| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155367 | A. Building<br>B. Wing | 01/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brickyard Healthcare -Sycamore Village Care Center | 2905 W Sycamore St<br>Kokomo, IN 46901 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the kitchen was maintained in a safe and sanitary condition in 1 of 1 kitchen reviewed. This deficient practice had the potential to affect 95 of 95 residents who received food from the kitchen.Findings include:During the kitchen observation, on 1/4/26 at 10:58 a.m., with the Dietary Manager (DM), the following were observed:a. The walk-in refrigerator contained two 16-ounce cans of Pepsi open, two cans of Pepsi not open, one 16-ounce bottle of water opened, a thirty-two-ounce bottle of Coffee Mate French Vanilla liquid creamer with no sugar and a Gordons choice whipped topping. All without a date or label.b. Four empty cardboard boxes were not broken down and stacked on the floor by the back exit door. c. The floor under the serving station had dried unknown food and unopened condiment packets. d. The floor under and around the oven had unknown food substances and grease.e. The floor in the refrigerator had small particles of unknown food, pieces of carboard, pieces of clear tape, and lids to unknown containers.f. The floor in the dry food area had dried sticky liquid of unknown substance, small particles of dried food, plastic white fork and spoon, and small pieces of paper.g. The floor in the dishwashing station had food, pieces of paper, aluminum foil, and grimy scuffing.h. Eight rolling carts had dried food products and dried liquid.i. The chemical storage closet had a pint [NAME] jar with clear orange liquid with no date or label.j. The juice dispenser station next to the hand-washing station had an open can of coke and a can of glass cleaner.k. The microwave had dried unknown food particles on the exterior and interior.l. The stove top had dried food product on it with a pan of butter uncovered with a brush in pan.During an interview, on 1/4/26 at 11:20 a.m., the Dietary Manager indicated the employees were not supposed to store their drinks in the refrigerator.During an interview, on 1/4/26 at 11:24 a.m., the Dietary Manager indicated cardboard boxes should not be stored on the floor.During an interview, on 1/4/26 at 11:28 p.m., the Dietary Manager indicated the flooring through the kitchen, refrigerator, freezer, and dry food pantry should be clean and free of debris.During an interview, on 1/4/26 at 11:29 p.m., the Dietary Manager indicated rolling carts should be clean.During an interview, on 1/4/26 at 11:30 a.m., the Dietary Manager indicated chemicals in storage area should be labeled.During an interview, on 1/4/26 at 11:34 a.m., the Dietary Manager indicated the juice station shelf should not have employee drinks or cleaning products on it.During an interview, on 1/4/26 at 11:40 a.m., the Dietary Manager indicated cooking appliances should be clean.During an interview, on 1/09/26 at 10:10 a.m., the Registered Dietician (RD) indicated no liquid substances should be stored in a [NAME] jar and kept in the chemical storage closet anywhere in the facility.A current facility policy, titled Sanitation Inspection, with no revision dated and received from the Executive Director (ED) on 1/9/26 at 11:45 a.m., indicated .It is the policy of this facility, as part of the department's sanitation program, to conduct inspections to ensure food service areas are clean, sanitary and in compliance with applicable state and federal regulations.All food service areas shall be kept clean, sanitary, free from litter, rubbish.A policy for chemical storage was not provided.3.1-21(i)(3) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155367 | A. Building<br>B. Wing | 01/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brickyard Healthcare -Sycamore Village Care Center | 2905 W Sycamore St<br>Kokomo, IN 46901 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Keep residents' personal and medical records private and confidential.<br><br>Based on observation, interview and record review, the facility failed to ensure privacy was provided for a resident during care for 1 of 1 resident randomly reviewed for privacy. (Resident 5)Findings include: During a random observation, on 1/7/26 at 11:21 a.m., RN 9 and QMA 15 entered Resident 5's room to administer medication through the resident's gastrostomy tube (a tube placed through the abdomen directly into the stomach for long-term feeding, hydration, and medication delivery). RN 9 placed the medication on the bedside table and asked QMA 15 to watch the medication while she washed her hands. RN 9 returned and QMA 15 exited the room. RN 9 did not have water to flush the medication and asked the Executive Director (ED) to get a cup of water off the medication cart. The ED brought the water to RN 9 and left the room. Resident 5's door and privacy curtain remained open. RN 9 pulled the resident's covers back, lifted his gown, and exposed his abdomen. The privacy curtain and the door remained open. A visitor in the facility walked by the resident's room and looked inside. The clinical record for Resident 5 was reviewed on 1/6/26 at 3:11 p.m. The diagnoses included, but were not limited to, cerebral infarction, diabetes mellitus, atrial fibrillation, acute kidney failure, and gastrostomy tube.A care plan, dated 4/21/25, indicated the resident required enteral feeding.During an interview, on 1/7/26 at 11:21 a.m., RN 9 indicated she did not close the door or the curtain to provide privacy for Resident 5. During an interview, on 1/7/26 11:41 a.m., QMA 15 indicated the privacy curtain, or door should always be closed when completing any kind of care with the resident. A current facility policy, titled Resident Rights, undated and received from the ED on 1/9/25 at 11:30 a.m., indicated .The resident has a right to a dignified existence, self-determination and communication with, and access to, persons and services inside and outside the Facility .Information about resident rights and responsibilities will be given to the resident both orally and in writing 3.1-3(p)(4) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155367 | A. Building<br>B. Wing | 01/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brickyard Healthcare -Sycamore Village Care Center | 2905 W Sycamore St<br>Kokomo, IN 46901 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>Based on interview and record review, the facility failed to ensure staff obtained another weight after a documented weight gain for 1 of 3 residents reviewed for quality of care. (Resident 23) Findings include:The clinical record for Resident 23 was reviewed on 1/7/26 at 9:53 a.m. The diagnoses included, but were not limited to, cerebral palsy, conversion disorder with seizure or convulsions, anxiety disorder, hypertension, cognitive communication deficit, and intellectual disabilities. A care plan, dated 6/23/25, indicated Resident 23 triggered for obesity and a body mass index (BMI) greater than 30. Interventions included, but were not limited to, weights according to the physician's order.A clinical record indicated Resident 23 had the following weight:On 7/1/25, the resident's weight was 244.0 pounds. On 8/5/25, the resident's weight was 270.0 pounds. Resident 23 had a significant weight gain of 10.66% in 36 days. There was no documentation located in the medical record to indicate another weight had been obtained to determine if the weight was correct or the physician was notified.During an interview, on 1/9/26 at 10:55 a.m., LPN 2 indicated if the resident had a significant weight gain or loss the physician should be called. If the resident had a weight gain and a diagnosis of congestive heart failure, the physician could order a diuretic. During an interview, on 1/9/26 at 10:58 a.m., RN 3 indicated it was very important to notify the physician if there was a significant weight change. The resident could need additional orders, or the physician could want to see the resident. RN 3 indicated she would also complete an assessment to determine if the resident had edema. During an interview, on 1/9/26 at 11:25 a.m., the Registered Dietician (RD) indicated nursing staff should complete another weight on a resident if there was a significant weight loss or gain. There was no documentation in the clinical record to indicate the resident was reweighed.During an interview, on 1/9/25 at 11:27 a.m., the Executive Director (ED) indicated there was no documentation the physician was notified of the weight gain. A current facility policy, titled Weight Monitoring, undated and received from the ED on 1/9/26 at 11:47 a.m., indicated .A significant change in weight is defined as: 5% change in weight in 1 month (30 days) .The physician should be informed of a significant change in weight and may order nutritional interventions 3.1-37(a) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155367 | A. Building<br>B. Wing | 01/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brickyard Healthcare -Sycamore Village Care Center | 2905 W Sycamore St<br>Kokomo, IN 46901 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>Based on observation, interview and record review, the facility failed to ensure a resident was kept safe during care and transfers for 1 of 4 residents reviewed for accidents. (Resident C)Findings include:During an interview, on 1/7/26 at 10:39 a.m., Resident C's daughter indicated the resident had fallen twice. The first was from her bed. The resident's bed was smaller than her current bed, she rolled out and fell on the floor during incontinence care. There was only one CNA in the room, and the CNA pushed the resident too hard, and she fell out of her bed. The second was from the mechanical lift. The facility did not call her when the resident's lift strap on the pad broke. The resident called from the ambulance. When the resident was in the emergency room, the Executive Director called but it was at least 30 minutes after the resident was in the emergency room. The Executive Director had asked if she wanted to see the broken pad and then when she asked to see the pad the Executive Director indicated it was no longer available. The clinical record for Resident C was reviewed on 1/6/26 at 10:34 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disorder, congestive heart failure, hypertension, morbid obesity, and osteoarthritis of the right and left knee.An annual Minimal Data Set (MDS) assessment, dated 10/23/25, indicated Resident C was dependent on staff with transfers.A care plan, dated 12/18/24, indicated Resident C had a self-care performance deficit. Interventions included, but were not limited to, 1/28/25, trapeze bar above the bed to assist with repositioning. 12/18/24, Resident C required substantial assistance to complete bed mobility, was dependent on toileting, and totally dependent on transfers. Encourage Resident C to participate, when possible, with each interaction.A care plan, dated 12/18/24, indicated Resident C was at risk of falls. Interventions included, but were not limited to, 12/18/24, assistance with transfers, ensure resident wore appropriate non-skid footwear, and the environment remained safe.1. A facility's change of condition note, dated 11/26/25 at 11:50 a.m., indicated Resident C was receiving incontinence care. While the resident turned towards the window on her left side, the resident fell out of the bed. The resident held herself with the trapeze, her hand slipped off, and she fell out. The resident received a small scratch on the back of her right lower leg. The new intervention was for two (2) people to assist with care. A fall risk evaluation, dated 11/26/25, indicated Resident C had a low risk for falls.A physician's progress note, dated 11/28/25 at 8:00 a.m., indicated Resident C was seen for follow-up of right ankle pain experienced post fall. Her x-ray did not show acute fracture. She had right ankle pain with no acute fracture or dislocation seen.An interdisciplinary team note, dated 12/4/25 at 11:11 a.m., indicated Resident C had a fall and slid off the edge of the bed during care, on 11/26/25. The new intervention was two (2) caregivers when providing peri care.During an interview, on 1/4/26 at 2:51p.m., Resident C indicated she had fallen when she was too close to the edge of the bed while staff were providing incontinence care, and she rolled off the bed. The bed was too small. During an interview, on 1/7/25 at 1:00 p.m., the Executive Director indicated Resident C did fall out of bed during incontinence care. Resident C did not get hurt.During an interview, on 1/7/26 at 5:04 p.m., CNA 17 indicated she was completing peri care on the resident. Resident C helped with turning from her back towards the window. She grabbed the overhead trapeze and rolled to the left. The bed was close to the window, Resident C slid off the bed, and her left foot went to the floor, and her right leg went up in the air. She landed on the floor and was in a split position between the bed and the window. CNA 17 yelled for the nurse, and they used the mechanical lift to help Resident C off the floor.2. An interdisciplinary team note, dated 12/4/25 at 12:45 p.m., indicated Resident C returned from the emergency room after a recent fall. Resident C had complaints of pain related to the fall.A facility's change of condition note, dated 12/4/25 at 3:00 p.m., indicated Resident C was being transferred with the Hoyer lift. Resident C was approximately an inch off the bed when the Hoyer sling snapped and the resident fell to floor. Three (3) staff members were present at the transfer. Resident C had significant pain in her lumbar area and was sent to the emergency<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155367 | A. Building<br>B. Wing | 01/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brickyard Healthcare -Sycamore Village Care Center | 2905 W Sycamore St<br>Kokomo, IN 46901 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | room for evaluation.A fall risk evaluation, dated 12/4/25 at 3:30 p.m., indicated Resident C had 1-2 falls in the past 3 months. Resident C was chairbound and incontinent.An interdisciplinary team note, dated 12/5/25 at 10:01 a.m., indicated Resident C fell from Hoyer sling. The Hoyer sling broke and the resident was sent to the emergency room for evaluation.A nursing progress note, dated 12/5/25 at 12:40 p.m., indicated Resident C returned from the hospital. She reported new back pain. New physician's orders were received for as needed Norco (a pain medication), Robaxin (a muscle relaxing medication), and routine Lidoderm patches (a topical patch used for pain) to her back.A nursing progress note, dated 12/5/25 at 2:53 p.m., indicated Resident C was assessed for side rails and passed the assessment.A post fall evaluation, dated 12/8/25 at 4:24 p.m., indicated Resident C was being transferred with the Hoyer lift when the Hoyer sling strap broke. The resident had a bruise on her hand and lower back pain.A hospital document, dated 12/26/25, indicated an x-ray of the spine was completed with no fractures detected. The hospital was unable to obtain a CT (computed tomography) scan due to patient's weight. The resident had a fall from a height of less than 3 feet and reported experiencing pain localized to the thoracic (middle section of the spine), right shoulder, and noted discomfort associated with positional changes in bed.A fall risk evaluation, dated 1/2/25, indicated Resident C was at moderate risk for falls. During an observation, on 1/6/26 at 11:11 a.m., Certified Nursing Assistant (CNA) 13 and CNA 14 were transferring Resident C into her recliner. Resident C was lying flat in her bariatric bed. Resident C grabbed the trapeze handle and assisted in rolling herself over onto her left side. CNA 13 placed the large blue Hoyer pad underneath the resident and instructed the resident to roll onto her right side. Once the pad was under the resident; CNA 14 pushed the mechanical lift to the right side of the bed. The CNAs attached the straps of the pad onto the hooks and began to lift Resident C off the bed. Resident C asked the CNAs to stop and to cross the straps at her feet. CNA 13 informed Resident C they could not cross the straps. CNA 13 indicated the pad was the correct pad for Resident C and the nurse had told her which pad to use. During an interview, on 1/6/26 at 11:19 a.m., Unit Manager 16 indicated the mechanical lift pads were based on the resident's weight and were normally stored in each resident's room. During an observation and interview, on 1/6/26 at 11:25 a.m., Unit Manager 16 indicated the lift pads were normally kept in the clean storage room or the resident's room. Unit Manager 16 pulled a lift pad out from a large blue barrel to look at the tag with the weight. The pad did not have a weight limit on tag and Unit Manager 16 indicated she was not sure why. The Patient Lift Safety Guide indicated assess the patient's size, weight, and hip measurement and choose the size of the sling based on the manufacturer's recommendation for the patient's measurements. Choosing the correct sling size was critical for safe patient transfer. If the sling was too large, the patient could slip out. If the sling was too small, the patient could fall out. If the sling was between sizes, the smaller size could keep the patient more secure. Using the wrong sling or attaching the sling incorrectly could cause an accident which could result in serious injury or death.During an interview, on 1/6/26 at 11:30 a.m., Resident C indicated the staff had crossed the straps down by her feet on more than one occasion. When staff used the large pad, she felt like she would slide out. The CNAs not normally assigned to her would use the incorrect pad. Resident C indicated the pad the staff used the day of the incident felt smaller. She told the CNAs and they said it would be okay then shortly after was when the strap broke and she fell. She hit her right shoulder and back on the mechanical lift legs. She felt like she broke her back. During an interview, on 1/7/25 at 4:22 p.m., CNA 10 indicated on the day of the incident, CNA 11, CNA 12, and herself hooked the straps to the lift. She could not remember how they attached the straps. CNA 12 raised the resident up about 2 inches off the bed and pulled the lift out. CNA 11 was guiding the resident when the stitching on the strap came loose, the resident fell and landed on the mechanical lift legs. Resident C hit her left lower back on the mechanical lift. CNA 10 was not sure which pad they used or if the pad was the correct weight limit for Resident C. During an interview, on 1/9/26 at 10:30 a.m., the Ombudsman indicated Resident C's family member had called him with concern. Resident C had fallen from a mechanical lift and had also fallen from the bed during peri care. During (continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155367 | A. Building<br>B. Wing | 01/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brickyard Healthcare -Sycamore Village Care Center | 2905 W Sycamore St<br>Kokomo, IN 46901 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | an interview, on 1/9/26 at 10:39 a.m., LPN 2 indicated Resident C required a mechanical lift. During an interview, on 1/9/26 at 10:42 a.m., RN 3 indicated to use the mechanical lift, you should know the weight of the resident. The pads were labeled with the weights. She believed the resident used a pad for 500 pounds. The CNAs should know which pad Resident C used. During an interview, on 1/9/26 at 12:50 p.m., CNA 11 indicated on the day of the incident, she helped CNA 10 and 12 with Resident C. They used the bigger pad which crossed under the resident at the legs. CNA 12 began to raise the resident up while she guided the resident off the bed. Resident C had just cleared the bed when the right strap unraveled and broke. The resident fell to the ground and hit her back on the mechanical lift legs. 3. During an interview, on 1/9/25 at 1:22 p.m., Resident C indicated earlier this morning two (2) guys, and a girl (unable to recall their names) came in with the mechanical lift to transfer her back to bed. The resident had an overhead trapeze at the head of bed. During the transfer, the mechanical lift hit her overhead trapeze bar and knocked the trapeze bar down. The trapeze bar bumped the back of her head. The resident indicated her head was a little sore but did not bleed. During an interview, on 1/9/25 at 9:45 a.m., the Executive Director (ED) indicated Resident C did have an incident with the mechanical lift today. The trapeze bar dropped and hit the back of her head. She had a small bump on her head, but it was not open. She spoke to the resident who stated she was fine.At the exit conference, the ED indicated she had no additional information provided related to the incidents. The facility did not have a policy on the use of mechanical lifts.A current facility policy, titled Accidents and Supervision, dated 12/4/25 and received from the ED on 1/9/25 at 11:30 a.m., indicated .The residents' environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents.All staff.are to be involved in observing and identifying potential hazards in the environment.This citation relates to Intake 2680656.3.1-45(a)(1)3.1-45(a)(2) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155367 | A. Building<br>B. Wing | 01/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brickyard Healthcare -Sycamore Village Care Center | 2905 W Sycamore St<br>Kokomo, IN 46901 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>Based on observation, interview and record review, the facility failed to ensure medications were dated when opened in 1 of 3 medication carts reviewed for medication storage. (East Hall)Findings include:During an observation, on 1/8/26 at 11:01 a.m., with the Infection Preventionist Nurse, the East Hall medication cart had the following:a. One multi-use tube of Triad Wound paste was not labeled with an open date.b. One multi-use tube of Diclofenac gel 1% was not labeled with an open date.During an interview, on 1/8/26 at 11:06 a.m., the Infection Preventionist Nurse indicated the medications should have been labeled with a date when they were opened.During an interview, on 1/9/26 at 10:52 a.m., RN 3 indicated if a new tube of medication was opened, it would be dated with the date opened and placed in the treatment cart with the residents' other medications.During an interview, on 1/9/26 at 12:46 p.m., Pharmacist 8 indicated she was unsure of the shelf life of Diclofenac gel and Triad Wound paste once opened, but they should be dated when they were opened.A current facility policy, titled Labeling of Medications and Biologicals, dated as revised 2025 and provided by the Executive Director on 1/8/26 at 2:00 p.m., indicated .Labels for multi-use vials must include: a. The date the vial was initially opened. 3.1-25(j) |