STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELLENIC SENIOR LIVING OF MISHAWAKA	1540 SOUTH LOGAN STREET, MISHAWAKA, , 46544

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00443940, IN00443664, IN00438450, and IN00436132. Complaint IN00443940 - State deficiencies related to the allegations are cited at R0241 and R0247. Complaint IN00443664 - No deficiencies related to the allegations are cited. Complaint IN00438450 - State deficiencies related to the allegations are cited at R0242. Complaint IN00436132 - State deficiencies related to the allegations are cited at R0241 and R0247. Survey date: November 6 & 7, 2024. Facility number: 014224 Residential Census: 107 These State Residential	R 0000		

	Findings are cited in accordance with 410 IAC 16.2-5. Quaity Reviw completed on 11/15/2024			
R 0241	Health Services - Offense 410 IAC 16.2-5-4(e)(1) (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on interview and record review, the facility failed to administer medications as ordered by the physician for 3 of 3 residents reviewed for medication administration, (Residents B, C & D). Findings include: 1. On 11/6/24 at 3:05 P.M., Resident B's clinical record was reviewed. Diagnoses included but were not limited to: glaucoma, urinary tract infection (10/5/24), shortness of breath, depression, dementia, gastro-esophageal reflux disease, bone density disorder, atherosclerotic heart disease,	R 0241	1. Corrections of previous time frames can not be made. No residents were affected by the alleged deficient practice. 2. All residents could have been affected, however in this case, no residents were affected. 3. All nursing staff in-service completed 11-14-24 in regards to community's policy on Medication Administration, proper documentation and notification of provider.Any staff found non-compliant will be re-educated and disciplined per facility policy. 4. DON/Designee will audit EMAR documentation 2x daily x5 days a week x4 weeks, then daily 5x week x8 weeks, then 3x weekly for 3months, to ensure procedure completed per policy for proper medication administration and documentation. Results of audits will be brought to Executive Director weeklyfor review and/or recommendations for six months and further if deficient practice continues.	12/06/2024

	overactive bladder, hyperlipidemia, chronic kidney disease, and neuropathy. The Resident's Service Plan, dated 3/6/23 and revised on 10/3/24, indicated the resident required assistance for medication administration. The current Physician's Orders for medications included: Licensed staff to administer medications, initiated on 3/6/23, One Cimetidine 300 mg tablet before meals for reflux disease, initiated on 3/27/23, One Doxycycline 100 mg capsule two times daily for urinary tract infection, initiated on 9/24/24, One Aspirin 81 mg tablet daily for heart disease, initiated on 3/7/23, One Calcium/D3 600 mg-5 mg tablet two times daily for bone density, initiated on 3/6/24, One Certavite multivitamin tablet daily for chronic kidney disease, initiated 3/6/23, One Acetaminophen 500 mg tablet three times daily for lower back pain, initiated on 3/6/23,			

	One Clopidogrel 75 mg tablet one time daily for chronic kidney disease, initiated on 3/3/23, One Donepezil 10 mg tablet every evening for dementia, initiated on 3/3/23, One Losartan Potassium 100 mg tablet every evening for hypertension, initiated on 3/3/23, One Rosuvastatin 10 mg tablet daily for hyperlipidemia, initiated on 3/3/23, One Fesoterodine 4 mg tablet daily for overactive bladder, initiated on 3/3/23. Review of Resident B's Medication Administration Records (MAR), from 9/1/24 to 11/6/24, indicated the resident did not receive the prescribed medications on the following dates and times: Cimetidine 300 mg tablet before meals for reflux disease, 9/1/24 at 7:00 A.M. and 11:00 A.M., 9/14/24 at 4:00 P.M., 9/24/24 at 7:00 A.M. and 11:00 A.M., 9/25/24 at 4:00 P.M., 9/26/34 at 4:00 P.M., and 9/27/24 at 11:00 A.M. and 4:00 P.M., 10/6/24 at 4:00 P.M., 10/8/24 at 11:00 A.M., 10/10/24 at 4:00 P.M., 10/11/24 at 4:00 P.M., 10/22/24 at 4:00 P.M., 10/24/24 - 10/27/24 at 4:00 P.M. and 10/29/24 -10/31/24 at 4:00 P.M.,11/2/24 at 4:00 P.M.,			

	11/5/24 at 4:00 P.M., 11/6/24 at 4:00 P.M. Doxycycline 100 mg capsule two times daily for urinary tract infection, never documented as administered 9/24/24 - 9/30/24. Aspirin 81 mg tablet daily for heart disease, 9/23/24 at 6:00 A.M. Calcium/D3 600 mg-5 mg tablet two times daily, 9/1/24 at 6:00 A.M., 9/14/24 at 2:00 P.M., 9/23/24 at 6:00 A.M., 9/25/24 - 9/27/24 at 2:00 P.M. Certavite multivitamin tablet daily, 9/23/24 at 6:00 A.M., Acetaminophen 500 mg tablet three times daily, 9/1/24 at 6:00 A.M. and 1:00 P.M., 9/10/24 at 8:00 P.M., 9/14/24 at 8:00 P.M., 9/23/24 at 6:00 A.M. and 1:00 P.M., 9/25/24 at 8:00 P.M., 9/26/24 at 4:00 P.M., 9/27/24 at 11:00 A.M. and 4:00 P.M., 10/10/24 - 10/12/24 at 8:00 P.M.,10/22/24 at 8:00 P.M., 10/24/24 -10/27/24 at 8:00 P.M., 10/29/24 - 10/31/24 at 8:00 P.M., 11/1/24, 11/2/24, 11/5/24, and 11/6/24 at 8:00 P.M. Clopidogrel 75 mg tablet one time daily, 9/23/24 at 6:00 A.M. Donepezil 10 mg tablet every evening, 9/14/24 at 2:00 P.M., 9/25-9/27 at 2:00 P.M., 1/6/24 at 2:00 P.M., 10/10/24-10/11/24 at 2:00 P.M., 10/22/24 at 2:00			

P.M., 10/24/24-10/27/24 at 2:00 P.M., 10/29/24-10/31/24 at 2:00 P.M., 11/2/24 at 2:00 P.M.

Losartan Potassium 100 mg tablet every evening, 9/14, 25, 26, and 27/24 at 2:00 P.M., 10/6,10,11, 22, 24, 25, 26, 27, 29, 30, and 31/ 24 at 2:00 P.M. ,11/2/24 at 2:00 P.M.

Rosuvastatin 10 mg tablet daily, 9/1/24, 9/13/24 at 6:00 A.M.

Fesoterodine 4 mg tablet daily 9/1/24, 9/23/24 at 6:00 A.M.

During an interview on 11/7/24 at 1:03 P.M., Resident B indicated she did not always receive her medications and very often received them late. The resident indicated, at times, the morning medications were administered too late and she was not able to take them with the noon medications because the administrations times were too close together.

2. On 11/6/24 at 3:51 P.M., Resident C's clinical record was reviewed. Diagnoses included but were not limited to: hypertension, arthritis, squamous cell carcinoma to the face, hyperlipidemia, radiculopathy of lower back, gastro-esophageal reflux disease, tremor, macular degeneration, bone density disorder, and edema.

The Resident's Service Plan

dated 2/20/23 and revised on 4/17/24, indicated the resident required assistance for medication administration.

The current Physician's Orders for medications included,

One Lorsartan Potassium 50 mg tablet daily for hypertension, initiated on 9/20/24,

One Pantoproazoe 40 mg tablet daily for Gastro-esophageal reflux, initiated on 8/22/22,

One Pravastatin 20 mg tablet daily at bedtime for hyperlipidemia, initiated on 3/19/24,

One Propranolol 40 mg tablet 3 times daily for hypertension, initiated on 3/19/24,

Review of Resident C's Medication Administration Records (MAR), from 9/1/24 to 11/6/24, indicated the resident did not receive the prescribed medications on the following dates and times:

Lorsartan Potassium 50 mg tablet daily, 9/22/24 - 9/30/24, 10/2/24-10/31/24 at 5:00 A.M., 11/1/24-116/24, at 5:00 A.M.,

Pantoproazoe 40 mg tablet daily, 9/15/24 and 9/18/24 at 6:00 A.M.,

Pravastatin 20 mg tablet daily at bedtime, 9/15/24, 9/16/24,

	9/18/24, 9/23/23, at 8:00 P.M., Propranolol 40 mg tablet 3 times daily, 9/12/24 at 9:00 P.M., 9/15/25 at 9:00 A.M., 2:00 P.M., 9:00 P.M., 9/18/24 at 9:00 A.M., 2:00 P.M., 9:00 P.M., 9/23/24 at 9:00 2:00 P.M., 9:00 P.M., 9/124/24 at 9:00 P.M., 9/28/24 at 9:00 P.M., 9/29/24 at 9:00 P.M., 10/1/24 at 9:00 P.M., 10/3/24 at 9:00 P.M., 10/6/24 at 9:00 P.M., 10/9/24 9:00 P.M., 10/11/24 at 2:00 P.M., 9:00 P.M., 10/13/24 at 9:00 P.M., 10/15/24 at 9:00 P.M., 10/18/24 at 9:00 P.M., 10/22/24 at 9:00 P.M., 1025/24 at 2:00 P.M., 9:00 P.M., 10/27/24 at 9:00 P.M., 10/28/24 at 9:00 P.M., 10/29/24 at 2:00 P.M., 9:00 P.M., 10/30/24 at 2:00 P.M., 9:00 P.M., 10/31/24 at 2:00 P.M., 9:00 P.M., 11/1/24 at 9:00 P.M., 11/4/24 at 9:00 P.M., 11/5/24 at 9:00 P.M., 11/6/24 at 9:00 P.M. During an interview on 11/7/24 at 12:11 P.M. Resident C indicated there had been one or two times when her medications were administered late. 3. On 11/7/24 at 10:10 A.M., Resident D's clinical record was reviewed. Diagnoses included but were not limited to: schizo-affective disorder, insomnia, type 2 diabetes, hyperlipidemia, dementia, depression, anxiety, panic disorder, epilepsy, chronic pain,			

hypertension, osteoarthritis, edema and low back pain.

The Resident's Service Plan dated 8/21/23 and revised on 9/1/24, indicated the resident required assistance for medication administration.

The current Physician's Orders for medications included,

One Olanzapine 5 mg tablet daily at bedtime for schizo-affective disorder, initiated on 9/3/24,

OneTrazadone 50 mg tablet, 1/2 tablet at bedtime for insomnia, initiated on 4/2/24,

Review of Resident D's Medication Administration Records (MAR), from 9/1/24 to 11/6/24, indicated the resident did not receive the prescribed medications on the following dates and times:

Olanzapine 5 mg tablet daily at bedtime, 9/4/24, 9/10/24, 9/14/24, 9/15/24, 9/25/25/ 9/26/24/ 9/28/24 10/10/24, 10/11/24, 10/12/24, 10/15/24, 1022/24, 10/24/24, 10/25/24, 10/26/24, 10/27/24, 10/29/24, 10/30/24, 10/31/24, 11/1/24, 11/5/24, 11/6/24, at 8:00 P.M.

Trazadone 50 mg tablet, 1/2 tablet at bedtime, 9/1/24, 9/6/24, 9/10/24, 9/11/24, 9/12/24, 9/22/24, 9/24/24, 9/25/24, 9/26/24, 9/27/24, 9/29/24,

	9/30/24, 9/31/24, 10/10/24, 10/14/24, 10/17/24, 10/25/24, 10/26/24, 10/27/24, 10/28/24, 11/1/24, 11/3/24, 11/5/24, at 9:00 P.M. During an interview on 11/6/24 at 12:44 P.M., the Director of Nursing indicated documentation of medications administration has been an ongoing concern at the facility. She indicated staff had received inservices related to the documentation of medications but continued to neglect to document medication administration per the facility's policy. On 11/6/24 at 4:05 P.M., the Regional Director of Clinical Operations proved the policy titled, "Medication Administration," dated 8/27/24 and indicated it was the current medication administration policy. The policy indicated the administration of medications shall be as ordered by the resident's physician and document the administration immediately after administration. This citation relates to Complaints IN00443940 and IN00436132. Based on interview and record review, the facility failed to administer medications as ordered by the physician for 3 of 3 residents reviewed for			

medication administration, (Residents B, C & D).

Findings include:

1. On 11/6/24 at 3:05 P.M., Resident B's clinical record was reviewed. Diagnoses included but were not limited to: glaucoma, urinary tract infection (10/5/24), shortness of breath, depression, dementia, gastro-esophageal reflux disease, bone density disorder, atherosclerotic heart disease, overactive bladder, hyperlipidemia, chronic kidney disease, and neuropathy.

The Resident's Service Plan, dated 3/6/23 and revised on 10/3/24, indicated the resident required assistance for medication administration.

The current Physician's Orders for medications included:

Licensed staff to administer medications, initiated on 3/6/23,

One Cimetidine 300 mg tablet before meals for reflux disease, initiated on 3/27/23,

One Doxycycline 100 mg capsule two times daily for urinary tract infection, initiated on 9/24/24,

One Aspirin 81 mg tablet daily for heart disease, initiated on 3/7/23,

	One Calcium/D3 600 mg-5 mg tablet two times daily for bone density, initiated on 3/6/24, One Certavite multivitamin tablet daily for chronic kidney disease, initiated 3/6/23, One Acetaminophen 500 mg tablet three times daily for lower back pain, initiated on 3/6/23, One Clopidogrel 75 mg tablet one time daily for chronic kidney disease, initiated on 3/3/23, One Donepezil 10 mg tablet every evening for dementia, initiated on 3/3/23, One Losartan Potassium 100 mg tablet every evening for hypertension, initiated on 3/3/23, One Rosuvastatin 10 mg tablet daily for hyperlipidemia, initiated on 3/3/23, One Fesoterodine 4 mg tablet daily for overactive bladder, initiated on 3/3/23. Review of Resident B's Medication Administration Records (MAR), from 9/1/24 to 11/6/24, indicated the resident did not receive the prescribed medications on the following dates and times: Cimetidine 300 mg tablet before meals for reflux disease, 9/1/24 at 7:00 A.M. and 11:00 A.M.,			

	9/14/24 at 4:00 P.M., 9/24/24 at 7:00 A.M. and 11:00 A.M., 9/25/24 at 4:00 P.M., 9/26/34 at 4:00 P.M., and 9/27/24 at 11:00 A.M. and 4:00 P.M., 10/6/24 at 4:00 P.M., 10/8/24 at 11:00 A.M., 10/10/24 at 4:00 P.M., 10/11/24 at 4:00 P.M., 10/22/24 at 4:00 P.M., 10/24/24 - 10/27/24 at 4:00 P.M. and 10/29/24 -10/31/24 at 4:00 P.M.,11/2/24 at 4:00 P.M., 11/5/24 at 4:00 P.M., 11/6/24 at 4:00 P.M. Doxycycline 100 mg capsule two times daily for urinary tract infection, never documented as administered 9/24/24 - 9/30/24. Aspirin 81 mg tablet daily for heart disease, 9/23/24 at 6:00 A.M. Calcium/D3 600 mg-5 mg tablet two times daily, 9/1/24 at 6:00 A.M., 9/14/24 at 2:00 P.M., 9/23/24 at 6:00 A.M., 9/25/24 - 9/27/24 at 2:00 P.M. Certavite multivitamin tablet daily, 9/23/24 at 6:00 A.M., Acetaminophen 500 mg tablet three times daily, 9/1/24 at 6:00 A.M. and 1:00 P.M., 9/10/24 at 8:00 P.M., 9/14/24 at 8:00 P.M., 9/23/24 at 6:00 A.M. and 1:00 P.M., 9/25/24 at 8:00 P.M., 9/26/24 at 4:00 P.M., 9/27/24 at 11:00 A.M. and 4:00 P.M., 10/10/24 - 10/12/24 at 8:00 P.M.,10/22/24 at 8:00 P.M., 10/24/24 -10/27/24 at 8:00 P.M.,			

	10/29/24 - 10/31/24 at 8:00 P.M., 11/1/24, 11/2/24, 11/5/24, and 11/6/24 at 8:00 P.M. Clopidogrel 75 mg tablet one time daily, 9/23/24 at 6:00 A.M. Donepezil 10 mg tablet every evening, 9/14/24 at 2:00 P.M., 9/25-9/27 at 2:00 P.M., 1/6/24 at 2:00 P.M., 10/10/24-10/11/24 at 2:00 P.M., 10/22/24 at 2:00 P.M., 10/24/24-10/27/24 at 2:00 P.M., 10/29/24-10/31/24 at 2:00 P.M., 11/2/24 at 2:00 P.M. Losartan Potassium 100 mg tablet every evening, 9/14, 25, 26, and 27/24 at 2:00 P.M., 10/6,10,11, 22, 24, 25, 26, 27, 29, 30, and 31/ 24 at 2:00 P.M. ,11/2/24 at 2:00 P.M. Rosuvastatin 10 mg tablet daily, 9/1/24, 9/13/24 at 6:00 A.M. Fesoterodine 4 mg tablet daily 9/1/24, 9/23/24 at 6:00 A.M. During an interview on 11/7/24 at 1:03 P.M., Resident B indicated she did not always receive her medications and very often received them late. The resident indicated, at times, the morning medications were administered too late and she was not able to take them with the noon medications because the administrations times were too close together. 2. On 11/6/24 at 3:51 P.M., Resident C's clinical record was			

	reviewed. Diagnoses included but were not limited to: hypertension, arthritis, squamous cell carcinoma to the face, hyperlipidemia, radiculopathy of lower back, gastro-esophageal reflux disease, tremor, macular degeneration, bone density disorder, and edema. The Resident's Service Plan dated 2/20/23 and revised on 4/17/24, indicated the resident required assistance for medication administration. The current Physician's Orders for medications included, One Lorsartan Potassium 50 mg tablet daily for hypertension, initiated on 9/20/24, One Pantoproazoe 40 mg tablet daily for Gastro-esophageal reflux, initiated on 8/22/22, One Pravastatin 20 mg tablet daily at bedtime for hyperlipidemia, initiated on 3/19/24, One Propranolol 40 mg tablet 3 times daily for hypertension, initiated on 3/19/24,			

	Review of Resident C's Medication Administration Records (MAR), from 9/1/24 to 11/6/24, indicated the resident did not receive the prescribed medications on the following dates and times: Lorsartan Potassium 50 mg tablet daily, 9/22/24 - 9/30/24, 10/2/24-10/31/24 at 5:00 A.M., 11/1/24-116/24, at 5:00 A.M., Pantoproazoe 40 mg tablet daily, 9/15/24 and 9/18/24 at 6:00 A.M., Pravastatin 20 mg tablet daily at bedtime, 9/15/24, 9/16/24, 9/18/24, 9/23/23, at 8:00 P.M., Propranolol 40 mg tablet 3 times daily, 9/12/24 at 9:00 P.M., 9/15/25 at 9:00 A.M., 2:00 P.M., 9:00 P.M., 9/18/24 at 9:00 A.M., 2:00 P.M., 9:00 P.M., 9/23/24 at 9:00 2:00 P.M., 9:00 P.M., 9/124/24 at 9:00 P.M., 9/28/24 at 9:00 P.M., 9/29/24 at 9:00 P.M., 10/1/24 at 9:00 P.M., 10/3/24 at 9:00 P.M., 10/6/24 at 9:00 P.M., 10/9/24 9:00 P.M., 10/11/24 at 2:00 P.M., 9:00 P.M., 10/13/24 at 9:00 P.M., 10/15/24 at 9:00 P.M., 10/18/24 at 9:00 P.M., 10/22/24 at 9:00 P.M., 1025/24 at 2:00 P.M., 9:00 P.M., 10/27/24 at 9:00 P.M., 10/28/24 at 9:00 P.M., 10/29/24 at 2:00 P.M., 9:00 P.M., 10/30/24 at 2:00 P.M., 9:00 P.M., 10/31/24 at 2:00 P.M., 9:00 P.M., 11/1/24 at 9:00			

P.M., 11/4/24 at 9:00 P.M., 11/5/24 at 9:00 P.M., 11/6/24 at 9:00 P.M.

During an interview on 11/7/24 at 12:11 P.M. Resident C indicated there had been one or two times when her medications were administered late.

3. On 11/7/24 at 10:10 A.M., Resident D's clinical record was reviewed. Diagnoses included but were not limited to: schizo-affective disorder, insomnia, type 2 diabetes, hyperlipidemia, dementia, depression, anxiety, panic disorder, epilepsy, chronic pain, hypertension, osteoarthritis, edema and low back pain.

The Resident's Service Plan dated 8/21/23 and revised on 9/1/24, indicated the resident required assistance for medication administration.

The current Physician's Orders for medications included,

One Olanzapine 5 mg tablet daily at bedtime for schizo-affective disorder, initiated on 9/3/24,

OneTrazadone 50 mg tablet, 1/2 tablet at bedtime for insomnia, initiated on 4/2/24,

Review of Resident D's Medication Administration Records (MAR), from 9/1/24 to 11/6/24, indicated the resident

did not receive the prescribed medications on the following dates and times:

Olanzapine 5 mg tablet daily at bedtime, 9/4/24, 9/10/24, 9/14/24, 9/15/24, 9/25/25/ 9/26/24/ 9/28/24 10/10/24, 10/11/24, 10/12/24, 10/15/24, 1022/24, 10/24/24, 10/25/24, 10/26/24, 10/27/24, 10/29/24, 10/30/24, 10/31/24, 11/1/24, 11/5/24, 11/6/24, at 8:00 P.M.

Trazadone 50 mg tablet, 1/2 tablet at bedtime, 9/1/24, 9/6/24, 9/10/24, 9/11/24, 9/12/24, 9/22/24, 9/24/24, 9/25/24, 9/26/24, 9/27/24, 9/29/24, 9/30/24, 9/31/24, 10/10/24, 10/14/24, 10/17/24, 10/25/24, 10/26/24, 10/27/24, 10/28/24, 11/1/24, 11/3/24, 11/5/24, at 9:00 P.M.

During an interview on 11/6/24 at 12:44 P.M., the Director of Nursing indicated documentation of medications administration has been an ongoing concern at the facility. She indicated staff had received inservices related to the documentation of medications but continued to neglect to document medication administration per the facility's policy.

On 11/6/24 at 4:05 P.M., the Regional Director of Clinical Operations proved the policy titled, "Medication

	Administration," dated 8/27/24 and indicated it was the current medication administration policy. The policy indicated the administration of medications shall be as ordered by the resident's physician and document the administration immediately after administration. This citation relates to Complaints IN00443940 and IN00436132.			
R 0242	Health Services - Offense 410 IAC 16.2-5-4(e)(2) (2) The resident shall be observed for effects of medications. Documentation of any undesirable effects shall be contained in the clinical record. The physician shall be notified immediately if undesirable effects occur, and such notification shall be documented in the clinical record. Based on interview and record review, the facility failed to follow physicians orders and ensure daily Blood Pressure (B/P) assessments were obtained for 2 of 3 residents reviewed, (Residents C and D). Findings include: 1. On 11/6/24 at 11:56 A.M., a review of the clinical record for Resident C was conducted. The resident's diagnoses included, but were not limited to:	R 0242	1. Corrections of previous time frames can not be made. No residents were affected by the alleged deficient practice. 2. All residents could have been affected, however in this case, no residents were affected. 3. All nursing staff in-service completed 11-14-24 in regards to community's policy on Medication Administration, proper documentation and notification of provider. Staff educated to accurately complete all provider orders with any/all supplementary documentation in the EMAR as ordered. Any staff found non-compliant will be re-educated and disciplined per facility policy. 4. DON/Designee will audit EMAR documentation or any/all supplementary documentation, ie) blood pressures, 2x daily x5 days a week x4 weeks, then daily 5x week x8 weeks, then 3x weekly for 3months, to ensure procedure completed per policy for proper medication administration and	12/06/2024

	hypertension and arthritis. A Physician's Order, dated 7/1/24, indicated the physician had ordered losartan (medication used to treat high blood pressure) 25 mg (milligrams), orally, at bedtime and to obtain a B/P assessment with the medication administration. A Nursing Progress Order Note, dated 7/4/24 at 4:24 P.M., indicated an order was received for losartan 25 mg, one tablet a day for hypertension, but the note did not include the physician's order to administer the medication at bedtime or to take the resident's B/P. A Nursing Progress Order Note, dated 7/9/24 at 8:01 A.M., indicated to administer losartan 25 mg orally at bedtime. The note did not include the B/P assessment order. A Nursing Progress Order Note, dated 7/18/24 at 8:01 P.M., indicated losartan 25 mg at bedtime for hypertension "...CHECK BLOOD PRESSURE DAILY...." The Medication Administration Record (MAR) for July 2024 indicated staff started documenting B/Ps, on 7/14/24, but did not document a B/P assessment on 7/20 and 7/22/24.		documentation. Results of audits will be brought to Executive Director weeklyfor review and/or recommendations for six months and further if deficient practice continues.	

	The MAR for August 2024 indicated staff did not document the resident's B/P on the following dates: 8/3, 8/4, 8/9, 8/13 and 8/30. On 8/7, 8/12, and 8/14 the B/P had been documented as "N/A" without an explanation as to why the B/P had not been obtained as ordered. During an interview, on 11/7/24 at 12:14 P.M., the Director of Nursing (DON) indicated the resident had been taking her own blood pressures but understood the physician had ordered the B/P's to be obtained and the readings would need to be documented on the MAR. The DON provided a booklet with the resident's handwritten blood pressure assessments. The booklet indicated the B/P assessment were started on 7/24/24. There was no indication staff were aware of the resident's blood pressure assessments daily nor were they documenting the blood pressure assessments in the MAR as ordered. 2. On 11/6/24 at 11:56 A.M., a review of the clinical record for Resident D was conducted. The resident's diagnoses included, but were not limited to: hypertension and dementia. A Nursing Progress Note, dated 10/8/24 at 7:50 P.M., indicated the resident's B/P was 187/100			

and the resident was not receiving any blood pressure medications. The Note indicated the Nurse Practitioner (NP) had been contacted and had ordered the resident to be taken to a nearby hospital for an evaluation

A Nursing Progress Note, dated 10/9/24 at 7:49 P.M., indicated the NP has evaluated the resident and had documented her assessment and given some orders for the resident..

A Physician's Order, dated 10/9/24, indicated "...Monitor B/P daily in AM - Document on PCC [Point Click Care]....", the electronic chart.

A Nursing Progress Note, dated 10/14/24 at 11:10 A.M., indicated the NP had seen the resident and new orders were given to obtain the resident's blood pressure, daily.

The MAR for October 2024, indicated no blood pressures had been obtained on 10/9, 10/10, 10/11, 10/12, 10/14, 10/17, 10/25, 10/26, 10/27 and 10/31/24.

The MAR for November 2024 indicated no blood pressures had been obtained on 11/1, 11/2 and 11/3.

On 11/6/24 at 4:05 P.M., the Regional Director of Clinical Services provided a policy titled,

"Medication Administration", dated 8/27/24, and indicated the policy was the one currently used by the facility. The policy indicated "...22 j) Check blood pressure and/or pulse before administrating any medications with orders to monitor and hold medication if beyond ordered high/low parameters. k) Document vital signs and administration immediately after administration...27. Medication refusal will be documented in on the residents EMAR [Electronic Medication Administration Record]...."

This citation relates to Complaint IN00438450.

Based on interview and record review, the facility failed to follow physicians orders and ensure daily Blood Pressure (B/P) assessments were obtained for 2 of 3 residents reviewed, (Residents C and D).

Findings include:

1. On 11/6/24 at 11:56 A.M., a review of the clinical record for Resident C was conducted. The resident's diagnoses included, but were not limited to: hypertension and arthritis.

A Physician's Order, dated 7/1/24, indicated the physician had ordered losartan (medication used to treat high blood pressure) 25 mg (milligrams), orally, at bedtime

and to obtain a B/P assessment with the medication administration.

A Nursing Progress Order Note, dated 7/4/24 at 4:24 P.M., indicated an order was received for losartan 25 mg, one tablet a day for hypertension, but the note did not include the physician's order to administer the medication at bedtime or to take the resident's B/P.

A Nursing Progress Order Note, dated 7/9/24 at 8:01 A.M., indicated to administer losartan 25 mg orally at bedtime. The note did not include the B/P assessment order.

A Nursing Progress Order Note, dated 7/18/24 at 8:01 P.M., indicated losartan 25 mg at bedtime for hypertension "...CHECK BLOOD PRESSURE DAILY...."

The Medication Administration Record (MAR) for July 2024 indicated staff started documenting B/Ps, on 7/14/24, but did not document a B/P assessment on 7/20 and 7/22/24.

The MAR for August 2024 indicated staff did not document the resident's B/P on the following dates: 8/3, 8/4, 8/9, 8/13 and 8/30. On 8/7, 8/12, and 8/14 the B/P had been documented as "N/A" without an explanation as to why the B/P

	had not been obtained as ordered. During an interview, on 11/7/24 at 12:14 P.M., the Director of Nursing (DON) indicated the resident had been taking her own blood pressures but understood the physician had ordered the B/P's to be obtained and the readings would need to be documented on the MAR. The DON provided a booklet with the resident's handwritten blood pressure assessments. The booklet indicated the B/P assessment were started on 7/24/24. There was no indication staff were aware of the resident's blood pressure assessments daily nor were they documenting the blood pressure assessments in the MAR as ordered. 2. On 11/6/24 at 11:56 A.M., a review of the clinical record for Resident D was conducted. The resident's diagnoses included, but were not limited to: hypertension and dementia.			

	A Nursing Progress Note, dated 10/8/24 at 7:50 P.M., indicated the resident's B/P was 187/100 and the resident was not receiving any blood pressure medications. The Note indicated the Nurse Practitioner (NP) had been contacted and had ordered the resident to be taken to a nearby hospital for an evaluation A Nursing Progress Note, dated 10/9/24 at 7:49 P.M., indicated the NP has evaluated the resident and had documented her assessment and given some orders for the resident.. A Physician's Order, dated 10/9/24, indicated "...Monitor B/P daily in AM - Document on PCC [Point Click Care]....", the electronic chart. A Nursing Progress Note, dated 10/14/24 at 11:10 A.M., indicated the NP had seen the resident and new orders were given to obtain the resident's blood pressure, daily. The MAR for October 2024, indicated no blood pressures had been obtained on 10/9, 10/10, 10/11, 10/12, 10/14, 10/17, 10/25, 10/26, 10/27 and 10/31/24. The MAR for November 2024 indicated no blood pressures had been obtained on 11/1, 11/2 and 11/3.			

	On 11/6/24 at 4:05 P.M., the Regional Director of Clinical Services provided a policy titled, "Medication Administration", dated 8/27/24, and indicated the policy was the one currently used by the facility. The policy indicated "...22 j) Check blood pressure and/or pulse before administrating any medications with orders to monitor and hold medication if beyond ordered high/low parameters. k) Document vital signs and administration immediately after administration...27. Medication refusal will be documented in on the residents EMAR [Electronic Medication Administration Record]...." This citation relates to Complaint IN00438450.			
R 0247	Health Services - Deficiency 410 IAC 16.2-5-4(e)(7) (7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident. Based on interview and record review, the facility failed to ensure the physician was notified when 3 of 3 residents reviewed for medication administration did not receive	R 0247	DON/Designee will audit EMAR documentation 2x daily x5 days a week x4 weeks, then daily 5x week x8 weeks, then 3x weekly for 3months, to ensure procedure completed per policy for proper medication administration and documentation. Results of audits will be brought to Executive Director weeklyfor review and/or recommendations for six months and further if deficient practice continues.	12/06/2024

medications as ordered or refused medications as ordered by the physician (Residents B, C & D).

Findings include:

1. On 11/6/24 at 3:05 P.M., Resident B's clinical record was reviewed. Diagnoses included but were not limited to: glaucoma, urinary tract infection (10/5/24), shortness of breath, depression, dementia, gastro-esophageal reflux disease, bone density disorder, atherosclerotic heart disease, overactive bladder, hyperlipidemia, chronic kidney disease and neuropathy.

The Resident's Service Plan dated 3/6/23 and revised on 10/3/24, indicated the resident required assistance for medication administration.

The Current Physician's Orders for medications included:

Licensed staff to administer medications, initiated on 3/6/23,

One Cimetidine 300 mg tablet before meals for reflux disease, initiated on 3/27/23,

One Doxycycline 100 mg capsule two times daily for urinary tract infection, initiated on 9/24/24,

One Aspirin 81 mg tablet daily for heart disease, initiated on

3/7/23,

One Calcium/D3 600 mg-5 mg tablet two times daily for bone density, initiated on 3/6/24,

One Certavite multivitamin tablet daily for chronic kidney disease, initiated on 3/6/23,

One Acetaminophen 500 mg tablet three times daily for lower back pain, initiated on 3/6/23,

One Clopidogrel 75 mg tablet one time daily for chronic kidney disease, initiated on 3/3/23,

One Donepezil 10 mg tablet every evening for dementia, initiated on 3/3/23,

One Losartan Potassium 100 mg tablet every evening for hypertension, initiated on 3/3/23,

One Rosuvastatin 10 mg tablet daily for hyperlipidemia,initiated on 3/3/23,

One Fesoterodine 4 mg tablet daily for overactive bladder, initiated on 3/3/23.

Review of Resident B's Medication Administration Records (MAR), from 9/1/24 to 11/6/24, indicated the resident did not receive the prescribed medications on the following dates and times:

Cimetidine 300 mg tablet before

meals for reflux disease, 9/1/24 at 7:00 A.M. and 11:00 A.M., 9/14/24 at 4:00 P.M., 9/24/24 at 7:00 A.M. and 11:00 A.M., 9/25/24 at 4:00 P.M., 9/26/34 at 4:00 P.M., and 9/27/24 at 11:00 A.M. and 4:00 P.M., 10/6/24 at 4:00 P.M., 10/8/24 at 11:00 A.M., 10/10/24 at 4:00 P.M., 10/11/24 at 4:00 P.M., 10/22/24 at 4:00 P.M., 10/24/24 - 10/27/24 at 4:00 P.M. and 10/29/24 -10/31/24 at 4:00 P.M.,11/2/24 at 4:00 P.M., 11/5/24 at 4:00 P.M., 11/6/24 at 4:00 P.M.

Doxycycline 100 mg capsule two times daily for urinary tract infection, never documented as administered 9/24/24 - 9/30/24.

Aspirin 81 mg tablet daily for heart disease, 9/23/24 at 6:00 A.M.

Calcium/D3 600 mg-5 mg tablet two times daily, 9/1/24 at 6:00 A.M., 9/14/24 at 2:00 P.M., 9/23/24 at 6:00 A.M., 9/25/24 - 9/27/24 at 2:00 P.M.

Certavite multivitamin tablet daily, 9/23/24 at 6:00 A.M.,

Acetaminophen 500 mg tablet three times daily, 9/1/24 at 6:00 A.M. and 1:00 P.M., 9/10/24 at 8:00 P.M., 9/14/24 at 8:00 P.M., 9/23/24 at 6:00 A.M. and 1:00 P.M., 9/25/24 at 8:00 P.M., 9/26/24 at 4:00 P.M., 9/27/24 at 11:00 A.M. and 4:00 P.M., 10/10/24 - 10/12/24 at 8:00

P.M.,10/22/24 at 8:00 P.M., 10/24/24 -10/27/24 at 8:00 P.M., 10/29/24 - 10/31/24 at 8:00 P.M., 11/1/24, 11/2/24, 11/5/24, and 11/6/24 at 8:00 P.M.

Clopidogrel 75 mg tablet one time daily, 9/23/24 at 6:00 A.M.

Donepezil 10 mg tablet every evening, 9/14/24 at 2:00 P.M., 9/25-9/27 at 2:00 P.M., 1/6/24 at 2:00 P.M., 10/10/24-10/11/24 at 2:00 P.M., 10/22/24 at 2:00 P.M., 10/24/24-10/27/24 at 2:00 P.M., 10/29/24-10/31/24 at 2:00 P.M., 11/2/24 at 2:00 P.M.

Losartan Potassium 100 mg tablet every evening, 9/14, 25, 26, and 27/24 at 2:00 P.M., 10/6,10,11, 22, 24, 25, 26, 27, 29, 30, and 31/ 24 at 2:00 P.M. ,11/2/24 at 2:00 P.M.

Rosuvastatin 10 mg tablet daily, 9/1/24, 9/13/24 at 6:00 A.M.

Fesoterodine 4 mg tablet daily 9/1/24, 9/23/24 at 6:00 A.M.

2. On 11/6/24 at 3:51 P.M., Resident C's clinical record was reviewed. Diagnoses included, but were not limited to: hypertension, arthritis, squamous cell carcinoma to the face, hyperlipidemia, radiculopathy of lower back, gastro-esophageal reflux disease, tremor, macular degeneration, bone density disorder and edema.

The Resident's Service Plan dated 2/20/23 and revised on 4/17/24, indicated the resident required assistance for medication administration.

The current Physician's Orders for medications included:

One Lorsartan Potassium 50 mg tablet daily for hypertension, initiated on 9/20/24,

One Pantoproazoe 40 mg tablet daily for Gastro-esophageal reflux, initiated on 3/22/22,

One Pravastatin 20 mg tablet daily at bedtime for hyperlipidemia, initiated on 3/19/24,

One Propranolol 40 mg tablet 3 times daily for hypertension, initiated on 3/19/24,

Review of Resident C's Medication Administration Records (MAR), from 9/1/24 to 11/6/24, indicated the resident did not receive the prescribed medications on the following dates and times:

Lorsartan Potassium 50 mg tablet daily, 9/22/24 - 9/30/24, 10/2/24-10/31/24 at 5:00 A.M., 11/1/24-116/24, at 5:00 A.M.,

Pantoproazoe 40 mg tablet daily, 9/15/24 and 9/18/24 at 6:00 A.M.,

Pravastatin 20 mg tablet daily at

bedtime, 9/15/24, 9/16/24, 9/18/24, 9/23/23, at 8:00 P.M.,

Propranolol 40 mg tablet 3 times daily, 9/12/24 at 9:00 P.M., 9/15/25 at 9:00 A.M., 2:00 P.M., 9:00 P.M., 9/18/24 at 9:00 A.M., 2:00 P.M., 9:00 P.M., 9/23/24 at 9:00 2:00 P.M., 9:00 P.M., 9/124/24 at 9:00 P.M., 9/28/24 at 9:00 P.M., 9/29/24 at 9:00 P.M., 10/1/24 at 9:00 P.M., 10/3/24 at 9:00 P.M., 10/6/24 at 9:00 P.M., 10/9/24 9:00 P.M., 10/11/24 at 2:00 P.M., 9:00 P.M., 10/13/24 at 9:00 P.M., 10/15/24 at 9:00 P.M., 10/18/24 at 9:00 P.M., 10/22/24 at 9:00 P.M., 1025/24 at 2:00 P.M., 9:00 P.M., 10/27/24 at 9:00 P.M., 10/28/24 at 9:00 P.M., 10/29/24 at 2:00 P.M., 9:00 P.M., 10/30/24 at 2:00 P.M., 9:00 P.M., 10/31/24 at 2:00 P.M., 9:00 P.M., 11/1/24 at 9:00 P.M., 11/4/24 at 9:00 P.M., 11/5/24 at 9:00 P.M., 11/6/24 at 9:00 P.M.

3. On 11/7/24 at 10:10 A.M., Resident D's clinical record was reviewed. Diagnoses included, but were not limited to: schizo-affective disorder and insomnia.

The Resident's Service Plan dated 8/21/23 and revised on 9/1/24, indicated the resident required assistance for medication administration.

The current Physician's Orders

for medications included:

One Olanzapine 5 mg tablet daily at bedtime for schizo-affective disorder, initiated on 9/3/24,

OneTrazadone 50 mg tablet, 1/2 tablet at bedtime for insomnia, initiated on 4/2/24,

Review of Resident D's Medication Administration Records (MAR), from 9/1/24 to 11/6/24, indicated the resident did not receive the prescribed medications on the following dates and times:

Olanzapine 5 mg tablet daily at bedtime, 9/4/24, 9/10/24, 9/14/24, 9/15/24, 9/25/25/ 9/26/24/ 9/28/24 10/10/24, 10/11/24, 10/12/24, 10/15/24, 1022/24, 10/24/24, 10/25/24, 10/26/24, 10/27/24, 10/29/24, 10/30/24, 10/31/24, 11/1/24, 11/5/24, 11/6/24, at 8:00 P.M.

Olanapine was refused on 9/5/24, 911/24, 9/12/24, 9/16/24, 9/18/24, 9/19/24, 9/20/24, 9/23/24, 10/5/24, 10/9/24, 10/16/24, 10/19/24, 10/20/24, 10/21/24, 10/23/24, 11/4/24.

Trazadone 50 mg tablet, 1/2 tablet at bedtime, 9/1/24, 9/6/24, 9/10/24, 9/11/24, 9/12/24, 9/22/24, 9/24/24, 9/25/24, 9/26/24, 9/27/24, 9/29/24, 9/30/24, 9/31/24, 10/10/24, 10/14/24, 10/17/24, 10/25/24,

10/26/24, 10/27/24, 10/28/24, 11/1/24, 11/3/24, 11/5/24, at 9:00 P.M.

Trazadone was refused on 9/20/24, 9/23/24.

On 11/6/24 at 4:05 P.M., the Regional Director of Clinical Operations proved the policy titled, "Medication Administration," dated 8/27/24 and indicated it was the current medication administration policy. The policy indicated the following: "... the administration of medications shall be as ordered by the resident's physician and document the administration immediately after administration. The licensed nurse or qualified medication aide will be responsible for monitoring medication refusal and medication refusal will be reported to the resident's attending physician. "

This citation relates to Complaints IN 00443940 and IN00436132.

Based on interview and record review, the facility failed to ensure the physician was notified when 3 of 3 residents reviewed for medication administration did not receive medications as ordered or refused medications as ordered by the physician (Residents B, C & D).

Findings include:

1. On 11/6/24 at 3:05 P.M., Resident B's clinical record was reviewed. Diagnoses included but were not limited to: glaucoma, urinary tract infection (10/5/24), shortness of breath, depression, dementia, gastro-esophageal reflux disease, bone density disorder, atherosclerotic heart disease, overactive bladder, hyperlipidemia, chronic kidney disease and neuropathy.

The Resident's Service Plan dated 3/6/23 and revised on 10/3/24, indicated the resident required assistance for medication administration.

The Current Physician's Orders for medications included:

Licensed staff to administer medications, initiated on 3/6/23,

One Cimetidine 300 mg tablet before meals for reflux disease, initiated on 3/27/23,

One Doxycycline 100 mg capsule two times daily for urinary tract infection, initiated on 9/24/24,

One Aspirin 81 mg tablet daily for heart disease, initiated on 3/7/23,

One Calcium/D3 600 mg-5 mg tablet two times daily for bone density, initiated on 3/6/24,

One Certavite multivitamin tablet daily for chronic kidney disease, initiated on 3/6/23,

One Acetaminophen 500 mg tablet three times daily for lower back pain, initiated on 3/6/23,

One Clopidogrel 75 mg tablet one time daily for chronic kidney disease, initiated on 3/3/23,

One Donepezil 10 mg tablet every evening for dementia, initiated on 3/3/23,

One Losartan Potassium 100 mg tablet every evening for hypertension, initiated on 3/3/23,

One Rosuvastatin 10 mg tablet daily for hyperlipidemia,initiated on 3/3/23,

One Fesoterodine 4 mg tablet daily for overactive bladder, initiated on 3/3/23.

Review of Resident B's Medication Administration Records (MAR), from 9/1/24 to 11/6/24, indicated the resident did not receive the prescribed medications on the following dates and times:

Cimetidine 300 mg tablet before meals for reflux disease, 9/1/24 at 7:00 A.M. and 11:00 A.M.,

9/14/24 at 4:00 P.M., 9/24/24 at 7:00 A.M. and 11:00 A.M., 9/25/24 at 4:00 P.M., 9/26/34 at 4:00 P.M., and 9/27/24 at 11:00 A.M. and 4:00 P.M., 10/6/24 at 4:00 P.M., 10/8/24 at 11:00 A.M., 10/10/24 at 4:00 P.M., 10/11/24 at 4:00 P.M., 10/22/24 at 4:00 P.M., 10/24/24 - 10/27/24 at 4:00 P.M. and 10/29/24 -10/31/24 at 4:00 P.M.,11/2/24 at 4:00 P.M., 11/5/24 at 4:00 P.M., 11/6/24 at 4:00 P.M.

Doxycycline 100 mg capsule two times daily for urinary tract infection, never documented as administered 9/24/24 - 9/30/24.

Aspirin 81 mg tablet daily for heart disease, 9/23/24 at 6:00 A.M.

Calcium/D3 600 mg-5 mg tablet two times daily, 9/1/24 at 6:00 A.M., 9/14/24 at 2:00 P.M., 9/23/24 at 6:00 A.M., 9/25/24 - 9/27/24 at 2:00 P.M.

Certavite multivitamin tablet daily, 9/23/24 at 6:00 A.M.,

Acetaminophen 500 mg tablet three times daily, 9/1/24 at 6:00 A.M. and 1:00 P.M., 9/10/24 at 8:00 P.M., 9/14/24 at 8:00 P.M., 9/23/24 at 6:00 A.M. and 1:00 P.M., 9/25/24 at 8:00 P.M., 9/26/24 at 4:00 P.M., 9/27/24 at 11:00 A.M. and 4:00 P.M., 10/10/24 - 10/12/24 at 8:00 P.M.,10/22/24 at 8:00 P.M., 10/24/24 -10/27/24 at 8:00 P.M.,

10/29/24 - 10/31/24 at 8:00 P.M., 11/1/24, 11/2/24, 11/5/24, and 11/6/24 at 8:00 P.M.

Clopidogrel 75 mg tablet one time daily, 9/23/24 at 6:00 A.M.

Donepezil 10 mg tablet every evening, 9/14/24 at 2:00 P.M., 9/25-9/27 at 2:00 P.M., 1/6/24 at 2:00 P.M., 10/10/24-10/11/24 at 2:00 P.M., 10/22/24 at 2:00 P.M., 10/24/24-10/27/24 at 2:00 P.M., 10/29/24-10/31/24 at 2:00 P.M., 11/2/24 at 2:00 P.M.

Losartan Potassium 100 mg tablet every evening, 9/14, 25, 26, and 27/24 at 2:00 P.M., 10/6,10,11, 22, 24, 25, 26, 27, 29, 30, and 31/ 24 at 2:00 P.M. ,11/2/24 at 2:00 P.M.

Rosuvastatin 10 mg tablet daily, 9/1/24, 9/13/24 at 6:00 A.M.

Fesoterodine 4 mg tablet daily 9/1/24, 9/23/24 at 6:00 A.M.

2. On 11/6/24 at 3:51 P.M., Resident C's clinical record was reviewed. Diagnoses included, but were not limited to: hypertension, arthritis, squamous cell carcinoma to the face, hyperlipidemia, radiculopathy of lower back, gastro-esophageal reflux disease, tremor, macular degeneration, bone density disorder and edema.

The Resident's Service Plan dated 2/20/23 and revised on

4/17/24, indicated the resident required assistance for medication administration.

The current Physician's Orders for medications included:

One Lorsartan Potassium 50 mg tablet daily for hypertension, initiated on 9/20/24,

One Pantoproazoe 40 mg tablet daily for Gastro-esophageal reflux, initiated on 3/22/22,

One Pravastatin 20 mg tablet daily at bedtime for hyperlipidemia, initiated on 3/19/24,

One Propranolol 40 mg tablet 3 times daily for hypertension, initiated on 3/19/24,

Review of Resident C's Medication Administration Records (MAR), from 9/1/24 to 11/6/24, indicated the resident did not receive the prescribed medications on the following dates and times:

Lorsartan Potassium 50 mg tablet daily, 9/22/24 - 9/30/24, 10/2/24-10/31/24 at 5:00 A.M., 11/1/24-116/24, at 5:00 A.M.,

Pantoproazoe 40 mg tablet daily, 9/15/24 and 9/18/24 at 6:00 A.M.,

Pravastatin 20 mg tablet daily at bedtime, 9/15/24, 9/16/24, 9/18/24, 9/23/23, at 8:00 P.M.,

Propranolol 40 mg tablet 3 times daily, 9/12/24 at 9:00 P.M., 9/15/25 at 9:00 A.M., 2:00 P.M., 9:00 P.M., 9/18/24 at 9:00 A.M., 2:00 P.M., 9:00 P.M., 9/23/24 at 9:00 2:00 P.M., 9:00 P.M., 9/124/24 at 9:00 P.M., 9/28/24 at 9:00 P.M., 9/29/24 at 9:00 P.M., 10/1/24 at 9:00 P.M., 10/3/24 at 9:00 P.M., 10/6/24 at 9:00 P.M., 10/9/24 9:00 P.M., 10/11/24 at 2:00 P.M., 9:00 P.M., 10/13/24 at 9:00 P.M., 10/15/24 at 9:00 P.M., 10/18/24 at 9:00 P.M., 10/22/24 at 9:00 P.M., 1025/24 at 2:00 P.M., 9:00 P.M., 10/27/24 at 9:00 P.M., 10/28/24 at 9:00 P.M., 10/29/24 at 2:00 P.M., 9:00 P.M., 10/30/24 at 2:00 P.M., 9:00 P.M., 10/31/24 at 2:00 P.M., 9:00 P.M., 11/1/24 at 9:00 P.M., 11/4/24 at 9:00 P.M., 11/5/24 at 9:00 P.M., 11/6/24 at 9:00 P.M.

3. On 11/7/24 at 10:10 A.M., Resident D's clinical record was reviewed. Diagnoses included, but were not limited to: schizo-affective disorder and insomnia.

The Resident's Service Plan dated 8/21/23 and revised on 9/1/24, indicated the resident required assistance for medication administration.

The current Physician's Orders for medications included:

One Olanzapine 5 mg tablet daily at bedtime for schizo-affective disorder, initiated on 9/3/24,

OneTrazadone 50 mg tablet, 1/2 tablet at bedtime for insomnia, initiated on 4/2/24,

Review of Resident D's Medication Administration Records (MAR), from 9/1/24 to 11/6/24, indicated the resident did not receive the prescribed medications on the following dates and times:

Olanzapine 5 mg tablet daily at bedtime, 9/4/24, 9/10/24, 9/14/24, 9/15/24, 9/25/25/ 9/26/24/ 9/28/24 10/10/24, 10/11/24, 10/12/24, 10/15/24, 1022/24, 10/24/24, 10/25/24, 10/26/24, 10/27/24, 10/29/24, 10/30/24, 10/31/24, 11/1/24, 11/5/24, 11/6/24, at 8:00 P.M.

Olanapine was refused on 9/5/24, 911/24, 9/12/24, 9/16/24, 9/18/24, 9/19/24, 9/20/24, 9/23/24, 10/5/24, 10/9/24, 10/16/24, 10/19/24, 10/20/24, 10/21/24, 10/23/24, 11/4/24.

Trazadone 50 mg tablet, 1/2 tablet at bedtime, 9/1/24, 9/6/24, 9/10/24, 9/11/24, 9/12/24, 9/22/24, 9/24/24, 9/25/24, 9/26/24, 9/27/24, 9/29/24, 9/30/24, 9/31/24, 10/10/24,

	10/14/24, 10/17/24, 10/25/24, 10/26/24, 10/27/24, 10/28/24, 11/1/24, 11/3/24, 11/5/24, at 9:00 P.M. Trazadone was refused on 9/20/24, 9/23/24. On 11/6/24 at 4:05 P.M., the Regional Director of Clinical Operations proved the policy titled, "Medication Administration," dated 8/27/24 and indicated it was the current medication administration policy. The policy indicated the following: "... the administration of medications shall be as ordered by the resident's physician and document the administration immediately after administration. The licensed nurse or qualified medication aide will be responsible for monitoring medication refusal and medication refusal will be reported to the resident's attending physician. " This citation relates to Complaints IN 00443940 and IN00436132.			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

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