then monthly X 3 months to ensure proper cleaning of cooler, appliances, dishwasher temp, and proper storage of dishes. 4 As a quality measure, the DFS and/or designee will review the findings of the audits with QAPI monthly X 6 months. The plan will be reviewed and updated as warranted.	03/08/2024

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	During an interview, on 2/19/2024 at 11:10 A.M., the Dietary Manager indicated the cooler, toaster, and microwave should have been cleaned, the dishes should not be put away wet, and the dishwasher temperature should have been 120 degrees. On 2/15/2024 at 9:00 A.M., the Corporate Nurse provided the policy titled."Storage Procedures", and indicated the policy was the one currently used by the facility. The policy indicated"...3. Refrigeration equipment is routinely cleaned and defrosted and free from garbage and other waste...." On 2/19/2024 at 2:06 P.M., the Administrator provided a copy of the manufactures instructions for a Hamilton Beach Smart Toaster. Page 3 of the guidelines indicated...13. Failure to clean crumb tray may result in a fire hazard... On page 8, under the Cleaning section was documented: Note: If the toaster is used every day, the crumb tray should be cleaned once a week. On 2/19/2024 at 2:05 P.M., the Administrator provided the policy titled," Dish Machine", dated 1/202, and indicated the policy was the one used by the facility, The policy indicated"...Low Temperature Dishwasher (chemical sanitization): Wash - 120 degrees F..."			
R 0295 Bldg. 00	410 IAC 16.2-5-6(a) Pharmaceutical Services - Noncompliance (a) Residents who self-medicate may keep and use prescription and nonprescription medications in their unit as long as they keep them secured from other residents. Based on observation, record review, and interview, the facility failed to secure medications	R 0295	1 Resident #3 was affected. No adverse effects were noted due to this alleged deficient practice.	03/08/2024

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	in a resident apartment, for 1 of 1 resident reviewed for self administration of medications. (Resident 3) Finding includes: During an observation of Resident 3's apartment, on 2/19/2024 at 10:07 A.M., there were 2 medication bottles on the table next to the resident's recliner and 3 medication bottles on the window sill. During an interview, on 2/19/2024 at 10:07 A.M., Resident 3 indicated she kept her thyroid medication next to her to remind her to take it first thing upon waking. The other bottles were other medications she takes, but she would have to look at them to know what they were. During an interview, on 2/19/2024 at 10:47 A.M., the Assisted Living Director indicated she did not think medications had to be locked if the resident self administers. A current policy provided by the Director of Nursing, dated 8/11/2016 and titled, "Assisted Living Self Administration of Medication Guidelines" included, but was not limited to, "...The medication will be kept in a locked drawer in the residents' room. The resident will maintain the key and a second key will be maintained by the licensed nurse and/or QMA...."		2 All residents have the potential to be affected. The nursing staff were educated to ensure that each resident who self-administers medications has their medications secured per policy. All like residents have been reviewed and medications have been secured per policy. 3 As a measure of ongoing compliance, the DHS and/or designee will audit like residents monthly X 6 months to ensure proper storage of self-administered medications. 4 As a quality measure, the DHS and/or designee will review findings with QAPI monthly X 6 months. The plan will be reviewed and updated as warranted.	