STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155740	A. Building B. Wing	08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Timbercrest Church of the Brethren Home	2201 East St North Manchester, IN 46962

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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation, interview, and record review the facility failed to ensure dietary employees were competent in both dishwasher and three compartment sink sanitation testing. This deficient practice had the potential to impact 60 of 60 residents who received meals prepared in the facility kitchen.Findings include:1.During an observation of dishwasher operations in the main kitchen, on 8/19/25 at 11:24 a.m., the following was observed:The dishwasher ran through the wash and rinse cycles three times. The temperature gauges did not fluctuate before, during, or after the cycles were completed. The Executive Chef indicated that she was unsure if the temperature gauges were working and she did not know if the dishwasher was a low or high temperature machine. She was unsure of the specifics of the dishwasher, including what the desired temperatures should be and what, if any, chemicals were used.2.During an observation of dishwasher operations in the main kitchen, on 8/20/25 at 10:15 a.m., the following was observed:The dishwasher ran through the wash and rinse cycles three times. The gauges had minimal fluctuation before, during, and after the cycles were completed. Dietary Aide 8 indicated the dishwasher had just been turned on at 10:00 a.m. and was not up to temperature. He indicated he was unsure if the dishwasher was a high or low temperature machine and the final cycles gauge did not move much due to the final rinse cycle had been converted to a chemical sanitizer.The Executive Chef took the blender blades that had been used for pureeing food to the three-compartment sink. She placed the blades in the first compartment and washed the blade off, dipped the blade in the second bin to rinse it off, and then dipped the blade in the third bin to sanitize. She placed the blender blade in the drying rack. She placed a test strip into the sanitizer bin and threw it away. She indicated she was unsure what test strips to use and retrieved another brand and style and placed the strip into the sanitation bin. Both strips did not register any parts per million of sanitizing agent was in the bin. She requested assistance from Dietary Aide 8. Dietary Aide 8 identified the correct test strips to used for the brand of sanitizer that was used at that time. The sanitizer used was pink in color and located in a plastic jug. The other strips had been used for another sanitizing agent that was located in the dispenser hanging over the sink, however the dispenser was empty, and the agent was on back order. Dietary Aide 8 placed a test strip into the sanitation bin. The strip did not register any parts per million of sanitizing agent was in the bin. Dietary Aide 8 drained the sanitation bin and poured some of the pink sanitizer into the bottom of the sink. He did not measure and indicated he wasn't sure of the exact amount used, but normally added sanitizer to the top of the drain and then filled it with water. When the water in the sanitation bin was at the desired height, Dietary Aide 8 placed a test strip in the sanitation bin. The test strip indicated 400 parts per million of sanitizer was present. The Executive Chef was uncertain what the desired range was for the sanitizer but thought it should be around 200 parts per million. Dietary Aide 8 indicated 400 parts per million was a good range. At 10:50 a.m., the blender blades remained in the drying rack and had not been rewashed.During an interview, on 8/20/25 at 12:15 p.m., Regional Support indicated the dishwasher was in place from the previously contracted dietary company and he did not know much about that type of dishwasher. He was unsure if it was normal or not to have the gauges fluctuate much before, during, or after the wash cycles.3.During an (continued on next page)

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

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	observation of dish washing operations in the main kitchen, on 8/26/25 at 11:20 a.m., the following was observed:Dietary Aide 8 was washing dishes in the three-compartment sink. He indicated that the dishwasher had not been used since the previous Sunday due to lack of detergent and all dishes were washed in the three-compartment sink. Several kitchen items were washed and placed in drying rack. All items used to prepare resident meals were washed in the main kitchen. Dietary Aide 8 placed a test strip in the sanitation bin. The test strip did not indicate any sanitizer was in the bin. Dietary Aide 8 placed a second strip in the sanitizer bin. The second strip did not indicate any sanitizer was in the bin. Dietary Aide 8 indicated he was not the staff member that filled the sink, and the sinks were to be drained and changed on average two or three times a day, but sometimes it occurred less. Dietary Aide 8 pushed a cart of dishes, that were located beside the drying rack, over to shelves and started to put the dishes away. The dishes had been washed prior to identifying the lack of sanitizer in the bin. Dietary Aide 8 considered the dishes on the cart clean and sanitized because he assumed there had been sanitizer in the bin earlier in the day. A second dietary aide walked over to the three-compartment sink and washed a couple of items and dipped them in the sanitizer bin, which had not been drained, and placed items in the drying rack.During an interview, on 8/26/25 at 11:30 a.m., the Dietary Manager indicated the parts per million were not correct in the sanitizer bin due to the calibration being off on the automatic dispenser that hung above the sink. Staff were not using the pink sanitizer in the plastic jug. The pink chemicals in the plastic jug were only to be used in the dishwasher. The dishwasher was rented, and he did not know much about the dishwasher and could not identify if it was a low or high temperature machine. The water in the three-compartment sink was changed three times a day, between meals.During an interview, on 8/26/25 at 2:23 p.m., the Dietary Manager indicated all residents that reside in the facility were served from the kitchen. Each meal was batch cooked in the main kitchen and then sent to the small facility kitchens.During an interview, on 8/26/25 at 4:19 p.m., Regional Support indicated he was unsure dishwasher was a low or high temperature machine, but thought it to be a high temperature. He was not aware the dishwasher was not in use since 8/25/25. He thought staff would have taken dishes to other facility kitchens to wash.During an interview, on 8/26/25 at 4:46 p.m., Regional Support indicated the Dishwasher was a low temperature machine. Arrangements were made to have the dishwasher sanitizer switched to another product soon. He was unsure if there were logs for the dishwasher and the three-compartment sink and will provide if found. The product used in the dispenser above the three-compartment sink ran out and was not being used and staff should have used the alternate sanitizer.A main kitchen log, dated August 2025, titled, DISHMACHINE TEMPERATURE LOG (Low Temperature), provided by Regional Support, on 8/26/25 at 5:00 p.m., indicated the dishwasher temperatures and sanitizer was checked at lunch and dinner. There was no temperature or sanitizer recordings entered for 8/7, 8/8, 8/9, 8/13, 8/14, 8/21, 8/22, 8/25, 8/26/25.A three-compartment sink log, dated August 2025, provided by Regional Support, on 8/26/25 at 5:00 p.m., indicated the following: Instructions: 1. Record three times a day (e.g. open, mid-day, close).Standard: Food-grade sanitizing solution must be a quaternary ammonium sanitizer with an effective range of 200-400 parts per million. Corrective action: Check supply lines, retest. If retest fails, notify manager, take equipment out of service, and notify chemical representative. The log recorded the time and parts per million at lunch and dinner. No time or parts per million recordings were entered for 8/8, 8/9, 8/13, 8/14, 8/21, or 8/22/25.A current facility policy, dated 9/7/22, titled, THREE COMPARTMENT SINK QUALITY ASSURANCE 6.028, provided by Regional Support, on 8/26/25 at 4:18 p.m., indicated the following: .Method/Procedure: The pot sink must have three compartments.The sanitizer sink must contain a chemical sanitizer at 200 PPM (parts per million).The water in the pot sink should be changed every two hours minimum. Titration of sanitizer and temperatures must be checked and logged three times daily.1.3-20(h)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review the facility failed to ensure food was prepared and served in a safe and sanitary manner regarding food handling and hand hygiene. This deficient practice had the potential to impact 60 of 60 residents who received their meals from the kitchen.Findings include:During a continuous lunch service observation, on 8/22/25 from 12:12 p.m. to 1:05p.m., the following food handling and food service concerns were observed: After preparing meal trays, [NAME] 5 exited the kitchen, walked into the dining area, turned around, and approached the meal window where the prepared meal trays sat. He removed his gloves and placed the used gloves in his front right pant pocket. [NAME] 5 delivered three resident meal trays. [NAME] 5 re-entered the kitchen and applied a new pair of gloves without performing hand hygiene. DC 5 touched several dietary meal tickets that were placed on meal trays. After he reviewed the meal tickets, he picked up the telephone and made a call. Wearing the same gloves, DC 5 reached into a plastic bag and retrieved a hotdog bun. With his gloved hands, he opened the hotdog bun, set the bun on a plate, and placed a hotdog in the bun. He grabbed the serving utensil handle and dished food onto the plate. He continued to dish two additional meal trays. DC 5 turned around to another countertop and handled the meal trays and dietary slips. After he looked at the meal tickets, he picked up the phone and made a phone call. He removed his gloves and retrieved a food container. Without performing hand hygiene, DC 5 applied new pair of gloves, and dished meal trays. He reached into a plastic bag and removed a hotdog bun, opened the bun, placed a hot dog in the bun, and returned to dishing food items. He left the serving area and retrieved a stack of meal trays on the opposite side of the kitchen. DC 5 sat the meal trays on the countertop behind the serving countertop. DC 5 returned to the serving countertop and dished out several plates. Dietary Server 6 assisted [NAME] 5 with dishing meals. She retrieved two bowls and set the bowls on a meal tray. She reached into plastic bag and retrieved a hotdog bun, opened the bun, and set it on the plate. She sat the plastic bag that contained the hotdog buns on a stack of clean meal trays. Without changing gloves, DC 5 diced cooked chicken breast by holding the chicken with his left hand and holding the knife in his right hand. DC 5 wiped his gloved hands on his apron. He walked around the kitchen and retrieved a stack of plates and placed them on the serving counter. He walked over and retrieved a hotdog bun from a plastic bag. He used his gloved hands to open the bun and place it on a plate. He cut the chicken and used his hands to pull the chicken apart and placed it on a plate. He rearranged the chicken pieces on the plate and returned to dishing the remaining food items for the meal tray. During an interview, on 8/22/25 at 1:19 p.m., DC 5 indicated he was to change his gloves after any object not used during serving, such as knobs, phone, and refrigerator and freezer handles were touched. He was to change his gloves after food was touched. He was aware he missed multiple opportunities to change his gloves and perform hand hygiene during the meal service. During an interview, on 8/22/25 at 1:23 p.m., the Executive Chef indicated staff was expected to change gloves after items not used for serving were handled or touched, especially a phone or cooked chicken. During an interview, on 8/26/25 at 2:23 p.m., the Dietary Manager indicated staff members who were dishing items for the meal trays were expected to change gloves anytime they touched an item not used to serve meal items. Staff could intermittently change between handles of serving utensils without changing gloves but should not touch any other objects. All dietary employees had previously received handwashing and glove use education. A current facility policy, dated 9/7/22, titled, DISPOSABLE GLOVES FOOD SAFETY & INFECTION CONTROL 6.009 , provided by the Executive Chef, on 8/26/ 25 at 2:240 p.m., indicated the following: .Method/Procedure: Hands must be washed before putting on and after removing disposable gloves when working in the kitchen .Hands must be leaned before outing on the gloves, and after removing the gloves.Disposable gloves must be changed, and hands washed when the gloves are dirty or ripped and when moving from one task to another, such as moving from handling dirty dishes to handling clean dishes. Hands must be (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	washed with soap and water before putting on or after use of gloves for plating on the resident units. Hand sanitizer may be used for tray delivery process only. 3.1-21(i)(3)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to ensure residents received a dignified dining experience for 2 of 16 residents during random dining observations. (Residents 54 and 45)Findings include:1.Resident 54's clinical record was reviewed on 8/21/25 at 2:03 p.m. Diagnoses included unspecified dementia (severe, with psychotic disturbance), generalized anxiety disorder, insomnia, impulse disorder, chronic kidney disease, and benign prostatic hyperplasia (enlarged prostate).Current physician orders included buspirone 10 milligrams (mg) three times a day for anxiety, donepezil 10 mg once a day for dementia, sertraline 25 mg once a day for anxiety, and trazodone 50 mg at bedtime for insomnia. A quarterly Minimum Data Set (MDS) assessment, dated 7/8/25, indicated Resident 54 was severely cognitively impaired, able to eat independently, and required substantial/maximal assistance for oral hygiene, toileting hygiene, showering/bathing, and dressing. A current care plan, initiated on 10/14/24 and revised on 8/21/25, indicated Resident 54 was at nutritional risk related to dementia and anxiety. He required supervision, cueing, and redirection at meals because he would wander. He was at risk of eating non-food items. Interventions included meal set-up, supervision, cueing, and redirection at meals.During a lunch observation, on 8/19/25 at 12:13 p.m., CNA 2 assisted Resident 54 with his meal and CNA 3, at the other end of the table, assisted Resident 45 with her meal. The two CNAs carried on a conversation about CNA 2's cat while intermittently assisting the residents with their meals. Neither CNA conversed with the residents. They continued their personal conversation and did not include the residents in the conversation about cats. During a lunch observation, on 8/21/25 at 12:13 p.m., CNA 3 was sitting to the right of Resident 54. CNA 3 reached in front of Resident 54's body, quickly removed something from the resident's left hand (which was resting on the table), and placed the item on the table to the CNA's right side. As the CNA was placing the item on the table, she said We don't do that! to Resident 54.During a lunch observation, on 8/22/25 at 11:36 a.m., Resident 54 was asleep at the dining table. The resident was startled awake when CNA 2 placed a drink in front of him and said, I've got your Pepsi! At 11:41 a.m., CNA 2 placed Resident 54's soup in front of him. The resident unwrapped his silverware and proceeded to try to eat the soup with his fork. CNA 2 got some oyster crackers and put them in Resident 54's soup. Resident 54 continued to attempt to eat his soup with the fork. At 11:44 a.m., CNA 2 moved the soup bowl closer to the resident. The resident continued to attempt to eat the soup with the fork. A spoon was sticking out of the resident's applesauce cup. At 11:55 a.m., Resident 54 was eating, when CNA 2 abruptly placed a drink in front of his face. The resident's head jerked backwards, and the CNA said Here, something to wash that down with. CNA 2 did not speak with Resident 54 except when offering food or drink. At 12:09 p.m., CNA 2 abruptly placed the drink back in front of Resident 54's face and said Here.that cornbread is dry. Resident 54 startled and his head jerked backwards. CNA 2 then moved the applesauce cup closer to the resident, got a spoonful of the applesauce, lifted it to Resident 54's lips and said, Try this! The resident accepted the bite, then moved the applesauce away. CNA 2 moved it back in front of the resident and continued to offer him bites of the applesauce. At 12:15 p.m., CNA 2 offered Resident 54 another drink, and the resident indicated he did not want anymore. The CNA proceeded to offer another drink, saying One more little drink. At 12:18 p.m., the resident reached for his meal ticket. CNA 2 said No, leave that there. and moved the ticket out of his reach.During an interview with CNA 2, on 8/22/25 at 12:36 p.m., she indicated Resident 54 often fell asleep during meals. Whenever she saw him eating with the wrong utensil(s), she would give him the correct utensil. She provided help with his drinks because, without assistance, he would pour the drink into his food, mix it with the food, and then try to eat the mixture with a fork.During an interview with RN 4 on 8/22/25 at 3:19 p.m., she indicated Resident 54 could be difficult to redirect and wandered around the unit much of the time. His dementia caused him to be more childlike, and he required a lot of redirection.During a lunch observation, on 8/25/25 at 12:05 (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	p.m., CNA 3 placed a drink in front of Resident 54 and said [Resident 54]! Take a drink! She did not lift the cup to Resident 54's lips, but waited for him to respond. The resident looked confused and did not attempt to take a drink. The CNA continued to tell Resident 54 to take a drink. When he did not respond, she lifted the drink to his lips and he took a drink.During an interview with RN 7, on 8/25/25 at 12:15 p.m., she agreed CNA 3's manner could be abrupt at times.During an interview with CNA 3, on 8/25/25 at 1:11 p.m., she indicated Resident 54 would often sleep during a meal. Staff had to keep an eye on him. Resident 54 would forget what he was supposed to do. Because of his dementia, he had the mind of a five-year-old and required a lot of help. Staff were supposed to encourage him by offering drinks. If it were another resident, she would ask them if they wanted a drink, but with Resident 54, she had to tell him what to do. Some days, he would respond when asked to do something. Other days, he had to be told what to do. It just depended on the day.2. Resident 45's clinical record was reviewed on 8/25/25 at 12:39 p.m. Diagnoses included Alzheimer's disease, generalized anxiety disorder, hypertension, and age-related osteoporosis.Current physician orders included buspirone 15 mg three times a day for anxiety, gabapentin 100 mg once a day for anxiety, memantine 5 mg twice a day for Alzheimer's disease, and mirtazapine 15 mg at bedtime for insomnia.A quarterly MDS assessment, dated 8/21/25, indicated Resident 45 was severely cognitively impaired, did not exhibit hallucination, delusions, or behaviors, used a walker to ambulate, could eat independently, required supervision/touch for oral hygiene, and substantial/maximal assistance with toileting hygiene.A current care plan, initiated on 6/20/25, indicated Resident 45 talked very loudly to herself at times, for long periods of time, sometimes in a chanting manner. Interventions included assessment of Resident 54's needs, i.e., toileting, pain, thirst, or hunger, engage Resident 45 in conversations about baking or cooking because she enjoyed talking about baking pies, cookies, and cakes, and encourage Resident 45 to vent her feelings and emotions by providing supportive listening and encouragement.A current care plan, initiated on 3/14/25, indicated Resident 45 often believed she was going somewhere with family. She stated she believed there are boys here who need something. She had exhibited exit seeking behaviors. Interventions included engagement of the resident in self-care and physical activities to channel energy, and encourage ventilation of feelings, fears, and anxiety.During a lunch observation, on 8/19/25 at 11:43 a.m., Resident 45 used a dining chair to ambulate from her walker to the dining table. CNA 2 observed the resident with the dining chair but did not intervene. At 12:07 p.m., Resident 45 pushed her chair away from the dining table. CNA 2 asked the resident where she was going. Resident 45 wanted to know why staff was asking her where she was going, but got no response from staff. She stayed in her chair and continued to talk about why everybody was so concerned about her going somewhere. As she continued to talk, CNA 2 and CNA 3 talked over Resident 45's head about CNA 2's cat. Neither CNA responded to Resident 45's question(s). They did not engage Resident 45 in conversation. CNA 2 interrupted Resident 45 by speaking over her and said [Resident 45]! Here's your soup! A second interruption occurred when CNA 2 said Here's your crackers!During an interview with the Director of Nursing (DON), on 8/25/25 at 4:48 p.m., she indicated CNA 3's manner was not as soft as some. CNA 3 had a hearing deficit. CNA 3 came across as gruff at times. Staff should not have personal conversations when assisting residents during mealtimes.A current facility policy, titled Dementia Care, provided by the ADON on 8/26/25 at 2:59 p.m., indicated the following: .4. Care and services will be person-centered and reflect each resident's individual goals while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety.9. All staff will be trained on dementia care practices upon hire, annually, and as needed to ensure they have the appropriate competencies and skill sets to ensure residents' safety and help residents attain or maintain the highest physical, mental, and psychosocial well-being. 3.1-3(a)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and record review, the facility failed to ensure the physician reviewed and addressed pharmacy recommendations in a timely manner for 1 of 5 residents reviewed for unnecessary medications (Resident 1). Finding includes:Resident 1's clinical record was reviewed on 8/21/25 at 12:26 p.m. Diagnoses included gastro-esophageal reflux disease (GERD) without esophagitis, folate deficiency, Vitamin D deficiency, constipation, chronic kidney disease, hypo-osmolality (lower-than-normal concentration of dissolved particles, such as sodium, in blood), hyponatremia (having too little sodium in the blood), and type 2 diabetes mellitus with polyneuropathy (damage to peripheral nerves). Current orders included famotidine 40 milligrams (mg) daily (7/25/24). Pharmacy recommendations on 11/11/24, 1/13/25, and 3/10/25, provided by the DON on 8/22/25 at 9:30 a.m., indicated the pharmacist indicated the resident received a proton pump inhibitor (PPI - treats disorders of the stomach), omeprazole 40 mg once daily, in addition to another gastroprotective therapy famotidine 40 mg once daily. Both therapies may not have been necessary. The discontinuation of one of the medications was recommended. A nursing progress note, dated 4/18/25 at 11:09 a.m., indicated a new order to discontinue omeprazole had been received due to multiple therapies. The resident's clinical record lacked physician notification and rationale for declination of the pharmacist's recommendations for 11/11/24, 1/13/25, and 3/12/25 prior to 4/18/25. During an interview, on 8/26/25 at 9:33 a.m., the ADON indicated the pharmacy sent the recommendations to the facility. The Social Services Designee printed them off. The ADON sent them to the physician or gave them to the nurses to send to the physician. The pharmacy usually notified the facility when a recommendation had not been addressed. An office visit note from the allergist, dated 7/24/24, provided by the ADON on 8/26/25 at 10:16 a.m., indicated the resident likely had uncontrolled GERD which contributed to her symptoms. Omeprazole 40 mg daily was added for reflux induced asthma. A pharmacy recommendation for 8/2024, provided by the ADON on 8/26/25 at 10:16 a.m., indicated the physician had declined discontinuing either omeprazole or famotidine because the resident had been symptomatic with the famotidine alone, and a trial of the omeprazole was being attempted to see if the resident improved. During an interview, on 8/26/25 at 10:40 a.m., the ADON indicated the resident had seen an allergist in July of 2024 who had ordered the omeprazole, and the primary care physician had declined to discontinue the medication. The resident had been seen by the allergist again in December of 2024. While the medications had been listed as ordered medications, the allergist had not specifically provided a rationale for continued use of both omeprazole and famotidine. She believed the resident was scheduled to go back to the allergist in March of 2025. During an interview, on 8/26/25 at 4:12 p.m., the ADON indicated she had been unable to locate additional information on the pharmacy recommendations for 11/11/24 and 1/13/25 that had been communicated to the physician and the rationale for declination. During an interview, on 8/26/25 at 4:18 p.m., the DON indicated pharmacy recommendations were sent to the physician and then tracked for being returned by the physician. She did not have additional information on communication with the physician about the pharmacy recommendations on 11/11/24 and 1/13/25. An undated, current policy, provided by the ADON on 8/26/25 at 2:59 p.m., titled Medication Regimen Review, indicated the following: .The Consultant Pharmacist performs a Medication Regimen Review (MRR) which is a comprehensive review of each resident's medication. This is also known as a Drug Regimen Review (DRR) and is completed at least monthly.Findings and recommendations are reported to the Director of Nursing, the attending physician, and the Medical Director.Recommendations are acted upon and documented by the facility staff and/or the prescriber. The Medical Director and attending physician must be notified of all recommendations/findings/irregularities involving medications. The physician accepts and acts upon suggestions, or rejects and provides an explanation for disagreeing. An undated, current policy, provided by the ADON on 8/26/25 at 2:59 p.m., titled Documentation and Communication of (continued on next page)

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Recommendations, indicated the following: .The Consultant Pharmacist works with the facility to establish a system whereby the Consultant Pharmacist's observations and recommendations regarding residents' medication therapy are communicated and responded to by those with authority, and/or responsibility to implement the recommendations in an appropriate and timely fashion.2. Comments and recommendations concerning medication therapy are communicated in a timely fashion. The timing of these recommendations should enable a response prior to the next medication regimen review. In the event of a problem requiring the immediate attention of the prescriber, the responsible physician or physician's designee is contacted by the Consultant Pharmacist or the facility, and the prescriber's response is documented on the Consultant Pharmacist review record or elsewhere in the resident's medical record. 3. Recommendations are acted upon and documented by the facility staff and/or prescriber. If the prescriber does not respond to recommendation directed to him/her within a reasonable timeframe, the Director of Nursing and/or Consultant Pharmacist may contact the Medical Director. 3.1-25(i)