STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365523	A. Building B. Wing	01/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbors at Oregon	904 Isaac Streets Drive Oregon, OH 43616

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident interview, staff interview, and policy review, the facility failed to timely report an allegation verbal abuse to the state agency. This affected one (#48) of three residents reviewed for abuse. The facility census was 77. Review of Resident #48's medical record revealed an admission date of 03/20/24, diagnoses included spinal stenosis of the cervical region, osteomyelitis, type II diabetes mellitus, and muscle weakness. Review of Resident #48's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #48 had intact cognition. Resident #48 was dependent for toilet hygiene, required partial/moderate assistance with personal hygiene, and was dependent for chair to bed transfers. Review of Resident #48's care plan dated 12/14/25 revealed Resident #48 had an activity of daily living (ADL) self-care performance deficit, interventions included the assistance of two people for bed mobility and the assistance of two people and the use of the mechanical lift for transfers. Review of Resident #48's progress notes from 12/12/25 to 12/16/25 revealed no notes regarding the alleged verbal abuse.Interview on 12/16/25 at 3:37 P.M. with Registered Nurse (RN) #157 revealed on 12/14/25, RN #157 asked Certified Nursing Assistant (CNA) #108 to transfer Resident #48 into bed so she could complete the resident's dressing changes. RN #157 stated a little after 4:00 P.M., CNA #108 came up to RN #157 and stated Resident #48 refused to get into bed. Further interview with RN #157 revealed CNA #108 reported Resident #48 asked for assistance to clean off her bed so the resident could be assisted with being transferred into the bed for her dressing changes. RN #157 stated CNA #108 told RN #157 that she told Resident #48 you made the mess on the bed, you can clean it up. RN #157 stated CNA #108 should have helped the resident, and it was inappropriate for CNA #108 to say what she did to Resident #48. RN #157 verified CNA #108 did not help the resident clean off her bed and did not assist with transferring Resident #48 into bed. RN #157 also verified Resident #48's dressing changes were not completed on 12/14/26 as a result. RN #157 stated she reported this to the Assistant Director of Nursing (ADON) that evening when she got home via text message.Interview on 12/16/25 at 4:10 P.M. with the ADON revealed RN #157 texted her on 12/14/25 at 7:06 P.M. and reported CNA #108 refused to help Resident #48 clean off her bed when asked and per the report of CNA #108 she told the resident you made the mess on the bed, you can clean it up. The ADON stated she did not feel the statement was verbal abuse and did nothing more with the information. The ADON verified if there is a concern of resident abuse it should be reported immediately to the Director of Nursing so an investigation can be started. The ADON verified on 12/16/25 at 4:15 P.M. she did not report the incident to the Director of Nursing and further verified an investigation of the incident had been initiated. Interview on 12/16/25 at 4:32 P.M. with Resident #48 revealed she did not recall CNA #108 telling her you made the mess on your bed, you need to clean it off, however Resident #48 did say that CNA #108 told the resident she needed to answer another call light and would come back but never did. Resident #48 verified her dressing was not changed on 12/14/25 as ordered. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/16/25 at 4:44 P.M. with CNA #108 revealed RN #157 had asked her to transfer Resident #48 into bed. CNA #108 stated she went into Resident #48's room and she had personal items on her bed. CNA #108 stated Resident #48 stated she would move her items off of her bed and put her call light on when she was finished. CNA #108 denied saying you made the mess on your bed, you need to clean it off. CNA #108 stated she told RN #157 that Resident #48 needed to get her bed cleaned off.Interview on 12/16/25 at 5:31 P.M. with the Director of Nursing revealed the ADON had just reported the incident to her approximately an hour prior. The Director of Nursing verified the allegation of verbal abuse should have been promptly reported to her and an investigation should have been started immediately, and the state agency should have been notified. Review of the facility policy last revised on 01/10/24 titled Abuse, Neglect, and Exploitation revealed alleged violations will be reported to the Administrator, state agency, adult protective services and all other required agencies immediately, but not later than two hours after the allegation is made, if the events that caused the allegation involve abuse or result in serious bodily injury, and not later than 24 hours if the even does not involve abuse or serious bodily injury. This deficiency represents non-compliance investigated under Master Complaint Number 2689998.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident interview, staff interview, and policy review, the facility failed to investigate a report of alleged verbal abuse. This affected one (#48) of three residents reviewed for abuse. The facility census was 77. Review of Resident #48's medical record revealed an admission date of 03/20/24, diagnoses included spinal stenosis of the cervical region, osteomyelitis, type II diabetes mellitus, and muscle weakness. Review of Resident #48's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #48 had intact cognition. Resident #48 was dependent for toilet hygiene, required partial/moderate assistance with personal hygiene, and was dependent for chair to bed transfers. Review of Resident #48's care plan dated 12/14/25 revealed Resident #48 had an activity of daily living (ADL) self-care performance deficit, interventions included the assistance of two people for bed mobility and the assistance of two people and the use of the mechanical lift for transfers. Review of Resident #48's progress notes from 12/12/25 to 12/16/25 revealed no notes regarding the alleged verbal abuse.Interview on 12/16/25 at 3:37 P.M. with Registered Nurse (RN) #157 revealed on 12/14/25, RN #157 asked Certified Nursing Assistant (CNA) #108 to transfer Resident #48 into bed so she could complete the resident's dressing changes. RN #157 stated a little after 4:00 P.M., CNA #108 came up to RN #157 and stated Resident #48 refused to get into bed. Further interview with RN #157 revealed CNA #108 reported Resident #48 asked for assistance to clean off her bed so the resident could be assisted with being transferred into the bed for her dressing changes. RN #157 stated CNA #108 told RN #157 that she told Resident #48 you made the mess on the bed, you can clean it up. RN #157 stated CNA #108 should have helped the resident, and it was inappropriate for CNA #108 to say what she did to Resident #48. RN #157 verified CNA #108 did not help the resident clean off her bed and did not assist with transferring Resident #48 into bed. RN #157 also verified Resident #48's dressing changes were not completed on 12/14/26 as a result. RN #157 stated she reported this to the Assistant Director of Nursing (ADON) that evening when she got home via text message.Interview on 12/16/25 at 4:10 P.M. with the ADON revealed RN #157 texted her on 12/14/25 at 7:06 P.M. and reported CNA #108 refused to help Resident #48 clean off her bed when asked and per the report of CNA #108 she told the resident you made the mess on the bed, you can clean it up. The ADON stated she did not feel the statement was verbal abuse and did nothing more with the information. The ADON verified if there is a concern of resident abuse it should be reported immediately to the Director of Nursing so an investigation can be started. The ADON verified on 12/16/25 at 4:15 P.M. she did not report the incident to the Director of Nursing and further verified an investigation of the incident had been initiated. Interview on 12/16/25 at 4:32 P.M. with Resident #48 revealed she did not recall CNA #108 telling her you made the mess on your bed, you need to clean it off, however Resident #48 did say that CNA #108 told the resident she needed to answer another call light and would come back but never did. Resident #48 verified her dressing was not changed on 12/14/25 as ordered. Interview on 12/16/25 at 4:44 P.M. with CNA #108 revealed RN #157 had asked her to transfer Resident #48 into bed. CNA #108 stated she went into Resident #48's room and she had personal items on her bed. CNA #108 stated Resident #48 stated she would move her items off of her bed and put her call light on when she was finished. CNA #108 denied saying you made the mess on your bed, you need to clean it off. CNA #108 stated she told RN #157 that Resident #48 needed to get her bed cleaned off.Interview on 12/16/25 at 5:31 P.M. with the Director of Nursing revealed the ADON had just reported the situation to her approximately an hour prior. The Director of Nursing verified the allegation of verbal abuse should have been promptly reported to her and an investigation should have been started immediately following the notification. Review of the facility policy last revised on (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	01/10/24 titled Abuse, Neglect, and Exploitation revealed possible indicators of abuse include but are not limited to resident, staff or family reporting abuse, verbal abuse, physical abuse, psychological abuse, and failure to provide care needs. The policy further stated an immediate investigation is warranted when there is a suspicion of abuse, neglect, or exploitation, or a report of abuse, neglect, or exploitation. The investigation should be thoroughly documented and include the identified person responsible for the investigation. Written procedures for the investigation include identifying and interviewing all involved persons, including the alleged victim. alleged perpetrator, and witnesses or others that may have knowledge of the allegation, and should focus on determining if abuse, neglect, exploitation and/or mistreatment occurred, the extent and the cause. This deficiency represents non-compliance investigated under Master Complaint Number 2689998.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff interview, review of the manufacturer instructions, and review of facility policy, the facility failed to maintain a medication administration error rate of less than five percent. This affected two (#04 and #24) of three residents reviewed for medication administration. There were 36 opportunities with two medication errors for a medication error rate that was 5.5 percent. The facility census was 77.1. Review of Resident #04's medical record revealed an initial admission date of 03/14/24 and a re-admission date of 08/12/25. Diagnoses included traumatic brain injury without loss of consciousness, type II diabetes mellitus, muscle weakness, depression, and dysphagia. Review of Resident #04's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #04 had moderately impaired cognition and received hypoglycemic medication.Review of Resident #04's care plan dated 11/13/25 revealed Resident #04 had an impaired metabolic status related to diabetes, interventions included to administer medications and treatments as ordered, and to administer insulin per the physician orders.Review of Resident #04's physician orders revealed an order for insulin Degludec using a pen-injector 100 units per milliliter (unit/ml), 15 units to be administered subcutaneously in the morning for diabetes mellitus. Continuous observation on 12/16/25 from 8:23 A.M. until 8:32 A.M. of medication administration completed by Licensed Practical Nurse (LPN) #195 revealed LPN #195 began to prepare a Degludec insulin pen for Resident #04 by applying the needle to the insulin pen. LPN #195 dialed the pen injector to 15 units, entered Resident 4's room and administered the insulin subcutaneously.2. Review of Resident #24 medical record revealed an admission date of 11/07/25. Diagnoses included acute and chronic respiratory failure with hypoxia, type two diabetes mellitus, peripheral vascular disease, chronic kidney disease, and hypertension. Review of Resident #24's admission MDS assessment dated [DATE] revealed Resident #24 had moderately impaired cognition and received hypoglycemic medication.Review of Resident #24's care plan dated 11/20/25 revealed Resident #24 had an impaired metabolic status related to diabetes, interventions included to administer medications and treatments as ordered, and to administer insulin per the physician orders.Review of Resident #24's physician orders revealed an order for insulin Lispro using a pen-injector, 100 units/ml, administer four units subcutaneously before meals and at bedtime for diabetes mellitus.Observation on 12/16/25 at 8:33 A.M. of medication administration, LPN #195 dialed the pen injector to four units, entered Resident #24's room and administered the insulin to Resident #24 in the . Interview on 12/16/25 at 8:57 A.M. with LPN #195 verified he did not prime the insulin pens prior to administering the insulin injections to Resident #4 and #24. LPN #195 stated there is no need to prime the insulin pens. Review of the manufacturer's instructions with a last revised date of July 2022 for insulin Degludec pen-injector revealed to apply the needle to the pen, dial up two units of insulin, hold the pen with the needle pointing up, gently tap on the needle a few times to allow air to rise to the top, press and hold the dose button until it shows zero, and a drop of insulin should be seen at the needle tip. Turn the dose selector to the needed dose and inject per the physician's orders.Review of the manufacturer's instructions with a last revised date of July 2023 for the Lispro pen-injector revealed to apply the needle to the pen, dial up two units of insulin, hold the pen with the needle pointing up, gently tap on the needle a few times to allow air to rise to the top, press and hold the dose button until it shows zero and hold the dose knob while slowly counting to five, and a drop of insulin should be seen at the needle tip. Turn the dose selector to the needed dose and inject per the physician order. Priming the insulin pen means removing the air from the needle and cartridge that may collect during normal use, and ensures the pen is working correctly. Not priming the before each injection, may provide too much or too (continued on next page)

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Arbors at Oregon	904 Isaac Streets Drive Oregon, OH 43616

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	little insulin. Review of the facility policy titled Medication Administration with a last revised date of 01/01/22 revealed to administer medication as ordered in accordance with manufacturer specifications.This deficiency represents non-compliance investigated under Master Complaint Number 2689998 and Complaint Number 2686783.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff interview, review of the manufacturer instructions, and review of facility policy, the facility failed to ensure insulin pens were primed prior to administration of insulin. This affected two residents (#04 and #24) of two residents reviewed for insulin administration. The facility census was 77.1. Review of Resident #04 ' s medical record revealed an initial admission date of 03/14/24 and a re-admission date of 08/12/25. Diagnoses included traumatic brain injury without loss of consciousness, type II diabetes mellitus, muscle weakness, depression, and dysphagia. Review of Resident #04 ' s quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #04 had moderately impaired cognition and received hypoglycemic medication.Review of Resident #04 ' s care plan dated 11/13/25 revealed Resident #04 had an impaired metabolic status related to diabetes, interventions included to administer medications and treatments as ordered, and to administer insulin per the physician orders.Review of Resident #04 ' s physician orders revealed an order for insulin Degludec using a pen-injector 100 units per milliliter (unit/ml), 15 units to be administered subcutaneously in the morning for diabetes mellitus. Continuous observation on 12/16/25 from 8:23 A.M. until 8:32 A.M. of medication administration completed by Licensed Practical Nurse (LPN) #195 revealed LPN #195 began to prepare a Degludec insulin pen for Resident #04 by applying the needle to the insulin pen. LPN #195 dialed the pen injector to 15 units, entered Resident 4's room and administered the insulin subcutaneously.2. Review of Resident #24 medical record revealed an admission date of 11/07/25. Diagnoses included acute and chronic respiratory failure with hypoxia, type two diabetes mellitus, peripheral vascular disease, chronic kidney disease, and hypertension. Review of Resident #24 ' s admission MDS assessment dated [DATE] revealed Resident #24 had moderately impaired cognition and received hypoglycemic medication.Review of Resident #24 ' s care plan dated 11/20/25 revealed Resident #24 had an impaired metabolic status related to diabetes, interventions included to administer medications and treatments as ordered, and to administer insulin per the physician orders.Review of Resident #24 ' s physician orders revealed an order for insulin Lispro using a pen-injector, 100 units/ml, administer four units subcutaneously before meals and at bedtime for diabetes mellitus.Observation on 12/16/25 at 8:33 A.M. of medication administration, LPN #195 dialed the pen injector to four units, entered Resident #24 ' s room and administered the insulin to Resident #24 in the . Interview on 12/16/25 at 8:57 A.M. with LPN #195 verified he did not prime the insulin pens prior to administering the insulin injections to Resident #4 and #24. LPN #195 stated there is no need to prime the insulin pens. Review of the manufacturer ' s instructions with a last revised date of July 2022 for insulin Degludec pen-injector revealed to apply the needle to the pen, dial up two units of insulin, hold the pen with the needle pointing up, gently tap on the needle a few times to allow air to rise to the top, press and hold the dose button until it shows zero, and a drop of insulin should be seen at the needle tip. Turn the dose selector to the needed dose and inject per the physician's orders.Review of the manufacturer ' s instructions with a last revised date of July 2023 for the Lispro pen-injector revealed to apply the needle to the pen, dial up two units of insulin, hold the pen with the needle pointing up, gently tap on the needle a few times to allow air to rise to the top, press and hold the dose button until it shows zero and hold the dose knob while slowly counting to five, and a drop of insulin should be seen at the needle tip. Turn the dose selector to the needed dose and inject per the physician order. Priming the insulin pen means removing the air from the needle and cartridge that may collect during normal use, and ensures the pen is working correctly. Not priming the before each injection, may provide too much or too little insulin. Review of the facility policy titled Medication Administration (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with a last revised date of 01/01/22 revealed to administer medication as ordered in accordance with manufacturer specifications.This deficiency represents non-compliance investigated under Master Complaint Number 2689998 and Complaint Number 2686783.

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(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 - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff interview, and policy review, the facility failed to ensure infection control standards were maintained during the preparation of medication for administration. This affected two residents (#04 and #24) of three residents reviewed for infection control. The facility census was 77. 1. Review of Resident #04's medical record revealed an initial admission date of 03/14/24 and a re-entry date of 08/12/25. Diagnoses included traumatic brain injury without loss of consciousness, type II diabetes mellitus, muscle weakness, depression, and dysphagia. Review of Resident #04's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #04 had moderately impaired cognition. Furthermore, Resident #04 took anti anxiety, antidepressant, hypoglycemic, and anticonvulsant medications. Review of Resident #04's physician orders revealed an order for Celexa 20 milligrams (mg) by mouth in the morning for depression and an order for Vimpat 100 mg by mouth every morning and at bedtime for seizures. Observation on 12/16/25 at 8:23 A.M. of medication administration completed by Licensed Practical Nurse (LPN) #195 revealed LPN #195 began to prepare medications for Resident #04. While preparing the medications, LPN #195 dropped Resident #04's Celexa onto the top of the medication cart. The pill bounced multiple times before LPN #195 picked up the pill with his bare right hand and placed the pill into the medication cup. While preparing Resident #04's Vimpat, the pill was also dropped onto the top of the medication cart where LPN #195 again picked up the pill with his bare right hand and placed it into the medication cup. After preparing all Resident #04's medications, LPN #195 returned the punch cards to the drawer, locked the medication cart, used the computer mouse to close the computer screen, picked up the medication cup containing the pills, walked into the resident's room, and handed the cup of pills to Resident #04. Resident #04 took the pills with water. 2. Review of Resident #24 medical record revealed an admission date of 11/07/25. Diagnoses included acute and chronic respiratory failure with hypoxia, type II diabetes mellitus, peripheral vascular disease, chronic kidney disease, and hypertension.Review of Resident #24's admission MDS assessment dated [DATE] revealed Resident #24 had moderately impaired cognition. Furthermore, Resident #24 took antipsychotic, anti anxiety, diuretic, opioid, antiplatelet, and hypoglycemic medication. Review of Resident #24's current physician orders revealed orders for Flomax 0.4mg by mouth in the morning for benign prostatic hyperplasia, buspar 5 mg, carvedilol 6.25 mg, clopidogrel 75 mg, ferrous sulfate 325 mg, folic acid 1000 micrograms (mcg), lasix 20 mg, levothyroxine 112 mcg, protonix 40 mg, potassium chloride 20 milliequivalents (meq), and seroquel 300 mg.Observation on 12/16/25 starting at 8:33 A.M. of medication administration completed by Licensed Practical Nurse (LPN) #195 revealed LPN #195 began to prepare medications for Resident #24. While preparing the medications, LPN #195 dropped Resident #24's Flomax, the pill bounced on the top of the medication cart and then between the narcotic book and a tray that held the water pitcher, medication cups and water cups. LPN #195 picked up the Flomax with his bare right hand and put it into the medication cup. Continued observation revealed LPN #195 picked up a medication card for buspar with his right hand, punched the 5 mg tablet into his left hand and then placed the tablet into the medication cup. LPN #195 placed the buspar medication card face down on the top of the medication cart and picked up a second medication card for carvedilol with his right hand, punch a 6.25 mg tablet into his left hand and then again placed the tablet into the medication cup, set the carvedilol medication card facedown on top the buspar medication card. The process of punching the medications from the medication card with the right hand into the left hand and placing the medication into the medication cup continued for each of the additional eight medications, clopidogrel 75 , ferrous sulfate 325 mg, folic acid 1000 mcg, lasix 20 mg, levothyroxine 112 mcg, protonix (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	40 mg, potassium chloride 20 meq, and seroquel 300 mg. After preparing all of Resident #24's medications, LPN #195 returned the punch cards to the drawer of the medication cart, locked the medication cart, used the computer mouse to close the computer screen from which LPN #195 was working from, picked up the medication cup of pills, walked into the Resident #24's room, handed the cup of pills to Resident #24 and observed Resident #24 take each of the pills with water. Interview on 12/16/25 at 8:57 A.M., following the observation, LPN #195 confirmed he had touched Resident #24's pills with his bare hands. LPN #195 verified he picked up the flomax tablet that he had dropped and bounced on the medication cart and further verified he punched each of Resident #24's medications into his bare hand prior to placing the pills into the medication cup and administered the medications to Resident #24 after touching them. Furthermore, LPN #195 verified that he usually punches the resident's pills into his bare hands because he drops them when he tries to punch them out directly into the medication cup. Review of the facility policy titled Medication Administration with a last revised date of 01/01/22 revealed when removing medication from the source, take care not to touch the medication with a bare hand.This deficiency represents non-compliance investigated under Complaint Number #2686783.