STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155816	A. BUILDING 00 B. WING	04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ARLINGTON PLACE HEALTH CAMPUS	1635 N ARLINGTON AVE INDIANAPOLIS, IN 46218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00406352, IN00406606, IN00406932, and IN00406986. Complaint IN00406352 - Federal/state deficiencies related to the allegations are cited at F0580 and F0695. Complaint IN00406606- Federal/state deficiencies related to the allegations are cited at F0760. Complaint IN00406932- No deficiencies related to the allegations are cited Compliant IN00406986- No deficiencies related to the allegations are cited. Unrelated deficiencies are cited. Survey dates: April 24, 25, and 26, 2023 Facility number: 013005 Provider number: 155816 AIM number: 201256400 Census Bed Type: SNF/NF: 29 SNF: 15 Total: 44 Census Payor Type: Medicare: 17 Medicaid: 24 Other: 7 Total: 44 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 28, 2023	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during complaint survey conducted on April 26, 2023. Please accept this Plan of Correction as the provider's credible allegation of compliance as of May 12, 2023. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amie Groce	RN	05/11/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, interview and record review, the facility failed to have the interdisciplinary (IDT) team determine and document timely that self administration of medications and treatments were clinically appropriate for 1 of 3 residents randomly observed during review of dialysis. (Resident E) Findings include: The clinical record for Resident E was reviewed on 4/25/23 at 11:45 a.m. The resident's diagnosis included, but was not limited to, end stage renal disease. An observation of Resident E in his room was made on 4/25/23 at 12:23 p.m. The resident's bedside table was observed with the following medications: 1 bottle of Robitussin, 1 bottle of Tums and a foiled package with yellow-white in color pill medications. An interview was conducted with Resident E at that time. He indicated the nursing staff were aware of medications in his room. The resident's family brought in the medications, so he could take for stomach ache and cough. The resident placed foil package of pills in his drawer. The resident's clinical record did not indicate the IDT team had determined the resident was able to store and take the medications observed at his bedside safely without the assistance of nursing staff.	F 0554	Resident E had self-medication administration assessment completed. Residents who self-administer medications have the potential to be affected. DHS or designee will complete an audit of in-house residents with orders to self-administer medications to ensure assessments are completed. As a measure of ongoing compliance DHS or designee will educate the licensed nursing staff on the policy of self-medication administration. DHS or designee will be responsible for auditing residents with orders for self-administer medications to ensure assessments are completed per policy. Audit of 5 residents will be conducted 2 times a week times 4 weeks, every 2 weeks times 2 months, monthly times 3 months and until continued compliance is maintained for 2 consecutive quarters (six months). The results of these audits will be reviewed by the QAPI committee overseen by the ED. For quality assurance, The ED and/or designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The	05/12/2023

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	An interview was conducted with License Practical Nurses (LPN) 3 at 4/25/23 at 12:35 p.m. He indicated he was Resident E's nurse and was unaware Resident E had medications in his room. An interview was conducted with the Director of Nursing on 4/25/23 at 12:38 p.m. She indicated after reviewing of Resident E's chart, she was unable to locate a self medication assessment that had been conducted to determine if Resident E could self administer medications. She will have Resident E assessed for self administer medications. A "Self-Administration of Medication" policy was provided by the Director of Nursing on 4/25/23 at 1:37 p.m. IT indicated "...Purpose: To ensure the safe administration of medication for residents who request to self-medicate or when self-medication is a part of their plan of care. Procedures 1. Residents requesting to self-medicate or has self-medication as a part of their plan of care shall be assessed using the observation Trilogy-Self Administration of Medication within the electronic health record. Results of the assessment will be presented to the physician for evaluation and an order for self-medication. a. The order should include the type of medication(s) the resident is able to self-medicate,...2. The resident and/or family/responsible party will be informed of the results of the assessment and whether the resident has been determined to safely self-administer medications. 3. The medication will be kept in a locked drawer in the resident's room. The resident will maintain the key, as well as, a key will be maintained by the license nurse and or QMA [Qualified Medication Aide]....6. A Self-Medication plan of care will be initiated and updated as indicated. 7. The Assessment will be		plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns noted and will decrease the frequency of audits if no concerns noted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	

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	reviewed quarterly, and PRN [as needed] with change of condition. 8. The assessment will be documented in the EHR [electronic health record]..." 3.1-11			
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate			

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	assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).			
	Based on interview and record review, the facility failed to timely notify the medical provider of a chest x-ray result for 1 of 3 residents reviewed for change of condition. (Resident D) Findings include: The clinical record for Resident D was reviewed on 4/24/23 at 11:30 a.m. The resident's diagnoses included, but were not limited to, sepsis and pneumonia. A medical provider visit note from Nurse Practitioner 10 dated 4/4/23 indicated Resident D "...now has increased BLE [bilateral lower extremities] edema, and SOB [shortness of breath] that is more than normal. She is on 3 liters of oxygen per NC [nasal cannula]. She had cold symptoms last week, now no longer has cough, but feels worse, she has diffuse wheezing. She appears ill...Will obtain CXR [chest X-ray] and	F 0580	Resident D has discharged. Residents who have in house chest x-rays have the potential to be affected by the alleged deficient practice. DHS or designee will complete an audit of in-house residents with chest x-rays completed in house to ensure results have been communicated to the provider. As a measure of ongoing compliance DHS or designee will educate the licensed nursing staff on the policy of provider notification. DHS or designee will be responsible for auditing residents with orders for in house chest x-rays to ensure the provider was timely notified of result. Audit of 5 residents will be conducted 2 times a week times 4 weeks,	05/12/2023

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	labs. Added Torsemide for edema. A Radiology report dated 4/4/23 at 8:24 p.m., for Resident D indicated a chest x-ray had been obtained, and the results were bilateral pneumonia in the lungs. An interview was conducted with License Practical Nurse (LPN) 11 on 4/45/23 at 3:16 p.m. She indicated she was Resident D's evening shift nurse on 4/4/23. The radiology service company had obtained the chest x-ray on her shift that day. She had not seen the results come through at the nurse's station fax machine. She was unaware the results had been faxed to the facility that evening. Normally, she would have entered the results in Tele med (electronic service for providers). An interview was conducted with Registered Nurse (RN) 9 on 4/25/23 at 4:28 p.m. He indicated he was unaware of Resident D's change of condition, and an chest x-ray was obtained for suspicion of pneumonia. He would have followed up for the radiology report results if he was aware. An interview was conducted with Nurse Practitioner 10 on 4/25/23 at 3:32 p.m. She indicated she would have liked to have been notified regarding the radiology report Resident D had pneumonia in her lungs. An interview was conducted with the Director of Nursing on 4/26/23 at 8:49 a.m. She indicated the radiology report result was faxed in the administration office instead of nurse's station fax machine. The nursing staff do have access to that office. The radiology service company was not located in Indiana and results were reported at 9:24 p.m., instead of 8:24 p.m., due to the service location was an hour behind Indiana time.		every 2 weeks times 2 months, monthly times 3 months and until continued compliance is maintained for 2 consecutive quarters (six months). The results of these audits will be reviewed by the QAPI committee overseen by the ED. For quality assurance, The ED and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns noted and will decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	

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	A physician provider notification policy was provided by the Director of Nursing on 4/25/23 at 3:10 p.m. It indicated "..Purpose. To ensure the resident's physician or practitioner (may include NP [Nurse Practitioner], PA [Physician Assistant], or clinical nurse specialist) is aware of all diagnostic testing results or change in condition in a timely manner to evaluate condition for need of provision of appropriate interventions for care. Procedures. 1. Resident assessments for change in condition,...or ordered lab and/or other diagnostic tests should be completed in a timely manner. 2. The provider should be notified of critical lab results or an immediate need by phone as soon as the results are known with a response received before the call is completed when possible...3. Prompt notification to practitioner of radiology results that fall outside of clinical normal reference range, or reference range for resident...6. During non-office hour times the nurse should notify the physician/provider by phone of abnormal lab results or the need for physician/provider intervention..." This Federal Tag relates to Complaint IN00406352. 3.1-5(a)(3)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan,			

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	the residents' goals and preferences, and 483.65 of this subpart. Based on interview and record review, the facility failed to obtain physician orders for a resident provided oxygen therapy for 1 of 3 residents reviewed for change of condition. (Resident D) Findings include: The clinical record for Resident D was reviewed on 4/24/23 at 11:30 a.m. The resident's diagnoses included, but were not limited to, sepsis and pneumonia. A physician order dated 2/16/23 indicated Resident D was to receive 3 liters of oxygen as needed. That order was discontinued on 3/3/23. A nursing progress note dated 3/3/23 indicated Resident D had returned from a hospital stay. Visit notes by Nurse Practitioner (NP) 10 dated 3/6/23, 3/13/23, and 3/28/23 indicated Resident D was using oxygen. A visit note by NP 10 dated 4/4/23 indicated Resident D was on 3 liters of oxygen. An April 2023 vitals report indicated the following days Resident D was using on 2 liters of oxygen: 4/2/23, 4/3/23 and 4/4/23 The resident's clinical record did not indicate the resident had physician orders for oxygen therapy. An interview was conducted with Physical Therapist 7 on 4/4/23 at 10:14 a.m. She indicated the resident was usually on 2-3 liters of oxygen. An interview was conducted with Clinical Support	F 0695	Resident D has discharged. Residents receiving oxygen have the potential to be affected. DHS or designee will complete an audit of in-house residents receiving oxygen to ensure a physician order is in place. As a measure of ongoing compliance DHS or designee will educate the licensed nursing staff on the policy for oxygen administration. DHS or designee will be responsible for auditing residents receiving oxygen to ensure a physician order is in place. Audit of 5 residents will be conducted 2 times a week times 4 weeks, every 2 weeks times 2 months, monthly times 3 months and until continued compliance is maintained for 2 consecutive quarters (six months). The results of these audits will be reviewed by the QAPI committee overseen by the ED. For quality assurance, The ED and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns noted and will decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue past 6	05/12/2023

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	13 on 4/26/23 at 10:49 a.m. She indicated she was unable to provide physician orders for oxygen therapy for Resident D. An "Administration of Oxygen" policy was provided by Director of Nursing on 4/26/23 at 11:45 a.m. It indicated "...1. Verify physician's order for the procedure. 2. In cases of emergency oxygen may be administered as a nursing intervention until a physician order may be obtained..." This Federal Tag relates to Complaint IN00406352. 3.1-47(a)(6)		months if warranted until 100% compliance met.	
F 0697 SS=G Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on interview and record review, the facility failed to administer a narcotic pain medication, as ordered by the physician. This failure resulted in a resident having uncontrolled pain and mental distress for 1 of 1 resident randomly observed for pain (Resident B). Findings include: The clinical record for Resident B was reviewed on 4/24/23 at 11:15 a.m. The Resident's diagnosis included, but was not limited to, arthritis of multiple sites and cervical disc disorder.	F 0697	Resident B's pain medication order has been re-instated. Pain management effective. Residents receiving routine pain medication have the potential to be affected. DHS or designee will complete an audit of in-house residents with orders for routine pain medication to ensure orders are not inadvertently discontinued. As a measure of ongoing compliance DHS or designee will educate the licensed nursing staff on the Guidelines for Pain Management Policy. DHS or designee will be	05/12/2023

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	A care plan, dated 4/11/22, indicated she was at risk for general pain and discomfort due to cervical myelopathy and arthritis. The goal was for her pain to be at a tolerable level with interventions. The approaches, dated 4/11/22, indicated to administer medications as ordered and notify MD for any side effects observed or lack of effectiveness, remove old patch before placing new patch on, attempt non-pharmacological interventions, notify MD of increased pain, observe for and record verbal or non-verbal signs of pain, and reposition as needed. A care plan, dated 8/31/22, indicated her cognitive functions were intact and that she was alert and oriented. The goal was for her cognitive functions would remain intact. A physician's order, dated 2/9/23, indicated Resident B was to receive one tablet of oxycodone-acetaminophen (narcotic pain medication) 5-325 mg (milligram) every 4 hours routinely. It was discontinued on 4/21/23. An Annual MDS (Minimum Data Set) Assessment, completed 4/3/23, indicated Resident B was cognitively intact and received narcotic medication daily. A progress note, written 4/13/23 at 11:06 by NP (Nurse Practitioner) 10 indicated Resident B's pain appeared well managed on the current regimen and the oxycodone- acetaminophen 5-325mg every 4 hours would be continued. Her chronic pain was stable. During an interview on 4/24/23 at 1:59 p.m., Resident B indicated she did not receive her scheduled pain medication over the past weekend.		responsible for auditing residents with orders for routine pain medication to ensure orders are not inadvertently discontinued. Audit of 5 residents will be conducted 5 times a week times 4 weeks, 2 times a week for 4 weeks, weekly times 1 month, monthly times 3 months and until continued compliance is maintained for 2 consecutive quarters (six months). The results of these audits will be reviewed by the QAPI committee overseen by the ED. **For quality assurance, the ED and or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review the audits at least quarterly and increase frequency of audits if increased concerns noted and will decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.**	

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	Her pain was "worse than bad", at time causing her to cry. She had asked why she was not receiving her scheduled pain medication, and no one seemed to know. The staff had told her it was discontinued, and they didn't know why. Resident B normally did not got headaches but had experienced headaches over the weekend and was unable to watch her television programs, which she loved, because of the headaches. She was in pain from her toes up. She had family visit over the weekend and she did get up in her wheelchair. She tried to act "normal" because she did not want her family to worry, but her family had asked her what was wrong. She had told her family she was hurting. She had been unable to eat because of the pain. She had felt "horrible" all weekend. She had been given Tylenol because the nurses told her that was all she had ordered for pain. The Tylenol did not help control her pain. Resident B had told the nurse this morning about her uncontrolled pain and not getting her pain medications. He had fixed the problem and she was receiving her scheduled pain medication again. The April 2023 MAR (Medication Administration Record) indicated that Resident B had received her oxycodone- acetaminophen 5-325mg as scheduled from April 1, 2023, through April 21,2023 at 8:00 a.m. A physician's order, dated 4/24/23, indicated Resident B was to receive 1 tablet of oxycodone-acetaminophen 5-325 mg every 4 hours routinely. During an interview on 4/25/23 at 10:15 a.m., Pharmacy Technician 6 indicated the pharmacy had not received an order that the oxycodone-acetaminophen had been discontinued and was			

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	unsure why Resident B had not received the medication as ordered. On 4/25/23 at 10:39 a.m., LPN (Licensed Practical Nurse) 3 and the DNS (Director of Nursing Services) were interviewed. LPN 3 indicated on Friday 4/21/23 the computer system was malfunctioning. The order for the oxycodone-acetaminophen 5-325mg must have been accidentally discontinued while they were attempting to fix the problem. The DNS indicated she remembered the problem with the computer system. During an interview on 4/25/23 at 1:24 p.m., LPN 3 indicated that when he started his shift that morning Resident B had told him she had not received her pain medication all weekend and that she was aching from her toes up. He had gotten the medication restarted. During an interview on 4/25/23 at 1:25 p.m., Resident B indicated that the nursing staff had not asked what her pain level or pain intensity was over the weekend. During an interview on 4/25/23 at 1:54 p.m., RN (Registered Nurse) 2 indicated that he had worked the 3rd shift on 4/22 and 4/23/23. He had cared for Resident B. Resident B had being upset about not receiving her scheduled pain medications. RN 2 did not know who discontinued the oxycodone-acetaminophen or why it had been discontinued. He had wondered why she had gone from oxycodone to Tylenol as it seemed like a big change to him. It had not been passed on to him in report. RN 2 could tell that Resident B was in pain. He had not called anyone to ask about the oxycodone being discontinued.			

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	155816	A. BUILDING 00 B. WING	04/26/2023

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	During an interview on 4/25/23 at 2:11 p.m., QMA (Qualified Medication Aide) 4 indicated he had worked on the 2nd shift over the past weekend. He not asked Resident B about her pain. He noticed that her oxycodone had been discontinued but assumed the physician had just stopped it. During an interview on 4/25/23 at 2:55 p.m., NP (Nurse Practitioner) 10 indicated was made aware that day of Resident B not receiving her scheduled oxycodone over the past weekend due to a computer error. NP 10 had not been on-call during the past weekend but had reviewed the call log and there had been no calls received about Resident B. NP 10 would have wanted to know about Resident B being in pain and would have immediately restarted the oxycodone-acetaminophen. On 4/25/23 at 2:43 p.m., the Director of Nursing Services provided the Guidelines for Pain Observation and Management policy, last reviewed 12/31/22, which read "...If there is a change in pain indicators or verbalizations from resident, a pain event form will be completed to indicate change and care plan updated...educate the resident/ family/ care givers on the pain management interventions and importance of notifying staff of changes in pain status.....implement the care plan approached to assist with pain management..." 3.1-37(a)			
F 0760 SS=D Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors.			

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	Based on interview and record review, the facility failed to ensure staff were not presetting more than one resident's medication during a medication administration resulting in a resident receiving the wrong medication for 1 of 3 residents reviewed. (Resident C) Findings include: The clinical record for Resident C was reviewed on 4/25/23 at 9:30 a.m. The resident's diagnosis included, but was not limited to, acute kidney failure. A nursing progress note for Resident C dated 4/12/23 at 8:00 p.m. It indicated "Per QMA [Qualified Medication Aide] 12 resident was administered meds for [Resident G] by her, this writer assessed resident's vitals and noticed a drop from 124/70 HR 64 [heart rate] (vitals upon administration per QMA) to 103/53 HR 38-42 within 20-30 minutes of medication error, resident complained of feeling dizzy, wobbly, headache and chest pain. 911 called and transported to [name of hospital]..." Hospital records dated 4/12/23 indicated Resident C arrived to emergency room at 8:09 p.m. The resident was given in error "9 medications" that were not ordered for him. The resident had complaints of being shaky. Labs were obtained during hospitalization. The resident was discharged on 4/12/23 at 10:53 p.m., Resident C's condition was stable and was discharged back to facility. The resident's blood pressure was 115/56 and heart rate was 75 at the time of discharge. The investigation for the medication error was provided by the Director of Nursing on 4/25/23 at 9:07 a.m. It indicated Resident C had received the	F 0760	Resident C has been discharged. Residents receiving medications have the potential to be affected. An audit of medication pass will be conducted to ensure staff are not preparing more than one resident's medications at a time. Licensed nursing staff will be educated on medication pass policy. As a measure of ongoing compliance DHS or designee will educate the licensed nursing staff on the Guidelines of Medication Administration. DHS or designee will be responsible for observing medication pass to ensure staff are not preparing more than one resident's medications. Audit of 5 residents will be conducted 2 times a week times 4 weeks, weekly times a week for 4 weeks, every 2 weeks times one month, then monthly times 3 months and until continued compliance is maintained for 2 consecutive quarters (six months). The results of these audits will be reviewed by the QAPI committee overseen by the ED. For quality assurance, the ED and/or designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurrance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns are noted and will decrease the frequency of audits if	05/12/2023

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	following evening medications that was ordered for Resident G: 20 milligrams of Atorvastatin (cholesterol medication), 8 milligrams of Doxazosin (hypertension medication), 30 milligrams of Duloxetine (antidepressant medication), 300 milligrams of Gabapentin (anticonvulsant medication), 100 milligrams of Labetalol (hypertension medication), 2 tabs of Senna docusate (laxative medication), and 100 milligrams of Hydralazine (hypertension medication) Resident C was suppose to receive the following medications: 80 milligrams of Atorvastatin, 0.2 milligrams of Clonidine, 5 milligrams of Eliquis, 3 units of humalog, 50 milligrams of Metoprolol tartrate, 10 milligrams Glipizide, 50 milligrams of Hydralazine An interview was conducted with Resident C on 4/24/23 at 2:44 p.m. He indicated he had received the wrong medications and was sent to hospital for evaluation to monitor his blood pressure. During his hospitalization, he was monitored due to low blood pressure, and then he was sent back to the facility. The worst of it all was receiving the laxative. He had gastrointestinal issues all night into the next day. "It was embarrassing." He has always believed the staff should come in and ask him his name prior to handing him a cup of pills to		no concerns are noted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	

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	take. Some times the staff will have his name on the medication cup and other times they don't. The resident was "grateful" that it did not cause him serious harm. An interview was conducted with Certified Resident Medication Aid (CRMA) 12 on 4/25/23 at 2:30 p.m. She indicated she had preset Resident C and Resident G's medications. She had gotten distracted and picked up the wrong medication cup to administer medications to Resident C on error. She does not normally preset more than one resident's medications. She had realized what she had done soon after. Resident C was a dialysis patient and was already a little "groggy" from that service and with the combination of medications given; the nursing staff thought it was best to send him out to the hospital for evaluation. She was "thankful" the resident was okay. A medication administration policy was provided by the Director of Nursing on 4/25/23 at 9:07 a.m. It indicated "...Policy. Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so...The facility has sufficient personnel and a medication distribution system to ensure safe administration of medications without unnecessary interruptions...4) Five Rights - right resident, right drug, right dose, right route, and right time, are applied for each medication being administered. A triple check of these 5 Rights is recommended at three steps in the process of preparation of a medication administration: (1) when the medication is selected, (2) when the dose is removed from the container, and finally (3) just after the dose is prepared and the medication put away..."			

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	A additional medication administration policy was provided by Director of Nursing on 4/25/23 at 9:07 a.m. It indicated "...Additional Procedural Med Pass Guidelines: Never prepare medications for more than one resident at a time..." This Federal Tag relates to Complaint IN00406606. 3.1-48(a)(c)(2)			