STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155521	A. BUILDING 00 B. WING	08/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALEXANDRIA CARE CENTER	1912 S PARK AVE ALEXANDRIA, IN 46001

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: August 8, 9, 10, 11, and 12, 2022. Facility number: 000518 Provider number: 155521 AIM number: 100266670 Census Bed Type: SNF/NF: 43 Total: 43 Census Payor Type: Medicare: 6 Medicaid: 31 Other: 6 Total: 43 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 18, 2022.	F 0000	Submission of this Plan of Correction does not constitute an admission to or an agreement with facts alleged on the survey report. Submission of the Plan of Correction does not constitute an admission or an agreement by the provider of the truth or facts alleged or corrections set forth on the statement of deficiencies. The Plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance	
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation, interview and record review, the facility failed to ensure residents had access to call lights for 3 of 3 residents reviewed for accommodation of needs (Residents 189, 2 and	F 0558	1 & 2. Residents 189, 2, and 35 did not have any negative outcome related to this alleged deficient practice but all residents have the	08/29/2022

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

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	35). Findings include: 1. During and observation, on 8/9/22 at 8:39 a.m., Resident 139 was lying in a low bed, the call light was under the low bed. On 8/9/22 at 1:39 p.m., she was lying in bed against the assist rail, the call light was in the waste-basket and not within her reach. The resident's clinical record was reviewed on 8/9/22 at 10:36 a.m. Diagnoses included, but were not limited to, debility. A 7/19/22 admission MDS (Minimum Data Set) assessment indicated she had moderate cognitive impairment and was totally dependent with bed mobility and toilet use. During an interview, on 8/10/22 at 8:48 a.m., LPN 7 indicated the resident was able to use the call light to ask for assistance.2. During an interview, on 8/8/22 at 1:37 p.m., Resident 2 was in his room in his wheelchair. He indicated he was waiting for his therapy session. His call light was secured to the bed behind him, out of his reach. He indicated he would have called to see when the therapist was coming, but he could not reach the call light. He couldn't transfer himself or propel the wheelchair due to weakness. On 8/8/22 at 1:42 p.m., COTA 34 entered the room and assisted the resident to the therapy room. Review of Resident 2's clinical record was completed on 8/8/22 at 2:10 p.m. A 4/15/22, quarterly, Minimum Data Set (MDS)		potential to be affected. Nursing staff has been educated on the call light policy with a special focus on keeping call lights in reach for the resident. 3. The facility's policy for call light use has been reviewed and no changes are indicated at this time. Nursing staff has been educated on the call light policy with a special focus on keeping call lights in reach for the resident. A monitoring tool has been implemented. 4. The DON or designee will be responsible for completing the monitoring tool and ensuring the call lights for the residents are within reach. This monitoring will be conducted on scheduled work days and on alternating shifts as follows: daily for two weeks, weekly for two weeks, monthly for two months, then quarterly thereafter. Should a concern be found, immediate corrective action will occur. Results of this monitoring and any corrective action will be reviewed during the facility's QA meetings on an ongoing basis for a minimum of six months. The plan will be adjusted by increasing or decreasing the monitoring until 100% compliance is achieved.	

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	assessment indicated he was cognitively intact and was dependent for transfers and locomotion. 3. During a care observation, on 8/10/22 at 11:03 a.m., Resident 35 was in bed. His call light was secured to the right side of his bed, while the resident was propped with pillows on his left side. During an interview, at the time of the observation, RN 35 indicated the resident was capable of using his call light, and it should have been kept in reach. Resident 35's clinical record was reviewed on 8/9/22 at 11:25 a.m. A 7/4/22, quarterly, MDS assessment indicated he was moderately cognitively impaired and required extensive assistance with bed mobility. Review of a current facility policy titled "CALL LIGHT," dated 10/2014 and provided by the Administrator on 8/12/22 at 8:45 a.m., indicated the following: "...Resident will have a call light to summon facility personnel to ensure the resident's needs will be met...Resident's call light is to be within reach...." 3.1-3(v)(1)			
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph			

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	should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. Based on record review and interview, the facility failed to ensure a resident's advance directive was reviewed and signed by the resident or representative for 1 of 16 reviewed for advance directives in the initial pool (Resident 23).	F 0578	1. Resident 23 did not experience any negative outcome related to this alleged deficient practice. The advance directive form has been signed by the resident's	08/29/2022

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	Findings include: Resident 23's clinical record was reviewed on 8/8/22 at 10:27 a.m. Diagnoses included, but were not limited to, major depressive disorder, recurrent severe without psychotic features,, dementia with behaviors, psychosis, and Alzheimer's disease. He had a current, signed physician's order for do not resuscitate. During an interview, on 8/12/22 at 9:29 a.m., the Admission Coordinator indicated Advance Directives were kept in the resident charts. During an interview, on 8/12/22 at 1:30 p.m., the Administrator indicated the resident's representative had filled out the information on the form for 1st and 2nd choice contacts, but had apparently forgotten to sign the form. Review of a current facility policy titled "Advance Directive," dated 1/2015 and provided by the Administrator on 8/12/22 at 1:05 p.m. indicated the following: "...When presented with an Advance Directive document, the facility shall verify the attending physician has a copy of the document and shall place a copy...as well as on the resident's clinical record in the nurses station...." 3.1-4(l)(4)(A)(ii)		representative. 2. All residents have the potential to be affected. The advanced directive for each resident has been reviewed and updated with signatures as indicated. 3. The facility's policy regarding Advanced Directives has been reviewed with no changes indicated at this time. Admissions, Social Services, and the Nurses have been educated on the policy with a special focus on getting the resident's or resident's representative's signature on the form. A monitoring tool has been initiated. 4. The Admissions Director or designee will be responsible for completing the monitoring tool to ensure the advance directive form has been signed. This monitoring will be completed on every new admission to the facility on an ongoing basis. Should a concern be found, immediate corrective action will occur. Results of this monitoring and any corrective action will be reviewed during the facility's QA meetings on an ongoing basis for a minimum of six months. The plan will be adjusted by increasing or decreasing the monitoring until 100% compliance is achieved.	

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F 0644 SS=E Bldg. 00	483.20(e)(1)(2) Coordination of PASARR and Assessments §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. Based on record review and interview, the facility failed to complete Preadmission Screening and Resident Review (PASRR) for residents newly diagnosed with mental illness for 4 of 7 residents reviewed for PASRR (Residents 19, 5, 31, and 33). Findings include: 1. Resident 19's clinical record was reviewed on 8/8/22 at 10:22 a.m. Diagnoses included, but were not limited to, depression, dementia, delusional disorder, schizoaffective disorder. She had a current, 7/29/21, care plan problem of delusions and hallucinations of things being wet such as her bed, blanket, briefs, or pants and the belief she was dying.	F 0644	1. Residents 19, 5, 31, and 33 did not experience any negative outcome related to the alleged deficient practice. An updated PASRR has been completed for each resident. 2. All residents have the potential to be affected. Their clinical record has been reviewed and an updated PASRR has been completed if indicated. 3. Indiana PASRR information has been reviewed by the facility at this time. The Social Service Director has been educated on Indiana PASRR information with a	08/29/2022

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	Review of a PASRR level 1 assessment, dated 11/10/19, did not indicate mental health diagnoses were present. The assessment was not repeated after she was diagnosed with schizoaffecitve disorder on 7/29/21. 2. Resident 5's clinical record was reviewed on 8/9/22 at 10:37 a.m. Diagnoses included, but were not limited to, chronic systolic heart failure, dementia with behaviors, major depressive disorder, expressive language disorder, schizoaffective disorder, and mood disorder. Current physician orders included, but were not limited to, desvenlafax (anti-depressant) 50 mg daily, quetiapine (anti-psychotic) 25 mg in a.m. and 50 mg at bedtime, tramadol (pain medication) 50 mg twice daily, and divalproex (mood stabilizer) 500 mg three times daily. Review of an 8/24/21 PASRR Level 1 assessment indicated he had depression and dementia. He was prescribed divalproex and quetiapine for depression. He had no diagnoses related to schizoaffective disorder. During an interview, on 8/12/22 at 10:16 a.m., the Social Service Director indicated the residents had not had a new Level 1 PASRR assessment completed when they had been diagnosed with mental illness. 3. During an observation, on 8/9/22 at 1:56 p.m., Resident 31 was lying in bed. On 8/10/22 at 9:51 a.m., she was lying in bed. On 8/11/22 at 8:58 a.m., she was sitting in a wheel-chair in the dining room. Her clinical record was reviewed on 8/9/22 at 11:16 a.m. She had admitted to the facility on 1/27/22.		special focus on updating PASRR information when there is a change in mental illness diagnosis. A monitoring tool has been initiated. 4. The Social Service Director or Designee will be responsible for completing the monitoring tool to ensure PASRR information has been updated with each new mental illness diagnosis. This monitoring will be completed on scheduled work days as follows: daily for two weeks, weekly for two weeks, monthly for two months, then quarterly thereafter. Should a concern be found, immediate corrective action will occur. Results of this monitoring and any corrective action will be reviewed during the facility's QA meetings on an ongoing basis for a minimum of six months. The plan will be adjusted by increasing or decreasing the monitoring until 100% compliance is achieved.	

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	Diagnoses included, but were not limited to, Alzheimer's disease, dementia with behavioral disturbance, anxiety, delusional disorder, psychotic disorder with hallucinations and schizoaffective disorder. Current physician orders included, but were not limited to the following: a. Buspar (anti-anxiety) 5 mg, one tablet three times a day for anxiety, the order date was 2/16/22. b. Risperdal (anti-psychotic) 0.5 mg (milligram), one tablet at bedtime for psychotic disorder with hallucinations, the order date was 2/22/2. A 7/1/22 quarterly MDS (Minimum Data Set) assessment indicated she had moderate cognitive impairment and had not had any behaviors during the assessment period. She had received an anti-psychotic and anti-anxiety medication everyday during the assessment period. The anti-psychotic had been received on a routine basis and there had not been an attempt of a GDR (Gradual Dose Reduction). A current care plan, with a revised date of 8/8/22, indicated she exhibited verbal behavioral symptoms directed towards others such as, threatening others, screaming at others, cursing at others and name calling. Interventions included, but were not limited to, attempt to use diversion, distraction and reorientation to calm her, such as singing and talking with staff. A current care plan, with a revised date of 8/8/22, indicated she suffered from delusions (fixed false beliefs) due to dementia as evidenced by false beliefs building was on fire, a gas leak and son was her spouse. Interventions included, but were			

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	not limited to, gently explain that belief was false and introduce evidence to prove why it was not true and administer medications as ordered. A Social Service Assessment, dated 6/10/22, indicated psychotic disorder with hallucinations, anxiety, recurrent depressive episodes, Alzheimer's disease and attention/concentration deficit. Behavioral symptoms and and care plan implementation to address behaviors: delusional disorders and confusion. Care plans reviewed and updated. A progress note, dated 6/15/22 at 4:00 p.m., indicated a new order to add a diagnosis of schizoaffective disorder. A Psychiatry Progress Note, dated 6/28/22, indicated dementia: no medication, continue appropriate behavioral interventions and psychotherapeutic communication. Behavioral and psychological symptoms of dementia: history of visual hallucinations and delusional thoughts that cause fear, tearfulness and anxiety, none recently reported, symptoms appeared stable and continue Risperdal 0.5 mg every bedtime. A mood and behavior communication memo, dated 7/19/22 at 2:00 p.m., indicated crying/tearfulness and wanted to go home. One on one was provided with her as well as reassurance and comfort, the interventions did not change the mood or behavior. A Psychiatry Progress Note, dated 7/20/22, indicated dementia: no medication, continue appropriate behavioral interventions and psychotherapeutic communication. Schizoaffective disorder: GDR- after reviewing current medication therapy as well as recent			

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	behaviors and discussion with DON (Director of Nursing), pharmacy, Administration, and Social Services, contraindicating any dose reduction of Risperdal as a reduction would likely increase symptoms of psychosis and anxiety, continued to have delusional thoughts about rats getting her that caused hear and anxiety. Delusional thoughts were less frequent. A mood and behavior communication memo, dated 7/20/22 from 6:00 to 10:00 p.m., indicated she had disturbed other residents by yelling out about seeing rats and worried about children playing in the street. Had been provided snacks and water, toileted, relaxation techniques, quiet environment, one on one, conversation of interest, time to calm then re-approach and redirection. Possible trigger: urinalysis results indicated an urinary tract infection, physician to be notified on 7/21/22. A Psychiatry Progress Note, dated 7/26/22, indicated dementia: no medication, continue appropriate behavioral interventions and psychotherapeutic communication. Anxiety: symptoms appear stable, continue Buspar 5 mg three times a day. Schizoaffective disorder: symptoms appeared stable, continue Risperdal 0.5 mg every bedtime. During an interview, on 8/12/22 at 8:46 a.m., RN 14 indicated the resident usually sang and made happy noises, had yelled out that the building was on fire, re-directing and distracting her usually helped. During an interview on 8/12/22 at 9:09 a.m., the Social Service Director indicted a PASRR (Preadmission Screening and Resident Review) referral for an evaluation and determination related to the new diagnosis of schizoaffective disorder			

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	had not been done because she had a diagnosis of dementia. 4. During an observation, on 8/9/22 at 3:16 p.m., Resident 33 was sitting in a chair in the lounge across from the nurses' station. On 8/11/22 at 8:56 a.m., he was assisted out of the shower room and into the lounge area. His clinical record was reviewed on 8/9/22 at 10:43 a.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance, physical aggression, depression, anxiety and schizoaffective disorder. Current physician orders included, but were not limited to the following: a. Buspar 10 mg, one tablet three times a day for anxiety, the order date was 8/24/21. b. Risperdal 1 mg, one tablet twice a day for dementia with behavioral disturbance, the order date was 9/28/21. c. Zoloft (anti-depressant) 25 mg, one tablet daily along with a Zoloft 50 mg tablet to equal 75 mg daily for depression, the order date was 6/15/22. A 7/1/22 quarterly MDS assessment indicated he had severe cognitive impairment. He had not had any hallucinations or delusions during the assessment period. Physical behavioral symptoms directed towards others and rejection of care had occurred 1 to 3 days during the assessment period. He had received an anti-psychotic, anti-depressant and anti-anxiety medication everyday during the assessment period. The anti-psychotic had been received on a routine			

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	basis and there had not been an attempt of a GDR. A current care plan, with a revised date of 7/13/22, indicated he was at risk for delirium or acute confusion related to dementia and schizoaffective disorder as evidenced by inattention, disorganized thinking and altered level of consciousness. The interventions included, but were not limited to, monitor for signs or symptoms of delirium such as: inattention, disorganized thinking, altered level of consciousness, psycho-motor retardation and acute confusion and administer medications as ordered. A current care plan, with a revised date of 714/22, indicated he required the use of an anti-psychotic medication, Risperdal, to treat dementia with behaviors and schizoaffective disorder. Interventions included, but were not limited to, observe for change in mood or behavior. A current care plan, with a revised date of 8/8/22, indicated he presented with a primary diagnosis of dementia with behaviors and may exhibit any or all of the following mood and behavior challenges: aggressive behaviors, hitting other and pushing and grabbing. Interventions included, but were not limited to, encourage activities of interest such as: (List). The care plan did not list activities of interest. A current care plan, with a revised date of 8/8/22, indicated he exhibited physical behavioral symptoms directed towards others such as: pushing, grabbing and hitting others. Interventions included, but were not limited to, psychotropic medications as ordered. A progress note, dated 6/15/22 at 4:00 p.m., indicated a new order to add a diagnosis of			

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	schizoaffective disorder. A Social Service Assessment, dated 6/15/22, indicated schizoaffective disorder, dementia with behavioral disturbance, physical aggression, depression and anxiety. Medications: Zoloft 75 mg for depression, Risperdal 1 mg for dementia with behavioral disturbance. A Psychiatry Progress Note, dated 6/15/22, indicated no behaviors or psychosis reported since last visit, no new concerns had been reported and appeared stable from a psychiatric standpoint. Schizoaffective disorder: symptoms appear stable, continue Risperdal 1 mg twice a day. During an interview, on 8/12/22 at 8:47 a.m., RN 14 indicated his behaviors were rejection of care, especially with incontinent care. During an interview, on 8/12/22 at 9:30 a.m., the Social Service Director indicated he did not have delusions, he did have aggression with care and rejection of care. A PASRR referral for an evaluation and determination related to the new diagnosis of schizoaffective disorder had not been done because he had a diagnosis of dementia. They did not have a policy related to PASRR's, they use the federal requirements as reference. A review of frequently asked questions related to Indiana PASRR for providers, located on website https://maximusclinicalservices.com/sites/default/files/pasrr/documents/IN%20PASRR%20FAQ_S%202021%20-%204.21.21.pdf and dated 2020, indicated "...22. When is a new Level I needed for a NF resident who admitted with a negative Level I PASRR approval? A negative Level I review is			

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	valid indefinitely, as long as there has been no change in mental health status...."			
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 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			

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	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 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 accurately screen for mental disorders prior to admission for 1 of 7 residents reviewed for Preadmission Screening and Resident Review (PASARR). (Resident 40)	F 0645	1. Resident 40 is no longer at the facility and had been discharged prior to this annual survey. 2. Any resident with a mental	08/29/2022

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	Findings include: Resident 40's clinical record was reviewed on 8/11/22 at 11:06 a.m. Physician's admission orders for 6/1/22 included, but were not limited to, quetiapine (antipsychotic) 50 mg daily at bedtime and melatonin (hormone that regulates the sleep cycle) 6 mg daily at bedtime. A social history and psychosocial assessment dated 6/2/22 lacked documentation of the physician's order for quetiapine. The current psychoactive medication section was blank. Progress notes dated 6/2/2022 from the Nurse Practitioner (NP) indicated quetiapine 50 mg daily was ordered. A social service assessment dated 6/3/22 lacked documentation of the quetiapine order. The PASARR with a review date of 6/3/22 listed a medication order for lorazepam (antianxiety) oral liquid 0.5 mg as discontinued under the mental health medications and lacked an entry for quetiapine. An interdisciplinary care plan conference record dated 6/6/22 listed melatonin under psychoactive medications and lacked documentation of the quetiapine order. During an interview, on 8/11/22 at 2:11 p.m., the Social Services Director indicated she vaguely remembered Resident 40. She indicated she did not remember the resident's quetiapine order. The PASARR lacked documentation of the physician's		disorder or receiving a psychotropic medication have the potential to be affected. The clinical records have been thoroughly reviewed and PASRR completed as indicated listing any mental disorder and psychotropic medication. 3. Indiana PASRR information has been reviewed by the facility at this time. The Social Service Director has been educated on Indiana PASRR information with a special focus on accurately completing the PASRR information for mental disorder diagnosis and/or psychotropic medications. A monitoring form has been implemented. 4. The Social Service Director or Designee will be responsible for completing the monitoring tool to ensure PASRR information has been accurately completed with mental disorder diagnosis and/or psychotropic medication. This monitoring will be completed on scheduled work days as follows: daily for two weeks, weekly for two weeks, monthly for two months, then quarterly thereafter. Should a concern be found, immediate corrective action will occur. Results of this monitoring and any corrective action will be reviewed during the facility's QA meetings on an ongoing basis for a minimum of six months. The plan	

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	quetiapine order. During an interview, on 8/12/22 at 10:38 a.m., the Nurse Consultant indicated the facility did not have a facility PASARR policy and used the state guidelines. 3.1-16(d)		will be adjusted by increasing or decreasing the monitoring until 100% compliance is achieved.	
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on observation, record review and interview, the facility failed to identify and implement individualized, non-pharmacological interventions for residents with expressions of behavior for 3 of 4 residents reviewed for dementia care (Residents 31, 33 and 5). Findings include: 1. During an observation, on 8/9/22 at 1:56 p.m., Resident 31 was lying in bed. On 8/10/22 at 9:51 a.m., she was lying in bed. On 8/11/22 at 8:58 a.m., she was sitting in a wheel-chair in the dining room. Her clinical record was reviewed on 8/9/22 at 11:16 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, dementia with behavioral disturbance, anxiety, delusional disorder, psychotic disorder with hallucinations and schizoaffective disorder.	F 0744	1. Residents 31, 33, and 5 did not experience any negative outcomes related to the alleged deficient practice. The facility has reviewed each resident and their behaviors and has developed and implemented individualized, non-pharmacological interventions for the residents. 2. All residents with Dementia and behaviors have the potential to be affected. The facility has reviewed each resident and their behaviors and has developed and implemented individualized, non-pharmacological interventions for the residents. 3. The facility's policy for behaviors has been reviewed and no changes are indicated at this time. The facility's staff has been	08/29/2022

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	Current physician orders included, but were not limited to the following: a. Buspar (anti-anxiety) 5 mg, one tablet three times a day for anxiety, the order date was 2/16/22. b. Risperdal (anti-psychotic) 0.5 mg (milligram), one tablet at bedtime for psychotic disorder with hallucinations, the order date was 2/22/22. A 7/1/22 quarterly MDS (Minimum Data Set) assessment indicated she had moderate cognitive impairment and had not had any behaviors during the assessment period. She had received an anti-psychotic and anti-anxiety medication everyday during the assessment period. The anti-psychotic had been received on a routine basis and there had not been an attempt of a GDR (Gradual Dose Reduction). A current care plan, with a revised date of 8/8/22, indicated she exhibited verbal behavioral symptoms directed towards others such as, threatening others, screaming at others, cursing at others and name calling. Interventions included, but were not limited to, attempt to use diversion, distraction and reorientation to calm her, such as singing and talking with staff. A current care plan, with a revised date of 8/8/22, indicated she suffered from delusions (fixed false beliefs) due to dementia as evidenced by false beliefs building was on fire, a gas leak and son was her spouse. Interventions included, but were not limited to, gently explain that belief was false and introduce evidence to prove why it was not true and administer medications as ordered. A mood and behavior communication memo,		educated on this policy with a special focus on non-pharmacological interventions to help with behaviors. A monitoring tool has been implemented. 4. The Social Service Director or designee will be responsible for completing the monitoring tool to ensure non-pharmacological interventions are being utilized to help with behaviors. This monitoring will occur on scheduled work days as follows: daily for two weeks, weekly for two weeks, monthly for two months then quarterly thereafter. Should a concern be found, immediate corrective action will occur. Results of this monitoring and any corrective action will be reviewed during the facility's QA meetings on an ongoing basis for a minimum of six months. The plan will be adjusted by increasing or decreasing the monitoring until 100% compliance is achieved.	

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	dated 4/24/22 at 1:00 a.m., indicated she had made repetitive verbalizations and hallucinations, thought there was a dog and kept yelling for the dog. Interventions attempted included toileting, provided liquids, quiet environment, snack, allowed her to vent her feelings and provided her reassurance and comfort, the behavior was unchanged. A mood and behavior communication memo, dated 5/9/22 at 4:00 a.m., indicated she had made negative statements, repetitive verbalizations and hallucinations she was getting bit by rats. Interventions attempted included toileting, placed in chair or bed and given time to calm and then re-approached, the behavior was unchanged. A mood and behavior communication memo, dated 5/19/22 at 3:00 a.m., indicted she had made negative statements, restlessness, repetitive verbalizations, repetitive concerns, verbally aggressive, rejection of care, socially inappropriate, hallucinations and delusions. She had refused to go to the bathroom, interventions attempted included provided relaxation technique and quiet environment, one on one, allowed her to vent feelings and redirection, the behavior was unchanged. A Social Service Assessment, dated 6/10/22, indicated psychotic disorder with hallucinations, anxiety, recurrent depressive episodes, Alzheimer's disease and attention/concentration deficit. Behavioral symptoms and and care plan implementation to address behaviors: delusional disorders and confusion. Care plans reviewed and updated. A Psychiatry Progress Note, dated 6/28/22, indicated dementia: no medication, continue			

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	appropriate behavioral interventions and psychotherapeutic communication. Behavioral and psychological symptoms of dementia: history of visual hallucinations and delusional thoughts that cause fear, tearfulness and anxiety, none recently reported, symptoms appeared stable and continue Risperdal 0.5 mg every bedtime. A mood and behavior communication memo, dated 7/19/22 at 2:00 p.m., indicated crying/tearfulness and wanted to go home. One on one was provided with her as well as reassurance and comfort, the interventions did not change the mood or behavior. A Psychiatry Progress Note, dated 7/20/22, indicated dementia: no medication, continue appropriate behavioral interventions and psychotherapeutic communication. Schizoaffective disorder: GDR- after reviewing current medication therapy as well as recent behaviors and discussion with DON (Director of Nursing), pharmacy, Administration, and Social Services, contraindicating any dose reduction of Risperdal as a reduction would likely increase symptoms of psychosis and anxiety, continued to have delusional thoughts about rats getting her that caused hear and anxiety. Delusional thoughts were less frequent. A mood and behavior communication memo, dated 7/20/22 from 6:00 to 10:00 p.m., indicated she had disturbed other residents by yelling out about seeing rats and worried about children playing in the street. Had been provided snacks and water, toileted, relaxation techniques, quiet environment, one on one, conversation of interest, time to calm then re-approach and redirection. Possible trigger: urinalysis results indicated an urinary tract infection, physician to be notified on 7/21/22.			

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	A Psychiatry Progress Note, dated 7/26/22, indicated dementia: no medication, continue appropriate behavioral interventions and psychotherapeutic communication. Anxiety: symptoms appear stable, continue Buspar 5 mg three times a day. Schizoaffective disorder: symptoms appeared stable, continue Risperdal 0.5 mg every bedtime. During an interview, on 8/12/22 at 8:46 a.m., RN 14 indicated the resident usually sang and made happy noises, had yelled out that the building was on fire, re-directing and distracting her usually helped. Cross Reference F644 2. During an observation, on 8/9/22 at 3:16 p.m., Resident 33 was sitting in a chair in the lounge across from the nurses' station. On 8/11/22 at 8:56 a.m., he was assisted out of the shower room and into the lounge area. His clinical record was reviewed on 8/9/22 at 10:43 a.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance, physical aggression, depression, anxiety and schizoaffective disorder. Current physician orders included, but were not limited to the following: a. Buspar 10 mg, one tablet three times a day for anxiety, the order date was 8/24/21. b. Risperdal 1 mg, one tablet twice a day for dementia with behavioral disturbance, the order date was 9/28/21.			

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	c. Zoloft (anti-depressant) 25 mg, one tablet daily along with a Zoloft 50 mg tablet to equal 75 mg daily for depression, the order date was 6/15/22. A 7/1/22 quarterly MDS assessment indicated he had severe cognitive impairment. He had not had any hallucinations or delusions during the assessment period. Physical behavioral symptoms directed towards others and rejection of care had occurred 1 to 3 days during the assessment period. He had received an anti-psychotic, anti-depressant and anti-anxiety medication everyday during the assessment period. The anti-psychotic had been received on a routine basis and there had not been an attempt of a GDR. A current care plan, with a revised date of 7/13/22, indicated he was at risk for delirium or acute confusion related to dementia and schizoaffective disorder as evidenced by inattention, disorganized thinking and altered level of consciousness. The interventions included, but were not limited to, monitor for signs or symptoms of delirium such as: inattention, disorganized thinking, altered level of consciousness, psycho-motor retardation and acute confusion and administer medications as ordered. A current care plan, with a revised date of 7/14/22, indicated he required the use of an anti-psychotic medication, Risperdal, to treat dementia with behaviors and schizoaffective disorder. Interventions included, but were not limited to, observe for change in mood or behavior. A current care plan, with a revised date of 8/8/22, indicated he presented with a primary diagnosis of dementia with behaviors and may exhibit any or all of the following mood and behavior challenges:			

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	aggressive behaviors, hitting other and pushing and grabbing. Interventions included, but were not limited to, encourage activities of interest such as: (List). The care plan did not list activities of interest. A current care plan, with a revised date of 8/8/22, indicated he exhibited physical behavioral symptoms directed towards others such as: pushing, grabbing and hitting others. Interventions included, but were not limited to, psychotropic medications as ordered. A Social Service Assessment, dated 6/15/22, indicated schizoaffective disorder, dementia with behavioral disturbance, physical aggression, depression and anxiety. Medications: Zoloft 75 mg for depression, Risperdal 1 mg for dementia with behavioral disturbance. A Psychiatry Progress Note, dated 6/15/22, indicated no behaviors or psychosis reported since last visit, no new concerns had been reported and appeared stable from a psychiatric standpoint. Schizoaffective disorder: symptoms appear stable, continue Risperdal 1 mg twice a day. A mood and behavior communication memo, dated 7/25/22 at 7:40 p.m., indicated he had been found in another resident's room and had been incontinent of bowel movement, uncooperative with care, was combative hitting staff and resisting shower, it took two CNA's to complete the shower and assist him to bed. A mood and behavior communication memo, dated 7/28/22 at 9:20 p.m., indicated he had removed his brief, staff attempted to put it back on him, and he punched staff in the arm, behavior			

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	unchanged after interventions attempted. A mood and behavior communication memo, dated 8/6/22 at 10:00 p.m., indicated he had been sleeping in a chair, staff woke him to offer toileting and he became physically aggressive, tried to assist him to bed, he refused to sit anywhere, had a bowel movement and refused to be changed, there had only been one staff member on the secure unit, interventions had been attempted but behavior was unchanged. During an interview, on 8/12/22 at 8:47 a.m., RN 14 indicated his behaviors were rejection of care, especially with incontinent care, give him time to calm the re-approach or change staff member typically was effective. During an interview, on 8/12/22 at 9:30 a.m., the Social Service Director indicated he did not have delusions, he did have aggression with care and rejection of care. Cross Reference F6443. On 8/9/22 at 11:26 a.m., Resident 5 was in his wheelchair in room, chin to chest. On 8/10/22 at 8:43 a.m., he was in his recliner in his room with his eyes closed, holding a cup in his left hand halfway to his mouth and a spoon in his right hand. On 8/10/22 at 1:45 p.m., he was in his recliner, asleep. On 8/11/22 at 10:15 a.m. he was asleep in bed with the room dark. On 8/12/22 at 8:07 a.m., he was up in his wheelchair in the dining area, eating breakfast.			

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	Resident 5's clinical record was reviewed on 8/9/22 at 10:37 a.m. Diagnoses included, but were not limited to, chronic systolic heart failure, dementia with behaviors, major depressive disorder, expressive language disorder, and mood disorder. Current physician orders included, but were not limited to, desvenlafax (anti-depressant) 50 mg daily, quetiapine (anti-psychotic) 25 mg in a.m. and 50 mg at bedtime, tramadol (pain medication) 50 mg twice daily, and divalproex (mood stabilizer) 500 mg three times daily. A 4/20/22, quarterly, MDS assessment indicated he was severely cognitively impaired and had a fluctuating behavior of disorganized thinking. He had no psychosis, but had verbal and physical behaviors 1-3 days of the assessment period. He required extensive assistance for mobility, transfers and hygiene. He had a current care plan problem, reviewed 8/8/22, of rejection of care such as medication, treatments, ADL assistance, and bathing. Interventions included, but were not limited to, approach from the front in a calm manner, call the resident by his name, explain the purpose of the visit, allow time to calm down and reapproach as needed, praise efforts, attempt to determine the reason for rejection and seek solutions if able, and limit distractions. The care plan lacked individualized interventions for the resident. A current care plan problem, reviewed 8/8/22, indicated he had agitation and aggression. Interventions included, but were not limited to, talk about vintage cars he has restored.			

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	A current care plan problem, reviewed 8/8/22, indicated he had physical behaviors of hitting. Interventions included, but were not limited to, allow to calm down, music, massage or exercise to calm, praise compliance, and psychiatric medications as ordered. The care plan lacked individualized interventions for the resident. A current care plan problem, reviewed 8/4/22, indicated he required the use of antipsychotic medication to treat dementia with behaviors and agitation/PBSD (psychological and behavioral symptoms of dementia). He had a failed dose reduction on 7/20/22. A current 8/8/22 care plan for daily preferences indicated it was somewhat important to the resident to have his daily preferences honored. He preferred to sleep in and go to bed at 11:00 p.m. A review of nurses notes and behavior memos indicated the following: On 5/3/22, he refused his medications. On 5/4/22, he spit out his medications. On 5/7/22, he struck staff in the face when they were removing his foot pedals. They went to get other staff to help lay him down and he tried hitting them as well. On 5/8/22 at 5:30 p.m., he started swinging at an aide while getting him ready for bed and was "inches from hitting aide" in the face.			

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	On 5/9/22, he was swinging at an aide, and kicking at her as well, during care. On 5/18/22, an order was received to decrease the desvenlafax to 50 mg daily. On 5/24/22, he was using expletives and hitting and kicking while staff was putting him to bed at 6:45 p.m. He eventually calmed down and allowed assist to bed and fell asleep. On 5/26/22 at 8:20 p.m., he refused his medications, and was balling up his fists and lunging forward. He attempted to knock the spoon of medications out of the nurses hand. A CNA took him to his room to put him to bed per his request, but he hit staff in the chest. A call was placed to the psychiatric nurse practitioner and a discussion was held regarding an inpatient psychiatric stay versus sending him to the emergency department. As of 9:30 p.m., he had been sitting in his room and had calmed down. When asked if he wanted to lay down, he yelled no. The behavior memo indicated the quetiapine was increased following a failed dose reduction. On 5/26/22 at 8:30 p.m., he had a behavior of hitting a staff member, refusing medications, and being verbally and physically aggressive. He refused to be assisted to bed. On 6/2/22, he refused his morning medications and raised his hand in a threatening manner and refused his bedtime medications. On 6/7/22, he hit a CNA in the stomach multiple times, squeezed a CNA's wrist and told the CNAs he was going to kill them. A 6/15/22 pharmacist note to the prescriber			

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	indicated the resident had dementia and an order for an anti-psychotic medication. In order to meet criteria for use of the medication, the resident must be deemed a danger to himself or others and have one of the following: mania or psychosis or behavioral interventions attempted or refusal of care. The document was signed by the NP with the notation he had psychological and behavioral symptoms of dementia. On 6/15/22, the quetiapine was changed to 25 mg twice daily and the divalproex was increased to 500 mg three times daily. On 6/18/22, he threw a water cup on staff during medication pass and refused his medications except the one for pain. On 7/13/22, he refused his bedtime medications and was agitated. On 7/7/22, he refused a shower or to get up. He "swung on staff and hit her in face" when gotten up for lunch. When the same staff member went to put him in his room after lunch, he tried to hit her again. On 7/13/22, he refused his bedtime medications. On 7/14/22, he refused a shower and ADL care; he indicated he was tired and in pain. A 7/20/22 psychiatric NP note indicated an acute visit for increased physical aggression since the reduction of quetiapine (on 6/15/22). He had no delusions or hallucinations. His symptoms of depression benefited from the quetiapine, and was increased to 25 mg in a.m. and 50 mg at bedtime and he was to continue the divalproex. His current diagnoses included, but were not limited			

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	to, psychotic disorder with delusions and schizoaffective disorder. On 7/20/22, he refused his bedtime medications. On 7/23/22, he was kicking and punching staff during cares. On 7/24/22, he hit a CNA in the chest during cares. A 7/26/22 psychiatric NP note indicated he had been combative and refused to eat or take his medications over the past week. He had no delusions or hallucinations. He had a diagnosis of schizoaffective disorder, depressive type, with increased signs and symptoms, but no recent reports of delusional thoughts. On 7/27/22, he refused restorative exercises. An 8/4/22 wound assessment indicated he had a 2.5 centimeter (cm) long (L) x 2.3 cm width (W) x 0.1 cm depth (D) abrasion to his right foot with a small serous exudate with slough and irregular edges. An 8/4/22 wound assessment indicated he had a 1.2 cm L x 1.3 cm W x 0.3 cm D skin tear to his right lateral foot with serous exudate and a yellow wound bed. On 8/9/22, he became physical during a shower and bit a CNA. The note indicated three CNAs were present during the shower. During an interview, on 8/12/22 at 9:02 a.m., CNA 31 indicated Resident 5 did not have any delusions or hallucinations, but did have lots of behaviors. He did not want to do things because			

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of pain, but the nurses say they're managing his pain. Sometimes if you told him his family was coming to visit, he would allow care to be done. Other times, he just needed re-approached.

During an interview, on 8/12/22 at 9:07 a.m., CNA 32 indicated the resident was confused. When he was approached about getting dressed, he would initially be okay with it, then he would change his mind. His foot wounds would upset him, and then he would become resistant to care. A lot of it was just his personality.

During an interview, on 8/12/22 at 9:10 a.m., LPN 33 indicated the resident could sometimes is resistant to care and he may be grumpy and not get along with others. She was not aware of him seeing or hearing things. He may cuss you one minute, then smile and love you the next.

During an interview, on 8/12/22 at 9:30 a.m., the SSD indicated the resident would cry at times, or think he was still in his old times. He would think his family was at the facility when they weren't or he had done things he shouldn't have. She was not aware of what the resident's signs of dementia were versus what his signs and symptoms of schizoaffective disorder were. He received the anti-psychotic medication for schizoaffective disorder.

Review of a current facility policy titled "ANTIPSYCHOTIC MEDICATION/GRADUAL DOSE REDUCTION," dated September 2017 and provided by the Nurse Consultant on 8/12/22 at 10:38 a.m., indicated the following: "...Since diagnoses alone do not warrant the use of antipsychotic medications, the clinical condition must also meet at least one of the following criteria...The symptoms are identified as being due

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	to mania or psychosis...delusions...The behavioral symptoms present a danger to the resident or to others...The symptoms are significant enough that the resident is experiencing one or more of the following: inconsolable or persistent distress...a significant decline in function; and/or substantial difficulty receiving needed care...." 3.1-37(a)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable			

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	an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on interview and record review, the facility failed to provide ordered medications for 1 of 7 residents reviewed for medication use. (Resident 40) Findings include: Resident 40's clinical record was reviewed on 8/11/22 at 11:06 a.m. The resident was admitted to the facility on 6/1/22 and discharged 6/6/22. Physician's admission orders for 6/1/22 included, but was not limited to, quetiapine (antipsychotic) 50 mg daily at bedtime. Progress notes dated 6/2/2022 from the Nurse Practitioner (NP) indicated quetiapine 50 mg was ordered. The medication administration record (MAR) lacked initials to indicate the resident was given the ordered quetiapine on 6/1/22. On 6/2/22, the initials were circled with a notation added to the back of the page which indicated the resident did not receive quetiapine due to a lack of supply. On 6/4/22 and 6/5/22 the initials were circled on the quetiapine order with a lack of documentation indicating why the initials were circled. The physician's orders lacked an order to hold the quetiapine or give an alternative during the resident's stay. The nurses' notes lacked documentation that	F 0755	1. Resident 40 is no longer at the facility and had been discharged prior to this annual survey. 2. All residents have the potential to be affected. Each residents medication orders have been reviewed and medications verified to be in house and utilized at this time. 3. The facility's policy Medications; obtaining from pharmacy for new admissions and readmissions has been reviewed and no changes are indicated at this time. The facility's nurses and QMAs have been educated on the policy with a special focus on ensuring all medications were delivered by the pharmacy and are currently in use. A monitoring tool has been implemented. 4. The DON or designee will be responsible for completing the monitoring tool to ensure medications are delivered from the pharmacy in a timely manner. This monitoring will occur on scheduled work days as follows: daily for two weeks, weekly for two weeks, monthly for two months, then quarterly thereafter. Should a	08/29/2022

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	quetiapine was not given. Documentation of pharmacy, physician, family, or Director of Nursing (DON) notification of quetiapine's unavailability was lacking. During an interview, on 8/11/22 at 2:22 p.m., the Nurse Consultant indicated when initials are circled on the MAR, there should be a note on the front or back of the page that indicated why a medication was not given. During an interview, on 8/11/22 at 2:56 p.m., the Nurse Consultant indicated she had spoken with the pharmacy. Quetiapine was not sent and was not in the emergency drug kit (EDK). Quetiapine was not given to the resident from 6/1/22 through 6/5/22 because of lack of supply. She indicated the DON usually followed up when medications were not available. If a medication is unavailable for greater than 72 hours, the chart is audited. During an interview, on 8/12/22 at 10:08 am., Registered Nurse (RN) 61 indicated if a medication was unavailable and not in the EDK, the physician must be notified to see if the medication can be held or if an alternative medication can be given until the medication was available. When a medication was not given, it was circled. Then, on the back of the MAR, a note was documented which contains the date, time, and reason the medication was not given. She indicated documentation of the medication unavailability should be documented in the nurses' notes with the physician and family notification. During an interview, on 8/12/22 at 11:07 a.m., RN 62 indicated if a medication was ordered and unavailable, it should be circled on the MAR and documented on the back of the MAR. The family and doctor should be notified. The pharmacy		concern be found, immediate corrective action will occur. Results of this monitoring and any corrective action will be reviewed during the facility's QA meetings on an ongoing basis for a minimum of six months. The plan will be adjusted by increasing or decreasing the monitoring until 100% compliance is achieved.	

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	should be notified to check on the medication's status. She indicated sometimes a medication required preauthorization before being sent. The DON reviewed all medications that required preauthorization. A current policy, titled "Medications, obtaining from pharmacy for new admissions and readmissions" and provided by the Nurse Consultant on 8/12/22 at 10:38 a.m., indicated " ...This facility will implement measures to ensure medication is obtained for administration as soon as possible following resident admission ..." 3.1-25(a)			
F 0758 SS=D 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			

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	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 §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 observation, interview and record review, the facility failed to ensure residents did not receive psychotropic medications without indication for 3 of 6 residents reviewed for unnecessary medications (Residents 31, 33 and 5). Findings include: 1. During an observation, on 8/9/22 at 1:56 p.m., Resident 31 was lying in bed. On 8/10/22 at 9:51 a.m., she was lying in bed. On 8/11/22 at 8:58 a.m., she was sitting in a	F 0758	1. Residents 31, 33, and 5 did not experience any negative outcome related to this alleged deficient practice. Their clinical records have been reviewed which includes medication orders, diagnoses, and behaviors the resident is experiencing. Behaviors are being documented in an effort to support the use of psychotropic medications and/or the medications have been reduced in an attempt to discontinue the medication.	08/29/2022

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	wheel-chair in the dining room. Her clinical record was reviewed on 8/9/22 at 11:16 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, dementia with behavioral disturbance, anxiety, delusional disorder, psychotic disorder with hallucinations and schizoaffective disorder. Current physician orders included, but were not limited to the following: a. Buspar (anti-anxiety) 5 mg, one tablet three times a day for anxiety, the order date was 2/16/22. b. Risperdal (anti-psychotic) 0.5 mg (milligram), one tablet at bedtime for psychotic disorder with hallucinations, the order date was 2/22/22. A 7/1/22 quarterly MDS (Minimum Data Set) assessment indicated she had moderate cognitive impairment and had not had any behaviors during the assessment period. She had received an anti-psychotic and anti-anxiety medication everyday during the assessment period. The anti-psychotic had been received on a routine basis and there had not been an attempt of a GDR (Gradual Dose Reduction). A current care plan, with a revised date of 8/8/22, indicated she exhibited verbal behavioral symptoms directed towards others such as, threatening others, screaming at others, cursing at others and name calling. Interventions included, but were not limited to, attempt to use diversion, distraction and reorientation to calm her, such as singing and talking with staff. A current care plan, with a revised date of 8/8/22, indicated she suffered from delusions (fixed false		2. All residents receiving psychotropic medications have the potential to be affected. Their clinical records have been reviewed which includes medication orders, diagnoses, and behaviors the resident is experiencing. Behaviors are being documented in an effort to support the use of psychotropic medications and/or the medications have been reduced in an attempt to discontinue the medication. 3. The facility's policy for Antipsychotic Medication/GDR has been reviewed and no changes are indicated at this time. Facility staff have been educated on the policy with a special focus on using non-pharmacological interventions if possible prior to utilizing a psychotropic medication and if indicated, to document negative behaviors in such a manner that would support the use of psychotropic medications as indicated. A monitoring tool has been implemented. 4. The Social Service Director or designee will be responsible for completing the monitoring tool to ensure non-pharmacological interventions are being used, psychotropic medications are used on a minimal basis as	

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	beliefs) due to dementia as evidenced by false beliefs building was on fire, a gas leak and son was her spouse. Interventions included, but were not limited to, gently explain that belief was false and introduce evidence to prove why it was not true and administer medications as ordered. A mood and behavior communication memo, dated 4/24/22 at 1:00 a.m., indicated she had made repetitive verbalizations and hallucinations, thought there was a dog and kept yelling for the dog. Interventions attempted included toileting, provided liquids, quiet environment, snack, allowed her to vent her feelings and provided her reassurance and comfort, the behavior was unchanged. A mood and behavior communication memo, dated 5/9/22 at 4:00 a.m., indicated she had made negative statements, repetitive verbalizations and hallucinations she was getting bit by rats. Interventions attempted included toileting, placed in chair or bed and given time to calm and then re-approached, the behavior was unchanged. A mood and behavior communication memo, dated 5/19/22 at 3:00 a.m., indicted she had made negative statements, restlessness, repetitive verbalizations, repetitive concerns, verbally aggressive, rejection of care, socially inappropriate, hallucinations and delusions. She had refused to go to the bathroom, interventions attempted included provided relaxation technique and quiet environment, one on one, allowed her to vent feelings and redirection, the behavior was unchanged. A Social Service Assessment, dated 6/10/22, indicated psychotic disorder with hallucinations, anxiety, recurrent depressive episodes,		indicated, and supporting behaviors are documented if receiving a psychotropic medication. This monitoring will occur on scheduled work days as follows: daily for two weeks, weekly for two weeks, monthly for two months, then quarterly thereafter. Should a concern be found, immediate corrective action will occur. Results of this monitoring and any corrective action will be reviewed during the facility's QA meetings on an ongoing basis for a minimum of six months. The plan will be adjusted by increasing or decreasing the monitoring until 100% compliance is achieved.	

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	Alzheimer's disease and attention/concentration deficit. Behavioral symptoms and and care plan implementation to address behaviors: delusional disorders and confusion. Care plans reviewed and updated. A Psychiatry Progress Note, dated 6/28/22, indicated dementia: no medication, continue appropriate behavioral interventions and psychotherapeutic communication. Behavioral and psychological symptoms of dementia: history of visual hallucinations and delusional thoughts that cause fear, tearfulness and anxiety, none recently reported, symptoms appeared stable and continue Risperdal 0.5 mg every bedtime. A mood and behavior communication memo, dated 7/19/22 at 2:00 p.m., indicated crying/tearfulness and wanted to go home. One on one was provided with her as well as reassurance and comfort, the interventions did not change the mood or behavior. A Psychiatry Progress Note, dated 7/20/22, indicated dementia: no medication, continue appropriate behavioral interventions and psychotherapeutic communication. Schizoaffective disorder: GDR- after reviewing current medication therapy as well as recent behaviors and discussion with DON (Director of Nursing), pharmacy, Administration, and Social Services, contraindicating any dose reduction of Risperdal as a reduction would likely increase symptoms of psychosis and anxiety, continued to have delusional thoughts about rats getting her that caused hear and anxiety. Delusional thoughts were less frequent. A mood and behavior communication memo, dated 7/20/22 from 6:00 to 10:00 p.m., indicated she			

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	had disturbed other residents by yelling out about seeing rats and worried about children playing in the street. Had been provided snacks and water, toileted, relaxation techniques, quiet environment, one on one, conversation of interest, time to calm then re-approach and redirection. Possible trigger: urinalysis results indicated an urinary tract infection, physician to be notified on 7/21/22. A Psychiatry Progress Note, dated 7/26/22, indicated dementia: no medication, continue appropriate behavioral interventions and psychotherapeutic communication. Anxiety: symptoms appear stable, continue Buspar 5 mg three times a day. Schizoaffective disorder: symptoms appeared stable, continue Risperdal 0.5 mg every bedtime. During an interview, on 8/12/22 at 8:46 a.m., RN 14 indicated the resident usually sang and made happy noises, had yelled out that the building was on fire, re-directing and distracting her usually helped. Cross Reference F644 and F744 2. During an observation, on 8/9/22 at 3:16 p.m., Resident 33 was sitting in a chair in the lounge across from the nurses' station. On 8/11/22 at 8:56 a.m., he was assisted out of the shower room and into the lounge area. His clinical record was reviewed on 8/9/22 at 10:43 a.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance, physical aggression, depression, anxiety and schizoaffective disorder. Current physician orders included, but were not			

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	limited to the following: a. Buspar 10 mg, one tablet three times a day for anxiety, the order date was 8/24/21. b. Risperdal 1 mg, one tablet twice a day for dementia with behavioral disturbance, the order date was 9/28/21. c. Zoloft (anti-depressant) 25 mg, one tablet daily along with a Zoloft 50 mg tablet to equal 75 mg daily for depression, the order date was 6/15/22. A 7/1/22 quarterly MDS assessment indicated he had severe cognitive impairment. He had not had any hallucinations or delusions during the assessment period. Physical behavioral symptoms directed towards others and rejection of care had occurred 1 to 3 days during the assessment period. He had received an anti-psychotic, anti-depressant and anti-anxiety medication everyday during the assessment period. The anti-psychotic had been received on a routine basis and there had not been an attempt of a GDR. A current care plan, with a revised date of 7/13/22, indicated he was at risk for delirium or acute confusion related to dementia and schizoaffective disorder as evidenced by inattention, disorganized thinking and altered level of consciousness. The interventions included, but were not limited to, monitor for signs or symptoms of delirium such as: inattention, disorganized thinking, altered level of consciousness, psycho-motor retardation and acute confusion and administer medications as ordered. A current care plan, with a revised date of 7/14/22, indicated he required the use of an anti-psychotic medication, Risperdal, to treat dementia with			

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	behaviors and schizoaffective disorder. Interventions included, but were not limited to, observe for change in mood or behavior. A current care plan, with a revised date of 8/8/22, indicated he presented with a primary diagnosis of dementia with behaviors and may exhibit any or all of the following mood and behavior challenges: aggressive behaviors, hitting other and pushing and grabbing. Interventions included, but were not limited to, encourage activities of interest such as: (List). The care plan did not list activities of interest. A current care plan, with a revised date of 8/8/22, indicated he exhibited physical behavioral symptoms directed towards others such as: pushing, grabbing and hitting others. Interventions included, but were not limited to, psychotropic medications as ordered. A Social Service Assessment, dated 6/15/22, indicated schizoaffective disorder, dementia with behavioral disturbance, physical aggression, depression and anxiety. Medications: Zoloft 75 mg for depression, Risperdal 1 mg for dementia with behavioral disturbance. A Psychiatry Progress Note, dated 6/15/22, indicated no behaviors or psychosis reported since last visit, no new concerns had been reported and appeared stable from a psychiatric standpoint. Schizoaffective disorder: symptoms appear stable, continue Risperdal 1 mg twice a day. A mood and behavior communication memo, dated 7/25/22 at 7:40 p.m., indicated he had been found in another resident's room and had been incontinent of bowel movement, uncooperative			

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	with care, was combative hitting staff and resisting shower, it took two CNA's to complete the shower and assist him to bed. A mood and behavior communication memo, dated 7/28/22 at 9:20 p.m., indicated he had removed his brief, staff attempted to put it back on him, and he punched staff in the arm, behavior unchanged after interventions attempted. A mood and behavior communication memo, dated 8/6/22 at 10:00 p.m., indicated he had been sleeping in a chair, staff woke him to offer toileting and he became physically aggressive, tried to assist him to bed, he refused to sit anywhere, had a bowel movement and refused to be changed, there had only been one staff member on the secure unit, interventions had been attempted but behavior was unchanged. During an interview, on 8/12/22 at 8:47 a.m., RN 14 indicated his behaviors were rejection of care, especially with incontinent care, give him time to calm the re-approach or change staff member typically was effective. During an interview, on 8/12/22 at 9:30 a.m., the Social Service Director indicated he did not have delusions, he did have aggression with care and rejection of care. Cross Reference F644 and F7443. On 8/9/22 at 11:26 a.m., Resident 5 was in his wheelchair in room, chin to chest. On 8/10/22 at 8:43 a.m., he was in his recliner in his room with his eyes closed, holding a cup in his left hand halfway to his mouth and a spoon in his right hand.			

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	On 8/10/22 at 1:45 p.m., he was in his recliner, asleep. On 8/11/22 at 10:15 a.m. he was asleep in bed with the room dark. On 8/12/22 at 8:07 a.m., he was up in his wheelchair in the dining area, eating breakfast. Resident 5's clinical record was reviewed on 8/9/22 at 10:37 a.m. Diagnoses included, but were not limited to, chronic systolic heart failure, dementia with behaviors, major depressive disorder, expressive language disorder, and mood disorder. Current physician orders included, but were not limited to, desvenlafax (anti-depressant) 50 mg daily, quetiapine (anti-psychotic) 25 mg in a.m. and 50 mg at bedtime, tramadol (pain medication) 50 mg twice daily, and divalproex (mood stabilizer) 500 mg three times daily. A 4/20/22, quarterly, MDS assessment indicated he was severely cognitively impaired and had a fluctuating behavior of disorganized thinking. He had no psychosis, but had verbal and physical behaviors 1-3 days of the assessment period. He required extensive assistance for mobility, transfers and hygiene. He had a current care plan problem, reviewed 8/8/22, of rejection of care such as medication, treatments, ADL assistance, and bathing. Interventions included, but were not limited to, approach from the front in a calm manner, call the resident by his name, explain the purpose of the visit, allow time to calm down and reapproach as needed, praise efforts, attempt to determine the reason for rejection and seek solutions if able, and limit distractions.			

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A current care plan problem, reviewed 8/8/22, indicated he had agitation and aggression. Interventions included, but were not limited to, talk about vintage cars he has restored.

A current care plan problem, reviewed 8/8/22, indicated he had physical behaviors of hitting. Interventions included, but were not limited to, allow to calm down, music, massage or exercise to calm, praise compliance, and psychiatric medications as ordered.

A current care plan problem, reviewed 8/4/22, indicated he required the use of antipsychotic medication to treat dementia with behaviors and agitation/PBSD (psychological and behavioral symptoms of dementia). He had a failed dose reduction on 7/20/22.

A current 8/8/22 care plan for daily preferences indicated it was somewhat important to the resident to have his daily preferences honored. He preferred to sleep in and go to bed at 11:00 p.m.

A review of nurses notes and behavior memos indicated the following:

On 5/3/22, he refused his medications.

On 5/4/22, he spit out his medications.

On 5/7/22, he struck staff in the face when they were removing his foot pedals. They went to get other staff to help lay him down and he tried hitting them as well.

On 5/8/22 at 5:30 p.m., he started swinging at an aide while getting him ready for bed and was

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	"inches from hitting aide" in the face. On 5/9/22, he was swinging at an aide, and kicking at her as well, during care. On 5/18/22, an order was received to decrease the desvenlafax to 50 mg daily. On 5/24/22, he was using expletives and hitting and kicking while staff was putting him to bed at 6:45 p.m. He eventually calmed down and allowed assist to bed and fell asleep. On 5/26/22 at 8:20 p.m., he refused his medications, and was balling up his fists and lunging forward. He attempted to knock the spoon of medications out of the nurses hand. A CNA took him to his room to put him to bed per his request, but he hit staff in the chest. A call was placed to the psychiatric nurse practitioner and a discussion was held regarding an inpatient psychiatric stay versus sending him to the emergency department. As of 9:30 p.m., he had been sitting in his room and had calmed down. When asked if he wanted to lay down, he yelled no. The behavior memo indicated the quetiapine was increased following a failed dose reduction. On 5/26/22 at 8:30 p.m., he had a behavior of hitting a staff member, refusing medications, and being verbally and physically aggressive. He refused to be assisted to bed. On 6/2/22, he refused his morning medications and raised his hand in a threatening manner and refused his bedtime medications. On 6/7/22, he hit a CNA in the stomach multiple times, squeezed a CNA's wrist and told the CNAs he was going to kill them.			

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	A 6/15/22 pharmacist note to the prescriber indicated the resident had dementia and an order for an anti-psychotic medication. In order to meet criteria for use of the medication, the resident must be deemed a danger to himself or others and have one of the following: mania or psychosis or behavioral interventions attempted or refusal of care. The document was signed by the NP with the notation he had psychological and behavioral symptoms of dementia. On 6/15/22, the quetiapine was changed to 25 mg twice daily and the divalproex was increased to 500 mg three times daily. On 6/18/22, he threw a water cup on staff during medication pass and refused his medications except the one for pain. On 7/13/22, he refused his bedtime medications and was agitated. On 7/7/22, he refused a shower or to get up. He "swung on staff and hit her in face" when gotten up for lunch. When the same staff member went to put him in his room after lunch, he tried to hit her again. On 7/13/22, he refused his bedtime medications. On 7/14/22, he refused a shower and ADL care; he indicated he was tired and in pain. A 7/20/22 psychiatric NP note indicated an acute visit for increased physical aggression since the reduction of quetiapine (on 6/15/22). He had no delusions or hallucinations. His symptoms of depression benefited from the quetiapine, and was increased to 25 mg in a.m. and 50 mg at bedtime			

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	and he was to continue the divalproex. His current diagnoses included, but were not limited to, psychotic disorder with delusions and schizoaffective disorder. On 7/20/22, he refused his bedtime medications. On 7/23/22, he was kicking and punching staff during cares. On 7/24/22, he hit a CNA in the chest during cares. A 7/26/22 psychiatric NP note indicated he had been combative and refused to eat or take his medications over the past week. He had no delusions or hallucinations. He had a diagnosis of schizoaffective disorder, depressive type, with increased signs and symptoms, but no recent reports of delusional thoughts. On 7/27/22, he refused restorative exercises. On 8/9/22, he became physical during a shower and bit a CNA. The note indicated three CNAs were present during the shower. An 8/4/22 wound assessment indicated he had a 2.5 centimeter (cm) long (L) x 2.3 cm width (W) x 0.1 cm depth (D) abrasion to his right foot with a small serous exudate with slough and irregular edges. An 8/4/22 wound assessment indicated he had a 1.2 cm L x 1.3 cm W x 0.3 cm D skin tear to his right lateral foot with serous exudate and a yellow wound bed. During an interview, on 8/12/22 at 9:02 a.m., CNA 31 indicated Resident 5 did not have any			

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	delusions or hallucinations, but did have lots of behaviors. He did not want to do things because of pain, but the nurses say they're managing his pain. Sometimes if you told him his family was coming to visit, he would allow care to be done. Other times, he just needed re-approached. During an interview, on 8/12/22 at 9:07 a.m., CNA 32 indicated the resident was confused. When he was approached about getting dressed, he would initially be okay with it, then he would change his mind. His foot wounds would upset him, and then he would become resistant to care. A lot of it was just his personality. During an interview, on 8/12/22 at 9:10 a.m., LPN 33 indicated the resident could sometimes is resistant to care and he may be grumpy and not get along with others. She was not aware of him seeing or hearing things. He may cuss you one minute, then smile and love you the next. During an interview, on 8/12/22 at 9:30 a.m., the SSD indicated the resident would cry at times, or think he was still in his old times. He would think his family was at the facility when they weren't or he had done things he shouldn't have. She was not aware of what the resident's signs of dementia were versus what his signs and symptoms of schizoaffective disorder were. He received the anti-psychotic medication for schizoaffective disorder. Review of a current facility policy titled "ANTIPSYCHOTIC MEDICATION/GRADUAL DOSE REDUCTION," dated September 2017 and provided by the Nurse Consultant on 8/12/22 at 10:38 a.m., indicated the following: "...Since diagnoses alone do not warrant the use of antipsychotic medications, the clinical condition			

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	must also meet at least one of the following criteria...The symptoms are identified as being due to mania or psychosis...delusions...The behavioral symptoms present a danger to the resident or to others...The symptoms are significant enough that the resident is experiencing one or more of the following: inconsolable or persistent distress...a significant decline in function; and/or substantial difficulty receiving needed care...." 3.1-48(a)(1) 3.1-48(a)(4)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which			

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	the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to ensure medications were securely and hygienically stored during 2 of 2 random observations of the 100 and 200 hall unit. Findings include: 1. During a random observation, on 8/8/22 at 9:19 a.m., a medication cart was observed unattended near the shower room on the 200 Hall with stacks of medication cards on top of it. The cards contained, but were not limited to, omeprazole capsules (for acid reflux), methotrexate (chemotherapy drug) 2.5 mg tablets, and quetiapine (anti-psychotic) 50 mg tablets. During an interview, on 8/8/22 at 9:23 a.m., RN 36 indicated she had been cleaning the cart out and had left the medications out. 2. During a random observation, on 8/10/22 at 9:48 a.m., the 100 and 200 Hall treatment cart was observed unlocked and unattended at the nurses station. During an observation of the cart, on 8/10/22 at 9:55 a.m., accompanied by the Regional Director/RN, the top drawer of the cart contained, but was not limited to, various open wound dressings with pieces cut out, urine test strips, Maxsorb (skin treatment) with no resident identifiers, diclofenac (anti-inflammatory) ointment, open and partially used phytoplex (skin protectant) ointment with no resident identifiers, and an open container of iodosorb (anti-microbial).	F 0761	1 & 2. There were no residents affected by this deficient practice but all residents have the potential to be affected. Nurses, including RN 36, and QMAs have been educated on storing medications and treatments appropriately in a locked cart. 3. The facility's policy for Medication Administration has been reviewed and no changes are indicated at this time. Nurses, including RN 36, and QMAs have been educated on storing medications and treatments appropriately in a locked cart. A monitoring tool has been implemented. 4 The DON or designee will be responsible for completing the monitoring tool to ensure medications and treatments are secured/locked at all times when not attended. This monitoring will occur on scheduled work days on alternating shifts as follows: daily for two weeks, weekly for two weeks, monthly for two months, then quarterly thereafter. Should a concern be found, immediate corrective action will occur. Results of this monitoring and any corrective action will be reviewed during the facility's QA meetings on an ongoing basis for a minimum of six months. The plan	08/29/2022

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	During an interview, at the time of the observation, the Regional Director indicated the cart should be kept locked when not in use. Review of a current facility policy titled "MEDICATION ADMINISTRATION," dated 4/2017 and provided by the Administrator on 8/12/22 at 8:45 a.m., indicated the following: "...The top of a medication cart should be kept free of any hazardous material including medications...Always lock the medication cart before leaving it out of visual range...." 3.1-25(m)		will be adjusted by increasing or decreasing the monitoring until 100% compliance is achieved.	
F 0773 SS=D Bldg. 00	483.50(a)(2)(i)(ii) Lab Srvcs Physician Order/Notify of Results §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. Based on record review and interview, the facility failed to ensure laboratory orders were collected and completed for 2 of 5 residents reviewed for unnecessary medications (Residents 35 and 5). Findings include: 1. Resident 35's clinical record was reviewed on 8/9/22 at 11:25 a.m. Diagnoses included, but were not limited to, type 2 diabetes (insulin dependent),	F 0773	1. Resident 35 and 5 did not experience any negative outcome related to the alleged deficient practice. Resident 35's AIC was done on 8/23/22. Resident 5's order for urinalysis has been discontinued by the primary physician. 2. All resident with lab orders have	08/29/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155521	A. BUILDING 00 B. WING	08/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALEXANDRIA CARE CENTER	1912 S PARK AVE ALEXANDRIA, IN 46001

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	dementia with behavioral disturbance, and schizoaffective disorder. He had a current, 4/10/20, physician order for a hemoglobin A1C test (to measure average blood sugars) every three months in May, August, November, and February. The clinical record lacked test results or indication they had been completed. During an interview, on 8/12/22 at 10:16 a.m., the Nurse Consultant indicated the facility could not locate the test results. The resident had been in the hospital in July and had the test completed there, but it had not been completed as ordered. 2. Resident 5's clinical record was reviewed on 8/9/22 at 10:37 a.m. Diagnoses included, but were not limited to, chronic systolic heart failure, dementia with behaviors, major depressive disorder, expressive language disorder, and mood disorder. On 7/7/22, he had an order for a urinalysis with culture and sensitivity if indicated. There was no indication in the clinical record the specimen had been collected. On 7/28/22, he had an order for a urinalysis. Collection with intermittent catheterization was not successful. There was no indication in the clinical record the specimen had been collected. During an interview, on 8/9/22 at 10:16 a.m., the Nurse Consultant indicated the urinalysis tests had not been completed. Review of a current facility policy titled "LABORATORY ORDERS, TIMELY DRAWS,"		the potential to affected. Their medical records have been reviewed for the past 30 days and if any labs were noted to be missing, the physician was contacted for further orders. 3. The facility's policy for Lab Orders-Timely Draws has been reviewed and no changes are indicated at this time. The nurses have been educated on the policy with a special focus on obtaining labs as ordered. A monitoring tool has been implemented. 4. The DON or designee will be responsible to complete the monitoring tool to ensure labs are done as ordered by the physician. This monitoring will occur on scheduled work days as follows: daily for two weeks, weekly for two weeks, monthly for two months, then quarterly thereafter. Should a concern be found, immediate corrective action will occur. Results of this monitoring and any corrective action will be reviewed during the facility's QA meetings on an ongoing basis for a minimum of six months. The plan will be adjusted by increasing or decreasing the monitoring until 100% compliance is achieved.	

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	dated 10/2014 and provided by the Regional Director on 8/12/22 at 11:13 a.m., indicated the following: "Laboratory testing shall be conducted in a timely manner...." 3.1-49(f)(1)			