PRINTED: 09/14/2022

CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155521			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 08/12/2022		
NAME OF 1	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD S PARK AVE			
ALEXANDRIA CARE CENTER			ALEXANDRIA, IN 46001				
(X4) ID	X4) ID SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	•	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPE	E RIATE	COMPLETION	
TAG	REGULATORY OI	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
F 0000							
Bldg. 00  This visit was for a Recertification and State Licensure Survey.  Survey dates: August 8, 9, 10, 11, and 12, 2022.		F 0000	Submission of this Plan of Correction does not constitu admission to or an agreeme facts alleged on the survey r	nt with			
		20710					
	Facility number: 00			Submission of the Plan of			
	Provider number: 1 AIM number: 1002			Correction does not constitu			
	Allyl humber, 1002	200070		admission or an agreement provider of the truth or facts	by trie		
	Census Bed Type:			alleged or corrections set for	th on		
	SNF/NF: 43			the statement of deficiencies			
	Total: 43						
	Total: 43  Census Payor Type: Medicare: 6 Medicaid: 31			The Plan of Correction is pre and submitted because of requirements under State an Federal law.			
	Other: 6 Total: 43			Please accept this Plan of			
	These deficiencies accordance with 41			Correction as our credible allegation of compliance			
	Quality review con	npleted on August 18, 2022.					
F 0558 SS=D Bldg. 00	services in the factorized accommodation of preferences exce	es e right to reside and receive cility with reasonable of resident needs and pt when to do so would alth or safety of the resident					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

for accommodation of needs (Residents 189, 2 and

Based on observation, interview and record

review, the facility failed to ensure residents had

access to call lights for 3 of 3 residents reviewed

TITLE

1 & 2. Residents 189, 2, and 35

related to this alleged deficient

did not have any negative outcome

practice but all residents have the

(X6) DATE

08/29/2022

Any defiency statement 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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F 0558

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLET			LETED	
		155521	B. W	ING		08/12/	/2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			PARK AVE		
ALEXAN	ALEXANDRIA CARE CENTER			ALEXA	NDRIA, IN 46001		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	35).				potential to be affected. Nursi	•	
					staff has been educated on th	е	
	Findings include:				call light policy with a special		
	1 During and abou	ervation, on 8/9/22 at 8:39 a.m.,			focus on keeping call lights in reach for the resident.		
	-	ying in a low bed, the call light			reach for the resident.		
	was under the low l				2. The facility's policy for call	liabt	
	was under the low t	Sed.			The facility's policy for call use has been reviewed and not be a second to the s	-	
	On 8/0/22 at 1:30 n	.m., she was lying in bed			changes are indicated at this	J	
	_				time. Nursing staff has been		
	against the assist rail, the call light was in the waste-basket and not within her reach.				educated on the call light police	21/	
	waste-basket and not within her reach.				with a special focus on keepin	-	
	The resident's clinical record was reviewed on				call lights in reach for the	9	
	8/9/22 at 10:36 a.m. Diagnoses included, but were				resident. A monitoring tool ha	ie.	
	not limited to, debility.				been implemented.	3	
	not innited to, deon	, .			been implemented.		
	A 7/19/22 admissio	on MDS (Minimum Data Set)			4. The DON or designee will I	he	
		ed she had moderate cognitive	responsible for completing the				
		s totally dependent with bed			monitoring tool and ensuring t		
	mobility and toilet				call lights for the residents are		
	,				within reach. This monitoring		
	During an interviev	v, on 8/10/22 at 8:48 a.m., LPN 7			be conducted on scheduled w		
	-	nt was able to use the call light			days and on alternating shifts	as	
		e.2. During an interview, on			follows: daily for two weeks,		
		Resident 2 was in his room in			weekly for two weeks, monthly	/ for	
	_	indicated he was waiting for			two months, then quarterly		
	his therapy session.	His call light was secured to			thereafter. Should a concern	be	
	the bed behind him	, out of his reach. He indicated			found, immediate corrective a		
		ed to see when the therapist			will occur. Results of this		
	was coming, but he	could not reach the call light.			monitoring and any corrective		
	He couldn't transfer	himself or propel the			action will be reviewed during	the	
	wheelchair due to v	veakness.			facility's QA meetings on an		
					ongoing basis for a minimum	of	
	On 8/8/22 at 1:42 p	.m., COTA 34 entered the room			six months. The plan will be		
	and assisted the resident to the therapy room.		adjusted by increasing or				
					decreasing the monitoring unt	il	
	Review of Resident	t 2's clinical record was			100% compliance is achieved		
	completed on 8/8/2	2 at 2:10 p.m.					
	Δ 4/15/22 quarterly Minimum Data Set (MDS)		1				İ

	of correction (X1) PROVIDER/SUPPLIER/CLIA (IDENTIFICATION NUMBER (155521)	(X2) MULTIPLE CO A. BUILDING B. WING	00	COME	E SURVEY PLETED 2/2022
	PROVIDER OR SUPPLIER	1912 S	ADDRESS, CITY, STATE, ZIP COD PARK AVE NDRIA, IN 46001	•	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	TION LD BE ROPRIATE	(X5) COMPLETION DATE
	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 metResident'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;FormIte 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.				
1	§483.10(c)(8) Nothing in this paragraph				

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	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1912 S PARK AVE ALEXANDRIA, IN 46001				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION  should be construed as the right of the		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (RACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE			
	resident to receive treatment or medi- medically unneces §483.10(g)(12) Th the requirements s 489, subpart I (Ad	e the provision of medical cal services deemed sary or inappropriate. The facility must comply with specified in 42 CFR part vance Directives).					
	inform and provide adult residents co or refuse medical at the resident's o directive.	nents include provisions to e written information to all encerning the right to accept or surgical treatment and, ption, formulate an advance					
	directives and app (iii) Facilities are p other entities to fu are still legally res the requirements of	o implement advance blicable State law. bermitted to contract with rnish this information but ponsible for ensuring that of this section are met. vidual is incapacitated at					
	the time of admiss receive informatio not he or she has directive, the facili directive information	sion and is unable to n or articulate whether or executed an advance ty may give advance on to the individual's eative in accordance with					
	to provide this info once he or she is information. Follow place to provide the	ot relieved of its obligation or mation to the individual able to receive such or procedures must be in the information to the appropriate time.					
	Based on record rev failed to ensure a re reviewed and signed representative for 1	riew and interview, the facility sident's advance directive was	F 0578	Resident 23 did not experie any negative outcome related this alleged deficient practice. The advance directive form have been signed by the resident's	to as		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED	
		155521	B. WING		08/12/2022	
			STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	£		PARK AVE		
ALEXANI	DRIA CARE CENTE	≣R		NDRIA, IN 46001		
			<u>, l</u>	I	<u> </u>	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		X5)
PREFIX	-	CY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	IE	LETION
TAG	AG REGULATOR OR ESCIDENTIFTING INFORMATION TAG		DA	TE		
	Findings include:  Resident 23's clinical record was reviewed on			representative.		
				2. All residents have the poter	tiol	
				to be affected. The advanced	uai	
		. Diagnoses included, but were		directive for each resident has		
		r depressive disorder, recurrent		been reviewed and updated w		
		chotic features,, dementia with		signatures as indicated.		
		s, and Alzheimer's disease.		orginatures as indicated.		
	, poj 211081	,		3. The facility's policy regardir	a	
	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			Advanced Directives has been	~	
				reviewed with no changes		
				indicated at this time.		
				Admissions, Social Services,	and	
				the Nurses have been educate		
	Directives were kep	t in the resident charts.		the policy with a special focus	on	
	_			getting the resident's or reside		
	During an interview	y, on 8/12/22 at 1:30 p.m., the		representative's signature on		
	Administrator indic	ated the resident's		form. A monitoring tool has be	en	
	representative had f	illed out the information on		initiated.		
	the form for 1st and	2nd choice contacts, but had				
	apparently forgotter	n to sign the form.		4. The Admissions Director or		
				designee will be responsible for		
		facility policy titled "Advance		completing the monitoring too		
		2015 and provided by the		ensure the advance directive t		
		12/22 at 1:05 p.m. indicated the		has been signed. This monito	-	
	_	presented with an Advance		will be completed on every ne	v	
		, the facility shall verify the		admission to the facility on an		
	• • •	has a copy of the document		ongoing basis. Should a cond		
	-	pyas well as on the		be found, immediate corrective		
	resident's clinical re	ecord in the nurses station"		action will occur. Results of th	IS	
	2 1 4/1\/4\/4\/*\			monitoring and any corrective	u	
	3.1-4(1)(4)(A)(ii)			action will be reviewed during	ine	
				facility's QA meetings on an	_	
				ongoing basis for a minimum	)	
				six months. The plan will be		
				adjusted by increasing or decreasing the monitoring unt		
				100% compliance is achieved		
				100 /0 COMPHANCE IS ACHIEVED		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155521	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY  COMPLETED  08/12/2022	
	PROVIDER OR SUPPLIED		STREET ADDRESS, CITY, STATE, ZIP COD 1912 S PARK AVE ALEXANDRIA, IN 46001			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIADEFICIENCY)	(X5) COMPLETION DATE	
F 0644 SS=E Bldg. 00	483.20(e)(1)(2) Coordination of P §483.20(e) Coord A facility must coord the pre-admission review (PASARR subpart C of this p practicable to avoid effort. Coordination §483.20(e)(1)Incorrecommendations determination and report into a resid planning, and trar §483.20(e)(2) Ref and all residents or possible serious r disability, or a relateresident review up status assessmer Based on record ref failed to complete to Resident Review (I diagnosed with me reviewed for PASR Findings include:  1. Resident 19's clit 8/8/22 at 10:22 a.m not limited to, depr disorder, schizoaffe She had a current, delusions and hallut	ASARR and Assessments ination.  ordinate assessments with a screening and resident of program under Medicaid in part to the maximum extent aid duplicative testing and on includes:  orporating the afformation from the PASARR level II at the PASARR evaluation ent's assessment, care assitions of care.  ferring all level II residents with newly evident or mental disorder, intellectual ated condition for level II from a significant change in a significant change in the condition of the sidents of the preadmission screening and PASRR) for residents newly antal illness for 4 of 7 residents are (Residents 19, 5, 31, and 33).  In Diagnoses included, but were the sidents of things being wet unket, briefs, or pants and the	F 0644	1. Residents 19, 5, 31, and 33 not experience any negative outcome related to the alleger deficient practice. An updated PASRR has been completed each resident.  2. All residents have the poter to be affected. Their clinical record has been reviewed and updated PASRR has been completed if indicated.  3. Indiana PASRR information been reviewed by the facility at this time. The Social Service Director has been educated or	3 did 08/29/2022 did for for finial did an has at	

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Indiana PASRR information with a

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
		155521	B. WING		08/12/2022		
				_	_		-
NAME OF F	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
					PARK AVE		
ALEXAN	ALEXANDRIA CARE CENTER			ALEXA	NDRIA, IN 46001		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
	Review of a PASRR level 1 assessment, dated				special focus on updating PAS	SRR	
	11/10/19, did not indicate mental health diagnoses				information when there is a		
	_	assessment was not repeated			change in mental illness		
	after she was diagnosed with schizoaffecitve				diagnosis. A monitoring tool h	as	
	disorder on 7/29/21.				been initiated.		
	2. Resident 5's clin	ical record was reviewed on			4. The Social Service Director	or	
		. Diagnoses included, but were			Designee will be responsible for		
	not limited to, chronic systolic heart failure,				completing the monitoring tool		
	dementia with behaviors, major depressive				ensure PASRR information ha		
	disorder, expressive language disorder,				been updated with each new	-	
	schizoaffective disorder, and mood disorder.				mental illness diagnosis. This		
					monitoring will be completed o		
	Current physician orders included, but were not				scheduled work days as follow		
	limited to, desvenlafax (anti-depressant) 50 mg				daily for two weeks, weekly for		
		nti-psychotic) 25 mg in a.m.			weeks, monthly for two months		
		ne, tramadol (pain medication)			then quarterly thereafter. Sho		
	_	and divalproex (mood stabilizer)			concern be found, immediate		
	500 mg three times	- · · · · · · · · · · · · · · · · · · ·			corrective action will occur.		
	8	3			Results of this monitoring and	anv	
	Review of an 8/24/2	21 PASRR Level 1 assessment			corrective action will be review	-	
		pression and dementia. He			during the facility's QA meeting		
		alproex and quetiapine for			on an ongoing basis for a	90	
		no diagnoses related to			minimum of six months. The p	nlan	
	schizoaffective disc	2			will be adjusted by increasing		
	Semzouricetive disc	71461.			decreasing the monitoring unti		
	During an interview	y, on 8/12/22 at 10:16 a.m., the			100% compliance is achieved.		
	_	ctor indicated the residents had			100 % compliance is deflicated.	•	
		1 1 PASRR assessment					
		ey had been diagnosed with					
	_	During an observation, on					
		Resident 31 was lying in bed.					
	6/9/22 at 1.30 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.						
		was reviewed on 8/9/22 at 11:16					
	a.m. She had admitted to the facility on 1/27/22.		1				

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	PROVIDER OR SUPPLIER		1912	ET ADDRESS, CITY, STATE, ZIP COD 2 S PARK AVE XANDRIA, IN 46001		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE .	(X5) COMPLETION DATE
	Alzheimer's disease disturbance, anxiety	l, but were not limited to, e, dementia with behavioral y, delusional disorder, with hallucinations and order.				
	Current physician of limited to the follow	orders included, but were not wing:				
	* `	ciety) 5 mg, one tablet three iety, the order date was 2/16/22.				
	one tablet at bedtim	osychotic) 0.5 mg (milligram), are for psychotic disorder with order date was 2/22/2.				
	assessment indicate impairment and had the assessment peri anti-psychotic and a everyday during the anti-psychotic had	MDS (Minimum Data Set) and she had moderate cognitive and not had any behaviors during od. She had received an anti-anxiety medication assessment period. The been received on a routine not been an attempt of a GDR uction).				
	indicated she exhib symptoms directed threatening others, others and name ca but were not limited	with a revised date of 8/8/22, ited verbal behavioral towards others such as, screaming at others, cursing at lling. Interventions included, d to, attempt to use diversion, rientation to calm her, such as with staff.				
	indicated she suffer beliefs) due to dem beliefs building wa	with a revised date of 8/8/22, red from delusions (fixed false entia as evidenced by false s on fire, a gas leak and son erventions included, but were				

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	F PROVIDER OR SUPPLIE ANDRIA CARE CENT		STREET ADDRESS, CITY, STATE, ZIP COD 1912 S PARK AVE ALEXANDRIA, IN 46001				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE
	and introduce evide	ly explain that belief was false ence to prove why it was not medications as ordered.					
	indicated psychotic anxiety, recurrent d Alzheimer's disease deficit. Behavioral implementation to	ssessment, dated 6/10/22, disorder with hallucinations, lepressive episodes, e and attention/concentration symptoms and and care plan address behaviors: delusional asion. Care plans reviewed and					
		ted 6/15/22 at 4:00 p.m., ler to add a diagnosis of order.					
	indicated dementia appropriate behavior psychotherapeutic of and psychological of of visual hallucinat that cause fear, tear recently reported, s	ess Note, dated 6/28/22, eno medication, continue oral interventions and communication. Behavioral symptoms of dementia: history ions and delusional thoughts fulness and anxiety, none ymptoms appeared stable and 0.5 mg every bedtime.					
	dated 7/19/22 at 2:0 crying/tearfulness a on one was provide	and wanted to go home. One and with her as well as mfort, the interventions did					
	indicated dementia appropriate behavious psychotherapeutic Schizoaffective dis	ess Note, dated 7/20/22, eno medication, continue oral interventions and communication. order: GDR- after reviewing therapy as well as recent					

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			COMPLETED	
		155521	B. W	B. WING			08/12/2022	
				CTREET	DDDEGG CITY CTATE ZID COD			
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD			
A1 = X A A I		-D			PARK AVE			
ALEXANI	DRIA CARE CENTE	ER .		ALEXA	NDRIA, IN 46001			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	behaviors and discu	ssion with DON (Director of						
	Nursing), pharmacy	y, Administration, and Social						
	Services, contraindi	icating any dose reduction of						
	Risperdal as a reduc	ction would likely increase						
	symptoms of psycho	osis and anxiety, continued to						
	have delusional tho	ughts about rats getting her						
		d anxiety. Delusional thoughts						
	were less frequent.	, c						
	1							
	A mood and behavi	or communication memo,						
		6:00 to 10:00 p.m., indicated she						
		residents by yelling out about						
		ried about children playing in						
	_	provided snacks and water,						
		techniques, quiet environment,						
		sation of interest, time to calm						
		d redirection. Possible trigger:						
		dicated an urinary tract						
	=	to be notified on 7/21/22.						
	mirection, physician	to be notified on 7/21/22.						
	A Psychiatry Progre	ess Note, dated 7/26/22,						
		no medication, continue						
		oral interventions and						
		communication. Anxiety:						
		table, continue Buspar 5 mg						
		chizoaffective disorder:						
	-	I stable, continue Risperdal 0.5						
	mg every bedtime.							
	ing every beatime.							
	During an interview	v, on 8/12/22 at 8:46 a.m., RN 14						
	_	nt usually sang and made						
		relled out that the building						
		eting and distracting her						
		ting and distracting her						
	usually helped.							
	Duning on intermi	y on 9/12/22 at 0:00 a tha						
	_	on 8/12/22 at 9:09 a.m., the ctor indicted a PASRR						
		ening and Resident Review)						
		nation and determination related						
	to the new diagnosis	s of schizoaffective disorder						

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2VCM11 Facility ID: 000518

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155521		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 08/12/2022	
	PROVIDER OR SUPPLIEF DRIA CARE CENTI		1912 5	ADDRESS, CITY, STATE, ZIP COD S PARK AVE ANDRIA, IN 46001	•
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
TAG		ecause she had a diagnosis	TAG	DEFICIENCY	DATE
	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.				
	a.m. Diagnoses incl				
	Current physician orders included, but were not limited to the following:				
	a. Buspar 10 mg, o anxiety, the order d	ne tablet three times a day for ate was 8/24/21.			
		one tablet twice a day for vioral disturbance, the order			
	along with a Zoloft	essant) 25 mg, one tablet daily 50 mg tablet to equal 75 mg a, the order date was 6/15/22.			
	had severe cognitive any hallucinations of assessment period. directed towards of occurred 1 to 3 day period. He had receanti-depressant and	MDS assessment indicated he e impairment. He had not had or delusions during the Physical behavioral symptoms hers and rejection of care had a during the assessment ived an anti-psychotic, anti-anxiety medication assessment period. The			
	period. He had rece anti-depressant and everyday during the	ived an anti-psychotic,			

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155521		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY  COMPLETED  08/12/2022			
	PROVIDER OR SUPPLIER DRIA CARE CENTI		STREET ADDRESS, CITY, STATE, ZIP COD 1912 S PARK AVE ALEXANDRIA, IN 46001				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
	A current care plan, indicated he was at confusion related to disorder as evidence disorganized thinking consciousness. The were not limited to, of delirium such as: thinking, altered lev psycho-motor retard and administer med.  A current care plan, indicated he require medication, Risperce behaviors and schiz Interventions included observe for change.  A current care plan, indicated he present dementia with behat of the following medicated he present dementia with behat of the following medicated he present dementia with behat of the following medicated he indicated to, encough as: (List). The of interest.  A current care plan, indicated he exhibit symptoms directed pushing, grabbing a Interventions included pushing, grabbing and Interventions included a progress note, day	interventions included, but monitor for signs or symptoms inattention, disorganized vel of consciousness, dation and acute confusion ications as ordered.  with a revised date of 714/22, and the use of an anti-psychotic dal, to treat dementia with oaffective disorder.  ded, but were not limited to, in mood or behavior.  with a revised date of 8/8/22, and with a primary diagnosis of viors and may exhibit any or all and behavior challenges: as, hitting other and pushing eventions included, but were urage activities of interest care plan did not list activities  with a revised date of 8/8/22, and the date of the da					

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Event ID:

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		155521	B. W	ING		08/12	/2022
		ı		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			PARK AVE		
ΔΙ ΕΧΔΝΙ	DRIA CARE CENTI	FR			NDRIA, IN 46001		
				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			•
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
	schizoaffective disc	order.					
		1.164.722					1
		ssessment, dated 6/15/22,					
	indicated schizoaffective disorder, dementia with						
		nce, physical aggression,					
		iety. Medications: Zoloft 75					
		Risperdal 1 mg for dementia					
	with behavioral dis	turbance.					
	A Davishi - t D.	aga Nata datad 6/15/22					
		ess Note, dated 6/15/22,					
		ors or psychosis reported					
		new concerns had been red stable from a psychiatric					
		iffective disorder: symptoms					
		nue Risperdal 1 mg twice a					
		nue Risperdai i ing twice a					
	day.						
	During an interview	v, on 8/12/22 at 8:47 a.m., RN 14					
	_	iors were rejection of care,					
	especially with inco	_					
	especially with med	similari cure.					
	During an interview	v, on 8/12/22 at 9:30 a.m., the					
	_	ctor indicated he did not have					
		ave aggression with care and					
		PASRR referral for an					
	1 -	rmination related to the new					
		affective disorder had not					
	_	he had a diagnosis of					
		not have a policy related to					
	1	the federal requirements as					
	reference.	•					
	A review of frequen	ntly asked questions related to					
		providers, located on website					
	https://maximusclin	nicalservices.com/sites/default/f					
	iles/pasrr/document	ts/IN%20PASRR%20FAQ_S%					
		21.21.pdf and dated 2020,					
		nen is a new Level I needed for					
		admitted with a negative Level					
		? A negative Level I review is					

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Event ID:

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/14/2022 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION	IDENTIFICATION NUMBER  155521	A. BUILDING B. WING	00		LETED 2/2022
NAME OF PROVIDER OR SUPPL ALEXANDRIA CARE CEN		1912 S	ADDRESS, CITY, STATE, ZIP PARK AVE NDRIA, IN 46001	COD	
PREFIX (EACH DEFIC TAG REGULATORY	RY STATEMENT OF DEFICIENCIE IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION (as long as there has been no	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
valid indefinitely change in menta  F 0645 SS=D Bldg. 00 Bldg. 00 S483.20(k)(1)-(3 PASARR Scree §483.20(k) Pre individuals with individuals with individuals with individuals with (i) Mental disor (3)(i) of this sechealth authority independent preformed by a the State mental admission, (A) That, because condition of the requires the leven nursing facility; (B) If the individuals with specialized ser (ii) Intellectual oparagraph (k)(3) State intellectual.	In health status"  In health authority must not see of the physical and mental evaluation person or entity other than health authority, prior to see of the physical and mental individual, the individual rel of services provided by a see the individual requires such level of health individual requires such level of health individual requires	TAG	DEFICIENCY		DATE
condition of the requires the lev nursing facility; (B) If the individual services, whether specialized services	ise of the physical and mental individual, the individual rel of services provided by a and requires such level of rer the individual requires vices for intellectual disability.				

FORM CMS-2567(02-99) Previous Versions Obsolete

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	OF HEALTH AND HUN				FOI	TED: 09/14/2022 RM APPROVED IB NO. 0938-039
STATEMEN		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155521	JILDING	onstruction 00	(X3) DATE SURVEY  COMPLETED  08/12/2022	
	ROVIDER OR SUPPLIER		1912 S	ADDRESS, CITY, STATE, ZIP COD PARK AVE NDRIA, IN 46001		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
	paragraph(k)(1) of provide for determ readmission to a rindividual who, aft nursing facility, wa hospital.  (ii) The State may preadmission screparagraph (k)(1) o admission to a nurindividual-  (A) Who is admitte from a hospital aft care at the hospital (B) Who requires a the condition for we care in the hospital (C) Whose attendibefore admission individual is likely days of nursing factors.	ed to the facility directly er receiving acute inpatient al, nursing facility services for which the individual received al, and ing physician has certified, to the facility that the to require less than 30				

(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

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08/29/2022

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155521	B. WI	ING		08/12/	2022
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	₹			PARK AVE		
\ \	DRIA CARE CENTI	ED					
ALEXAN	DNIA CARE CENTI			ALEXA	NDRIA, IN 46001		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					disorder or receiving a		
	Findings include:				psychotropic medication have	the	
					potential to be affected. The		
	Resident 40's clinical record was reviewed on				clinical records have been		
	8/11/22 at 11:06 a.m.				thoroughly reviewed and PAS	RR	
					completed as indicated listing	-	
	1 -	on orders for 6/1/22 included,			mental disorder and psychotro	pic	
		d to, quetiapine (antipsychotic)			medication.		
		ime and melatonin (hormone					
	1	eep cycle) 6 mg daily at			3. Indiana PASRR information		
	bedtime.				been reviewed by the facility a	ıt	
					this time. The Social Service		
	· ·	l psychosocial assessment			Director has been educated or	n	
		documentation of the			Indiana PASRR information w	ith a	
		r quetiapine. The current			special focus on accurately		
	psychoactive medic	eation section was blank.			completing the PASRR		
					information for mental disorde	r	
	_	d 6/2/2022 from the Nurse			diagnosis and/or psychotropic		
		dicated quetiapine 50 mg daily			medications. A monitoring for	m	
	was ordered.				has been implemented.		
		essment dated 6/3/22 lacked			4. The Social Service Director		
	documentation of the	ne quetiapine order.			Designee will be responsible f		
					completing the monitoring tool		
		a review date of 6/3/22 listed a			ensure PASRR information ha		
		or lorazepam (antianxiety) oral			been accurately completed wi		
		continued under the mental			mental disorder diagnosis and		
		and lacked an entry for			psychotropic medication. This		
	quetiapine.				monitoring will be completed of		
		1 0			scheduled work days as follow		
		v care plan conference record			daily for two weeks, weekly fo		
		melatonin under psychoactive			weeks, monthly for two month		
		eked documentation of the			then quarterly thereafter. Sho	uld a	
	quetiapine order.				concern be found, immediate		
		0/11/02 + 0.15			corrective action will occur.		
	During an interview, on 8/11/22 at 2:11 p.m., the				Results of this monitoring and	-	
	Social Services Director indicated she vaguely				corrective action will be review		
		ent 40. She indicated she did			during the facility's QA meetin	gs	
		esident's quetiapine order. The			on an ongoing basis for a		
	PASARR lacked documentation of the physician's		1		minimum of six months. The	olan	

STATEMENT OF DEFICIENCIES X1)		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155521	B. W	NG		08/12/	/2022
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	R			PARK AVE		
AI FXANI	DRIA CARE CENTI	FR			NDRIA, IN 46001		
				, (22) 0 (	1		1
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	-	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΙΤΕ	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
	quetiapine order.				will be adjusted by increasing		
	D	9/12/22 / 10/29 / 4			decreasing the monitoring unt		
	_	v, on 8/12/22 at 10:38 a.m., the			100% compliance is achieved	•	
		ARR policy and yeard the state					
	guidelines.	ARR policy and used the state					
	guidennes.						
	3.1-16(d)						
	3.1-10(u)						
F 0744	483.40(b)(3)						
SS=D	Treatment/Service	e for Dementia					
Bldg. 00		esident who displays or is					
Ŭ	- ' ' ' '	ementia, receives the					
		nent and services to attain					
	or maintain his or	her highest practicable					
	physical, mental, a	and psychosocial					
	well-being.						
		on, record review and	F 0'	744	1. Residents 31, 33, and 5 did	l not	08/29/2022
		ty failed to identify and			experience any negative outco		
	_	alized, non-pharmacological			related to the alleged deficient		
		sidents with expressions of			practice. The facility has revie		
		residents reviewed for			each resident and their behav	iors	
	dementia care (Resi	idents 31, 33 and 5).			and has developed and		
	E' 1' ' 1 1				implemented individualized,		
	Findings include:				non-pharmacological interven	tions	
	1 During an abase	vation, on 8/9/22 at 1:56 p.m.,			for the residents.		
	Resident 31 was lyi	-			2. All residents with Dementia	and	
	Kesidelit 31 was iyi	ing in occ.			behaviors have the potential to		
	On 8/10/22 at 9:51	a.m., she was lying in bed.			affected. The facility has review		
	On 6/10/22 at 9.51	u.m., she was lying in oca.			each resident and their behav		
	On 8/11/22 at 8:58	a.m., she was sitting in a			and has developed and	.010	
	wheel-chair in the d				implemented individualized,		
					non-pharmacological interven	tions	
	Her clinical record	was reviewed on 8/9/22 at 11:16			for the residents.		
	a.m. Diagnoses incl	uded, but were not limited to,					
		e, dementia with behavioral			3. The facility's policy for		
	disturbance, anxiety	y, delusional disorder,			behaviors has been reviewed	and	
		with hallucinations and			no changes are indicated at th	nis	
	schizoaffective disc				time. The facility's staff has b		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155521		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 08/12/2022	
	ROVIDER OR SUPPLIER		1912 S	ADDRESS, CITY, STATE, ZIP COD PARK AVE NDRIA, IN 46001	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	limited to the follow  a. Buspar (anti-anx	rders included, but were not ving: iety) 5 mg, one tablet three ety, the order date was 2/16/22.		educated on this policy with a special focus on non-pharmacological interven to help with behaviors. A monitoring tool has been implemented.	
	b. Risperdal (anti-pone tablet at bedtim hallucinations, the control of the contr	asychotic) 0.5 mg (milligram), are for psychotic disorder with order date was 2/22/22.  MDS (Minimum Data Set) dishe had moderate cognitive and that any behaviors during od. She had received an anti-anxiety medication assessment period. The open received on a routine not been an attempt of a GDR action).  with a revised date of 8/8/22, atted verbal behavioral towards others such as, ascreaming at others, cursing at ling. Interventions included, atto, attempt to use diversion, dientation to calm her, such as with staff.  with a revised date of 8/8/22, and ded from delusions (fixed false)		4. The Social Service Director designee will be responsible frompleting the monitoring too ensure non-pharmacological interventions are being utilized help with behaviors. This monitoring will occur on schedwork days as follows: daily for two weeks, weekly for two we monthly for two months then quarterly thereafter. Should a concern be found, immediate corrective action will occur. Results of this monitoring and corrective action will be review during the facility's QA meeting on an ongoing basis for a minimum of six months. The will be adjusted by increasing decreasing the monitoring unta 100% compliance is achieved.	or I to I to d to duled r eks, any ved gs plan or il
	beliefs building was was her spouse. Into not limited to, gentl and introduce evide true and administer	entia as evidenced by false s on fire, a gas leak and son erventions included, but were y explain that belief was false nce to prove why it was not medications as ordered. or communication memo,			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		155521	B. W	ING		08/12/	2022
	PROVIDER OR SUPPLIEF			1912 S	ADDRESS, CITY, STATE, ZIP COD PARK AVE NDRIA, IN 46001		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	*	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
		00 a.m., indicated she had made					
	repetitive verbaliza	tions and hallucinations,					
	thought there was a	dog and kept yelling for the					
	dog. Interventions a	attempted included toileting,					
	provided liquids, qu	uiet environment, snack,					
	allowed her to vent	her feelings and provided her					
		nfort, the behavior was					
	unchanged.						
		. ,.					
		or communication memo,  a.m., indicated she had made					
		s, repetitive verbalizations and vas getting bit by rats.					
		pted included toileting, placed					
	l	given time to calm and then					
		behavior was unchanged.					
	re-approached, the	ochavior was unchanged.					
	A mood and behavi	or communication memo,					
		00 a.m., indicted she had made					
	negative statements	, restlessness, repetitive					
	verbalizations, repe	titive concerns, verbally					
	aggressive, rejection	n of care, socially					
	inappropriate, hallu	cinations and delusions. She					
	had refused to go to	the bathroom, interventions					
		provided relaxation technique					
	_	ent, one on one, allowed her to					
		direction, the behavior was					
	unchanged.						
	A G - :-1 G						
		ssessment, dated 6/10/22,					
		disorder with hallucinations,					
	anxiety, recurrent d	e and attention/concentration					
		symptoms and and care plan					
		address behaviors: delusional					
	_	sion. Care plans reviewed and					
	updated.	ision. Care plans reviewed and					
	пришен.						
	A Psychiatry Progr	ess Note, dated 6/28/22,					
		no medication, continue					

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/14/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155521		(X2) MULT A. BUILD B. WING		nstruction 00	(X3) DATE : COMPL 08/12/	ETED	
	PROVIDER OR SUPPLIEF		1	912 S F	DDRESS, CITY, STATE, ZIP COD PARK AVE IDRIA, IN 46001		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PRI	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
TAG	appropriate behavior psychotherapeutic of and psychological soft visual hallucinate that cause fear, tear recently reported, soft continue Risperdal.  A mood and behavior dated 7/19/22 at 2:00 crying/tearfulness at on one was provided reassurance and connot change the mood.  A Psychiatry Program indicated dementiate appropriate behavior psychotherapeutic of Schizoaffective discurrent medication behaviors and discursing), pharmacy Services, contraind	oral interventions and communication. Behavioral symptoms of dementia: history ions and delusional thoughts fulness and anxiety, none symptoms appeared stable and 0.5 mg every bedtime.  For communication memo, 00 p.m., indicated and wanted to go home. One d with her as well as infort, the interventions did individual or behavior.  The sess Note, dated 7/20/22, and medication, continue oral interventions and communication.  Forder: GDR- after reviewing therapy as well as recent assion with DON (Director of the second intervention), and Social interior and dose reduction of intervention of the second intervention and social intervention and social intervention of the second intervention in	T	AG			DATE
	Risperdal as a redusymptoms of psychhave delusional tho that caused hear anywere less frequent.  A mood and behave dated 7/20/22 from had disturbed other seeing rats and wor the street. Had beer toileted, relaxation one on one, convertien re-approach ar urinalysis results in	ction would likely increase osis and anxiety, continued to ughts about rats getting her d anxiety. Delusional thoughts  for communication memo, 6:00 to 10:00 p.m., indicated she residents by yelling out about ried about children playing in a provided snacks and water, techniques, quiet environment, sation of interest, time to calm and redirection. Possible trigger: dicated an urinary tract to be notified on 7/21/22.					

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Event ID:

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/14/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155521		UILDING	nstruction <u>00</u>	(X3) DATE COMPL <b>08/12</b> /	ETED	
	PROVIDER OR SUPPLIEF DRIA CARE CENTI		1912 S	DDRESS, CITY, STATE, ZIP COD PARK AVE NDRIA, IN 46001		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	indicated dementia: appropriate behavior psychotherapeutic of symptoms appears in three times a day. So symptoms appeared mg every bedtime.  During an interview indicated the reside happy noises, had ywas on fire, re-direct usually helped.  Cross Reference F6  2. During an obser Resident 33 was sit across from the nur.  On 8/11/22 at 8:56 shower room and in this clinical record a.m. Diagnoses includementia with beha aggression, depress schizoaffective discontinuities of the following and the f	vation, on 8/9/22 at 3:16 p.m., ting in a chair in the lounge ses' station.  a.m., he was assisted out of the nto the lounge area.  was reviewed on 8/9/22 at 10:43 luded, but were not limited to, twioral disturbance, physical ion, anxiety and order.  orders included, but were not wing:  one tablet three times a day for				
	date was 9/28/21.	,				

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155521	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	COM	TE SURVEY TPLETED 12/2022		
	PROVIDER OR SUPPLIEI		STREET ADDRESS, CITY, STATE, ZIP COD  1912 S PARK AVE  ALEXANDRIA, IN 46001					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE		
TAG	c. Zoloft (anti-depralong with a Zoloft daily for depression A 7/1/22 quarterly had severe cognitive any hallucinations assessment period. directed towards of occurred 1 to 3 day period. He had receanti-depressant and everyday during the anti-psychotic had basis and there had A current care plan indicated he was at confusion related to disorder as evidence disorganized thinking consciousness. The were not limited to of delirium such as thinking, altered lepsycho-motor retar	essant) 25 mg, one tablet daily 50 mg tablet to equal 75 mg n, the order date was 6/15/22.  MDS assessment indicated he re impairment. He had not had or delusions during the Physical behavioral symptoms hers and rejection of care had s during the assessment eived an anti-psychotic, anti-anxiety medication e assessment period. The been received on a routine not been an attempt of a GDR.  with a revised date of 7/13/22, risk for delirium or acute of dementia and schizoaffective	TAG	DEFICIENCY		DATE		
	A current care plan indicated he require medication, Rispere behaviors and schiz Interventions inclus observe for change  A current care plan indicated he presendementia with behaviors.	, with a revised date of 7/14/22, ed the use of an anti-psychotic dal, to treat dementia with coaffective disorder. ded, but were not limited to, in mood or behavior.  , with a revised date of 8/8/22, ted with a primary diagnosis of twiors and may exhibit any or all bod and behavior challenges:						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155521	B. W	ING		08/12	/2022
NAME OF F	DDOMDED OD GUDDUTER			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	<b>C</b>			PARK AVE		
ALEXAN	DRIA CARE CENTI	ER		ALEXA	NDRIA, IN 46001		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	~~	rs, hitting other and pushing ventions 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,						
		ted physical behavioral					
	1	towards others such as:					
	pushing, grabbing a	led, but were not limited to,					
	psychotropic medic						
	ps, enought medic	and an oracion					
	A Social Service As	ssessment, dated 6/15/22,					
	indicated schizoaffe	ective disorder, dementia with					
		nce, physical aggression,					
	_	iety. Medications: Zoloft 75					
		Risperdal 1 mg for dementia					
	with behavioral dist	turbance.					
	A Psychiatry Progre	ess Note, dated 6/15/22,					
		ors or psychosis reported					
	since last visit, no n	new concerns had been					
	reported and appear	red stable from a psychiatric					
	_	ffective disorder: symptoms					
	appear stable, conti	nue Risperdal 1 mg twice a					
	day.						
	A mood and behavi	or communication memo,					
		10 p.m., indicated he had been					
		sident's room and had been					
		el movement, uncooperative					
	with care, was com	bative hitting staff and					
	resisting shower, it	took two CNA's to complete					
	the shower and assi	st him to bed.					
	A mood and behavi	or communication memo,					
		20 p.m., indicated he had					
		staff attempted to put it back on					
		d staff in the arm, behavior					

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AND PLAN OF CORRECTION IDENTIFICA		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155521	· /	JILDING	ONSTRUCTION 00	(X3) DATE COMPI 08/12	LETED
		100021	B. WI			00/12	12022
NAME OF P	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD PARK AVE		
	DRIA CARE CENT	ER	_		NDRIA, IN 46001		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	unchanged after in	terventions attempted.					
	A mood and behave dated 8/6/22 at 10:00 sleeping in a chair, and he became phy assist him to bed, he a bowel movement there had only been secure unit, interves behavior was unchainly been secured indicated his behave especially with incompact and the re-approare typically was effect During an interview Social Service Directly delusions, he did here is considered to the secure of the secure o	ior communication memo, 00 p.m., indicated he had been staff woke him to offer toileting visically aggressive, tried to be refused to sit anywhere, had and refused to be changed, in one staff member on the entions had been attempted but be anged.  We on 8/12/22 at 8:47 a.m., RN 14 priors were rejection of care, continent care, give him time to ch or change staff member					
	On 8/10/22 at 1:45 asleep.	p.m., he was in his recliner,					
	On 8/11/22 at 10:1 the room dark.	5 a.m. he was asleep in bed with					
		a.m., he was up in his ining area, eating breakfast.					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPI	LETED
		155521	B. W	ING		08/12	/2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	t .			PARK AVE		
ALEXAN	DRIA CARE CENTI	ER	_	ALEXA	NDRIA, IN 46001		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	Dagidant Sla aliniaa	I managed group may jayyad am 8/0/22					
		l 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.						
		orders included, but were not					
		afax (anti-depressant) 50 mg					
		nti-psychotic) 25 mg in a.m.					
	-	me, tramadol (pain medication)					
	-	and divalproex (mood stabilizer)					
	500 mg three times	daily.					
	A 4/20/22 quarterly	y, MDS assessment indicated					
		gnitively impaired and had a					
		r of disorganized thinking. He					
		out had verbal and physical					
		of the assessment period. He					
	required extensive	assistance for mobility,					
	transfers and hygier	ne.					
		re plan problem, reviewed					
	-	of care such as medication,					
		sistance, and bathing.					
		led, but were not limited to,					
		front in a calm manner, call the					
	-	e, explain the purpose of the					
	· ·	calm down and reapproach as rts, attempt to determine the					
	-	and seek solutions if able, and					
	limit distractions.	and seek solutions if able, and					
	The care plan lacke	d individualized interventions					
	for the resident.						
	_	problem, reviewed 8/8/22,					
	_	itation and aggression.					
		led, but were not limited to,					
	talk about vintage c	ars he has restored.	1				

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ì í		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		155521	B. WI	_		08/12/	/2022
NAME OF P	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
ALEXAN	DRIA CARE CENTI	ER			PARK AVE NDRIA, IN 46001		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	1	ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	.16	DATE
TAG	A current care plan indicated he had ph Interventions includallow to calm down calm, praise complishmedications as order the care plan lacke for the resident.  A current care plan indicated he require medication to treat agitation/PBSD (ps. symptoms of demer reduction on 7/20/2 A current 8/8/22 care indicated it was son resident to have his He preferred to sleep.m.  A review of nurses indicated the follow On 5/3/22, he refused On 5/4/22, he spit of the staff to help la hitting them as well of the staff to help la hitting them as well or simple complex control or staff to help la hitting them as well or s	problem, reviewed 8/8/22, ysical behaviors of hitting. led, but were not limited to, a, music, massage or exercise to ance, and psychiatric ered.  d individualized interventions  problem, reviewed 8/4/22, ed the use of antipsychotic dementia with behaviors and ychological and behavioral intia). He had a failed dose 2.  re plan for daily preferences newhat important to the daily preferences honored. Exp in and go to bed at 11:00  notes and behavior memos ving:  ed his medications.  k staff in the face when they foot pedals. They went to get any him down and he tried		IAG	DEPLENCT		DATE
	aide while getting h "inches from hitting	nim ready for bed and was g aide" in the face.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  00			(X3) DATE SURVEY COMPLETED		
		155521	B. WI	ING		08/12/	/2022
	PROVIDER OR SUPPLIER		<u>,                                      </u>	1912 S	ADDRESS, CITY, STATE, ZIP COD PARK AVE NDRIA, IN 46001		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION swinging at an aide, and kicking		TAG	DEFICIENCY)		DATE
	at her as well, durin						
	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						
	_	staff was putting him to bed at					
	6:45 p.m. He event assist to bed and fel	tually calmed down and allowed					
	assist to bed and re-	n asieep.					
	medications, and w lunging forward. E spoon of medicatio CNA took him to h his request, but he l was placed to the p and a discussion wa psychiatric stay ver emergency departm	p.m., he refused his as balling up his fists and He attempted to knock the ns out of the nurses hand. A is room to put him to bed per hit staff in the chest. A call sychiatric nurse practitioner as held regarding an inpatient rsus sending him to the nent. As of 9:30 p.m., he had oom and had calmed down.					
	_	vanted to lay down, he yelled					
		nemo indicated the quetiapine wing a failed dose reduction.					
	On 5/26/22 at 8:30 hitting a staff memb	p.m., he had a behavior of ber, refusing medications, and physically aggressive. He					
		ed his morning medications in a threatening manner and e medications.					
		CNA in the stomach multiple CNA's wrist and told the CNAs I them.					
	A 6/15/22 nharmac	ist note to the prescriber					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155521		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 08/12/2022	
	PROVIDER OR SUPPLIER DRIA CARE CENTI		1912 S	ADDRESS, CITY, STATE, ZIP COD PARK AVE NDRIA, IN 46001	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERNCED TO THE APPRODEFICIENCY)	OBE COMPLETION
	indicated the resider for an anti-psychotic criteria for use of the must be deemed a dhave one of the follobehavioral intervent care. The document the notation he had symptoms of demer On 6/15/22, the questwice daily and the 500 mg three times On 6/18/22, he three medication pass and except the one for properties of the one for	nt had dementia and an order of medication. In order to meet the medication, the resident stanger to himself or others and cowing: mania or psychosis or the trions attempted or refusal of the trions attempted to 25 mg divalproex was increased to daily.  The trions attempted or refusal of the trions attempted to the trions attempted to the trion attempted to the trion after lunch, he tried to hit the sed his bedtime medications.  The trions attempted or refusal of the trions attempted to the trions atte			

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155521		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 08/12/2022	
	PROVIDER OR SUPPLIER		1912 S	ADDRESS, CITY, STATE, ZIP COD PARK AVE NDRIA, IN 46001	•
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	PRIATE COMPLETION
TAG		er with delusions and order.	TAG	Janeare.	DATE
	On 7/20/22, he refu	sed his bedtime medications.			
	On 7/23/22, he was during cares.	kicking and punching staff			
	On 7/24/22, he hit a cares.	CNA in the chest during			
	been combative and medications over th delusions or halluci of schizoaffective d	ric NP note indicated he had I refused to eat or take his e past week. He had no nations. He had a diagnosis isorder, depressive type, with symptoms, but no recent I thoughts.			
	On 7/27/22, he refu	sed restorative exercises.			
	2.5 centimeter (cm) 0.1 cm depth (D) ab	long (L) x 2.3 cm width (W) x brasion to his right foot with a se with slough and irregular			
	1.2 cm L x 1.3 cm V	ssessment indicated he had a W x 0.3 cm D skin tear to his right ous exudate and a yellow			
	· ·	ne physical during a shower e note indicated three CNAs the shower.			
	31 indicated Reside delusions or halluci	nt 5 did not have any nations, but did have lots of not want to do things because			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155521		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/12/2022	
	PROVIDER OR SUPPLIEF		1912 S	ADDRESS, CITY, STATE, ZIP COD PARK AVE NDRIA, IN 46001	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B: CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION
TAG	of pain, but the nurs pain. Sometimes if coming to visit, he of Other times, he just. During an interview 32 indicated the ress was approached about initially be okay with mind. His foot wou he would become registed in the part of the would become registed in the part of the would be restricted in the would be restricted in the would be restricted in the part of the would be restricted in the part of the would be restricted in the work of the wor	Ses say they're managing his syou told him his family was would allow care to be done. needed re-approached.  7, on 8/12/22 at 9:07 a.m., CNA ident was confused. When he but getting dressed, he would that it, then he would change his ands would upset him, and then esistant to care. A lot of it was the may be grumpy and not res. She was not aware of him ings. He may cuss you one and love you the next.  7, on 8/12/22 at 9:30 a.m., the esident would cry at times, or his old times. He would think the facility when they weren't or the shouldn't have. She was the resident's signs of dementia its signs and symptoms of order were. He received the cation for schizoaffective  1. facility policy titled C MEDICATION/GRADUAL N," dated September 2017 and rese Consultant on 8/12/22 at d the following: "Since not warrant the use of cations, the clinical condition cast one of the following oms are identified as being due	TAG		DATE
l	l sincinainc sympt	onio are racinifica as being auc	- 1	1	

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/14/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF C	CORRECTION	IDENTIFICATION NUMBER		ILDING	00	COMPL	
		155521	B. WI	NG		08/12/	2022
NAME OF PROV	VIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
	RIA CARE CENTE				PARK AVE NDRIA, IN 46001		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	DROWDENG DLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
sy ot th fo si; di	ymptoms present a thersThe sympton he resident is exper- following: inconsola	isdelusionsThe behavioral danger to the resident or to ms are significant enough that iencing one or more of the able or persistent distressa in function; and/or substantial needed care"					
F 0755 SS=D Bldg. 00 Si \$2 Th er de pe dr ge dr ge m lice s2 m s2 m lice s4	83.45(a)(b)(1)-(3) Pharmacy Pharmacy Procedures/ 483.45 Pharmacy The facility must procedures of the facility must procedure of the facility must procedure of the facility must procedure of the facility of the facility.  83.45(a) Procedure of the facility of the facility.  83.45(b) Service of the procedure of the facility.  83.45(b)(2) Esta	Pharmacist/Records y Services rovide routine and and biologicals to its n them under an agreement 70(g). The facility may personnel to administer permits, but only under the n of a licensed nurse.  dures. A facility must utical services (including sure the accurate g, dispensing, and I drugs and biologicals) to each resident.  e Consultation. The facility stain the services of a					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE	DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	ETED
		155521	B. W	NG		08/12	/2022
				_	_		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
					PARK AVE		
ALEXAN	DRIA CARE CENTI	ER		ALEXA	NDRIA, IN 46001		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	an accurate recor	nciliation; and					
	§483.45(b)(3) Det	ermines that drug records					
		nat an account of all					
	controlled drugs is	s maintained and					
	periodically recon-	ciled.					
	Based on interview and record review, the facility failed to provide ordered medications for 1 of 7		F 0'	755	1. Resident 40 is no longer at	the	08/29/2022
					facility and had been discharg		
	residents reviewed	for medication use. (Resident			prior to this annual survey.		
	40)						
					2. All residents have the poter	ntial	
	Findings include:				to be affected. Each residents	S	
					medication orders have been		
	Resident 40's clinical record was reviewed on				reviewed and medications verified		
	8/11/22 at 11:06 a.m. The resident was admitted to				to be in house and utilized at t	this	
	the facility on 6/1/2	22 and discharged 6/6/22.	time.				
		on orders for 6/1/22 included,			3. The facility's policy		
		to, quetiapine (antipsychotic)			Medications; obtaining from		
	50 mg daily at bedt	ime.			pharmacy for new admissions	and	
					readmissions has been review	ved	
	-	d 6/2/2022 from the Nurse			and no changes are indicated		
		dicated quetiapine 50 mg was			this time. The facility's nurses		
	ordered.				and QMAs have been educate		
					the policy with a special focus		
		ninistration record (MAR)			ensuring all medications were		
		dicate the resident was given			delivered by the pharmacy and		
		ine on 6/1/22. On 6/2/22, the			currently in use. A monitoring	tool	
		with a notation added to the			has been implemented.		
		nich indicated the resident did					
		ine due to a lack of supply. On			4. The DON or designee will be		
		he initials were circled on the			responsible for completing the	<del>)</del>	
		th a lack of documentation			monitoring tool to ensure		
	indicating why the	initials were circled.			medications are delivered from		
					pharmacy in a timely manner.		
		ers lacked an order to hold the			This monitoring will occur on		
		an alternative during the			scheduled work days as follow		
	resident's stay.				daily for two weeks, weekly fo		
					weeks, monthly for two month		
	The nurses' notes la	cked documentation that			then quarterly thereafter. Sho	uld a	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155521  NAME OF PROVIDER OR SUPPLIER  A. BUILDING B. WING  STREET ADDRESS, CITY, STATE, ZIP COD 1912 S PARK AVE ALEXANDRIA CARE CENTER  (X4) ID  SUMMARY STATEMENT OF DEFICIENCIE  ID  NOUVERS NAME OF CORRECTION  (X5)	STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
155521  NAME OF PROVIDER OR SUPPLIER  ALEXANDRIA CARE CENTER  STREET ADDRESS, CITY, STATE, ZIP COD 1912 S PARK AVE ALEXANDRIA, IN 46001  (X4) ID  SUMMARY STATEMENT OF DEFICIENCIE  ID  (X5)	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
NAME OF PROVIDER OR SUPPLIER  ALEXANDRIA CARE CENTER  STREET ADDRESS, CITY, STATE, ZIP COD  1912 S PARK AVE  ALEXANDRIA, IN 46001  (X4) ID  SUMMARY STATEMENT OF DEFICIENCIE  ID  (X5)			155521	B. WI	NG		08/12/	/2022
NAME OF PROVIDER OR SUPPLIER  ALEXANDRIA CARE CENTER  1912 S PARK AVE  ALEXANDRIA, IN 46001  (X4) ID  SUMMARY STATEMENT OF DEFICIENCIE  ID  (X5)					_			
ALEXANDRIA CARE CENTER  ALEXANDRIA, IN 46001  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5)	NAME OF J	PROVIDER OR SUPPLIER	8					
(X4) ID SLIMMARY STATEMENT OF DEFICIENCIE ID (X5)								
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5)	ALEXAN	DRIA CARE CENTI	ER		ALEXAI	NDRIA, IN 46001		
PROVIDER'S PLAN OF CORRECTION	(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CEACH CORRECTIVE ACTION SHOULD BE COMPLETION	PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤΕ	COMPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE	TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
quetiapine was not given. Documentation of concern be found, immediate		quetiapine was not	given. Documentation of			concern be found, immediate		
pharmacy, physician, family, or Director of corrective action will occur.		pharmacy, physicia	n, family, or Director of			corrective action will occur.		
Nursing (DON) notification of quetiapine's Results of this monitoring and any						Results of this monitoring and	any	
unavailability was lacking. corrective action will be reviewed		unavailability was lacking.				corrective action will be review	ved	
during the facility's QA meetings						during the facility's QA meetin	gs	
During an interview, on 8/11/22 at 2:22 p.m., the on an ongoing basis for a		During an interview	y, on 8/11/22 at 2:22 p.m., the			on an ongoing basis for a		
Nurse Consultant indicated when initials are minimum of six months. The plan		Nurse Consultant in	ndicated when initials are			minimum of six months. The	plan	
circled on the MAR, there should be a note on the will be adjusted by increasing or		circled on the MAR	t, there should be a note on the			· ·		
front or back of the page that indicated why a decreasing the monitoring until		front or back of the	page that indicated why a			decreasing the monitoring unt	il	
medication was not given. 100% compliance is achieved.		medication was not	given.					
						·		
During an interview, on 8/11/22 at 2:56 p.m., the		During an interview	y, on 8/11/22 at 2:56 p.m., the					
Nurse Consultant indicated she had spoken with		Nurse Consultant in	ndicated she had spoken with					
the pharmacy. Quetiapine was not sent and was		the pharmacy. Quet	iapine was not sent and was					
not in the emergency drug kit (EDK). Quetiapine		not in the emergence	y drug kit (EDK). Quetiapine					
was not given to the resident from 6/1/22 through		was not given to the	e resident from 6/1/22 through					
6/5/22 because of lack of supply. She indicated		6/5/22 because of la	ack of supply. She indicated					
the DON usually followed up when medications		the DON usually fo	llowed up when medications					
were not available. If a medication is unavailable		were not available.	If a medication is unavailable					
for greater than 72 hours, the chart is audited.		for greater than 72 l	hours, the chart is audited.					
During an interview, on 8/12/22 at 10:08 am.,		During an interview	an 9/12/22 at 10:09 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								
								1
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.		the physician and fa	amily notification.					
During an interview, on 8/12/22 at 11:07 a.m., RN		During an interview	v, 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								1
documented on the back of the MAR. The family								
and doctor should be notified. The pharmacy			-					

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/14/2022 FORM APPROVED OMB NO. 0938-039

		IDENTIFICATION NUMBER  155521		UILDING	00	COMPL 08/12/	ETED
	PROVIDER OR SUPPLIER		•	1912 S	DDRESS, CITY, STATE, ZIP COD PARK AVE NDRIA, IN 46001		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
F 0758 SS=D Bldg. 00	status. She indicated required preauthorization.  A current policy, tittle from pharmacy for a readmissions" and p Consultant on 8/12/2 This facility will is medication is obtain as possible following 3.1-25(a)  483.45(c)(3)(e)(1)-Free from Unnec Four Use §483.45(c)(3) A psecurity of the following category include, but the following category includes the follow	rovided by the Nurse 22 at 10:38 a.m., indicated " implement measures to ensure ited for administration as soon g resident admission"  (5) Psychotropic Meds/PRN  otropic Drugs. sychotropic drug is any rain activities associated asses and behavior. These are not limited to, drugs in pories:  t; ind  ehensive assessment of a y must ensure that idents who have not used as are not given these drugs tion is necessary to treat a as diagnosed and a clinical record;					

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PRINTED: 09/14/2022 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES  STATEMENT OF DEFICIENCIES   X1) PROVIDER/SUPPLIER/CLIA					OMB NO. 0938-039	
	NT OF DEFICIENCIES I OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155521	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction (	(X3) DATE SURVEY COMPLETED 08/12/2022	
	PROVIDER OR SUPPLIE		1912 S	ADDRESS, CITY, STATE, ZIP COD S PARK AVE NDRIA, IN 46001		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	(X5) COMPLETION DATE	
	psychotropic drug reductions, and bunless clinically of to discontinue the §483.45(e)(3) Repsychotropic drug unless that medic a diagnosed specific documented in the §483.45(e)(4) PR drugs are limited provided in §483. physician or presthat it is appropriate extended beyond document their ramedical record and the PRN order.  §483.45(e)(5) PR drugs are limited renewed unless the prescribing practifor the appropriate Based on observative review, the facility not receive psychological indication for 3 of unnecessary medical.	gs receive gradual dose behavioral interventions, contraindicated, in an effort esse drugs;  sidents do not receive gs pursuant to a PRN order cation is necessary to treat cific condition that is the clinical record; and the clinical record to 14 days. Except as the control of the PRN order to be the control of the PRN order to be the clinical in the resident's and indicate the duration for the control of the con	F 0758	1. Residents 31, 33, and 5 did a experience any negative outcorrelated to this alleged deficient practice. Their clinical records have been reviewed which inclumedication orders, diagnoses, behaviors the resident is experiencing. Behaviors are be documented in an effort to supply the use of psychotropic medications and/or the	not 08/29/2022 me udes and eing	

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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

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medication.

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medications have been reduced in an attempt to discontinue the

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155521	B. W	ING		08/12/	
NAME OF I	ROVIDER OR SUPPLIER	<b>t</b>			ADDRESS, CITY, STATE, ZIP COD		
A1 = X A A I		-D			PARK AVE		
ALEXAN	DRIA CARE CENTI	EK		ALEXA	NDRIA, IN 46001		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	wheel-chair in the d	lining room.					
					2. All residents receiving		
	Her clinical record	was reviewed on 8/9/22 at 11:16			psychotropic medications hav	e the	
	a.m. Diagnoses incl	luded, but were not limited to,			potential to be affected. Their	r	
	Alzheimer's disease, dementia with behavioral				clinical records have been		
	disturbance, anxiety, delusional disorder,				reviewed which includes		
	psychotic disorder with hallucinations and				medication orders, diagnoses	, and	
	schizoaffective disorder.				behaviors the resident is		
					experiencing. Behaviors are	being	
	Current physician o	orders included, but were not			documented in an effort to su	pport	
	limited to the following:				the use of psychotropic		
					medications and/or the		
	a. Buspar (anti-anxiety) 5 mg, one tablet three				medications have been reduc	ed in	
	times a day for anxiety, the order date was 2/16/22.				an attempt to discontinue the		
					medication.		
	b. Risperdal (anti-p	osychotic) 0.5 mg (milligram),					
	one tablet at bedtim	e for psychotic disorder with			3. The facility's policy for		
	hallucinations, the	order date was 2/22/22.			Antipsychotic Medication/GDF	₹	
					has been reviewed and no		
		MDS (Minimum Data Set)			changes are indicated at this		
	assessment indicate	ed she had moderate cognitive			time. Facility staff have been		
	impairment and had	l not had any behaviors during			educated on the policy with a		
	-	od. She had received an			special focus on using		
		anti-anxiety medication			non-pharmacological interven	tions	
		e assessment period. The			if possible prior to utilizing a		
		been received on a routine			psychotropic medication and		
		not been an attempt of a GDR			indicated, to document negati	ve	
	(Gradual Dose Red	uction).			behaviors in such a manner th	nat	
					would support the use of		
	-	, with a revised date of 8/8/22,			psychotropic medications as		
		ited verbal behavioral			indicated. A monitoring tool h	as	
		towards others such as,			been implemented.		
		screaming at others, cursing at					
		lling. Interventions included,			4. The Social Service Director		
		d to, attempt to use diversion,			designee will be responsible f		
		ientation to calm her, such as			completing the monitoring too	l to	
	singing and talking	with staff.			ensure non-pharmacological		
					interventions are being used,		
		, with a revised date of 8/8/22,			psychotropic medications are		
	indicated she suffer	red from delusions (fixed false			used on a minimal basis as		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155521	B. W	ING		08/12/	2022
				_			
NAME OF P	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
					PARK AVE		
ALEXAN	DRIA CARE CENT	ER		ALEXA	NDRIA, IN 46001		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	· ·	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		nentia as evidenced by false			indicated, and supporting		
		s on fire, a gas leak and son			behaviors are documented if		
	_	terventions included, but were			receiving a psychotropic		
	_	ly explain that belief was false				:11	
	_	ence to prove why it was not			medication. This monitoring w		
		-			occur on scheduled work days	as	
	true and administer	r medications as ordered.			follows: daily for two weeks,	,	
					weekly for two weeks, monthly	/ tor	
		rior communication memo,			two months, then quarterly		
		00 a.m., indicated she had made			thereafter. Should a concern		
	1 -	ations and hallucinations,			found, immediate corrective a	ction	
	thought there was a dog and kept yelling for the				will occur. Results of this		
	dog. Interventions attempted included toileting,				monitoring and any corrective		
provided liquids, quiet environment, snack,				action will be reviewed during	the		
	allowed her to vent her feelings and provided her				facility's QA meetings on an		
		mfort, the behavior was			ongoing basis for a minimum of	of	
	unchanged.				six months. The plan will be		
					adjusted by increasing or		
		ior communication memo,			decreasing the monitoring unt	il	
	dated 5/9/22 at 4:00	0 a.m., indicated she had made			100% compliance is achieved		
	negative statements	s, repetitive verbalizations and					
	hallucinations she	was getting bit by rats.					
	Interventions attem	npted included toileting, placed					
	in chair or bed and	given time to calm and then					
	re-approached, the	behavior was unchanged.					
	A mood and behav	ior communication memo,					
	dated 5/19/22 at 3:0	00 a.m., indicted she had made					
	negative statements	s, restlessness, repetitive					
	verbalizations, repe	etitive concerns, verbally					
	aggressive, rejection						
		icinations and delusions. She					
		o the bathroom, interventions					
	_	provided relaxation technique					
	_	nent, one on one, allowed her to					
	_	edirection, the behavior was					
	unchanged.						
	anonangou.						
	A Social Service A	assessment, dated 6/10/22,					
		e disorder with hallucinations,					
	anxiety, recurrent of	depressive episodes,					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155521	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	COM	TE SURVEY  MPLETED  12/2022
	PROVIDER OR SUPPLIEF		1912 S	ADDRESS, CITY, STATE, ZIP S PARK AVE NDRIA, IN 46001	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
TAG	Alzheimer's disease deficit. Behavioral implementation to a disorders and confuupdated.  A Psychiatry Programidicated dementia: appropriate behavior psychotherapeutic of and psychological sof visual hallucinate that cause fear, tear recently reported, secontinue Risperdal  A mood and behavior dated 7/19/22 at 2:00 crying/tearfulness at on one was provide	e and attention/concentration symptoms and and care plan address behaviors: delusional sion. Care plans reviewed and  ess Note, dated 6/28/22, no medication, continue oral interventions and communication. Behavioral symptoms of dementia: history cons and delusional thoughts fulness and anxiety, none symptoms appeared stable and 0.5 mg every bedtime.  or communication memo, 00 p.m., indicated nd wanted to go home. One d with her as well as infort, the interventions did	TAG	DEFICIENCE		DATE
	indicated dementia: appropriate behavior psychotherapeutic of Schizoaffective discourrent medication behaviors and discu Nursing), pharmacy Services, contraind. Risperdal as a reduce symptoms of psych have delusional tho that caused hear and were less frequent.  A mood and behavior	no medication, continue oral interventions and communication.  order: GDR- after reviewing therapy as well as recent assion with DON (Director of a Administration, and Social acating any dose reduction of action would likely increase assis and anxiety, continued to aughts about rats getting her anxiety. Delusional thoughts  or communication memo, 6:00 to 10:00 p.m., indicated she				

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155521	CATION NUMBER A. BUILDING <u>00</u>		(X3) DATE SURVEY COMPLETED 08/12/2022	
	PROVIDER OR SUPPLIEF		1912 S	ADDRESS, CITY, STATE, ZIP COD PARK AVE NDRIA, IN 46001	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE	
	had disturbed other seeing rats and wor the street. Had been toileted, relaxation one on one, convers then re-approach an urinalysis results in infection, physician A Psychiatry Progresindicated dementia: appropriate behavior psychotherapeutic consymptoms appears at three times a day. So symptoms appeared mg every bedtime.  During an interview indicated the reside happy noises, had ywas on fire, re-direct usually helped.  Cross Reference F6  2. During an obsert Resident 33 was sit across from the nur.  On 8/11/22 at 8:56 shower room and in this clinical record of a.m. Diagnoses includementia with behat aggression, depress schizoaffective discontinuation.	residents by yelling out about ried about children playing in provided snacks and water, techniques, quiet environment, tation of interest, time to calm d redirection. Possible trigger: dicated an urinary tract to be notified on 7/21/22.  The sess Note, dated 7/26/22, no medication, continue aral interventions and communication. Anxiety: able, continue Buspar 5 mg chizoaffective disorder: a stable, continue Risperdal 0.5  To on 8/12/22 at 8:46 a.m., RN 14 and usually sang and made elled out that the building tring and distracting her  44 and F744  The vation, on 8/9/22 at 3:16 p.m., tring in a chair in the lounge sees' station.  The was assisted out of the to the lounge area.  The was reviewed on 8/9/22 at 10:43 and disturbance, physical ion, anxiety and				

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155521	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	COM	TE SURVEY  IPLETED  12/2022
	PROVIDER OR SUPPLIER		1912 S	ADDRESS, CITY, STATE, ZIP PARK AVE NDRIA, IN 46001	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
TAG	a. Buspar 10 mg, o anxiety, the order decorated 1 mg, dementia with behadate was 9/28/21.  c. Zoloft (anti-depression A 7/1/22 quarterly had severe cognitive any hallucinations of assessment period. I directed towards off occurred 1 to 3 days period. He had rece anti-depressant and everyday during the anti-psychotic had basis and there had A current care plan, indicated he was at	wing:  me tablet three times a day for ate was 8/24/21.  one tablet twice a day for vioral disturbance, the order  essant) 25 mg, one tablet daily 50 mg tablet to equal 75 mg, the order date was 6/15/22.  MDS assessment indicated he enimpairment. He had not had or delusions during the Physical behavioral symptoms hers and rejection of care had a during the assessment ived an anti-psychotic, anti-anxiety medication assessment period. The been received on a routine mot been an attempt of a GDR.  with a revised date of 7/13/22, risk for delirium or acute	TAG	DEFICIENCY		DATE
	disorder as evidence disorganized thinkin consciousness. The were not limited to, of delirium such as: thinking, altered lev psycho-motor retard and administer med A current care plan, indicated he require	ng and altered level of interventions included, but monitor for signs or symptoms inattention, disorganized rel of consciousness, lation and acute confusion				

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155521	ľ	JILDING	nstruction <u>00</u>	(X3) DATE : COMPL 08/12/	ETED
	ROVIDER OR SUPPLIER DRIA CARE CENTE			1912 S	NDDRESS, CITY, STATE, ZIP COD PARK AVE NDRIA, IN 46001		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
TAG	behaviors and schiz Interventions include observe for change  A current care plan, indicated he present dementia with beha of the following me aggressive behavior and grabbing. Intervention indicated to, encous such as: (List). The of interest.  A current care plan, indicated he exhibit symptoms directed pushing, grabbing a Interventions include psychotropic medic  A Social Service As indicated schizoaffe	oaffective disorder. led, but were not limited to, in mood or behavior.  with a revised date of 8/8/22, ted with a primary diagnosis of viors and may exhibit any or all rod and behavior challenges: rs, hitting other and pushing ventions included, but were urage activities of interest care plan did not list activities  with a revised date of 8/8/22, red physical behavioral towards others such as: nd hitting others. led, but were not limited to,		TAG	DEPICIENCY		DATE
	depression and anximg for depression, make the depression, make the depression, make the depression and anximg for depression. A Psychiatry Program indicated no behavior since last visit, no make the depression and appear standpoint. Schizoa	ety. Medications: Zoloft 75 Risperdal 1 mg for dementia					
	dated 7/25/22 at 7:4 found in another res	or communication memo, 0 p.m., indicated he had been sident's room and had been el movement, uncooperative					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155521	B. W	ING		08/12/	2022
				CED FIFT	DDDEGG CVTV CTATE JID COD		
NAME OF F	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP COD		
A. = \ (A. b.)	DDIA GADE GENE				PARK AVE		
ALEXAN	DRIA CARE CENTI	ER		ALEXA	NDRIA, IN 46001		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID PROVIDENCE NO LOCAL CONTROLLE		(X5)		
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
		bative hitting staff and					
		took two CNA's to complete					
	the shower and assi	-					
	the shower and assi	St IIII to occ.					
	A mood and behavi	or communication memo,					
		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						
		sically aggressive, tried to					
		e refused to sit anywhere, had					
		and refused to be changed,					
	1	one staff member on the					
		ntions had been attempted but					
	behavior was uncha	anged.					
	<b>.</b>	0/10/00 + 0.45 - DV.14					
	1	v, on 8/12/22 at 8:47 a.m., RN 14					
		iors were rejection of care,					
		ontinent care, give him time to					
		ch or change staff member					
	typically was effect	ive.					
		0/10/00 + 0.00					
	1	v, on 8/12/22 at 9:30 a.m., the					
		ctor indicated he did not have					
		ave aggression with care and					
	rejection of care.						
		544 and F7443. On 8/9/22 at					
		nt 5 was in his wheelchair in					
	room, chin to chest.	•					
		a.m., he was in his recliner in his					
	1	closed, holding a cup in his					
	left hand halfway to	his mouth and a spoon in his					
	right hand.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING  155521 B. WING			onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 08/12/2022	
	PROVIDER OR SUPPLIER DRIA CARE CENTI		1912 S	ADDRESS, CITY, STATE, ZIP COD S PARK AVE ANDRIA, IN 46001	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	asleep.	p.m., he was in his recliner,			
	On 8/11/22 at 10:15 a.m. he was asleep in bed with the room dark.				
		a.m., he was up in his ning area, eating breakfast.			
	at 10:37 a.m. Diagramited to, chronic swith behaviors, maj	record was reviewed on 8/9/22 noses included, but were not systolic heart failure, dementia or depressive disorder, e disorder, and mood disorder.			
	limited to, desvenla daily, quetiapine (an and 50 mg at bedtin	rders included, but were not fax (anti-depressant) 50 mg nti-psychotic) 25 mg in a.m. ne, tramadol (pain medication) and divalproex (mood stabilizer) daily.			
	he was severely cog fluctuating behavior had no psychosis, b behaviors 1-3 days	y, MDS assessment indicated entitively impaired and had a r of disorganized thinking. He to that verbal and physical of the assessment period. He assistance for mobility, the.			
	8/8/22, of rejection treatments, ADL as Interventions include approach from the fresident by his name visit, allow time to needed, praise effor	re plan problem, reviewed of care such as medication, sistance, and bathing. led, but were not limited to, front in a calm manner, call the e, explain the purpose of the calm down and reapproach as ts, attempt to determine the and seek solutions if able, and			

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AND PLAN OF CORRECTION 155521  A. BUILDING B. WING COMPLETED 08/12/2022  NAME OF PROVIDER OR SUPPLIER  ALEXANDRIA CARE CENTER  ALEXANDRIA CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MIST BE PRECEDED BY PULL. TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG REGULATORY OR LSC IDENTIFYING INFORMATION 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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	LTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
NAME OF PROVIDER OR SUPPLIER  ALEXANDRIA CARE CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  A current care plan problem, reviewed 8/8/22, indicated he had agitation and aggression. Interventions included, but were not limited to, allow to calm down, music, massage or exercise to calm, praise compliance, and psychiatric medications to reta 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 somewhat important to the resident to have his daily preferences somewhat important to the resident to bave his daily preferences honored. He preferred to sleep in and go to bed at 11:00 p.m.							· ′	
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He preferred to sleep in and go to bed at 11:00 p.m.			_					
p.m.								
		-	p in and go to oct at 11.00					
A raview of purses notes and behavior memos		1						
indicated the following:		indicated the follow	ving:					
On 5/3/22, he refused his medications.		On 5/3/22 he refue	ed his medications					
On 5/5/22, he refused his inedications.		On 5/5/22, he refus	ocu ms medications.					
On 5/4/22, he spit out his medications.		On 5/4/22, he spit of	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.		other staff to help lay him down and he tried						
mung mem as wen.		mung mem as wer	1.					
On 5/8/22 at 5:30 p.m., he started swinging at an		On 5/8/22 at 5:30 p	o.m., he started swinging at an					
aide while getting him ready for bed and was		_						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155521		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/12/2022		
	PROVIDER OR SUPPLIER		1912 S	ADDRESS, CITY, STATE, ZIP COD PARK AVE NDRIA, IN 46001	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
	"inches from hitting				
	On 5/9/22, he was s at her as well, durin	winging at an aide, and kicking g care.			
	On 5/18/22, an order was received to decrease the desvenlafax to 50 mg daily.				
	and kicking while s	using expletives and hitting taff was putting him to bed at tually calmed down and allowed I asleep.			
	lunging forward. H spoon of medication CNA took him to hi his request, but he has placed to the per and a discussion war psychiatric stay ver- emergency departmants been sitting in his real When asked if he we no. The behavior may was increased follow	p.m., he refused his as balling up his fists and the attempted to knock the as out of the nurses hand. A his room to put him to bed per that staff in the chest. A call sychiatric nurse practitioner as held regarding an inpatient sus sending him to the hent. As of 9:30 p.m., he had been and had calmed down. Franted to lay down, he yelled hemo indicated the quetiapine wing a failed dose reduction.			
	being verbally and prefused to be assisted	physically aggressive. He ed to bed.			
		ed his morning medications in a threatening manner and medications.			
		CNA in the stomach multiple 'NA's wrist and told the CNAs them.			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155521		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 08/12/2022	
	PROVIDER OR SUPPLIER DRIA CARE CENTI		1912 S	ADDRESS, CITY, STATE, ZIP COD PARK AVE NDRIA, IN 46001	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E COMPLETION
	indicated the resider for an anti-psychotic criteria for use of the must be deemed a dhave one of the follobehavioral intervent care. The documenthe notation he had symptoms of demer On 6/15/22, the quetwice daily and the 500 mg three times On 6/18/22, he three medication pass and except the one for pone of 7/13/22, he refusing and was agitated.  On 7/7/22, he refusing with min his room of 10 lunch. When to put him in his room her again.  On 7/13/22, he refusing on 7/14/22, he refusing indicated he was tired a 7/20/22 psychiatry visit for increased preduction of quetiant delusions or hallucide depression benefited.	etiapine was changed to 25 mg divalproex was increased to daily.  we a water cup on staff during direfused his medications vain.  sed his bedtime medications  et a shower or to get up. He directly his medications at the same staff member went om after lunch, he tried to hit  sed his bedtime medications.			

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155521	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	COM	TE SURVEY  TPLETED  12/2022
	PROVIDER OR SUPPLIER DRIA CARE CENT		1912 S	ADDRESS, CITY, STATE, ZIP CO PARK AVE NDRIA, IN 46001	OD	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
	current diagnoses in	nue the divalproex. His neluded, but were not limited ler with delusions and order.				
	On 7/20/22, he refu	sed his bedtime medications.				
	On 7/23/22, he was during cares.	kicking and punching staff				
	On 7/24/22, he hit a cares.	a CNA in the chest during				
	been combative and medications over the delusions or halluci of schizoaffective d	ric NP note indicated he had a refused to eat or take his the past week. He had no inations. He had a diagnosis disorder, depressive type, with symptoms, but no recent all thoughts.				
	On 7/27/22, he refu	sed restorative exercises.				
		me physical during a shower e note indicated three CNAs g the shower.				
	2.5 centimeter (cm) 0.1 cm depth (D) al	ssessment indicated he had a long (L) x 2.3 cm width (W) x brasion to his right foot with a te with slough and irregular				
	1.2 cm L x 1.3 cm	ssessment indicated he had a W x 0.3 cm D skin tear to his right rous exudate and a yellow				
	_	v, on 8/12/22 at 9:02 a.m., CNA ent 5 did not have any				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 B. WING			(X3) DATE SURVEY COMPLETED 08/12/2022				
	PROVIDER OR SUPPLIEI DRIA CARE CENT		1	912 S F	DDRESS, CITY, STATE, ZIP COD PARK AVE DRIA, IN 46001		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PRI	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
IAU	delusions or halluct behaviors. He did to of pain, but the nur pain. Sometimes if coming to visit, he Other times, he just During an interview 32 indicated the res was approached abinitially be okay wi mind. His foot won he would become r just his personality. During an interview 33 indicated the res resistant to care and get along with othe seeing or hearing the minute, then smile During an interview SSD indicated the restriction of the had done things not aware of what the were versus what he schizoaffective discanti-psychotic med disorder.  Review of a curren "ANTIPSYCHOTI DOSE REDUCTION provided by the Nutlo:38 a.m., indicated to the nutlo.38 a.m., indicated the nutlo.38 a.m., indicated to the nutlo.38 a.m., indicated	inations, but did have lots of not want to do things because ses say they're managing his Eyou told him his family was would allow care to be done. It needed re-approached.  In the sident was confused. When he cout getting dressed, he would the it, then he would change his ands would upset him, and then sesistant to care. A lot of it was					DATE
		cations, the clinical condition					

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155521	JILDING	nstruction <u>00</u>	(X3) DATE COMPL 08/12/	ETED
	ROVIDER OR SUPPLIER		1912 S I	DDRESS, CITY, STATE, ZIP COD PARK AVE NDRIA, IN 46001		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	must also meet at le criteriaThe sympt to mania or psychos symptoms present a othersThe sympto the resident is exper following: inconsola	ast one of the following oms are identified as being due sisdelusionsThe behavioral danger to the resident or to ms are significant enough that riencing one or more of the able or persistent distressa n function; and/or substantial				
	3.1-48(a)(1) 3.1-48(a)(4)					
F 0761 SS=D Bldg. 00	Drugs and biologic must be labeled in accepted profession the appropriate accepted					
	§483.45(h)(1) In a Federal laws, the and biologicals in under proper temp	ccordance with State and facility must store all drugs locked compartments perature controls, and ized personnel to have s.				
	separately locked, compartments for listed in Schedule Drug Abuse Preve 1976 and other drexcept when the fa	facility must provide permanently affixed storage of controlled drugs II of the Comprehensive ention and Control Act of ugs subject to abuse, acility uses single unit ribution systems in which				

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER	ì í	JILDING	00	COMPL		
		155521	B. WING		· · · · · · · · · · · · · · · · · · ·		2/2022	
				CTREET	ADDRESS CITY STATE ZID COD			
NAME OF P	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD PARK AVE			
ALEXANDRIA CARE CENTER					NDRIA, IN 46001			
	DINIA OAINE OEINT	LIX		ALLAA	14D1AA, II4 7000 I			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE	
		d is minimal and a missing						
	dose can be read			- < 1			00/00/00	
		on, interview, and record	F 0'	/61	1 & 2. There were no resident		08/29/2022	
	-	failed to ensure medications			affected by this deficient prac			
		hygienically stored during 2 of			but all residents have the pote			
		tions of the 100 and 200 hall			to be affected. Nurses, includ	•		
	unit.				RN 36, and QMAs have been			
	Findings include:				educated on storing medication	storing medications its appropriately in a		
	r manigs include:				locked cart.			
	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				IOUNEU UAIT.			
					3. The facility's policy for			
					Medication Administration has	3		
					been reviewed and no change	-		
					indicated at this time. Nurses			
		reflux), methotrexate			including RN 36, and QMAs h	-		
	(chemotherapy drug) 2.5 mg tablets, and				been educated on storing			
		ychotic) 50 mg tablets.			medications and treatments			
	_ · · •				appropriately in a locked cart.	Α		
	During an interview, on 8/8/22 at 9:23 a.m., RN 36 indicated she had been cleaning the cart out and				monitoring tool has been			
					implemented.			
	had left the medica	itions out.						
					4 The DON or designee will b			
		n observation, on 8/10/22 at 9:48			responsible for completing the	9		
		00 Hall treatment cart was			monitoring tool to ensure			
		and unattended at the nurses			medications and treatments a			
	station.				secured/locked at all times wh			
					not attended. This monitoring	•		
	-	tion of the cart, on 8/10/22 at			occur on scheduled work day			
		anied by the Regional			alternating shifts as follows:	•		
		op drawer of the cart contained,			for two weeks, weekly for two			
		I to, various open wound			weeks, monthly for two month			
		tes cut out, urine test strips,			then quarterly thereafter. Sho			
		tment) with no resident nac (anti-inflammatory)			concern be found, immediate			
					corrective action will occur.	Lony		
	_	I partially used phytoplex (skin nt with no resident identifiers,			Results of this monitoring and corrective action will be review	-		
	and an open contain				during the facility's QA meetir			
	(anti-microbial).	101 01 10003010			on an ongoing basis for a	iyə		
	(anti-inicional).				minimum of six months. The	nlan		
	i		1		I minimum of Six months. The	PIUII	1	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155521	A. BU	A. BUILDING 00  B. WING  GENERAL ADDRESS CITY STATE ZIP COD		(X3) DATE SURVEY COMPLETED 08/12/2022			
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1912 S PARK AVE ALEXANDRIA, IN 46001					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE		
mo	During an interview observation, the Re- cart should be kept			me	will be adjusted by increasing decreasing the monitoring unti 100% compliance is achieved.	I	BALL		
	"MEDICATION AI 4/2017 and provide 8/12/22 at 8:45 a.m "The top of a med free of any hazardor medicationsAlway before leaving it ou	DMINISTRATION," dated d by the Administrator on ., indicated the following: lication cart should be kept us material including ys lock the medication cart							
F 0773 SS=D Bldg. 00	§483.50(a)(2) The (i) Provide or obta when ordered by a assistant; nurse proposed including scope of (ii) Promptly notify physician assistant clinical nurse specifical nurse specificated of accordance with far procedures for no per the ordering p	an laboratory services only a physician; physician ractitioner or clinical nurse dance with State law, f practice laws. I the ordering physician, at, nurse practitioner, or cialist of laboratory results clinical reference ranges in acility policies and tification of a practitioner or hysician's orders.							
	failed to ensure laborand completed for 2 unnecessary medical Findings include:  1. Resident 35's clir 8/9/22 at 11:25 a.m	view and interview, the facility pratory orders were collected 2 of 5 residents reviewed for ations (Residents 35 and 5).  nical record was reviewed on . Diagnoses included, but were 2 diabetes (insulin dependent),	F 07	773	Resident 35 and 5 did not experience any negative outcorrelated to the alleged deficient practice. Resident 35's AIC widone on 8/23/22. Resident 5's order for urinalysis has been discontinued by the primary physician.      All resident with lab orders have any negative continued.	as s	08/29/2022		
	I not infined to, type	2 diaoctes (msumi dependent),	ı		∠. Ali resident with Iad orders f	iave			

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
		155521	B. WING			08/12/2022	
			<u> </u>	STDEET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF PROVIDER OR SUPPLIER					PARK AVE		
ALEXANDRIA CARE CENTER					NDRIA, IN 46001		
ALLAAN		LIX		ALLAA	TIDITIA, IN TOUCH		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
		vioral disturbance, and			the potential to affected. Thei	r	
	schizoaffective disc	order.			medical records have been		
		40/00 1 1 1			reviewed for the past 30 days	and	
		/10/20, physician order for a			if any labs were noted to be		
	_	est (to measure average blood			missing, the physician was		
		months in May, August,			contacted for further orders.	orders.	
	November, and Feb	oruary.			O The feelible as 18 18 1		
	The clinical mass 1	looked test results or indication			3. The facility's policy for Lab		
		lacked test results or indication			Orders-Timely Draws has bee		
	they had been comp	picied.			reviewed and no changes are indicated at this time. The nu		
	During on interview	y on 9/12/22 at 10:16 a.m. the					
	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				have been educated on the po with a special focus on obtain	-	
					labs as ordered. A monitoring	•	
	the hospital in July and had the test completed				has been implemented.	, 1001	
	there, but it had not been completed as ordered.				nas been implemented.		
	there, out it had not	decir completed as ordered.			4. The DON or designee will b	ne	
	2. Resident 5's clini	ical record was reviewed on			responsible to complete the	,0	
		. Diagnoses included, but were			monitoring tool to ensure labs	are	
		nic systolic heart failure,			done as ordered by the physic		
		viors, major depressive			This monitoring will occur on		
		e language disorder, and mood			scheduled work days as follow	vs:	
	disorder.				daily for two weeks, weekly fo		
					weeks, monthly for two month		
	On 7/7/22, he had a	nn order for a urinalysis with			then quarterly thereafter. Show		
	culture and sensitiv	ity if indicated. There was no			concern be found, immediate		
	indication in the cli	nical record the specimen had			corrective action will occur.		
	been collected.				Results of this monitoring and	any	
					corrective action will be reviev	ved	
		an order for a urinalysis.			during the facility's QA meetin	gs	
		ermittent catheterization was			on an ongoing basis for a		
		ere was no indication in the			minimum of six months. The	plan	
	clinical record the s	specimen had been collected.			will be adjusted by increasing		
					decreasing the monitoring unt		
		v, on 8/9/22 at 10:16 a.m., the			100% compliance is achieved		
		ndicated the urinalysis tests					
	had not been compl	leted.					
		t facility policy titled					
	"LABORATORY (	ORDERS, TIMELY DRAWS,"	1				İ

DEPARTMENT OF HEALTH AND HUMAN SERVICE	ES
CENTERS FOR MEDICARE & MEDICAID SERVICE	ES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X				(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	A. BUILDING <u>00</u>			COMPLETED		
155521			B. Wl	B. WING			08/12/2022	
NAME OF PROVIDER OR SUPPLIER  ALEXANDRIA CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP COD 1912 S PARK AVE ALEXANDRIA, IN 46001				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODE TAG DEFICIENCY)		BE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION				DATE		
dated 10/2014 and provided by the Regional								
	Director on 8/12/22 at 11:13 a.m., indicated the							
	following: "Labora	tory testing shall be conducted						
in a timely manner"								
	3.1-49(f)(1)							

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