STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155794	A. BUILDING 00 B. WING	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RETREAT AT THE STRATFORD, THE	2460 GLEBE ST CARMEL, IN 46032

(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: March 3, 4, 5, 6, and 7, 2025. Facility number: 011151 Provider number: 155794 Census Bed Type: SNF: 13 Residential: 28 Total: 41 Census Payor Type: Medicare: 8 Other: 5 Total: 13 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on March 14, 2025.	F 0000	This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.	
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir Based on interview and record review, the facility failed to ensure the physician was notified of the residents' advanced directives and an order was documented in the residents' medical record for 3 of 3 residents reviewed for advanced directives. (Resident 8, 63 and 68) Findings include: 1. The clinical record for Resident 8 was reviewed	F 0578	**Plan of Correction for F578: Request/Refuse/Discontinue Treatment – Formulate Advanced Directives** **Step 1:** The physician was immediately notified by the Social Worker of the advanced directives for Residents 8, 63, and 68, and orders were documented in their medical records. The Social	03/28/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Bradley Miller	Care Service Administrator	03/25/2025

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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	on 3/4/25 at 9:51 a.m. The diagnoses included, but were not limited to, hypertension, senile degeneration of the brain, and muscle weakness. An Indiana Physicians Orders for Scope of Treatment (POST) form was completed and signed on 11/12/24 and indicated the resident wished to be a Do Not Resuscitate (DNR). Resident 8 was admitted to the facility on 11/15/24. A physician's order, dated 3/4/25, indicated the resident was a DNR. The physician's order was not in place until 3.5 months after the resident was admitted to the facility. 2. The clinical record for Resident 63 was reviewed on 3/4/25 at 2:04 p.m. The diagnoses included, but were not limited to, heart failure, stage 3 chronic kidney disease, and adult failure to thrive. An Indiana Physicians Orders for Scope of Treatment (POST) form was completed and signed on 2/21/25 and indicated the resident wished to be a DNR. Resident 63 was admitted to the facility on 2/17/25. The physician's order, dated 3/4/25, indicated the resident was a DNR. The physician's order was not in place until 15 days after the resident was admitted to the facility.3. The clinical record for Resident 68 was reviewed on 3/3/25 at 11:38 a.m. The diagnoses included, but were not limited to, morbid obesity,		Worker will verify that each resident's preferences are accurately reflected in the electronic health record, the physician is notified and the order is placed according to the advanced directive. **Step 2:** This alleged deficient practice has the potential to impact all residents. A facility-wide audit will be conducted by the Social Worker to ensure all active residents with advanced directives have corresponding physician orders documented in their medical records and the physician has been notified by Social Worker and/or Director of Nursing. All negative findings will be corrected immediately. **Step 3:** The Social Worker, Director of Nursing, and Nurses will receive re-education on the proper procedure for obtaining, verifying, and documenting advanced directives, including timely physician notification and order entry. Education will be completed upon hire, annually, and as needed following identified concerns. **Step 4:** The Social Worker and/or designee will conduct weekly audits of all new admissions of resident records for 90 days or longer if needed until 100% compliance is maintained to ensure physician notification and documented orders for advanced	

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	fracture of the right femur, and hypertension. Resident 68 was admitted to the facility on 2/20/25. Resident 68 did not have an order for the resident's code status entered into the record. During an interview, on 3/4/25 at 9:43 a.m., the Director of Nursing indicated the residents should have had a physician's order. During an interview, on 3/7/25 at 1:11 p.m., the Corporate Support Nurse indicated the facility followed state and federal regulations and had no other information to present. A current facility policy, dated as revised April 2009 and received from the Clinical Support Nurse on 3/7/25 at 1:00 p.m., indicated "...The director of nursing services (DNS) or designee notifies the attending physician of advanced directives (or changes in advanced directives) so that appropriate orders can be documented in the residents medical record and plan of care...." 3.1-4(f)(5) 3.1-4(f)(7)		directives are in place. All negative findings will be corrected immediately. All findings will be reviewed in the monthly Quality Assurance and Performance Improvement (QAPI) meeting, with further staff education or corrective action implemented as necessary. **Step 5:** All corrective actions will be completed by **3/28/2025**.	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan Based on interview and record review, the facility failed to ensure person-centered comprehensive care plan interventions were developed for a resident who had a significant weight loss for 1 of 1 resident reviewed for nutrition. (Resident 6) Findings include:	F 0656	**Plan of Correction for F656: Develop/Implement Comprehensive Care Plan** **Step 1:** The Care Manager will immediately update Resident 6's care plan to reflect the significant weight loss, incorporating the Registered Dietitian's	04/02/2025

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	The clinical record for Resident 6 was reviewed on 3/4/25 at 12:52 p.m. The diagnoses included, but were not limited to, heart failure, vitamin deficiency, dysphagia, and anorexia. A physician's order, dated 5/1/23, indicated the resident was to be weighed monthly. A vitals tab indicated the following: On 1/1/25, the resident weighed 107.12 pounds. On 2/1/25, the resident weighed 101 pounds. On 2/10/25, the resident weighed 96 pounds. Resident 6 had a significant weight loss of 5.7% in 30 days and then continued to lose more weight on 2/10/25. A Registered Dietician (RD) note, dated 2/18/25, indicated the resident triggered for a significant weight loss. The current body weight was 96 pounds and recommended Ensure Plus (nutritional supplement) twice per day to help with weight stability. A current care plan, effective 4/6/23, indicated the resident was at risk for altered nutrition and hydration related to heart failure. During an interview, on 3/6/25 at 3:02 p.m., the Clinical Support nurse indicated the facility should have updated the resident's care plan within 14 days after a significant weight loss. During an interview, on 3/7/25 at 12:05 p.m., the Director of Nursing indicated the care plan should have been updated within 14 days after significant weight loss. During an interview, on 3/7/25 at 1:11 p.m., the Corporate Support Nurse indicated the facility		recommendations for Magic Cup twice per day in line with Resident 6's preferences. The care plan will be reviewed with the resident and/or responsible party to ensure alignment with their preferences and goals. **Step 2:** This alleged deficient practice has the potential to impact all residents. A facility-wide audit will be conducted to review residents with significant weight loss over the past 90 days to ensure appropriate care plan updates were completed within the required timeframe. **Step 3:** Nursing staff, dietitians, and the interdisciplinary team will receive re-education on the requirement to update comprehensive care plans within 14 days of a significant weight change. Training will emphasize timely documentation of interventions and ongoing monitoring to ensure compliance with federal regulations. **Step 4:** The Director of Nursing or designee will conduct weekly audits of 20% of residents identified with significant weight loss for 90 days to verify timely updates to care plans. Audit results will be reported in the monthly Quality Assurance and Performance Improvement (QAPI) meeting, with additional staff training or corrective action implemented as necessary.	

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	followed state and federal regulations and had no other information to present. A current facility policy, titled "Goals and Objectives, Care Plans," dated as revised April 2009 and received from the Clinical Support Nurse on 3/7/25 at 1:00 p.m., indicated "...When goals and objectives are not achieved, the resident's clinical record will be documented as to why the results were not achieved and what new goals and objectives have been established. Care plans will be modified accordingly...." 3.1-35(a) 3.1-35(b)(1)		**Step 5:** All corrective actions will be completed by **4/02/2025**.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on observation, interview and record review, the facility failed to assess and document skin issues for 1 of 2 residents reviewed for quality of care. (Resident 5) Findings include: During an observation, on 3/3/25 at 10:15 a.m., Resident 5 was noted to have multiple bruises on both her arms. The clinical record for Resident 5 was reviewed on 3/4/25 at 11:10 a.m. The diagnoses included, but were not limited to, diabetes mellitus, hypertension, hyperlipidemia, and a history of a stroke. A care plan, initiated on 4/17/24, indicated the resident was at risk for skin alterations and to perform and record complete skin assessments.	F 0684	**Plan of Correction for F684: Quality of Care** **Step 1:** Resident 5 received a comprehensive skin assessment, and all observed skin issues were documented in the medical record by the Charge Nurse. Ongoing monitoring was initiated by the Director of Nursing and care plan interventions were updated by the Care Manager to reflect the resident's skin condition and risk factors. **Step 2:** This alleged deficient practice has the potential to impact all residents. A full-scope audit of skin assessments for all residents for skin issues will be conducted by the Director of Nursing and/or Designee to ensure accurate documentation and	03/30/2025

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	A physician's order, initiated on 4/18/24, indicated to give aspirin (a medication used to prevent platelets from sticking together and causing clots) 81 milligrams once a day. The only documented bruise found in Resident 5's record was an area on the right lateral elbow. No other skin concerns had been found in the record. During an interview, on 3/3/25 at 10:36 a.m., LPN 2 indicated the resident had lots of bruises. During an interview, on 3/7/25 at 10:06 a.m., the Corporate Support Nurse indicated the bruising on both arms should have been documented on skin sheets and monitored. During an interview, on 3/7/25 at 11:31 a.m., the Corporate Support Nurse indicated weekly assessments of the skin were to be completed and should note any discolorations, rashes, wounds, open areas and dryness. The documentation was to include the characteristics of the areas such as color and size. During an interview, on 3/7/25 at 1:11 p.m., the Corporate Support Nurse indicated the facility followed state and federal regulations and had no other information to present. A current facility policy, titled "Resident Examination and Assessment," dated as last revised in 2/14 and received from the Corporate Support Nurse on 3/7/25 at 1:07 p.m., indicated "Physical Exam...Skin...presence of bruises...Documentation...All assessment data obtained during the procedure...." 3.1-37(a)		timely intervention. All negative findings will be corrected upon discovery. **Step 3:** Licensed nurses will receive re-education on completing thorough weekly skin assessments and documenting all findings, including bruises, discoloration, wounds, and other skin issues. **Step 4:** The Director of Nursing and/or designee will audit weekly skin assessments for all active residents for eight weeks or longer if needed until 100% compliance is met. Spot checks of completed skin assessments conducted by the Director of Nursing and/or designee will continue after 100% compliance is achieved to maintain compliance. All negative findings will be corrected immediately. Audit findings will be reported to the Quality Assurance and Performance Improvement (QAPI) committee for further monitoring and corrective actions as needed. **Step 5:** All corrective actions will be completed by **3/30/2025**.	

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F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on observation, interview and record review, the facility failed to ensure narcotic count sheets were signed off by the on-coming and off-going nurses to ensure an accurate reconciliation was completed for 1 of 1 narcotic book reviewed for reconciliation. Findings include: During an observation, on 3/3/25 at 5:27 a.m., with RN 1 in attendance, the narcotic book was found to be missing entries to show the on-coming and off-going nurses had reconciled the narcotic count and signed the narcotic book to indicate the count had been reviewed. During an interview, on 3/3/25 at 5:27 a.m., RN 1 indicated staff were supposed to sign the narcotic count sheets each shift. A facility document, titled "Narcotic Count January 2025 Skilled," was provided by the Director of Nursing on 3/3/25 at 5:29 a.m., and indicated the following: On 1/4/25, there were no signatures for the on-coming and off-going day and evening shifts. On 1/5/25, there were no signatures for the on-coming and off-going day and evening shifts. On 1/11/25, there was no signature for the off-going evening shift. On 1/12/25, there was no signature for the off-going evening shift. On 1/13/25, there were no signatures for the on-coming or off-going evening shift. On 1/16/25, there were no signatures for the on-coming or off-going evening shift. On 1/18/25, there was no signature for the	F 0755	**Plan of Correction for F755: Pharmacy Services** **Step 1:** All missing narcotic count signatures will be immediately addressed by requiring oncoming and off-going nurses to verify and sign the narcotic count for the current shift. Any discrepancies will be reported and resolved by the Director of Nursing and/or Designee. **Step 2:** This alleged deficient practice has the potential to impact all residents. A facility-wide audit will be conducted by the Director of Nursing and/or designee to review narcotic count sheets 3 times weekly with shift variations for three months or longer if needed until 100% compliance is met to identify any additional missing signatures or discrepancies. **Step 3:** Licensed nursing staff and QMAs will receive re-education by the Director of Nursing and/or designee on proper narcotic count procedures, including the requirement to conduct shift-to-shift reconciliation and document signatures. **Step 4:** Findings will be reported to the Quality Assurance and Performance Improvement (QAPI) committee for monitoring and further corrective action if needed. **Step 5:** All corrective actions will	03/30/2025

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	off-going evening shift. On 1/19/25, there was no signature for the off-going evening shift. There were five (5) other blank signature boxes on the form. A facility document, titled "Narcotic Count February 2025 Skilled," was provided by the Director of Nursing on 3/3/25 at 5:29 a.m., and indicated there were 24 of 84 missed opportunities to sign off on the narcotic count sheet. During an interview, on 3/6/25 at 3:43 p.m., the Director of Nursing indicated the narcotic count sheet was to be signed by the on-coming and off-going staff. A facility document located in the narcotic book and received from RN 1 on 3/3/25 at 5:29 a.m., indicated "...ATTENTION!!! Nurses and QMA's...Please Make Sure That You Are SIGNING ON/OFF IN The NARC BOOK Each Shift!!!...." A current facility policy, titled "Controlled Substances," dated as last revised 11/22 and received from the Clinical Support Nurse on 3/6/25 at 3:25 p.m., indicated "...Nursing staff count controlled medication inventory at the end of each shift...The nurse coming on duty and the nurse going off duty make the count together...." 3.1-25(e)(3)		be completed by **3/30/2025**.	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation, interview and record review, the facility failed to ensure medications were stored in their original packaging, failed to	F 0761	**Plan of Correction for F761: Label/Store Drugs and Biologicals**	03/30/2025

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	label an open vial with a date, and failed to monitor and document medication refrigerator temperatures for 1 of 1 medication cart and 1 of 1 medication refrigerator reviewed for medication storage. Findings include: 1. During an observation of medication storage, on 3/3/25 at 5:21 a.m., with RN 1 in attendance, the following pills were found outside of their packaging and loose in the cart: One round white oval tablet with imprint C-2. Three small round white tablets. Three oval white tables. One medium round white tablet and one rectangular white tablet. During an interview, on 3/3/25 at 5:21 a.m., RN 1 indicated another nurse last cleaned the cart. 2. During an observation of the medication refrigerator, on 3/3/25 at 5:30 a.m., with RN 1 in attendance, a bottle of Aplisol (tuberculosis testing serum) was found opened and without an open date. During the observation the medication refrigerator temperature logs were reviewed. The refrigerator temperatures had not been documented on January 3, 5, 6, 10, 12, 13, 17, 19, 20, 24, 26, 27, 29, 30 and January 31st, 2025. The February refrigerator temperature log was also found to be missing 13 of 28 temperatures. During an interview, on 3/3/25 at 5:33 a.m., RN 1 indicated the vial of Aplisol should have been labeled with a date when it was opened, and the refrigerator temperatures were to be checked and logged on the sheet every night.		**Step 1:** All loose medications in the Medication Cart(s) were immediately discarded by the Charge Nurse, and all remaining medications were verified to be in their original packaging. The open vial of Aplisol was discarded by the Charge Nurse, and the medication refrigerator was checked to ensure all items were properly labeled by the Charge Nurse. **Step 2:** This alleged deficient practice has the potential to impact all residents. An audit by the Director of Nursing and/or Designee of all medication carts and refrigerators will be conducted to ensure medications are properly stored, labeled, and that refrigerator temperatures are documented daily. **Step 3:** Licensed nurses will receive re-education by the Director of Nursing and/or designee on medication storage procedures, including keeping medications in original packaging, labeling multi-dose vials with an open date, and completing daily refrigerator temperature logs. Compliance will be reinforced through routine medication storage checks by charge nurses. **Step 4:** The Director of Nursing and/or designee will conduct weekly audits of medication carts and refrigerators for four weeks, or longer until 100% compliance is met. The Director of Nursing	

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	During an interview, on 3/6/25 at 3:25 p.m., the Corporate Support Nurse indicated the refrigerator temperatures were to be monitored daily. A current facility policy, titled "MEDICATION STORAGE," dated as last reviewed in 7/12 and received from the Clinical Support Nurse on 3/6/25 at 3:25 p.m., indicated "...Medication storage areas are kept clean...Medication storage conditions are monitored on a regular basis...." 3.1-25(j) 3.1-25(m)		and/or designee will spot check thereafter ensuring adherence to proper storage, labeling, and temperature monitoring practices. All negative findings will be corrected upon discovery. Findings will be reported to the Quality Assurance and Performance Improvement (QAPI) committee for ongoing oversight. **Step 5:** All corrective actions will be completed by **3/30/2025**.	
F 0804 SS=D Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp Based on observation, interview and record review, the facility failed to ensure a recipe was available and followed for puree foods to ensure nutritive value and flavor was conserved for 2 of 2 residents reviewed for a pureed diet. (Resident 1 and 4) Findings include: During a continuous observation, on 3/4/25 at 10:34 a.m., Dietary Manager (DM) 5 was pureeing tuna melt sandwiches for the residents who required a puree diet. As she was pureeing the sandwich, there was no recipe out and she was using an unmeasured amount of cold milk to thin the food out. During an interview, on 3/4/25 at 10:44 a.m., DM 5 indicated they did not have recipes for how to puree food. They did not have recipes for portion sizes or for what thickeners and thinners to use for each meal. They thinned the meal with the	F 0804	**Plan of Correction for F804: Nutritive Value/Appear, Palatable/Prefer Temp** **Step 1:** A standardized recipe book for pureed foods was implemented immediately by the Certified Dietary Manager, ensuring all recipes' specifications. All dietary staff were instructed to follow these recipes when preparing pureed meals. **Step 2:** This alleged deficient practice has the potential to impact all residents. An audit of all pureed meal preparations will be conducted by the Administrator and/or designee to ensure proper recipes are within view and are followed, and resident satisfaction interviews will be completed for those on a pureed diet.	03/30/2025

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	appropriate liquids, and they trained staff in orientation about what liquids to use. During an interview, on 3/4/25 at 11:01 a.m., DM 5 indicated she was not sure how someone would know what liquids to use for the puree if someone had to fill in for absent staff members. They trained staff during orientation on what liquids to use but they did not have a recipe. During an interview, on 3/5/25 at 11:47 a.m., DM 5 indicated she made a recipe book yesterday. The recipe was not in place on the day of the observation and indicated to use hot milk and DM 5 used cold milk when completing the puree. A Dining Manager recipe, titled "Pureed Tuna Melt," dated 2025 and received from DM 5 on 3/5/25 at 3:15 p.m., indicated "...Ingredients: Tuna Melt...Milk, hot...." A current facility policy, titled "Pureed Diet," dated 2022 and received from DM 5 on 3/5/25 at 3:15 p.m., indicated "...Gather the equipment needed: scale, measuring cups, measuring spoons, spatulas, recipes...Add measured amounts of hot liquid for cooked foods and cold liquid (if required) for cold foods and process until a smooth consistency is achieved...." 3.1-21(a)(1)		**Step 3:** All dietary staff will receive re-education on the facility's "Pureed Diet" policy, emphasizing the use of standardized recipes, proper measuring techniques, and the importance of using hot liquids for cooked foods. Ongoing re-education will be conducted by the Certified Dietary Manager as needed to reinforce adherence. **Step 4:** The Dietary Manager and/or designee will audit pureed meal preparations three times per week for four weeks, then weekly for 90 days or longer if needed until 100% compliance is met, ensuring compliance with standardized recipes. All negative findings will be corrected immediately. Findings will be reviewed in the Quality Assurance and Performance Improvement (QAPI) committee meetings for continued monitoring. **Step 5:** All corrective actions will be completed by **3/30/2025**.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: March 3, 4, 5, 6, and 7, 2025	R 0000	This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an	

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	155794	A. BUILDING 00 B. WING	03/07/2025

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	Facility number: 011151 Residential Census: 28 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on March 14, 2025.		admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.	
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance Based on interview and record review, the facility failed to provide documentation to show they had invited the local fire department to attend a fire and disaster drill at least every six (6) months. Findings include: A review of the fire department invites was conducted on 3/5/25. The facility was not able to provide documentation to show the fire department had been invited to attend and participate in a fire and disaster drill at least every six months in the last year. During an interview, on 3/5/25 at 10:17 a.m., Maintenance Staff 8 indicated he was not aware he was to invite the fire department to attend fire/disaster drills every six (6) months, and this was the first time he had heard of the regulation. During an interview, on 3/7/25 at 10:30 a.m., the Resident Care Director indicated the facility did not have any documentation to show the fire department had been invited to attend and participate in a fire and disaster drill at least every six months in the last year.	R 0092	The facility immediately contacted the local fire department and scheduled fire and disaster drills with their participation. Documentation of the invitation and their response will be maintained in the facility's fire drill records. This alleged deficient practice has the potential to impact all residents. A full audit of the past year's fire and disaster drill records was conducted to ensure compliance with all required drills and documentation. The Director of Facility Services and/or designee and administrative staff were re-educated by the VP of Facilities on the requirement to invite the local fire department to participate in fire and disaster drills every six months. A tracking system was implemented to ensure timely invitations and proper documentation. The Administrator and/or designee will audit fire drill documentation	03/25/2025

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	During an interview, on 3/7/25 at 1:11 p.m., the Corporate Support Nurse indicated the facility followed all state regulations and had no other information to present related to the concerns. The facility was not able to provide a policy by the exit date of 3/7/25.		monthly for six months to ensure compliance with fire department invitations. All negative findings will be corrected immediately. Audit results will be reviewed during Quality Assurance and Performance Improvement (QAPI) meetings for ongoing oversight. Date of Compliance: All corrective actions will be completed by **3.25.2025**.	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance Based on observation, interview and record review, the facility failed to ensure a resident had been assessed to self-administer medications and to ensure the resident had an order to self-administer medications for 1 of 1 resident reviewed for self-administration of medication. (Resident 7) Findings include: During an observation of medication administration, on 3/4/25 at 1:28 p.m., QMA 9 administered oral medications to Resident 7. The resident had a large clear bag on her table containing three bottles of eye drops: latanoprost, dorzolamide and brimonidine. During this time, Resident 7 picked up the bag, removed an eye drop, and was observed to administer the eye drops to herself. During an interview, on 3/4/25 at 1:33 p.m., QMA 9 indicated Resident 7 administered her own eye drops.	R 0216	Resident 7 was immediately assessed for self-administration of medications, and a physician's order was obtained to clarify whether self-administration was appropriate. The resident and nursing team members were educated on proper medication management protocols. This alleged deficient practice has the potential to impact all residents. A full audit of all current residents was conducted to ensure that all individuals who self-administer medications have a completed assessment and a physician's order in place. The Resident Care Director and all licensed nurses and QMAs were re-educated on the requirement to complete a self-administration assessment and obtain a physician's order before allowing a resident to self-administer medications. Ongoing training will	03/30/2025

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	The clinical record for Resident 7 was reviewed on 3/4/25 at 1:46 p.m. The diagnoses included, but were not limited to, hypertension, hypothyroidism, and right foot drop. A physician's order, dated 8/23/24, indicated to administer latanoprost 0.005% in both eyes daily. There was no order for self-administration in the record. A physician's order, dated 8/24/24, indicated to administer dorzolamide 22.3 milligrams-timolol 6.8 milligrams/milliliter in both eyes twice daily. There was no order for self-administration in the record. A physician's order, dated 8/24/24, indicated to administer brimonidine 0.2% in both eyes twice daily. There was no order for self-administration in the record. There was no assessment to self-administer medications found in the resident's record. During an interview, on 3/4/25 at 1:56 p.m., the Resident Care Director indicated she was not aware Resident 7 had self-administered eye drops. The family might have provided eye drops. The resident did not have an assessment to self-administer any medications, and she did not have a physician's order to self-administer medications. A current facility policy, titled "Medication Management-Medication Reminders," undated and received from the Corporate Support Nurse on 3/6/25 at 3:37 p.m., indicated "...The facility shall ensure that residents who have been evaluated and found capable of medication self-administration...received medication reminders in a timely manner...Each resident		be provided during new The Resident Care Director and/or designee will conduct weekly room sweeps of resident rooms 30 days or longer if needed until 100% Compliance is achieved to ensure medications are not stored in the resident rooms for resident self-administration without physician notification and/or physician order. The Resident Care Director and/or designee will verify that self-administration assessments and physician orders are completed as required. All negative findings will be corrected immediately. Audit results will be reviewed during the Quality Assurance and Performance Improvement (QAPI) meetings for further oversight. **Date of Compliance:** All corrective actions will be completed 3/30/**2025**	

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	deemed capable of medication self-administration...will have a physician's order specifying this...."			