STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155131	A. BUILDING 00 B. WING	02/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MUNSTER MED-INN	7935 CALUMET AVE MUNSTER, IN 46321

(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 the Investigation of Complaints IN00363312, IN00366657, IN00371730, and IN00371773. Complaint IN00363312 - Unsubstantiated due to lack of evidence. Complaint IN00366657 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00371730 - Substantiated. Federal/State deficiencies related to the allegations are cited at F585 and F757. Complaint IN00371773 - Substantiated. Federal/State deficiencies related to the allegations are cited at F690. Unrelated deficiency is cited. Survey dates: February 7 & 8, 2022 Facility number: 000056 Provider number: 155131 AIM number: 100289450 Census Bed Type: SNF/NF: 155 SNF: 15 Total: 170 Census Payor Type: Medicare: 48 Medicaid: 93 Other: 29 Total: 170	F 0000	The facility respectfully asks for a desk review	

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

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	These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 2/11/22.			
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, record review, and interview, the facility failed to ensure inhalers were secured in the medication cart and not at the resident's bed side for 1 of 3 residents reviewed for unnecessary medication. (Resident E) Finding includes: During an interview with Resident E on 2/7/22 at 1:30 p.m., indicated she was using her own medical supplies and medicine for the nebulizer treatments and had a Symbicort inhaler in her room for her to use when she needed it. She indicated she was able to self administer her own inhalers. On 2/27/22 at 2:00 p.m., the Unit Manager entered the resident's room and removed a package of Albuterol for the nebulizer treatment, a Symbicort hand held inhaler, and a facility pharmacy package of an Albuterol hand held inhaler. The record for Resident E was reviewed on 2/7/22 at 11:55 a.m. Diagnoses included, but were not limited to, glaucoma, osteoarthritis, wedge compression fracture of lumbar vertebrae, chronic respiratory failure, urinary tract infection, anxiety,	F 0554	**Munster Med-Inn** **Complaint Survey: 2/8/22** 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. **F554 Resident Self Admin Meds-Clinically Appropriate** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident E's- physician was notified and orders were received for the Symbicort inhaler. A self-administration assessment was completed for Resident E and orders were received for resident to self-administer Symbicort inhaler and nebulizer treatments. **How the facility will identify other residents having the**	02/16/2022

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	and high blood pressure. The Admission Minimum Data Set (MDS) assessment, dated 12/16/21, indicated the resident was cognitively intact and needed limited assist with a 1 person physical assist for toilet use. The resident received oxygen while a resident. Physician's Orders, dated 12/10/21, indicated Ipratropium-Albuterol .5 milligrams (mg)-3 mg/3 milliliters (ml) solution for nebulizer treatment every 4 hours. Physician's Orders, dated 1/26/22, indicated Albuterol Sulfate 90 mcg HFA aerosol inhaler, inhale 2 puffs every 6 hours as needed. There was no order for Symbicort inhaler. There was no order for the resident to self administer her medications by herself There was no self administer assessment for the resident to self administer her medications. Interview with the Unit Manager on 2/7/22 at 2:00 p.m., indicated when the resident moved to the third floor, there was a bag of medications the resident had in her possession that she had given them to the family to take home. She instructed the resident's family to take the medications home and not to bring any medications as the facility would supply them. She was unaware the resident had the inhalers in her room and any nurse or QMA could have given her the Albuterol inhaler for her to keep and use as needed. The resident had no order to self administer her medications. 3.1-25(m)		**potential to be affected by the same deficient practice and what corrective action will be taken;** All facility residents with medication orders have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Staff were educated on not leaving medications at resident bedside unless there is an order for self-administration in place. Staff were also educated on ensuring medications are stored properly. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Facility Angel's will audit 10 residents 3 days per week to ensure no medication is improperly stored at the bedside. The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.	

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F 0585 SS=D Bldg. 00	483.10(j)(1)-(4) Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file		**Date by which systemic corrections will be completed: 2/16/2022**	

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	grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;			

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	(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.			
	Based on record review, and interview, the facility failed to investigate and complete grievances that were reported to staff for 1 of 3 residents reviewed for abuse. (Resident E) Finding includes: During an interview with Resident E on 2/7/22 at 11:10 a.m., indicated she has had many nursing and care concerns in which she has reported to the Social Service Director (SSD) and Social Service Employee 1 (SS 1). She never had been informed of the results of those concerns. The record for Resident E was reviewed on 2/7/22	F 0585	**Munster Med-Inn** **Complaint Survey: 2/8/2022** 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. **F585 Grievances** **What corrective action(s) will be accomplished for those residents found to have been**	02/16/2022

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	at 11:55 a.m. Diagnoses included, but were not limited to, glaucoma, osteoarthritis, wedge compression fracture of lumbar vertebrae, chronic respiratory failure, urinary tract infection, anxiety, and high blood pressure. The Admission Minimum Data Set (MDS) assessment, dated 12/16/21, indicated the resident was cognitively intact and needed limited assist with a 1 person physical assist for toilet use. The resident received oxygen while a resident. A Resident Grievance/Complaint Form, dated 12/21/21, indicated the resident had care, customer service, long call light times, and medication concerns. The information was taken by SS 1 and was noted "Follow up with Nursing Manager." The resolution indicated "Resolved" with the Unit Manager's initials. There was no action plan or what was investigated regarding the resident's concerns. The grievance form was also not completed. The Administrator had not signed off and the grievance resolved to the satisfaction of all concerned area was not completed. A Resident grievance/complaint form, dated 12/24/21, indicated the resident had medication concerns. The information was taken by SS 1 and was noted "Follow up with Nursing Manager." The resolution indicated "Resolved, resident concerned about Prednisone orders. Pulmonologist called and new orders given." The grievance form was not complete, the Administrator had not signed off nor was the grievance resolved to the satisfaction of all concerned completed. A Resident Grievance/Complaint Form, dated 12/29/21, indicated the resident had medication concerns. The information was taken by SS 1 and		**affected by the deficient practice;** Resident E's grievances have been resolved. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents with grievances have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Staff were in serviced on the process of reporting a resident grievance and resolving the grievance in a timely manner as well as how to properly complete the grievance which will conclude with the administrator's review and signature. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Social Service Director/Designee will audit 5 grievances weekly to ensure they are resolved timely. Social Service/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the	

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	was noted "Follow up with Nursing Manager." The resolution indicated "Resolved, resident confused about medication times. Education provided to resident regarding med times." The grievance form was not completed, the Administrator had not signed off nor was the grievance resolved to the satisfaction of all concerned completed. A Resident Grievance/Complaint Form, dated 1/11/22, indicated the resident had care concerns regarding being checked every 2 hours, ice water and bed linen not being changed. The information was taken by SS 1 and was noted "Follow up with Nursing." The resolution indicated "Resident placed on behavior monitoring of wellness checks hourly times 48 hours." There was no investigation completed as to why things were not being completed for the resident. The grievance form was not complete, the Administrator had not signed off, nor was the grievance resolved to the satisfaction of all concerned completed. Interview with SS 1 on 2/7/21 at 1:45 p.m., indicated the resident has had many grievances which she had filled out and filed for the resident and given to the Unit Manager for follow up. Interview with the Unit Manager on 2/7/22 at 2:00 p.m., indicated she had all of the grievances, however, they have not been completed and were not signed off by the Administrator. She had lost track of time for completing the grievances. Interview with the Administrator on 2/8/22 at 2:50 p.m., indicated he was not aware grievances were not being completed timely. Interview with the SSD on 2/8/22 at 1:51 p.m.,		Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 2/16/22**	

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	indicated whoever completes the grievance form will give it to the SS employee on each floor. If SS completes the form, they will give it to the appropriate department or nursing unit manager. At the end of each week, SS should follow up with the department and collect the grievances and give to the Administrator to sign. SS should follow up with the resident and/or family the next day after the grievance has been made and enter a note in the chart. The current 11/2016, "Grievance" policy, provided by the SSD on 2/8/22 at 1:51 p.m., indicated "Upon receipt of a written grievance and/or complaint, the designated individual will investigate the allegation and submit a written report of such findings to the Administrator within 5 working days of receiving the grievance. The resident or person filing the grievance will be informed of the findings of the report and the actions that will be taken to correct any identified problems. The report will be made orally by the Administrator or designee within 5 working days of filing the grievance. This Federal tag relates to Complaint IN00371730 3.1-7(a)(2)			
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			

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	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 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 record review and interview, the facility failed to ensure a follow-up assessment and documentation of the resident's urine was completed after an Urinary Tract Infection (UTI), orders were obtained for foley catheters and catheter care, and catheter care was completed for 2 of 3 residents reviewed for urinary tract infections. (Residents E and D) Findings include: 1. The record for Resident E was reviewed on 2/7/22 at 11:55 a.m. Diagnoses included, but were not limited to, glaucoma, osteoarthritis, wedge	F 0690	**Munster Med-Inn** **Complaint Survey: 2/8/2022** 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. **F690 Bowel/Bladder Incontinence, Catheter, UTI** **What corrective action(s) will**	02/16/2022

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	compression fracture of lumbar vertebrae, chronic respiratory failure, urinary tract infection, anxiety, and high blood pressure. The Admission Minimum Data Set (MDS) assessment, dated 12/16/21, indicated the resident was cognitively intact and needed limited assist with a 1 person physical assist for toilet use. The resident received oxygen while a resident. A Care Plan, dated 12/30/21, indicated the resident had potential for complications related to bowel/bladder incontinence. The Nursing approaches were to obtain lab work as ordered by doctor, report any abnormalities, and signs and symptoms of an urinary tract infection. Nurses' Notes, dated 1/9/22 at 10:43 a.m., indicated the writer was alerted the resident had red urine. The writer entered the room to find bright red urine in a drainage container. The writer called and notified the doctor of the situation and new orders were received to start Macrobid (an antibiotic medication) 100 milligrams (mg) stat twice a day times 5 days and collect an urine culture. Physician's Orders, dated 1/9/22, indicated Macrobid 100 mg twice a day for 5 days for UTI. A urinalysis, collected on 1/10/22 and reported on 1/11/22, indicated the resident's urine was dark yellow, had a large amount of blood and leukocytes, and was negative for nitrates. The urine culture reported on 1/12/22 indicated the resident had 10-50000 colonies of proteus mirabilis. Nurses' Notes, dated 1/9/22 at 10:13 p.m., indicated antibiotic continued for UTI without		**be accomplished for those residents found to have been affected by the deficient practice;** Resident D no longer resides in the facility. Resident E Urinary tract infection has resolved. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Staff were in-serviced on the documentation in MATRIX/clinical record/MAR/TAR including: · Ongoing clinical assessments · Any change in condition · Treatment of UTI · Transcription of physician's orders including orders for Foley catheters · Foley catheter care **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Nurse Managers will audit clinical	

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	adverse reactions. There was no assessment of the resident's urine. Nurses' Notes, dated 1/10/22 at 9:50 p.m., indicated the resident remained on an oral antibiotic. There was no assessment of the resident's urine. Nurses' Notes, dated 1/11/22 at 6:00 a.m., indicated the resident continued on Macrobid due to recent hematuria. Her urine was yellow and has no complaints. Nurses' Notes, dated 1/12/22 at 12:00 a.m., indicated the resident had no complaints. She denied any dysuria or frequency and her urine was yellow and transparent. Continued on antibiotic for 2 more days The next entry was on 1/17/22 by the Physician and there was no information or documentation regarding the recent UTI. There were no more assessments or follow-up documentation regarding the UTI. There was no consistent follow-up assessment or documentation of the resident's urine after the antibiotic was initiated. The Medication Administration Record (MAR) for 1/2022 indicated the Macrobid was signed out as being administered twice a day from 1/9-1/13/22. Interview with the Director of Nursing on 2/8/21 at 1:10 p.m., indicated there was no follow-up assessment of the resident's urine after the antibiotic started.2. Resident D's closed record was reviewed on 2/7/22 at 10:01 a.m. Diagnoses included, but were not limited to, hypertension, type 2 diabetes mellitus, and chronic kidney		charting documentation 3 times per week to ensure follow up of change in condition documentation is completed with special focus on residents with UTI's and infections. Nurse Managers will audit 5 residents with foley catheters weekly to ensure foley catheter orders are in place. The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 2/16/2022**	

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(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
	disease. The resident was admitted to the facility on 11/3/21. The Admission MDS assessment, dated 11/9/21, indicated the resident had an indwelling urinary catheter and had a urinary tract infection (UTI) within the last 30 days. A Care Plan, dated 11/9/21, indicated the resident required an indwelling urinary catheter. The nursing interventions included, "...provide assistance for catheter care as needed..." A Progress Note, dated 11/3/21 at 9:00 p.m., indicated the resident had just been admitted to the facility that evening and had a Foley (a type of urinary catheter) catheter in place. A Physician's Order, dated 11/4/21, indicated the resident was to receive Levaquin (an antibiotic) orally for the treatment of a urinary tract infection as well as ampicillin-sulbactam (an antibiotic) intravenously. Progress Notes, dated 11/28/21, indicated the resident was sent to the Emergency Room (ER) because she had a change in mental status, slurred speech, and lethargy. She was admitted to the hospital with the diagnosis of UTI. The resident returned to the facility on 12/7/21 with a Physician's Order for an antibiotic to treat the UTI. Progress Notes, dated 12/22/21, indicated the resident was sent to the ER related to critical lab results. She returned to the facility on 12/23/21 with a Physician's Order for intravenous (IV) antibiotics to treat a UTI. A Progress Note, dated 1/4/22, indicated the resident had a Foley catheter intact. The resident			

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	155131	A. BUILDING 00 B. WING	02/08/2022

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	was discharged to the hospital on 1/4/22. There was lack of a Physician's Order for the indwelling urinary catheter or for the completion of catheter care. The Medication Administration Record (MAR) and Treatment Administration (TAR) records, dated 11/2021, 12/2021, and 1/2022, lacked documentation of any catheter care. Interview with the Director of Nursing (DON) on 2/8/22 at 1:06 p.m., indicated the resident had a care plan for the urinary catheter but she was unable to find a Physician's Order for it or for catheter care. The catheter care should have been documented on the TAR. A facility policy, titled "Catheter Care, Urinary," received from the DON on 2/8/22 at 2:06 p.m., indicated "...Documentation. The following information should be recorded in the resident's medical record: 1. The date and time the catheter care was given. 2. The name and title of the individual(s) giving the catheter care..." This Federal tag relates to Complaint IN00371773. 3.1-41(a)(1) 3.1-41(a)(2)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including			

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	duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to ensure blood pressure and pulse were monitored before administering blood pressure medications and eye drops were administered as ordered for glaucoma and vision loss for 1 of 3 residents reviewed for unnecessary medications. (Resident E) Finding includes: During an interview with Resident E on 2/7/22 at 11:10 a.m., indicated she has filed many complaints regarding her blood pressure medications and eye drops not being administered. The record for Resident E was reviewed on 2/7/22 at 11:55 a.m. Diagnoses included, but were not limited to, glaucoma, osteoarthritis, wedge compression fracture of lumbar vertebrae, chronic respiratory failure, urinary tract infection, anxiety, and high blood pressure.	F 0757	**Munster Med-Inn** **Complaint Survey: 2/8/22** 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. **F757 Drug regimen is Free from Unnecessary Drugs** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident E's- physician was notified and orders were received for blood pressure parameters. Resident E's eyedrops were administered as per orders.	02/16/2022

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	The Admission Minimum Data Set (MDS) assessment, dated 12/16/21, indicated the resident was cognitively intact and needed limited assist with a 1 person physical assist for toilet use. The resident received oxygen while a resident. A Care Plan, dated 2/8/22, indicated the resident had visual impairment related to current status with diagnosis of glaucoma. The nursing approaches were to administer eye medication as per physician's order. Physician's Orders, dated 12/10/21, indicated Brimonidine (used for glaucoma) eye drops .2% instill 1 drop both eyes at 9:00 a.m., and 5:00 p.m., Timolol Maleate (used for glaucoma) eye drops .5% instill 1 drop both eyes at 9:00 a.m., and 5:00 p.m., and Xalatan (used for glaucoma) eye drops .005% instill 1 drop both eyes every evening. Physician's Orders, dated 12/23/21, indicated Cardizem (used to treat high blood pressure and chest pain) 60 milligrams (mg) hold if pulse less than 60 or blood pressure less than 110/70 every 6 hours, at 12 a.m., 6 a.m., 12 p.m., and 6 p.m. Physician's Orders, dated 1/7/22, indicated Azopt (used for glaucoma) eye drops 1 drop both eyes at 9:00 a.m., and 5:00 p.m., and Travatan (used for glaucoma) eye drops .004% instill 1 drop both eyes at 9 a.m. and 5 p.m. The Medication Administration Record (MAR) for 12/2021, indicated the Brimonidine eye drops were not signed out as being administered on 12/13 and 12/14 at 9 a.m., and 5 p.m., and 12/19 at 9 a.m. The Timolol eye drops were not signed out as being administered on 12/13 at 9 a.m., and 5 p.m. The Cardizem was not signed out as being administered on 12/14 at 12 p.m., and 6 p.m., 12/15		**How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All facility residents with blood pressure parameters and eye drops have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Nurses were in-serviced on following blood pressure parameters as ordered before administering the medication. Nurses were in-serviced on administering medications including eye drops and blood pressure medications as per physician orders. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Nurse managers will randomly audit 5 residents medication administration record weekly to ensure blood pressure parameters are followed as ordered. Nurse managers will monitor/ randomly audit 5 residents medication administration record weekly for all medications,	

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	at 12 a.m., 12/16-12/17 at 12 a.m., and 12/22 at 12 p.m. The 1/2022 MAR indicated the Brimonidine and Timolol eye drops were not signed out as being administered on 1/15 and 1/21 at 5 p.m. The Xalatan eye drops were not signed out as being administered on 1/15 at 5 p.m. The Azopt and Travatan eye drops were not signed out as being administered on 1/21 and 1/30 at 5 p.m. The Cardizem was administered without documentation of a blood pressure or pulse on 1/15 at 6 a.m., 1/21 at 12 a.m., 1/31 at 6 p.m. The Cardizem was not signed out as being administered at all on 1/15 at 12 p.m., 1/19 at 6 p.m., 1/21 at 12 p.m. and 6 p.m., and 1/31/22 at 12 p.m. Interview with the Unit Manager on 2/7/22 at 2:00 p.m., indicated nursing staff were to document on the MAR when they administered the medications and eye drops. This Federal tag relates to Complaint IN00371730 3.1-48(a)(3)		especially eye drops to ensure they are administered as ordered. The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 2/16/2022**	