STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155448	A. BUILDING 00 B. WING	02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LOWELL HEALTHCARE	710 MICHIGAN ST LOWELL, IN 46356

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: February 6, 7, 8, 9, and 10, 2023. Facility number: 00361 Provider number: 155448 AIM number: 100266340 Census Bed Type: SNF/NF: 78 Total: 78 Census Payor Type: Medicare: 4 Medicaid: 60 Other: 14 Total: 78 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 2/14/23.	F 0000	**Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. We respectfully request consideration for paper compliance.**	
F 0638 SS=A Bldg. 00	483.20(c) Qrtly Assessment at Least Every 3 Months §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. Based on record review and interview, the facility failed to ensure the Quarterly Minimum Data Set (MDS) comprehensive assessment was submitted on time for 1 of 18 MDS assessments reviewed. (Resident 67)	F 0638	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** · Resident 67 MDS	02/28/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Emily Bailey	Executive Director	03/03/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Finding includes: Resident 67's record was reviewed on 2/8/23 at 1:05 p.m. Diagnoses included, but were not limited to, cerebral vascular accident and aphasia. The Quarterly MDS assessment, dated 1/25/23, was incomplete and had not been submitted. The previous MDS assessment was completed on 11/4/22. Telephone interview with the RAI (Resident Assessment Instrument) Specialist on 2/9/23 at 1:55 p.m., indicated they were behind schedule and the assessment was late. 3.1-31(d)(3)		Assessment has been completed and submitted. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** · All residents requiring an MDS Assessment have the potential to be affected by this finding. All current residents have been reviewed to ensure completion of a Quarterly MDS Assessment in the past 3 months. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · RAI Support Specialist will in-service MDSC and other relevant MDS staff on timeliness of MDS scheduling and completion on or before 02/28/2023. MDSC will ensure that all assessments are completed timely per CMS regulations. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** · Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). MDSC or designee will complete the QA	

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			tool labeled MDS Scheduling and Timeliness weekly for 4 weeks and then monthly for 6 months. If threshold of 95% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.	
F 0641 SS=A Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) comprehensive assessment was accurately completed related to hypnotic medication use and a fall with a major injury for 2 of 18 MDS assessments reviewed. (Residents 56 and 72) Findings include: 1. Resident 56's record was reviewed on 2/9/23 at 9:24 a.m. Diagnoses included, but were not limited to, cerebral infarction and dementia. The Quarterly MDS assessment, dated 11/23/22, section N Medications, indicated the resident had not used hypnotics in the past seven days, and had used anti-anxiety medications in the past seven days. The current Physician Order Summary (POS) indicated the resident took eszopiclone (a sedative/hypnotic medication) 3 milligrams at bedtime for insomnia. There were no anti-anxiety medications in the current or previous months POS.	F 0641	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** · Resident 56 MDS Assessment has been modified and resubmitted. · Resident 72 MDS Assessment has been modified and resubmitted. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** · All residents requiring an MDS Assessment have the potential to be affected by this finding. All MDS Assessments within the last 30 days were audited to ensure the residents assessment was coded accurately for antianxiety and sedative/hypnotic medication, as well as any resident with recent	02/28/2023

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	2. Resident 72's record was reviewed on 2/7/23 at 2:56 p.m. Diagnoses included, but were not limited to, Diabetes Mellitus and epilepsy. A Progress Note, dated 9/16/22, indicated the resident had fallen in the shower and was complaining of pain to her right ankle. The Nurse Practitioner was notified and ordered a portable X-ray. The X-ray results, on 9/16/22, indicated an acute displaced distal 5th metatarsal neck fracture (fractured small toe). The Quarterly MDS, dated 10/11/22, section J Health Conditions, indicated the resident had one fall without major injury since the last assessment. The resident had no falls with a major injury (fractures) since the last assessment. Telephone interview with RAI (Resident Assessment Instrument) Specialist on 2/9/23 at 1:55 p.m., indicated the eszopiclone had been coded incorrectly as an anti-anxiety medication for Resident 56 and the fall should have been coded as major injury due to a fracture for Resident 72. 3.1-31(i)		falls. Any inaccurate coding identified will be modified and resubmitted to ensure accuracy. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · RAI Support Specialist will in-service MDSC and other relevant MDS staff on accuracy of assessments on or before 02/28/2023. MDSC will ensure that coding of medications and falls are completed accurately before completing and submitting the MDS Assessment. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** · Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). MDSC or designee will complete the QA tool labeled MDS Coding and Accuracy weekly for 4 weeks and then monthly for 6 months. If threshold of 95% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.	

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F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review, and interview, the facility failed to ensure ADL (activities of daily living) care was provided related to not assisting a dependent resident with shaving for 1 of 3 residents reviewed for ADL care. (Resident 56) Finding includes: On 2/7/23 at 11:22 a.m. and 2/8/23 at 8:51 a.m., Resident 56 was observed in his bed, he was unshaven. On 2/9/23 at 1:20 p.m., the resident was in bed and unshaven. At that time, he indicated he preferred to be clean shaved. The resident's record was reviewed on 2/9/23 at 9:24 a.m. Diagnoses included, but were not limited to, cerebral infarction and dementia. The Quarterly Minimum Data Set assessment, dated 11/23/22, indicated he had moderate cognitive impairment and required extensive assistance of one for personal hygiene. The shower book indicated the resident received showers twice weekly on Wednesday and Saturdays. Shower sheets for the past 30 days indicated the resident had only been shaved on 1/10/23 and 1/25/23. There were no refusals noted. Interview with CNA 3 on 2/9/23 at 11:45 a.m., indicated they would give him a shower twice weekly and he needed assistance with shaving.	F 0677	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** · Resident 56 was shaven per preference on the date of observation (2/8/2023). **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** · All residents have the potential to be affected by the alleged deficient practice. DNS/Designee conducted an audit to ensure all residents are appropriately groomed per preferences. No concerns noted from audit. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** · DNS or Designee will in-service all staff on providing ADL care per preference as well as accurately documenting completion or refusal. **How the corrective action(s) will be monitored to ensure the**	02/28/2023

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	She was unsure when the resident had been shaved last. 3.1-38(a)(3)		**deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed;** · Ongoing compliance with this corrective action will be monitored through the facility QAPI tool for five (5) random residents. The DNS/designee will be responsible for completing the QAPI Audit tool for five (5) random residents weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and interview, the facility failed to ensure tubi grips (elastic compression bandage) were in use as ordered for 1 of 1 residents reviewed for edema. (Resident 225)	F 0684	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** · Resident 225 order for Tubi	02/28/2023

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	Finding includes: On 2/7/23 at 9:55 a.m., Resident 225 was observed seated in her wheelchair in her room. She had white crew socks and shoes in place to both feet. Her ankles appeared to be slightly swollen. On 2/8/23 at 2:18 p.m., Resident 225 was observed seated in her wheelchair in the first floor lounge area watching television. She had white crew socks and shoes in place to both feet. Her ankles appeared to be slightly swollen. On 2/9/23 at 2:05 p.m., Resident 225 was observed seated in her wheelchair in the first floor lounge area. She had white crew socks and shoes in place to both feet. Staff then escorted resident out of the lounge area to an activity. The resident's record was reviewed on 2/10/23 at 10:10 a.m. Diagnoses included, but were not limited to, hypertension, dementia, and pulmonary hypertension. The Admission Minimum Data Set (MDS) assessment, dated 11/28/22, indicated the resident was cognitively impaired. She required extensive one person assistance for bed mobility and extensive two person assistance for transfers. A Physician's Order, dated 1/25/23, indicated tubi grips to bilateral lower extremities for edema, may remove for hygiene and to be removed before bed. The Treatment Administration Record (TAR), dated 2/2023, indicated the tubi grips were signed off as in place on the day shift (7 a.m. through 3 p.m.) on 2/7/23, 2/8/23, and 2/9/23. Interview with the Director of Nursing (DON) on		Grip (elastic compression bandages) were reviewed with NP on her next visit on 02/11/2023. New order to d/c it due to residents refusal to wear them. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** · All residents have the potential to be affected by the alleged deficient practice. DNS/Designee will conduct an audit to identify anyone who may wear preventative/adaptive devices to ensure they are in place or documented accurately for refusal. No further concerns from audit. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** · DNS or Designee will in-service all nursing staff regarding applying adaptive/preventative devices per order and accurately documenting refusals. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed;** · Ongoing compliance with this corrective action will be	

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	2/9/23 at 2:30 p.m., indicated the resident was wearing regular socks and the tubi grips were not in place. She was going to ask the Nurse Practitioner if they could discontinue them since the resident's edema had decreased. 3.1-37(a)		monitored through the facility QAPI tool for five (5) random residents. The DNS/designee will be responsible for completing the QAPI Audit tool for five (5) random residents weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.	
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder			

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	receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, record review, and interview, the facility failed to ensure a resident with a urinary catheter, who was awaiting results of a urine Culture and Sensitivity (C&S) for a possible Urinary Tract Infection (UTI), received the proper care and services related to improper catheter positioning for 1 of 2 residents reviewed for catheters. (Resident 14) Finding includes: On 2/7/23 at 12:54 p.m., Resident 14 was observed sitting in a wheelchair in her room. The resident's catheter bag was hanging from underneath the wheelchair, out of the dignity bag and resting directly on the floor. On 2/8/23 at 9:13 a.m., Resident 14 was observed sitting in a wheelchair in her room. The resident's catheter bag was hanging from underneath the wheelchair. The bag was touching up against the legs of the wheelchair and the inner tire. The dignity bag was on the floor underneath the wheelchair. Record review for Resident 14 was completed on 2/8/23 at 9:06 a.m. Diagnoses included, but were not limited to, neurogenic bladder, and dementia.	F 0690	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** · Resident 14's foley was changed as well as adaptive straps to help with placement to keep off the ground. Dignity bag also adjusted to ensure bag remains covered. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** · All residents have the potential to be affected by the alleged deficient practice. A house audit was completed for anyone who has a foley catheter to ensure dignity bags were in place and not touching the ground. No concerns were identified by the audit. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;**	02/28/2023

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	The Significant Change Minimum Data Set (MDS) assessment, dated 12/25/22, indicated the resident was cognitively intact. The resident required an extensive 1 person assist for toilet use and had an indwelling Foley catheter. A Care Plan, dated 10/21/22 and revised 1/4/23, indicated the resident required an indwelling supra-pubic urinary catheter due to: neuromuscular dysfunction of the bladder. Interventions included to not allow tubing or any part of the drainage system to touch the floor and to store the collection bag inside a protective dignity pouch. A Progress Note, dated 2/5/23 at 2:15 p.m., indicated urine was collected from the catheter collection bag to be picked up by the laboratory. The urine was dark amber, slight foul odor and sediment were noted. A Progress Note, dated 2/10/23 at 6:27 a.m., indicated the urine C&S test remained pending at the laboratory at that time. Interview with LPN 1 on 2/8/23 at 9:16 a.m., indicated the resident had a urinalysis completed. The results were received but they still had not received the C&S results. The resident's catheter bag should always be covered and not on the floor or touching any part of the wheelchair while being uncovered. 3.1-41(a)(2)		· DNS or Designee will in-service all nursing staff on importance of providing dignity coverings for those with a catheter. Also, that it should never touch the ground. Facility also ordered new catheter bags that come with an attached dignity cover. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed;** · Ongoing compliance with this corrective action will be monitored through the facility QAPI tool for five (5) random residents. The DNS/designee will be responsible for completing the QAPI Audit tool weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic			

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	gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, record review, and interview, the facility failed to ensure food consumption logs were completed for residents with a history of weight loss for 2 of 3 residents reviewed for nutrition. (Residents 18 and 36) Findings include: 1. The record for Resident 18 was reviewed on 2/9/23 at 10:34 a.m. Diagnoses included, but were not limited to, hypertension, dementia, and cerebral infarction. The resident was hospitalized on 1/16/23 and returned to the facility on 1/20/23. The Significant Change Minimum Data Set (MDS) assessment, dated 1/7/23, indicated the resident was cognitively impaired and required an extensive assistance of one with eating. The resident weighed 230 pounds on 1/4/23 and 209 pounds on 2/6/23.	F 0692	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** · Resident 18 and 36 was reviewed in Nutrition At Risk (NAR) meeting by IDT team and RD. Resident 18 is on hospice and resident 36 is on palliative care. IDT and RD did not have any further recommendations for supplements and both residents' weights have since stabilized. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** · All residents have the potential to be affected by the	02/28/2023

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	A Progress Note, dated 2/8/23, indicated the resident had a 9.1% weight loss in 90 days and a 10.7% weight loss in 180 days. The Meal Consumption Log for February 2023 lacked documentation of the following meals: - Breakfast on 2/1/23, 2/6/23, and 2/8/23 - Lunch on 2/1/23, 2/6/23, and 2/8/23 The Meal Consumption Log for January 2023 lacked documentation of the following meals: - Breakfast on 1/20/23 - Lunch on 1/3/23, 1/6/23, 1/8/23, 1/13/23, 1/15/23, 1/20/23, and 1/30/23 - Dinner on 1/2/23, 1/4/23, 1/5/23, and 1/6/23 Interview with the Director of Nursing (DON) on 2/8/23 at 10:41 a.m., indicated the food consumption logs were incomplete and they had been having trouble with their electronic charting going in and out. She was unable to provide any further documentation. 2. The record for Resident 36 was reviewed on 2/8/23 at 2:27 p.m. Diagnoses included, but were not limited to, dementia, hypertension, and adult failure to thrive. The Significant Change Minimum Data Set (MDS) assessment, dated 1/11/23, indicated the resident was cognitively impaired and had weight loss. The resident weighed 130 pounds on 8/6/22 and 117 pounds on 2/6/23. A Progress Note, dated 2/8/23, indicated the resident had a 10% weight loss in 180 days. The Meal Consumption Log for February 2023		alleged deficient practice. An audit was completed on all residents being reviewed by NAR team for significant weight loss to ensure charting was completed to ensure proper intake. No concerns noted for those residents. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** · DNS or Designee will in-service all nursing on importance of documentation for food and fluids to accurately to ensure of any significant weight loss. Facility also implemented back up paper charting in case of power outage or technical difficulties. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed;** · Ongoing compliance with this corrective action will be monitored through the facility QAPI tool for five (5) random residents who are currently being monitored for significant weight loss. The DNS/designee will be responsible for completing the QAPI Audit tool weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2	

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	155448	A. BUILDING 00 B. WING	02/10/2023

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	lacked documentation of the following meals: - Breakfast on 2/4/23 - Lunch on 2/7/23, and 2/4/23 - Dinner on 2/6/23 The Meal Consumption Log for January 2023 lacked documentation of the following meals: - Lunch on 1/6/23, 1/7/23, 1/27/23, and 1/31/23 - Dinner on 1/3/23, 1/4/23, 1/15/23, 1/16/23, 1/21/23, 1/27/23, 1/28/23, and 1/29/23 Interview with the Director of Nursing (DON) on 2/8/23 at 10:41 a.m., indicated the food consumption logs were incomplete and they had been having trouble with their electronic charting going in and out. She was unable to provide any further documentation. 3.1-46(a)(1) 3.1-46(a)(2)		quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.	
F 0756 SS=D Bldg. 00	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an			

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	unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.			
	Based on record review and interview, the facility failed to ensure each resident's medication regimen was managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being related to Pharmacy recommendations lacking follow up for 1 of 5 residents reviewed for unnecessary medications. (Resident 61) Finding includes: The record for Resident 61 was reviewed on 2/10/23 at 11:31 a.m. The resident diagnoses included, but were not limited to, Alzheimer's	F 0756	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** · Resident 61 pharmacy recommendation was accepted by the NP on 02/10/2023 with no concerns. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;**	02/28/2023

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	dementia and a history of falls. The current Physician's Order Summary indicated the resident took meclizine (a medication used to treat dizziness and nausea) 12.5 milligrams (mg) in the morning and 25 mg in the evening. A Pharmacy Review, dated 1/11/23, recommended decreasing the meclizine to 12.5 mg twice daily due to a recent fall. The Pharmacy review had been signed by the Nurse Practitioner, but it was left blank as to whether to accept or decline the recommendation. Interview with the Director of Nursing on 2/10/23 at 1:46 p.m., indicated she had contacted the Nurse Practitioner and they were going to accept the recommendation to decrease the meclizine. She was unsure why it had not been completed before. 3.1-48(a)(5)		· All residents have the potential to be affected by the alleged deficient practice. Facility, as well as pharmacy completed a whole house audit and found no other pharmacy recommendations out of compliance or not addressed in a timely manner. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** · DNS or Designee will in-service all nursing management on importance of addressing pharmacy recommendations timely and accurately to ensure all fields are filled out by physician for either accepting or declining recommendations. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed;** · Ongoing compliance with this corrective action will be monitored through the facility QAPI tool for five (5) random residents. The DNS/designee will be responsible for completing the QAPI Audit tool weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be	

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			developed. Findings will be submitted to the QAPI Committee for review and follow up.	