STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brickyard Healthcare - Lincoln Hills Care Center	402 19th Street Tell City, IN 47586

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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review, the facility failed to ensure privacy was provided for the residents for 6 of 6 random observations on 2 of 3 halls. Resident information was visible on the computer screens in Hall A and Hall B and staff did not knock prior to entering a resident room. (Hall A, Hall B, Resident D)Findings include:1. On 4/9/26 at 8:37 A.M., Hall A's Medication Cart was observed in the hallway with resident information (resident name, picture, and room number) visible on the computer screen without staff present at the computer.2. On 4/13/26 from 6:13 A.M. to 6:19 A.M., Hall A's Medication Cart was observed in the hallway with resident information (resident name, picture, and room number) visible on the computer screen without staff present at the computer.3. On 4/13/26 from 6:24 A.M. to 6:29 A.M., Hall B's Medication Cart was observed in the hallway with resident information (resident name, picture, and room number) visible on the computer screen without staff present at the computer.4. On 4/13/26 at 6:49 A.M., Licensed Practical Nurse (LPN) 22 did not knock or announce herself prior to entering Resident D's room to get the blood sugar reading. When she got to the resident's bedside and said the resident's name, Resident D was startled and jumped. LPN 22 went back out to the medication cart to prepare Resident D's medications and walked back into Resident D's room with those medications and did not knock or announce herself prior to entering the room. LPN went back out to get the resident a snack and her prepare her insulin. LPN 22 did not knock or announce herself prior to entering Resident D's room.During an interview on 4/15/26 at 1:41 P.M., the Director of Nursing (DON) indicated nursing staff should knock before entering resident rooms and should not leave computer screens with resident information visible while they are not at the computer. On 4/16/26 at 8:30 A.M., a current non dated Medication Administration Policy was provided by the Administrator and indicated, . 5. Knock or announce presence . 7. Provide privacy . On 4/16/26 at 8:30 A.M., a current non dated Resident Rights Policy was provided by the Administrator and indicated, . The facility will ensure that all direct care and indirect care staff members, including contractors and volunteers, are educated on the rights of residents . 410 Indiana Administration Code (IAC) 16.2-3.1-3(o)

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
	155384	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brickyard Healthcare - Lincoln Hills Care Center	402 19th Street Tell City, IN 47586

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review, the facility failed to ensure physician orders were followed for 2 of 5 residents reviewed for unnecessary medications, and an insulin pen was not primed for 2 of 2 insulin administration observations. A blood pressure medication was not held as indicated in the order parameters, and a resident's blood sugar was not re-checked as ordered. (Resident 5, Resident 4, Resident D)Findings include:1. On 4/14/26 at 9:46 A.M., Resident 5's clinical record was reviewed. Diagnosis included, but was not limited to, diabetes mellitus. The most recent quarterly Minimum Data Set (MDS) assessment, dated 2/15/26, indicated no cognitive impairment and 7 of 7 days of insulin injections. Current physician orders included, but was not limited to: Insulin Aspart FlexPen 100 unit/ml (milliliter), Inject as per sliding scale: if 100 - 150 = 4 units <100 eat small snack and recheck blood sugar in 15 mins then administer insulin; 151 - 175 = 5 units; 176 - 200 = 6 units; 201 - 225 = 7 units; 226 - 250 = 8 units; 251 - 300 = 9 units; 301 - 325 = 10 units; 326 - 350 = 11 units; 351 - 375 = 12 units; 376 - 400 = 13 units; 401 - 450 = 14 units If blood sugar is <60 or > 450 notify MD, subcutaneously before meals, dated 1/22/26. Resident 5's Medication Administration Record (MAR) indicated the following blood sugars below 100 with no documented re-check: 4/3/26 at lunch, blood sugar 85. 4/4/26 at lunch, blood sugar 74. 4/7/26 at dinner, blood sugar 96. Resident 5's MAR indicated on 4/2/26 at dinner, no blood sugar or insulin was administered. Resident 5's progress notes lacked documentation of a blood sugar re-check on 4/3/26, 4/4/26, or 4/7/26. The progress notes also lacked documentation of why a blood sugar was not completed or insulin given on 4/2/26 at dinner. 2. On 4/13/26 at 6:40 A.M., Licensed Practical Nurse (LPN) 22 was observed preparing insulin for Resident 5. She put on gloves, grabbed Resident 5's Novalog Flexpen 100 units/milliliter (u/ml), wiped the tip of it with alcohol, and applied the needle leaving the outer cover on it. The nurse held the pen horizontally and pushed the plunger of the pen to prime it with one unit of insulin. Then she dialed the pen to four units and administered the insulin to the resident. 3. On 4/13/26 at 6:49 A.M. LPN 22 was observed preparing insulin for Resident D. She put on gloves, grabbed Resident D's Humalog Kwikpen 100 u/ml, wiped the tip of it with alcohol, and applied the needle leaving the outer cover on it. The nurse held the pen horizontally and pushed the plunger of the pen to prime it with one unit of insulin. Then she dialed the pen to one unit and administered the insulin to the resident. During an interview on 4/13/26 at 7:04 A.M., LPN 22 indicated that she primed insulin pens with one unit of insulin. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brickyard Healthcare - Lincoln Hills Care Center	402 19th Street Tell City, IN 47586

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. On 4/10/26 at 12:38 P.M., Resident 4's clinical record was reviewed. Diagnosis included, but was not limited to, hypertension (high blood pressure). The most recent annual Significant Change Data Set (MDS) assessment, dated 3/19/26, indicated Resident 4 was cognitively intact. Current physician orders included, but was not limited to the following: Hydralazine oral tablet 50 milligrams (mg) (hypertension medication). Give 1 tablet every by mouth 3 times a day for hypertension. Hold for a systolic (top number) blood pressure (bp) less than 140, dated 1/20/26. On the following dates and times, hydralazine was given when Resident 4's systolic blood pressure was less than 140: February 2, 2026: bp of 136/80—evening shift February 4, 2026: bp of 136/64—middle shift February 4, 2026: bp of 132/75—evening shift February 5, 2026: bp of 132/75—morning shift February 5, 2026: bp of 138/68—middle shift February 5, 2026: bp of 120/60—evening shift February 6, 2026: bp of 132/72—middle shift February 7, 2026: bp of 125/68—evening shift February 8, 2026: bp of 135/65—evening shift February 9, 2026: bp of 128/70—middle shift February 13, 2026: bp of 139/82—evening shift February 14, 2026: bp of 139/82—morning shift February 14, 2026: bp of 139/82—middle shift February 17, 2026: bp of 105/63—middle shift March 2, 2026: bp of 127/60—morning shift March 2, 2026: bp of 127/60—middle shift March 10, 2026: bp of 138/70—middle shift (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brickyard Healthcare - Lincoln Hills Care Center	402 19th Street Tell City, IN 47586

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	March 14, 2026: bp of 128/78—middle shift March 17, 2026: bp of 117/66—morning shift March 20, 2026: bp of 128/68—middle shift March 21, 2026: bp of 128/68—morning shift March 21, 2026: bp of 128/68—middle shift March 28, 2026: bp of 139/87—morning shift March 29, 2026: bp of 135/76—morning shift During an interview on 4/14/26 at 10:38 A.M., Registered Nurse (RN) 8 indicated if the resident's systolic blood pressure is less than 140, the medication should not be given. On 4/16/26 at 8:30 A.M., the Administrator provided a current non-dated Medication Administration that indicated, .Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters. On 4/16/26 at 8:30 A.M., the Administrator provided a current non-dated Insulin Pen policy that indicated Monitor blood sugar as ordered by physician . always review physician orders prior to administering any medication On 4/16/26 at 8:30 A.M., a current non dated Insulin Pen Policy was provided by the Administrator and indicated, It is the policy of this facility to use insulin pens in order to improve the accuracy of insulin dosing . insulin pens will be primed prior to each use to avoid collection of air in the insulin reservoir . Procedure: g. Attach pen needle: . iv. Twist open and remove outter cover from the pen needle. h. Prime the insulin pen: i. Dial 2 units by turning the dose selector clockwise. ii. With the needle pointing up, push the plunger, and watch to see that at least one drop of insulin appears on the tip of the needle. If not, repeat until at least one drop appears . 410 IAC (Indiana Administrative Code) 16.2-3.1-37(a) 410 Indiana Administrative Code (IAC) 16.2-3.1-35(g)(1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brickyard Healthcare - Lincoln Hills Care Center	402 19th Street Tell City, IN 47586

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. Based on observation, interview, and record review, the facility failed to ensure residents were provided activities to meet the interests of and well-being of each resident for 1 of 1 weekends reviewed for activities.Findings include:During the resident council meeting on 4/13/26 at 11:20 A.M., residents indicated they don't have activities on the weekends. One resident indicated he can't get around to host them or even tell people there are any. On 4/14/26 at 9:55 A.M., an activity calendar hanging in Hall 2 was reviewed and indicated the following dates and activities to be held:Saturday, 4/11/26 at 10:00 A.M. magnet game, 11:00 A.M. mealtime memories, 1:00 P.M. daily chronicles, 1:30 P.M. music and conversationsSunday, 4/12/26 at 10:00 A.M. tv time, 11:00 A.M. mealtime music, 1:00 P.M. daily chronicles, 1:30 P.M. friendly conversations, 3:00 P.M. church servicesTuesday, 4/14/26 at 10:00 A.M. nails on station 4. On 4/14/26 at 10:00 A.M., the Activity Manager was in the dining room sitting at a table with three male residents talking.During an interview on 4/14/26 at 9:45 A.M., the Activity Director indicated the activity department was not staffed on weekends and the weekend manager on duty should do the activities. They had church on Sunday. On 4/14/26 at 10:00 A.M., the Regional Consultant provided the weekend manager on duty schedule for April 2026, and it indicated on 4/11/26 the Business Office Manager (BOM) was manager on duty and on 4/12/26 the payroll staff was on duty.On 4/14/26 at 10:21 A.M., the Activity Director was asked to provide the participation list forms from 4/11/26 and 4/12/26. She indicated she would find them.On 4/14/25 at 10:45 A.M., the Activity Director provided handwritten activity participation lists (written in the same handwriting) for the following activities:4/11/26-Daily chronicles, magnet game (changed to TV time because there was no interest), music and conversations, and mealtime melodies 4/12/26-Daily chronicles (list was identical to 4/11/26 list except the date was changed), mealtime music, friendly chats, TV time, and church services.During an interview on 4/14/26 at 10:03 A.M., the payroll staff indicated they don't do activities on Sundays because they have church. On Saturdays, they will do activities such as crafts, daily chronicles, and music. The manager on duty should write on paper participation form and should provide it to the Activity Director on Monday or put it in her mailbox. She was currently out of the forms so she was not able to provide one.During an interview on 4/14/26 at 10:05 A.M., the BOM indicated she was on duty Saturday 4/11/26. She indicated they usually have puzzles and daily chronicles. But that Saturday, she had to do other tasks, so she was not able to help with the activities. She indicated staff really didn't round up the residents. There was usually a handful of residents that participated. Every resident had a copy of the activity calendar to see what was offered and if they wanted to come, they would. She also indicated they were to fill out a paper participation form.During an interview on 4/14/26 at 10:17 A.M., Certified Nurse Aide (CNA) 6 indicated sometimes there were activities on the weekend, it just depended what staff was available. She indicated they try to tell the residents when activities were going to happen, but most of the time the same residents went to activities, so they knew what was going on.On 4/16/26 at 8:30 A.M., a current non dated Weekend Manager Checklist was provided by the Administrator and listed, but was not limited to, the following duties: appropriate activities in lobby, Weekend activities with who participated list left for Activities Director.On 4/16/26 at 8:30 A.M., a current non dated Activities Policy was provided by the Administrator and indicated, It is the policy of this facility to provide an ongoing program to support residents in their choice of activities . 410 Indiana Administration Code (IAC) 16.2-3.1-33(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brickyard Healthcare - Lincoln Hills Care Center	402 19th Street Tell City, IN 47586

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure infection control practices were followed for 2 of 4 residents during observation of incontinence care and 2 ofv4 observations of medication administration. Gloves were not changed and hand hygiene was not performed between dirty and clean tasks during perineal care. The nurses dropped medications onto the medication cart, picked them up with their bare hand, and administered it to the residents. (Resident C, Resident B, Resident D, Resident G). Findings include:1. On 4/13/26 at 6:13 A.M., Licensed Practical Nurse (LPN) 5 was observed preparing medications for Resident G. When she poured the prepackaged medications into the medication cup, one pill fell onto the medication cart. LPN 5 picked it up with her bare hand and put it into the medication cup. LPN 5 took the medications into Resident G's room and administered them to the resident. 2. On 4/13/2026 at 6:49 A.M., LPN 22 was observed preparing medications for Resident D. When she poured the prepackaged medications into the medication cup, one pill fell onto the medication cart. LPN 22 picked it up with her bare hand and put it into the medication cup. LPN 22 took the medications into Resident D's room and administered them to the resident. During an interview on 4/15/26 at 9:50 A.M., Registered Nurse (RN) 35 indicated if a medication fell out of package while administering medications, nursing staff should use gloves so they aren't touching the medication with their bare hands and should dispose of the medication and not administer it to a resident. 3. During an observation of care on 4/13/26 at 11:03 A.M., Certified Nurse Aide (CNA) 6 and CNA 7 performed perineal care on Resident C. CNA 6 washed her hands and donned gloves and used her right gloved hand to raise Resident C's bed up. CNA 6 used the same gloved hand to wipe Resident C's perineal area with a washcloth. At that time, CNA 6 grabbed a clean incontinence pad and placed it on the bed with the same gloved hand. Then she removed gloves, sanitized, and donned new gloves while the soiled incontinence pad was still on the bed under Resident C. Resident C rolled to the right side and CNA 6 wiped Resident C's buttocks with a washcloth, removed gloves, sanitized, and donned new gloves. CNA 6 then removed the soiled incontinence pad from under the resident and failed to change gloves and sanitize before the clean incontinence pad was placed under Resident C. 4. On 4/13/26 at 9:20 A.M. Licensed Practical Nurse (LPN) 41 was observed performing perineal care for Resident B. Resident B gave permission to watch care. LPN 41 closed the curtains on the window and the curtain around the bed. She explained to Resident B what she was going to do, filled water basin with warm water, washed her hands, put on gloves, and took blankets off resident. LPN 41 unfastened the brief, pushed it between Resident B's legs, wet a washcloth and sprayed the washcloth with peri cleaner. LPN 41 washed down both sides of the front of Resident B's perineal area, and down between the labia. LPN 41 put the soiled washcloth in a trash bag on the bed and asked Resident B to turn to her left side. When LPN 41 took the brief that contained stool out from under Resident B, stool got on the pad under Resident B and the lift sheet. LPN 41 put the soiled brief into a trash bag on the bed and rolled the pad and lift sheet under the resident. LPN 41 changed gloves but did not sanitize her hands before putting clean gloves on. LPN 41 placed a clean pad and lift sheet on bed, used a wet washcloth with peri clean and washed buttocks with several clean washcloths until Resident B was clean, dried her with a towel and placed soiled linens in the trash bag. LPN 41 asked Resident B to turn to the right side, pulled pad and lift sheet through, pulled brief up between Resident B's legs and fastened. LPN 41 tied the trash bags shut, took gloves off, and cleaned hands with sanitizer. Resident B asked for a Pepsi and LPN 41 told the resident she had to (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brickyard Healthcare - Lincoln Hills Care Center	402 19th Street Tell City, IN 47586

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wash her hands first. During an interview on 4/15/26 at 9:50 A.M., the Infection Preventionist (IP) indicated staff should change gloves and perform hand hygiene between dirty and clean tasks. On 4/16/26 at 8:30 A.M., a current non dated Medication Administration Policy was provided by the Administrator and indicated, . 14. Remove medication from source, taking care not to touch medication with bare hand . On 4/16/26 at 8:30 A.M., the Administrator provided a non dated Personal Protective Equipment (PPE) policy that indicated, 4. Indications/considerations for PPE use: .iv. Change gloves and perform hand hygience between clean and dirty tasks, when moving from one body part to another, when heavily contaminated, or when torn . This citation relates to Intake 2971495. 410 Indiana Administrative Code (IAC) 16.2-3.1-18(b)(1) 410 Indiana Administrative Code (IAC) 16.2-3.1-18(l)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155384	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brickyard Healthcare - Lincoln Hills Care Center	402 19th Street Tell City, IN 47586

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were properly assessed for self administering medications for 2 of 2 random observations. A resident had a medication cup containing medications sitting on her bedside table and a resident was left alone with his medications. (Resident 14, Resident G)Findings include:1. On 04/13/26 at 6:40 A.M., Licensed Practical Nurse (LPN) 22 went to check a blood sugar on Resident 14's roommate. Resident 14 was laying in the dark, in her bed, with her eyes closed. A medication cup containing medications was on her bedside table. On 4/13/26 at 8:07 A.M., Resident 14's clinical record was reviewed. Diagnoses included, but were not limited to, chronic heart failure, stroke, diabetes mellitus type II, atrial fibrillation, and bipolar disorder.The most recent quarterly Minimum Data Set (MDS) assessment, dated 1/5/26, indicated Resident 14's cognition was intact.The clinical record lacked an order, care plan, and assessment of the resident to safely self-administer medications.During an interview on 4/13/26 at 7:04 LPN 22 indicated she was unsure what the pills were on the resident's bedside table. The night shift nurse may have given some medications depending on the time they were ordered. She indicated she did not prepare any medications for Resident 14 that morning. She was not sure if there were narcotics in the medication cup. At that time, the resident indicated she took one and would take the rest later. During an interview on 4/13/26 at 8:04 A.M., LPN 22 confirmed there were no narcotics in the medication cup at that time and they were the resident's medications for the morning medication pass. 2. On 4/13/26 at 6:19 A.M., LPN 5 was administering medications to Resident G in the dining room. The resident dumped the medications out from the medication cup onto the table. The resident requested more water and LPN 5 left the resident in the dining room with eight pills left to administer. LPN 5 went back to the medication cart at the Station 4 Nurse's Station to get more water while the resident continued taking his medications. The resident was blocked from LPN 5's sight by a wall that was between them. On 4/13/26 at 8:20 A.M., Resident G's clinical record was reviewed. Diagnoses included, but were not limited to, stroke, dysphagia (difficulty swallowing), anxiety, and diabetes mellitus type II. The resident was admitted on [DATE].The resident's admission MDS assessment was still in process.The clinical record lacked an order, care plan, and assessment of the resident to safely self-administer medications.On 4/15/26 at 1:41 P.M., the Director of Nursing (DON) indicated there were no residents in the facility who self-administer medications. At that time, she indicated the nursing staff should not leave medications alone with a resident to administer.On 4/16/26 at 8:30 A.M., a current non dated Medication Administration Policy was provided by the Administrator and indicated, . Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice . observe consumption of medications .410 Indiana Administration Code (IAC) 16.2-3.1-11(a)