STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155755	A. BUILDING 00 B. WING	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GOLDEN YEARS HOMESTEAD	3136 GOEGLEIN RD FORT WAYNE, IN 46815

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit was also in conjunction with the Investigation of Complaint IN00392744, IN00392799, and IN00392903 Survey dates: October 17, 18, 19, 20, and 21, 2022 Facility number:000282 Provider number:155755 AIM number:100287520 Census Bed Type: SNF/NF:93 SNF:3 Residential:43 Total:139 Census Payor Type: Medicare:6 Medicaid:71 Other:62 Total:139 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed October 25, 2022	F 0000	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.	
F 0645 SS=D Bldg. 00	483.20(k)(1)-(3) PASARR Screening for MD & ID §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new			

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

Steven Schaaf | HFA, V.P. Operations | 11/10/2022

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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	residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the			

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	admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.			
	Based on interview and record review the facility failed to ensure assessment for appropriate placement was completed for 1 of 5 residents reviewed. (Resident 95) Findings include: Resident 95's record was reviewed on 10/17/22 at 11:33 AM. Resident 95's diagnosis included heart failure, schizophrenia, insomnia, depression, paraplegia, and chronic kidney disease. The quarterly MDS (minimal data set) section C indicated Resident 95 had no cognitive impairment. Resident 95's provider orders included foley	F 0645	F645 The facility was alleged to be out of compliance by failing to ensure assessment for appropriate placement was completed for 1 of 5 residents. a. A Level 2 was completed for resident #95 b. An audit was completed of the last 30 days of admissions to determine if any others required a Level 2. Any identified will have a Level 2 completed. c. Social Services was educated on the PASRR policy. d. Social Services or	12/06/2022

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	catheter care, an antidepressant, and 2 medications for insomnia. Resident 95's PASRR (Preadmission Screening and Resident Review) was determined in June 2022 and expired in September 2022. The PASRR had short term approval without specialized services. The conclusion of the PASRR was for a level 2 evaluation to be completed at facility. There were no level 2 documents on file available for review. In an interview, on 10/21/22 at 9:27 AM, SS4 (Social Services) indicated the admission coordinator does the initial screening and social services was responsible for any thereafter. Situations that could require more than the initial screening was identified as the following: payor source changed, resident began experiencing increased behaviors, psychotropic medication changes, and when PASRR was a temporary approval. SS4 indicated the facility did a new level 1 PASRR after being made aware the old one was only for a short term stay. SS4 indicated it was 30 days late. SS4 indicated they would need to develop a system to catch ones that are expiring in the future. There was no policy and procedure availble at time of exit related to PASRR. 3.1-16(d)		designee will audit admissions 3 times per week for 4 weeks, twice a week for 4 weeks, weekly for 4 weeks or until substantial compliance is reached. Results of the audits will be reviewed during quarterly Quality Assurance meetings for one year to ensure substantial compliance is maintained.	
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			

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	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, interview, and record review the facility failed to coordinate care with hospice for 1 of 4 residents reviewed. (Resident 92) Findings include: During an observation and family interview on10/17/22 11:47 AM, Resident 92 and her husband were present in her room. Resident 92 had nasal cannula oxygen running at 2 Liters per minute (l/m). The nasal cannula was directed into her chin rather than her nose. Husband indicated Resident 92 was on hospice and majority of her direct care was done by hospice staff. Husband did put oxygen back into Resident 92's nose and indicated she fidgeted. Resident 92 was nonverbal throughout the interview. Resident 92's record was reviewed on 10/18/22 at 02:12 PM. Resident 92's diagnosis included dementia, high blood pressure, atrial fibrillation, anxiety, depression, and delusional disorder. There was no diagnosis of dyspnea listed. Resident 92's orders included admit to hospice with prognosis of less than 6 months to live, oxygen at 2 liters via nasal cannula every shift as needed for dyspnea, and several medications for pain and anxiety. The current care plan for Resident 92 indicated under the area of hospice the following interventions: hospice will provide ADL (activities	F 0684	F684 The facility was alleged to be out of compliance by failing to coordinate care with hospice for 1 of 4 residents. a. The Care plans for resident #92 have been updated. b. Careplans for all hospice residents were reviewed to determine coordination of care. Careplans for residents identified were updated. c. Nursing was educated on Coordination of Hospice Care. d. The DON or designee will audit hospice admissions and care plans 3 times per week for 4 weeks, twice a week for 4 weeks, weekly for 4 weeks or until substantial compliance is reached. Results of the audits will be reviewed during quarterly Quality Assurance meetings for one year to ensure substantial compliance is maintained.	12/06/2022

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	of daily living) care twice a week at minimum, hospice nurse and facility nurse will work together on pain and changes in medical condition, offer psychosocial support, offer clergy visits, support and care for family. None of the care planned areas addressed Resident 92's oxygen use. A hospice comprehensive assessment and plan of care update report was provided by DON on 10/21/22 at 9am. The most recent date of coordination was 9/11/22. The facility provided no additional information regarding coordination of care between themselves and hospice providers. In an interview on 10/20/22 at 10:16AM, the DON indicated Resident 92 should have had oxygen care planned. A contract for all hospice providers was requested at entrance 10/17/22 at 9:02AM and on 10/20/22 at 9:00AM. No contract for Resident 92's provider was available prior to exit on 10/21/22 at 11:47AM. A current facility policy, Oxygen Administration, dated 05/2022, was provided by the DON on 10/20/22 at 9:00AM. The policy indicated "...oxygen is administered to residents who need it, the comprehensive care plan, and resident's goals and preferences. ... 4. The residents care plan shall identify the intervention for oxygen therapy based upon the resident's assessment and orders. a) the type of oxygen delivery system. b) when to administer oxygen. When to discontinue oxygen. d) monitor of oxygen levels. 6) oxygen warning signs must be placed on the door of the resident's room where oxygen is in use			

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	... A current facility policy, Care Plan Revisions, dated 10/2019, was provided by the DON on 10/20/22 at 9:00AM. Purpose: it is the policy of this facility to ensure care plans are maintained and updated timely. Policy: The purpose of this procedure is to provide a consistent process for reviewing and revising the are plan for those residents experiencing a change. ... 3.1-37			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review the facility failed to implement resident specific fall interventions for 1 of 4 residents reviewed. (Resident 69) Findings include: During an observation, on 10/17/22 at 10:18 AM, noted Resident 69 was using a walker for ambulation. Resident 69's room was tidy. Resident 69 had no fall mats on floor or inside room. Resident 69's bed had grab bars to assist in repositioning. The bed was not in lowest position. In an interview, on 10/17/22 at 10:18AM, Resident	F 0689	F689 The facility was alleged to be out of compliance by failing to implement resident specific fall interventions for 1 of 4 residents. a. Resident #69's falls were reviewed and appropriate interventions care planned b. An audit of all falls for appropriate interventions in the last 30 days was completed. Residents identified had care plan interventions updated as appropriate. c. Nursing staff was educated	12/06/2022

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	69 indicated she has fallen several times at home and since at the facility. Resident 69 indicated she currently had minor pain and slightly limited rotation of left arm after breaking her humerus as result of fall in the facility. Resident 69 indicated she also fell and broke her pelvis while residing in the facility. Resident 69 described her most recent fall and explained that she was straightening her bed sheets near head of the bed and the next thing she knew she was past the foot of the bed on the floor. She was unable to remember losing her balance, feeling unsafe, or falling. Resident 69 was unable to think of any changes in care or abilities due to falls other than slight stiffness of her left shoulder. Resident 69 indicated the only change in assistance from staff had been the therapy she has completed. Resident 69's record review, began on 10/18/22 at 01:45 PM, indicated Resident 69's diagnosis included repeated falls, fracture of left pubis, fracture of left humerus, heart failure, and presence of heart pacemaker. Resident 69 had no diagnosis of osteoporosis or any other bone density (strength) indications. Resident 69's most recent quarterly MDS (minimal data set) section C (cognitive patterns) indicated Resident 69 had a BIMS (brief interview of memory score) of 14 showing little to no cognitive deficit. The facility listed resident as interview able at entrance, indicating her answers were reliable. Resident 69's physician orders included up as tolerated, Lasix, pain medication, several heart medications, weigh daily, and therapy. There were no orders to check pacemaker, watch for signs of pacemaker failure, or to see cardiologist. Resident 69's progress notes indicated she fell		on Fall Prevention and Interventions. d. The DON or designee will audit falls 3 times per week for 4 weeks, twice a week for 4 weeks, weekly for 4 weeks or until substantial compliance is reached. Results of the audits will be reviewed during quarterly Quality Assurance meetings for one year to ensure substantial compliance is maintained.	

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	5/1/22, 5/10/22, 6/14/22 (broken humerus), and 8/18/22 (broken pelvis). Resident 69's care plan indicated a problem of falls. The interventions were listed were initiated on 3/30/22: be sure call light was always within reach, proper fitting nonskid footwear, bed in low position, complete fall risk assessments, side rail assessments, and if fall occurs notify nurse. Interventions specific to after falls included: After fall on 5/1/22, staff educated to ensure call light and personal items within reach. After fall on 5/10/22 resident education to use call light for assistance prior to getting up. After fall on 6/14/22 sent to emergency room for evaluation and treatment for fracture of humerus. After fall on 8/19/22 reeducation of resident to call for help and wait for help to arrive. Follow up with cardiology, also recently received pacemaker transmitter to send results to cardiologist as ordered. Follow up with optometrist. There were no resident specific needs addressed in the care plan. None of the interventions addressed reduction of fractures from falls. None of the interventions addressed fall trend time of before meals and bedtime. The care plan did not include pacemaker insertion on 8/19/22. There was no policy addressing falls available for review. 3.1-45(a)			
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			

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	drug is any drug when used- §483.45(d)(1) In excessive dose (including 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 interview and record review the facility failed to ensure adverse medication side effects were monitored for 2 of 3 residents reviewed. (Resident 63, and Resident 25) Findings include: 1. A record review on 10/19/22 at 03:16 PM indicated Resident 63 had the following medical diagnoses: Type 2 diabetes with diabetic neuropathy. A physician order dated 08/13/22, Novolog 100 unit/mL (milliliters) subcutaneous insulin solution as directed three times a day for DM type 2. A physician order dated 05/12/22, indicated to utilize a Trulicity pen injector 0.75mg/0.5mL subcutaneous every week for Diabetes type 2.	F 0757	F757 The facility was alleged to be out of compliance by failing to ensure adverse medication side effects were monitored for 2 of 3 residents. a. An order was obtained and MARs and Care-plans updated to observe for adverse side effects for residents 63 and 25. b. All residents with orders for Trulicity, Insulin and Eliquis were audited for orders to observe for adverse side effects. Those identified receive orders to observe for adverse side effects, MARs and Care-plans were updated. c. Policies were updated. Nursing was educated to observe for side effects of anticoagulants	12/06/2022

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	A physician order dated 05/12/22 indicated to complete blood sugar checks AC, HS (before meals and at bedtime), four times a day. A care plan for hyperglycemia and hypoglycemia monitoring indicated: Problem: potential for hypo/hyperglycemia r/t (related to) diabetes. Goal: to be free from complications r/t diabetes through next review. The approaches were: administer medications as ordered. Observe for s/s (signs and symptoms) of hyperglycemia: increased urinary output, weakness, fatigue, headache, nausea and vomiting, abdominal cramps, loss of appetite, thirst, dry/flushed skin. Observe for s/s of hypoglycemia: diaphoresis, moist/cool skin, pallor, drooling, hunger, blurred vision, shaking, shallow/rapid respirations, weakness, stupor, decrease in cognition. Monitor blood sugar as ordered. A medication administration record (MAR) for the month of October 2022, indicated Resident 63 was given the medication Novolog on 10/03/2022, and 10/15/2022 at 07:30 AM. There were no indications adverse side effects were monitored. A MAR for the month of October 2022, indicated Resident 63 was given the medication Trulicity for the days 3, 11, and 18. There were no indications adverse side effects were monitored. 2. A record review, began on 10/19/22 at 11:38 AM, indicated Resident 25 had the following medical diagnoses: auditory hallucinations, vascular dementia unspecific severity, without behavior/psychosis/mood/anxiety and major depressive disorder. A brief interview for mental status indicated Resident 25 had a score of 3 of 15.		and anti-glycemics. d. The DON or designee will audit anti-glycemics and anticoagulants 3 times a week for 4 weeks, twice a week for 4 weeks, weekly for 4 weeks or until substantial compliance is achieved. Results of the audits will be reviewed during quarterly Quality Assurance meetings for one year to ensure substantial compliance is maintained.	

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	A physician order dated 11/21, indicated to give Eliquis 5 mg tablet (anticoagulant), take 1 tablet by mouth twice a day for Atrial Fibrillation. There were no physician orders to monitor for side effects for this medication. A care plan for medications and treatments had the focus of: Resident has potential for adverse effects and injury related to use of anticoagulant therapy. The goal: Resident will show no signs and symptoms of adverse effects or injury related use of anticoagulant through the next review. The interventions: administered medications as ordered. Staff to monitored labs as ordered. Notify physician of results. Observe for signs and symptoms of bleeding, bleeding gums, nose bleeding, unusual bruising, tarry black stools, hematuria, decreased HCT or blood pressure. Document and notify physician if noted. A medication administration record (MAR) for the month of September 2022, indicated Resident 25 was given the medication Eliquis 5 mg tablet twice a day at 9:00 AM and 5:00 PM. There were no indications adverse side effects were monitored. A MAR for October 2022 indicated Resident 25 was given the medication Eliquis 5 mg tablet twice a day at 9:00 AM and 5:00 PM for the dates 1, 2, 3, 4, 5, 6, 7, 8, 9,10, 11, 12, 13, 14, 15, 16, 17, 18 and 19. There were no indications that adverse side effects were monitored. A review of the interdisciplinary notes from September 2022 to October 2022, did not indicated staff were monitoring adverse side effects for the medications. In an interview on 10/19/22 at 12:11 PM, the Director of Nursing indicated there should be a			

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	physician order to monitor adverse side effects for every shift. 3.1-48(a)			
F 0758 SS=E Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and			

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	155755	A. BUILDING 00 B. WING	10/21/2022

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	§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on interview and record review the facility failed to ensure adverse psychotropic medication side effects were monitored for 4 of 4 residents reviewed. (Resident 25, Resident 15, Resident 82 and Resident 88) Findings include: 1. A record review, began on 10/19/22 at 11:38 AM, indicated Resident 25 had the following medical diagnoses: auditory hallucinations, vascular dementia unspecific severity, without behavior/psychosis/mood/anxiety and major depressive disorder. A brief interview for mental status indicated Resident 25 had a score of 3 of 15. A physician order dated 8/18/22, indicated to give Citalopram 30 mg (milligrams) capsule (anti-depressant) 1 cap by mouth every AM for depression. There were no physician orders to indicate to monitor for side effects for this medication. A physician order dated 5/6/22, indicated to give	F 0758	F758 The facility was alleged to be out of compliance by failing to ensure adverse effects of psychotropic medications were monitored for 4 residents. a. Care plans and MARs were updated for residents #25. 25. 82, and 88. b. All residents on psychotropics were audited. Identified residents received orders to observe for side effects of psychotropic medications. Care plans and MARs were updated. c. The Psychotropic policy was updated. Social Services and Nursing were educated to ensure residents on psychotropics were observed for side effects. d. The DON or designee will audit psychotropics 3 times a week for 4 weeks, twice a week for 4 weeks, weekly for 4 weeks or until substantial compliance is	12/06/2022

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	Olanzapine 5 mg tablet (anti-psychotic) 1 tablet by mouth at bedtime for hallucinations. There were no physician orders to indicated to monitor for side effects for this medication. A care plan for psychotropic drug use indicated the focus was: Resident has potential for adverse effects related to daily use of psychotropic medications. The goal was: Resident will have no adverse effects related to use of antidepressant. The interventions were: administer medications as ordered. Monitor vital signs weekly and as needed for changes. Monitor for adverse side effects. Nausea, vomiting, weight gain, diarrhea, sleepiness, thoughts of suicide, agitation, restlessness, insomnia, etc. Pharmacist to review drug regime per policy. Notify physician with concerns. A goal was: Resident will have no adverse side effects related to use of antipsychotic medication. The interventions: administered medications as ordered. Monitor vital signs weekly and as needed for changes. Monitor for adverse side effects. Drowsiness, dizziness, restlessness, weight gain, dry mouth, constipation, nausea, vomiting, etc. Pharmacist to review drug regime per policy. Notify physician with concerns. AIMS test every 6 months. A MAR for the month of September 2022, indicated Resident 25 was given the medication Citalopram 30 mg capsule every morning at 9:00 AM. There were no indications that adverse side effects were monitored. A MAR for the month of September 2022, indicated Resident 25 was given the medication Olanzapine 5 mg tablet every night at 9:00 PM. There were no indications that adverse side effects were monitored.		achieved. Results of the audits will be reviewed during quarterly Quality Assurance meetings for one year to ensure substantial compliance is maintained.	

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	A MAR for October 2022 indicated Resident 25 was given the medication Citalopram 30 mg capsule every morning at 9:00 AM for the dates 1, 2, 3, 4, 5, 6, 7, 8, 9,10, 11, 12, 13, 14, 15, 16, 17, 18 and 19. There were no indications that adverse side effects were monitored. A MAR for October 2022 indicated Resident 25 was given the medication Olanzapine 5 mg tablet every night at 9:00 PM for the dates 1, 2, 3, 4, 5, 6, 7, 8, 9,10, 11, 12, 13, 14, 15, 16, 17, 18 and 19. There were no indications that adverse side effects were monitored. A review of the interdisciplinary notes from September 2022 to October 2022, did not indicate staff were monitoring adverse side effects for the medications. 2. A record review, began on 10/19/22 at 12:32 AM, indicated Resident 15 had the following medical diagnoses: dementia unspecific severity, without behavior/psychosis/mood/anxiety and depressive episodes, insomnia, and anxiety disorder. A brief interview for mental status (BIMS) was not done due to severely impairment. A physician order dated 8/18/22, indicated to gove Lexapro 10 mg tablet (antidepressant) 1 and ½ tablets by mouth every morning, give a total of 15 mg. There were no physician orders to monitor for side effects for this medication. A physician order dated 8/18/22, indicated to give Risperidone 1 mg tablet (antipsychotic). ½ tablet by mouth every morning. There were no physician orders to monitor for side effects for this medication. A physician order dated 5/20/22, indicated to give			

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	Buspirone 5 mg tablet (antianxiety) 1 tablet by mouth 3 times a day. There were no physician orders to monitor for side effects for this medication. A physician order dated 5/19/22, indicated to give Risperidone 2 mg tablet (antipsychotic) 1 tablet by mouth every night. There were no physician orders to monitor for side effects for this medication. A physician order dated 7/28/21, indicated to give Trazadone 100 mg tablet (antidepressant) 1 tablet by mouth every night. There were no physician orders to monitor for side effects for this medication. A care plan for psychotropic drug use indicated the focus was: the resident had potential for adverse effects related to daily use of psychotropic medications. The goal was: the resident would have no adverse effects related to use of antidepressant. The interventions were: Administer medications as ordered. Monitor vital signs weekly and as needed for changes. Monitor for adverse side effects. Nausea, vomiting, weight gain, diarrhea, sleepiness, thoughts of suicide, agitation, restlessness, insomnia, etc. Pharmacist to review drug regime per policy. Notify physician with concerns. A goal was: Resident will have no adverse side effects related to use of antipsychotic medication. The interventions: administered medications as ordered. Monitor vital signs weekly and as needed for changes. Monitor for adverse side effects. Drowsiness, dizziness, restlessness, weight gain, dry mouth, constipation, nausea, vomiting, etc. Pharmacist to review drug regime per policy. Notify physician with concerns. AIMS test every 6 months. A goal was: to have no adverse effects related to use of			

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	antianxiety medication. The interventions: administer medication as ordered monitor vitals signs weekly and as needed for changes. Monitor for adverse side effects. Drowsiness, dizziness, restlessness, weight gain, dry mouth, constipation, nausea, vomiting, etc. Pharmacist to review drug regime per policy. Notify physician with concerns. A MAR for the month of September 2022, indicated Resident 15 was given the medication Lexapro 10 mg tablet every morning at 9:00 AM. There were no indications adverse side effects were monitored. A MAR for the month of September 2022, indicated Resident 15 was given the medication Risperidone 1 mg tablet every morning at 9:00 AM. There were no indications adverse side effects were monitored. A MAR for the month of September 2022, indicated Resident 15 was given the medication Buspirone 5 mg tablet 3 times a day 9:00 AM, 1:00 PM, and 5:00 PM. There were no indications adverse side effects were monitored. A MAR for the month of September 2022, indicated Resident 15 was given the medication Risperidone 2 mg tablet every night at 9:00 PM. There were no indications adverse side effects were monitored. A MAR for the month of September 2022, indicated Resident 15 was given the medication Trazadone 100 mg tablet every night at 9:00 PM. There were no indications adverse side effects were monitored. A MAR for the month of October 2022, indicated			

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	Resident 15 was given the medication Lexapro 10 mg tablet every morning at 9:00 AM for the dates 1, 2, 3, 4, 5, 6, 7, 8, 9,10, 11, 12, 13, 14, 15, 16, 17, 18 and 19. There were no indications adverse side effects were monitored. A MAR for the month of October 2022, indicated Resident 15 was given the medication Risperidone 1 mg tablet every morning at 9:00 AM for the dates 1, 2, 3, 4, 5, 6, 7, 8, 9,10, 11, 12, 13, 14, 15, 16, 17, 18 and 19. There were no indications adverse side effects were monitored. A MAR for the month of October 2022, indicated Resident 15 was given the medication Buspirone 5 mg tablet 3 times a day 9:00 AM, 1:00 PM, and 5:00 PM for the dates 1, 2, 3, 4, 5, 6, 7, 8, 9,10, 11, 12, 13, 14, 15, 16, 17, 18 and 19. There were no indications adverse side effects were monitored. A MAR for the month of October 2022, indicated Resident 15 was given the medication Risperidone 2 mg tablet every night at 9:00 PM for the dates 1, 2, 3, 4, 5, 6, 7, 8, 9,10, 11, 12, 13, 14, 15, 16, 17, 18 and 19. There were no indications adverse side effects were monitored. A MAR for the month of October 2022, indicated Resident 15 was given the medication Trazadone 100 mg tablet every night at 9:00 PM for the dates 1, 2, 3, 4, 5, 6, 7, 8, 9,10, 11, 12, 13, 14, 15, 16, 17, 18 and 19. There were no indications adverse side effects were monitored. A review of the interdisciplinary notes from September 2022 to October 2022, did not indicate staff were monitoring adverse side effects for the medications. In an interview on 10/19/22 at 12:11 PM, the			

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	Director of Nursing indicated there should be a physician order to monitor adverse side effects for every shift. 3. Resident 82's record was reviewed on 10/18/22 at 1:28 PM. Diagnoses included generalized anxiety disorder, anxiety disorder, unspecified, unspecified dementia, unspecified severity with behavioral disturbances, depression, unspecified, and unspecified psychosis not due to a substance or known physiological condition. A brief interview for mental status, dated 9/12/22, indicated Resident 82 had a score of 15 (cognitively intact). A physician order, dated 12/2/21, indicated to give Abilify 5 mg tablet (anti-psychotic, medication used to treat psychosis, a mental disorder characterized by a disconnection from reality), 1 tablet by mouth every day for psychosis. There was no physician order to monitor for side effects of this medication. A physician order, dated 4/14/21, indicated to give Lexapro 20mg tablet (anti-depressant/ anti-anxiety, medication used to treat depression and anxiety) 1 tablet by mouth every day for anxiety. There was no physician order to monitor for side effects of this medication. A physician order, dated 8/18/22, indicated to give Cymbalta 20mg capsule, delayed release (anti-depressant), 20mg by mouth every HS (bedtime) for depression/hand pain. There was no physician order to monitor for side effects of this medication. A current care plan, titled psychotropic drug use, indicated the resident had the potential for adverse effects related to daily use of psychotropic medication. The goal indicated the			

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	resident would have no adverse effects related to the use of the antidepressant. The interventions included administer the medication as ordered, monitor vital signs weekly and as needed for changes, monitor for adverse side effects (nausea, vomiting, weight gain, diarrhea, sleepiness, thoughts about suicide, agitation, restlessness, insomnia, etc.). The pharmacist was to review the resident's drug regime per policy. The physician or nurse practitioner was to be notified with concerns. A MAR, for the month of September 2022, indicated Resident 82 was given the medication Abilify 5mg tablet every day at 9:00 AM. There was no documentation indicating side effects of this medication were monitored. A MAR, for the month of September 2022, indicated Resident 82 was given the medication, Lexapro 20mg tablet every day at 9:00 AM. There was no documentation indicating side effects of this medication were monitored. A MAR, for the month of September 2022, indicated Resident 82 was given the medication, Cymbalta 20mg capsule, delayed release, every day at bedtime (9:00 PM). There was no documentation indicating side effects of this medication were monitored. A MAR, for the month of October 2022, indicated Resident 82 was given the medication, Abilify 5mg tablet every day at 9:00 AM for the dates 1, 2, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, and 18. Documentation indicated Resident was not given Abilify 5mg tablet on October 3; the medication was not available. There was no documentation indicating side effects of this medication were monitored.			

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	A MAR, for the month of October 2022, indicated Resident 82 was given the medication, Lexapro 20 mg tablet every day at 9:00 AM for the dates 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, and 18. There was no documentation indicating side effects of this medication were monitored. A review of the interdisciplinary notes, from September 2022 to October 2022, indicated no documentation related to monitoring Resident 82 for side effects of the administered psychotropic medication. 4. Resident 88's record was reviewed on 10/19/22 at 10:24 AM. Diagnoses included Parkinson's disease, unspecified dementia, unspecified severity with behavioral disturbances, major depressive disorder, single episode, anxiety disorder, unspecified, delusional disorders, restlessness and agitation, hallucinations, unspecified, psychotic disorder with delusions due to known physiological condition, neurocognitive disorder with Lewy bodies. A brief interview for mental status, dated 9/12/22, indicated Resident 88 had a score of 12 (moderate cognitive impairment). A physician order, dated 5/20/22, indicated to give Lorazepam 2mg/ml (milliliter) oral concentration, (anti-depressant/anti-anxiety), 0.5ml by mouth every HS (bedtime) for restlessness. There was no physician order to monitor for side effects of this medication. A physician order, dated 12/23/21, indicated to give Trazadone 50mg tablet, (antidepressant/ sedative- medication to help a person sleep), 1 tablet by mouth every HS for insomnia (trouble sleeping). There was no physician order to			

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	monitor for side effects of this medication. A physician order, dated 12/23/21, indicated to give Seroquel 50mg tablet, (anti-psychotic), 1 tablet by mouth every HS for Parkinson's psychosis, hold for sedation. There was no physician order to monitor for side effects of this medication. A physician order, dated 12/1/21, indicated to give Buspirone 5 mg tablet, (antianxiety), 1 tablet by mouth three times a day for restlessness with behaviors. There was no physician order to monitor for side effects of this medication. A physician order, dated 4/9/20, indicated to give Citalopram 20mg tablet, (antidepressant), 1 by mouth every day for depression. There was no physician order to monitor for side effects of this medication. A physician order, dated 9/18/19, indicated to give Donepezil 10mg tablet, (medication to improve thinking), give 1 tablet by mouth daily for Alzheimer's dementia. There was no physician order to monitor for side effects of this medication. A current care plan, psychotropic drug use, indicated the resident had the potential for adverse effects related to daily use of psychotropic medication. A goal indicated the resident would have no adverse effects related to the use of antidepressant medication. The interventions for this goal included administer the medication as ordered, monitor vital signs weekly and as needed for changes, monitor for adverse side effects (nausea, vomiting, weight gain, diarrhea, sleepiness, thoughts about suicide, agitation, restlessness, insomnia, etc.). The			

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	pharmacist was to review the resident's drug regime per policy. The physician or nurse practitioner was to be notified with concerns. A second goal indicated the resident would have no adverse side effects related to the use of antipsychotic medication. The interventions for this goal included administer the medication as ordered, monitor vital signs weekly and as needed for changes, monitor for adverse side effects (drowsiness, dizziness, restlessness, weight gain, dry mouth, constipation, nausea, vomiting, etc.). The pharmacist was to review the resident's drug regime per policy. The physician or nurse practitioner was to be notified with concerns. An Abnormal Involuntary Movement Scale (AIMS) test (assess for abnormal movements) was to be completed every 6 months. A third goal indicated the resident would have no adverse side effects related to the use of anti-anxiety medication. The interventions for this goal included administer the medication as ordered, monitor vital signs weekly and as needed for changes, monitor for adverse side effects (nausea, nervousness, restlessness, dizziness, drowsiness, insomnia, weight gain or loss, headache, etc.). The pharmacist was to review the resident's drug regime per policy. The physician or nurse practitioner was to be notified with concerns. A MAR, for the month of September 2022, indicated Resident 88 was given the medication Lorazepam 2mg/ml, 0.5ml dose every day at bedtime (9:00 PM). There was no documentation indicating side effects of this medication were monitored. A MAR, for the month of September 2022, indicated Resident 88 was given the medication Trazadone 50mg tablet every day at bedtime (9:00 PM). There was no documentation indicating side			

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	effects of this medication were monitored. A MAR, for the month of September 2022, indicated Resident 88 was given the medication Seroquel 50mg tablet every day at bedtime (9 :00PM). There was no documentation indicating side effects of this medication were monitored. A MAR, for the month of September 2022, indicated Resident 88 was given the medication Buspirone 5mg three times a day (8:00 AM, 12:00 PM, 5:00 PM) on September 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, 12, 13, 14, 16, 17 18, 19, 20, 22, 23, 24, 25, 26, 27, 28, 29, and 30. On September 9, the documentation indicated the resident was given the medication at 8:00 AM and 12:00 PM; the resident refused the 5:00 PM dose. On September 15, the documentation indicated the resident was given the dose at 8:00 AM and 5:00 PM; the resident refused the dose at 12:00 PM. On September 21, the documentation indicated the resident refused the medication at 8:00 AM, 12:00 PM, and 5:00 PM. There was no documentation indicating side effects of this medication were monitored. A MAR, for the month of September 2022, indicated Resident 88 was given the medication Citalopram 20mg every day at 9:00 PM. There was no documentation indicating side effects of this medication were monitored. A MAR, for the month of September 2022, indicated Resident 88 was given Donepezil 10mg every day at 5:00 PM on September 1, 2, 3, 4, 5, 6, 7, 8, 10, 11,12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 23, 24, 25, 26, 27, 28, 29 and 30. On September 9 and 21, the documentation indicated the resident refused the medication. There was no documentation indicating side effects of this medication were monitored.			

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	A MAR, for the month of October 2022, indicated Resident 88 was given the medication Lorazepam 2mg/ml oral concentration, 0.5ml every HS at 9:00 PM for the dates 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, and 18. There was no documentation indicating side effects of this medication were monitored. A MAR, for the month of October 2022, indicated Resident 88 was given the medication Trazadone 50mg tablet every HS at 9:00 PM for the dates 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, and 18. There was no documentation indicating side effects of this medication were monitored. A MAR, for the month of October 2022, indicated Resident 88 was given the medication Seroquel 50 mg tablet every HS at 9:00 PM for the dates 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, and 18. There was no documentation indicating side effects of this medication were monitored. A MAR, for the month of October 2022, indicated Resident 88 was given the medication Buspirone 5mg three times a day (8:00 AM, 12:00 PM, 5:00 PM) on October 1, 2, 4, 5, 6, 7, 8, 9, 11, 12, 13, 14, 15 16, 17, and 18. On October 3, the documentation indicated the resident was given the medication at 8:00 AM and 12:00 PM; the medication was not available for the 5:00 PM dose. On October 10, the documentation indicated the resident was given the medication at 8:00 AM and 5:00 PM; the resident refused the 12:00 PM dose. On October 19, the documentation indicated the resident received the medication as scheduled at 8:00 AM and 12:00 PM. There was no documentation indicating side effects of this medication were monitored.			

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	155755	A. BUILDING 00 B. WING	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	A MAR, for the month of October 2022, indicated Resident 88 was given the medication Citalopram 20 mg tablet every day at 9:00 PM for the dates 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, and 18. There was no documentation indicating side effects of this medication were monitored. A MAR, for the month of October 2022, indicated Resident 88 was given the medication Donepezil 10 mg tablet every day at 5:00 PM for the dates 1, 2, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, and 18. On October 3, the documentation indicated the resident was not given the medication; the medication was not available. There was no documentation indicating side effects of this medication were monitored. A review of the interdisciplinary notes, from September 2022 to October 2022, indicated no documentation related to monitoring Resident 88 for side effects of the administered psychotropic medication. On 10/19/22 at 2:10 PM, a facility policy was requested from the DON regarding monitoring for side effects of psychotropic medication. On 10/19/22 at 2:23PM, the DON indicated she could not locate a policy for monitoring for side effects for psychotropic medication but was having other staff continue to look and would provide the policy if found. 10/21/22 11:47PM During the exit conference, the DON and Administrator indicated they had no further questions or additional information to provide. A policy regarding monitoring for the side effects of psychotropic medication was not provided by the facility.			

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F 0759 SS=D Bldg. 00	3.1-48(a)(3) 483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, interview, and record review the facility failed to ensure medication administration errors were under 5%. With 25 opportunities and 14 errors the error rate was 56% were for 2 of 4 residents observed during medication administration. (Resident 76 and Resident 53) Findings include: During an observation with an interview, on 10/18/22 beginning at 8:03AM, QMA 3 (Qualified Medical Assistant) gathered 6 of Resident 76's medications. QMA 3 took the medications into Resident 76's room and sat them on the bedside table. QMA 3 then left the room. There was no monitoring of administration nor assurance medication was taken. QMA 3 verbally indicated Resident 76 was capable and good about taking the medication when she woke up. QMA3 proceeded to gather Resident 53's 9 medications and took them into the Resident 53's room, took Resident 53's blood pressure. QMA3 then removed one of the medications, and indicated to Resident 53, her blood pressure medication was to be held due to her blood pressure reading. Resident 53's husband was present in the room. QMA 3 then left the room. There was no monitoring of administration or	F 0759	F759 The facility was alleged to be out of compliance by failing to ensure medication administration errors were under 5%. The error rate was 56% for 2 of 4 residents. a. QMA 3 was educated to ensure to observe residents taking medication, to obtain vitals prior to dispensing medication, and self-administration of medication. b. Residents were audited to determine those who desired to self-administer medications. Identified residents received a self-administration of medications assessment. If able to self-administer per the assessment, an order was obtained and careplan updated for self-administration. c. Nursing was education on medication administration and self-administration of medications. d. The DON or designee will perform med pass audits 3 times a week for 4 weeks, twice a week for 4 weeks, weekly for 4 weeks or until substantial compliance. Results of the audits will be	12/06/2022

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	assurance the medication was taken. QMA 3 stated she could not and did not leave everyone's meds at bedside. The QMA 3 then documented the medications as being administered. An interview with the DON (Director of Nursing) on 10/18/22 at 10:04AM indicated there were a handful of residents who were able to self-administer eye drops, inhalers, and lotions with oversight from qualified medical staff. The DON indicated there were no residents approved to administer their own medications. The DON indicated medications were to be administered by qualified nursing staff and documented. 1) Resident 76's record was reviewed on 10/18/22 at 9:29AM. The record indicated the medications left at bedside were prescribed by the physician to be administered. The medications included a blood thinner, and a medication used for nerve pain. There was not a physician order for self-administration of medication or leaving medications at bedside. There was no assessment for ability to self-administer medication. Resident 76's care plan stated under several categories the need for staff to administer medications. In the care plan there was no indication regarding self-administration of medications or medications to be kept at bedside. The medication administration record had documentation of medication administration by QMA 3 without any indication of medications left at bedside. 2)Resident 53's record, reviewed on 10/18/22 at 9:29AM, indicated the medications left at bedside were prescribed by the physician to be administered. The medications included a blood		reviewed during quarterly Quality Assurance meetings for one year to ensure substantial compliance is maintained.	

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	thinner, a diuretic, and a medication used for depression. Resident 53's diagnosis included acute kidney failure, major depression, and anxiety. There was not a physician order for self-administration of medication or leaving medications at bedside. There was no assessment for ability to self-administer medication. Resident 76's current care plan stated under several categories the need for staff to administer medications as ordered. In the care plan there was no indication regarding self-administration of medications or medications to be kept at bedside. The medication administration record had documentation of medication administration by QMA 3 without any indication of medications left at bedside or given outside of time frame. A current facility policy, Medication Administration, dated 05/20/22, was provided by DON on 10/20/22 at 11:16 am. The policy indicated "...14. Administer medication as ordered ...15. Observe resident consumption of medications ...17. Sign MAR (Medication Administration Record) after administration. A current facility policy, Resident Self Administration of Medications, dated 4/9/2019, was provided by DON on 10/20/22 at 11:16 am. The policy indicated " ...A resident may only self-administer medications after the facilities interdisciplinary team has determined which medications may be administered safely. ... 3) When determining if self-administration is clinically appropriate for a resident, the interdisciplinary team should at a minimum consider. a. medication appropriate and safe for			

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	self-administration ... c. The resident's cognitive status, including ability to correctly name their medications and know what condition they are taken for .... e. The resident's comprehension of instruction for the medication they are taking, including, the dose, timing, and signs of side effects, and when to report to facility staff .... g. The resident's ability to ensure that medication is stored safely and securely. 7)Bedside medication storage is permitted only when it does not present a risk to confused residents who wander into others resident's rooms. 12) The care plan must reflect self-administration and storage arrangements for each medication... 3.1-48(c)(2)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. This visit was also in conjunction with the Investigation of Complaint IN00392744, IN00392799, and IN00392903. Survey dates:October 17, 18, 19, 20, and 21, 2022. Facility number: 000282 Residential Census:43 Golden Years was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review completed October 25, 2022	R 0000	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.	