STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155828	A. BUILDING 00 B. WING	03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE POINTE OF FORT WAYNE	5250 HERITAGE PARKWAY FORT WAYNE, IN 46835

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey.This visit included a State Residential Licensure Survey. This visit was in conjunction with the Investigation of Complaint IN00400592. Survey dates: March 13, 14, 15, 16 and 17, 2023. Facility number: 012931 Provider number: 155828 AIM number: 201278730 Census Bed Type: SNF/NF: 51 Residential: 23 Total: 74 Census Payor Type: Medicare: 3 Medicaid: 17 Other: 31 Total: 51 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed March 20, 2023.	F 0000	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. The Facility respectfully requests paper compliance for this citation.	
F 0742 SS=D Bldg. 00	483.40(b)(1) Treatment/Srvcs Mental/Psychoscial Concerns §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Matthew Souder	Executive Director	03/31/2023

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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	difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; Based on observation, interview, and record review the facility failed to document and monitor behaviors to for 2 of 3 residents reviewed. (Resident 38 and Resident 48). Findings include: 1) An interview with LPN 2 (Licensed Practical Nurse) on 03/13/23 at 11:03 AM indicated Resident 38 frequently refused to get up until closer to lunch. LPN 2 indicated Resident 38 did not stay up late or wander, she simply was unwilling to participate in life at times. LPN 2 indicated the behavior was normal for Resident 38. LPN 2 indicated Resident 38 did have some behaviors, but they were not overly aggressive or disruptive. Resident 38's record review began on 03/15/23 at 10:26 AM. Diagnosis included dementia, anxiety, depression, vitamin deficiency, and malnutrition. Resident 38's current annual MDS (Minimal Data Set) dated 2/1/23 indicated BIMS (Brief Interview for Mental Status) score was a 6. A score of 6 indicated significant cognitive decline. Section D for mood indicated no problems with mood regarding interest or pleasure in doing things, feeling down or depressed, trouble falling or staying asleep, feeling tired or low energy, poor appetite, or overeating, feeling bad about self, or thoughts of better off dead, or hurting self in some ways in the 14 days prior to the assessment. Section E for Behavior indicated Residnet 38 had	F 0742	=" b=""> Resident 38 and 48 have been added to the behavioral management program by the Social Service Director on 3/20/2023. =" b="">Facility completed chart audit review of residents residing on the secured memory care unit to ensure all behaviors are being documented and tracked in the facility's behavioral management program. No other residents appear affected by this deficient practice. =" b="">The facility has established a new Behavioral Health policy as well as updated its current Behavior Management policy. Social Services will be required to track all behaviors using the new Behavioral Documentation Tool in a central location to ensure behaviors are being captured by the Interdisciplinary Team. All nursing and social service employees will be required to complete additional education, by April 10th , regarding residential behaviors to ensure employees do not normalize resident actions and understand procedures to track	03/20/2023

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	no hallucinations or delusions, physical behaviors towards others, verbal behaviors directed towards others, nor other behavior symptoms not directed towards others. The assessment further indicated Residnet 38 had no rejection of care. A review of Resident 38's progress notes included on December 23, 2022, the Social Worker (SW) indicated she was informed by the staff Resident 38 refused to get out of bed, was tearful and making negative statements. Staff indicated to the SW Resident 38 had periods of crying, being tearful when speaking of husband and how much she missed him. The documented note indicated when the SW inquired about statements Resident 38 stated "oh I was just kidding". The note indicated Resident 38 woke up excited about an idea to share with her husband and then remembered he was no longer living. A progress note dated 12/22/22 indicated Resident 38 had some tearful episodes, was staying in bed later and not getting up until the afternoon, sometimes after 2pm. The note indicated Resident 38 was grieving for her husband and her first Christmas without him. A progress note dated 12/29/22 indicated Resident 38 slept in, was having some sadness over loss of husband, and moving slowly. A progress note dated 1/30/23 indicated Resident 38 had no behaviors noted during the assessment period. A progress note dated 2/16/23 indicated Resident 38 refused care and medications. Resident 38 stated "let me lie down and die" and "throw me in the streets". A psych prescriber indicated		behaviors. The Administrator will perform a weekly spot audit for the next 6 months to ensure all behaviors are being tracked using the new Behavioral Documentation Tool and that the facility's Behavioral Management Program is being followed per policy. Should 100% compliance not be achieved, findings will be presented to QA Committee for further interventions.	

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	Resident 38 did not take part in any conversation and nursing was to monitor. A physician note dated 2/22/23 indicated to continue to monitor behaviors. A progress note dated 3/6/23 indicated Resident 38 was tearful and upset regarding missing her husband when she recalls he was no longer living. A progress note dated 3/6/23 indicated the resident stated to a CNA (Certified Nursing Aid) "I just want to die". Resident 38 indicated she was not a harm to herself she was just ready to go. A physician note dated 3/6/23 indicated recent statements of wanting to die, no plans, thoughts, or intent to harm herself. The resident continued to grieve the loss of her husband. The staff were to continue to provide support as Resident 38 continued to grieve. Resident 38's current care plan indicated she had focus of verbal aggression. An intervention listed was to monitor/record occurrence of target behavior symptoms: pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others. etc. and document per facility protocol. There was no behavior tracking for aggression, tearfulness, refusal of care, or statements of wishing to die in Resident 38's behavior tracker. There were no documented specific problems related to trauma triggers, symptoms, or approaches. No behavior plan was provided. A follow up interview with LPN 2 and observation of Resident 38 on 3/16/23 at 10:35AM indicated			

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	Resident 38 was sitting in her room slightly disheveled with her head in between her hands. LPN 2 indicated this was Resident 38's normal, therefore it was not considered a behavior and not documented or tracked. LPN 2 indicated Resident 38 refused to get up and refused care including showers. In an interview on 3/16/23 at 2:34PM, SS 5 (Social Services) indicated the MDS section for mood was to evaluate for depression along with verbalization of depression. Answers positive for depression would be cause to investigate. SS 5 indicated the psychologist for the facility indicated talk therapy was not appropriate for people who have low BIMS scores due to need for carry over from session to session. SS 5 indicated they have a behavior notes template to address what was occurring before behavior, what interventions were tried, and what was found to be helpful. SS 5 indicated she looks at all progress notes for the last 24 hrs. when she begins her day. SS 5 indicated she cannot depend on the notes being in behavior notes format. SS 5 indicated despite if the behavior was known or frequent it required documentation and tracking to determine behavior plan needs. SS 5 indicated Resident 38 was seen by a psych prescriber every Tuesday, Resident 38 was not a threat to self or others, and that Resident 38 did not receive therapy for the trauma of losing her husband. 2) During an observation on 03/13/23 from 9:30AM to 11:45AM, Resident 48 was making loud non articulate noises. As Resident 48 sat at a table with the assistance of 2 staff and gait belt she stated "I made it"; showing the ability to speak clearly and softly. Resident 48's record review began on 03/13/23 at			

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	11:10 AM. Resident 48's diagnosis included dementia, PBA (pseudobulbar affect), and lower back pain. Resident 48's current admission MDS (Minimal Data Set) dated 2/14/23 had a BIMS score of 3, this indicated a significant impairment of cognitive status. Section D for mood indicated Resident 48 felt down or depressed 2-6 days in the 2 weeks of the observation period. Section E for Behavior indicated other behavior symptoms not directed at others such as verbal/vocal symptoms like screaming, disruptive sounds 1 to 3 days of the week prior to assessment. Resident 48's current care plan included the focus of episodes of loud, explosive laughter not appropriate to the environment. Interventions included receive medication as ordered, monitor for side effects, and to offer conversation when distressed. A review of Resident 48's social services note dated 2/13/23 late entried for 2/8/23 indicated Resident 48 had an episode of laughing loudly when not appropriate. A progress note dated 2/25/23 at 3:45 PM indicated Resident 48 slept well with no unwanted behaviors. An observation of Resident 48 and an interview with LPN 2 on 03/16/23 at 10:31 AM indicated she was involved in activity sitting quietly. During the interview LPN 2 indicated Resident 48 had a diagnosis related to loud outbursts. She indicated Resident 48 was unable to help it; therefore, it was not considered a behavior. LPN 2 indicated she had been disruptive and upsetting to other residents a couple times. She had been removed			

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	from peers. LPN 2 indicated Resident 48 took medication for the condition, the loud outbursts were expected to happen and therefore were not documented. An interview on 3/16/23 at 10:36 AM, Activities 6 indicated Resident 48 does upset peers at times and requires direct 1 to 1 care to calm down. A current policy and procedure titled, "Behavior Management Plan" revised 04/2022, was provided by the executive director on 3/16/23 at 12:12PM. The policy indicated; " ...quality of life through the management of problematic behaviors that are distressing or harmful ... 1. Staff will document behavior in the EMR (electronic medical record) ...Residents enrolled in Behavioral Management will be reviewed monthly by Social Services to ensure Behavior Care Plan accuracy ..... 3.1-43(a)(1)			
F 0757 SS=E Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or			

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	§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview the facility failed to ensure monitoring of opioid medication side effects for 4 of 4 residents reviewed (Resident 3, Resident 38, Resident 48, and Resident 201). Findings include: 1) Resident 201's record review began on 03/15/23 at 9:21 AM. Diagnoses include traumatic subarachnoid hemorrhage with loss of consciousness of unspecified duration, muscle weakness, type 2 diabetes mellitus with diabetic neuropathy, and major depressive disorder. A Minimum Data Set (MDS) assessment dated 03/01/23 indicated Resident 201 had a BIMS (brief interview for mental status) score of 14 (cognitively intact). The MDS indicated resident 201 received opioid pain medication 2 out of the prior 7 days of the assessment period. A physician's order dated 02/22/23 indicated Tramadol HCL (hydrochloride) oral tablet 50MG was to be given 1 tablet by mouth every 6 hours as needed for pain. Start date 02/22/23 1430, DC date, 03/13/23. A subsequent physician's order indicated Tramadol HCL oral tablet 50MG was to be given 0.5 tablet by mouth every 6 hours as needed for pain. Start date 03/13/23. There were no care plans regarding opioid	F 0757	=" b1. immediate=""> =" p=""> =" b2. identification=""> =" span=""> =" b3. actions="">MDS Coordinator updated all residents currently utilizing opioids have been updated to include an order to monitor for opioid side effects that include slurred speech, shallow breathing, decrease in alertness and LOC with specific instructions to initiate further assessment if S/SX observed. Nursing Managers identified any resident using opioids for pain management and ensured resident EMR included an order to monitor for opioid side effects. Opioid Management policy updated and new Pain Management policy established with specific guidelines for monitoring a resident receiving opioid medication for adverse effects. Licensed nursing staff education on updated policies expected to be completed by April 10th via in-services. New order template created in EMR with specific monitoring instructions for	03/20/2023

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	medication for Resident 201. A review of the Medication Administration Record (MAR) indicated Resident 201 received Tramadol HCL 50MG 1 tablet on 02/27/23 and 02/28/23. There were no orders to monitor for the side effects of opioid administration. 2) Resident 38's record review began on 3/14/23 at 12:17 PM. Diagnosis included dementia, anxiety, depression, vitamin deficiency, arthritis, and non displaced fracture. The current annual MDS (Minimal Data Set) for Resident 38 dated 2/1/23 indicated a BIMS (Brief Interview for Mental Status) score was a 6. A score of 6 indicated significant cognitive decline. Section J for Health Conditions addressed pain management. The pain assessment indicated Resident 38 receives pain medication routinely and has pain frequently. The assessment indicated Resident 38 rated her pain a 2 at the worst point in the previous 5 days of the assessment period. Section N of the assessment for Medications indicated Resident 38 received opioids for 7 of 7 days in week prior to assessment period. Resident 38's physician orders included to monitor for side effects of the following medications; antidepressant, antipsychotic, and diuretics. There were no orders to monitor for side effects of opiod medications. Resident 38 had the following order for opioid medication started on 2/1/22, give Norco 5-325 1 tablet by mouth one time a day for pain management. A review of Resident 38's medication		residents receiving opioid medication. MDS Coordinator and Nurse Managers have been assigned the responsibility to review order listings in the EMR to ensure all new opioid orders have corresponding orders to monitor for side effects. The Administrator will perform weekly spot audits for the next 12 weeks, then monthly for 3 months, on resident orders to ensure residents receiving opioid medication have corresponding orders to monitor for side effects. Should 100% compliance not be achieved, findings will be presented to QA Committee for further interventions.	

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	administration record for Norco was documented as given for the time period of 2/1/23 to 3/13/23. A review of Resident 38's progress notes indicated there were no non medication interventions for pain documented for the period of 30 days. A review of Resident 38's current care plan indicated the focus of pain with the following interventions: medication as ordered, monitor for side effects, and use non-drug interventions. 3) Resident 48's record review began on 03/13/23 at 11:10 AM. Resident 48's diagnosis included dementia, spinal stenosis, compression fracture of lumbar spine, and lower back pain. Resident 48's admission MDS (Minimal Data Set) dated 2/14/23 indicated a BIMS score of 3, indicated a significant impairment of cognitive status. Section J for Health Conditions indicated Resident 48 received pain medication routinely. Pain frequency was documented at occasionally with the highest pain rating in 5 days of the assessment period as 4. Section N in the data set for Medications indicated Resident 48 received opiods 6 of the 7 days in the prior week of the assessment period. Resident 48's physician orders included to monitor for side effects of the following medications; antipsychotic and diuretics. Resident 48 did not have physician orders to monitor for side effects of opioid medication. Resident 48 had a physician order for Norco 5-325 one tablet as needed for pain on 2/7/23 and 2/8/23; it was not documented as given. Resident 48 had an order for Norco5-325mg three times a day for chronic pain on 2/9/23.			

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	A review of Resident 48's medication administration record (MAR) documented Resident 48 was administered Norco three times a day from February 9th through March 13th. During this review period Resident 48's pain level was documented as below: A review Resident 48's progress notes indicated there were no non medication interventions for pain documented for the period of 30 days. 4. Resident 3's record was reviewed on 3/14/23 at 1:56 PM. Diagnoses included unspecified diastolic (congestive) heart failure, anxiety disorder, unspecified, major depressive disorder, single episode, unspecified, chronic pain syndrome, primary osteoarthritis, unspecified site, scoliosis, unspecified, rheumatoid arthritis, unspecified. A Minimum Data Set (MSD) assessment, dated 1/23/2023, indicated Resident 3 had a brief interview for mental status (BIMS) score of 13 (cognitively intact). The MDS assessment indicated Resident 3 received scheduled pain medication and prn (as needed) pain medication or prn pain medication was offered and declined. The MDS assessment indicated Resident 3 received opioid pain medication 2 of 7 days prior to the MDS assessment. A physician's order, dated 12/28/22, indicated Fentanyl (an opioid pain medication)72-hour patch 12 micrograms (mcg)/hour (hr.), apply 1 patch transdermally (on the skin) every 72 hrs. for chronic pain. Rotate the site (place the patch in a different area of the body) and remove per schedule. Resident 3's record did not include an order to monitor for adverse (harmful) side effects of			

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	opioids. A current care plan, dated 7/19/22, indicated Resident 3 had potential for pain related to decreased mobility, weakness, and osteoarthritis (a type of arthritis that occurs when the flexible tissue at the ends of bones wears down). The goal indicated Resident 3 would maintain comfort to the highest degree possible through the next review. The interventions included use a cervical collar (neck support brace) prn, monitor and assess Resident 3 for pain every shift, administer medication as ordered, monitor for side effects, perform nondrug interventions (use means other than medication to help relieve pain- massage, position change, etc.). Resident 3's Progress Notes, dated February 1-28, 2023, indicated no documentation for monitoring for side effects of opioid medication. Resident 3's Progress Notes, dated March 1-15, 2023, indicated no documentation for monitoring for side effects of opioid medication. Resident 3's Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated February 2023, indicated Resident 3 had a Fentanyl 12mcg/hr. patch applied on 2/2/23 at 11:35 AM, 2/5/23 at 7:37 AM, 2/8/23 at 8:17 AM, 2/11/23 at 8:15 AM, 2/14/23 at 9:56 AM, 2/17/23 at 7:55 AM, 2/20/23 at 8:43 AM, 2/23/23 at 10:23 AM, and 2/26/23 at 8:36 AM. Resident 3's MAR and TAR, dated March 2023, indicated Resident 3 had a Fentanyl 12mcg/hr. patch applied on 3/1/23 at 9:36 AM, 3/4/23 at 9:07 AM, 3/7/23 at 7:41 AM, 3/10/23 at 9:42 AM, and 3/13/23 at 7:10 AM.			

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	Resident 3's MARs and TARs, dated February 2023 and March 2023, indicated no documentation for monitoring for side effects of opioid medication. In an interview on 3/16/23 at 10:20 AM, RN 9 indicated she monitored for adverse side effects when a resident received blood pressure medication, any new medication, and any behavior medication. RN 9 did not indicate she monitored for adverse side effects when a resident received an opioid pain medication. RN 9 indicated an order or alert note would indicate a resident needed monitored for side effects of a medication. RN 9 indicated residents were monitored for adverse side effects every shift. Documentation of the monitoring for adverse side effects was done on the MAR and TAR and any specific observations of adverse side effects were documented in a health status progress note. In an interview on 3/16/23 at 11:00 AM, LPN 3 indicated residents were monitored for adverse side effects if they received antianxiety medication (relieve/control anxiousness), antipsychotic medication (relieve/control symptoms of hallucinations-thinking something is present when it's not, paranoia- unjustified suspicion or mistrust , hearing voices, delusion-false beliefs, anxiety) , an anticoagulant (blood thinner), a sedative (cause sleepiness), a hypnotic (cause sleepiness), an antidepressant (control anxiety and feeling severe sadness), a diuretic (used to get rid of excess fluid in the body, "water pill"), or insulin (used to treat high blood sugar). LPN 3 indicated she did not know if they had to monitor for adverse side effects if a resident received an opioid medication. She indicated she would check with other staff. LPN 3 indicated there were templates on the computer program to indicate a			

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	resident needed to be monitored for adverse side effects of a medication. These templates needed to be added to the orders by the nurse when the order for the medication was entered. LPN 3 indicated there was a reference guide in the narcotic books listing the medications that required a resident to be monitored for adverse side effects. Documentation was done on the MAR and TAR to indicate the resident was being monitored for adverse side effects of the medication. Documentation of the observed adverse side effects was done in a progress note and the doctor or Nurse Practitioner (NP) would be notified. In an interview on 3/16/23 at 11:12 AM, LPN 3 indicated monitoring for adverse side effects of a medication was considered a nursing measure. Nurses would notify the doctor/NP if adverse side effects were observed. An order to monitor for adverse side effects of opioid medication would have to be entered as an order when the order for the medication was placed. A current policy, titled Opioid Overdose Management, dated 10/2022, was provided by the Executive Director (ED) on 3/16/23 at 11:44 AM. The policy indicated it was the policy of the facility to recognize and treat opioid overdose per current standards of practice. The compliance guidelines indicated " ...4. The facility will train all staff to recognize the signs of opioid overdose and respond to it according to facility policy. 5. If a resident exhibits any of the following overdose symptoms, the facility will call 911, initiate basic life support, if indicated, and administer naloxone as per facility protocol and manufacturer's instructions: a. extremely pale face or clammy to the touch, b. limp body, c. blue or purplish color to fingernails or lips, d. vomiting or making			

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	gurgling noises, e. inability to awaken or speak, f. breathing or heartbeat slows or stops ...." This policy did not indicate specific guidelines for monitoring a resident, receiving an opioid medication, for adverse side effects. A current policy, titled Medication Error and Adverse Reaction Reporting, dated 1/2020, was provided by the ED on 3/16/23 at 11:55 AM. The policy indicated medication errors and adverse drug reactions shall be documented in the resident's clinical record and reported to the resident's attending physician. The procedure indicated " ...1. In the event of a medication error or adverse reaction, nursing personnel should first take whatever immediate action is necessary to protect the resident's safety and welfare. 2. Notify the attending physician promptly of the error or significant adverse drug reaction (heavy sedation, extrapyramidal symptoms-(restlessness, muscles contract involuntarily, tremors, stiff muscles, involuntary facial movements), agitation, psychotic manifestations-(delusions, hallucinations, nonsense speech, inappropriate behavior for the situation), severe cramping, nausea, vomiting, diarrhea, allergic manifestations-(swelling, rash, itching, shortness of breath), and ataxia-(impaired balance or coordination). 3. Implement physician's orders and monitor the resident closely for 24 hrs., or as directed by the physician. 4. Document the following in the resident's clinical record. Clearly describe the error or adverse reaction. Limit documentation to the facts; avoid opinions .... This policy did not indicate specific guidelines for monitoring a resident receiving an opioid medication for adverse side effects. In an interview on 3/16/23 at 11:55 AM, the ED indicated the facility did not have any other			

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

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	§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on record review and interview the facility failed to ensure monitoring of psychotropic medications for 3 of 4 residents reviewed (Resident 3, Resident 38, and Resident 201). Findings include: Resident 201's record review began on 03/15/23 at 9:21 AM. Diagnoses include traumatic subarachnoid hemorrhage with loss of consciousness of unspecified duration, muscle weakness, type 2 diabetes mellitus with diabetic neuropathy, and major depressive disorder. A Minimum Data Set (MDS) assessment dated 03/01/23 indicated Resident 201 had a BIMS (brief interview for mental status) score of 14 (cognitively intact).	F 0758	=" b1. immediate="">
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MDS Coordinator updated Resident 3 and Resident 38 medical records to include orders with specific instructions on monitoring for potential	03/20/2023

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	A physician's order, dated 2/23/23, indicated to give Sertraline HCL (hydrochloride) oral tablet 25mg 1 tablet by mouth one time a day for depression was administered daily starting 2/23/23 to 3/14/23. A physician's orders dated 3/13/23 included to monitor antidepressant medication - monitor for headache, nausea and vomiting, diarrhea, fatigue, drowsiness, lethargy, dizziness, agitation, irritability. If any signs and symptoms observed, note findings in a progress note every shift. A review of progress notes between 2/23/23 and 3/13/23 did not indicate side effects of Steraline had been monitored. There were no orders prior to 03/13/23 to monitor for side effects of antidepressant medication. 2) Resident 38's record review began on 03/14/23 at 12:17 PM. Diagnosis included dementia, anxiety, depression, vitamin deficiency, arthritis, and non-displaced fracture. Resident 38's current annual MDS (Minimal Data Set) dated 2/1/23 indicated BIMS (Brief Interview for Mental Status) score was a 6. A score of 6 indicated significant cognitive decline. Section N for Medications of MDS indicated Resident 38 took antianxiety medication for 7 of the last 7 days of the assessment period. Resident 38's physician orders included to monitor for side effects of the following medications; antidepressant, antipsychotic, and diuretics. There were no orders to monitor for side effects of antianxiety medication side effects. Resident 38 had the following order for Buspirone		psychotropic medication side effects that include drowsiness, dizziness, nausea, aggressive/impulse slurred speech, shallow breathing, decrease in alertness and LOC with specific instructions to initiate further assessment if S/SX observed. Residents currently utilizing psychotropic medications, specifically anti-anxiety and/or antidepressants, have been reviewed to ensure corresponding side effect monitoring order is in place. No other residents appear affected by this deficient practice. New “Use of Psychotropic Medication” policy created that establishes specific guidelines for monitoring a resident receiving anti-anxiety or antidepressant medications, including monitoring for side effects.Licensed nursing staff education on new policy expected to be completed by April 10th via in-services.MDS Coordinator and Nurse Managers have been assigned the responsibility to review order listings in the EMR to ensure all new anti-psychotic orders have corresponding orders to monitor for side effects. The Administrator will perform weekly spot audits for the next 12 weeks, then monthly for 3 months, on resident orders to ensure residents receiving anti-psychotic medication have corresponding	

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	5mg 1 tablet three times a day started on 12/23/22. In the medication administration record for Buspirone 5mg tablet for February and March 2023 up to the 13th documented administered three times a day. There was no indication the side effects of Buspar had been monitored. 3. Resident 3's record was reviewed on 3/14/23 at 1:56 PM. Diagnoses included unspecified diastolic (congestive) heart failure, anxiety disorder, unspecified, major depressive disorder, single episode, unspecified, chronic pain syndrome, primary osteoarthritis, unspecified site, scoliosis, unspecified, rheumatoid arthritis, unspecified. A Minimum Data Set (MSD) assessment, dated 1/23/2023, indicated Resident 3 had a brief interview for mental status (BIMS) score of 13 (cognitively intact). A physician's order, dated 3/6/23, indicated to give Ativan (Lorazepam) oral tablet 0.5 milligram (mg.) (medication used to treat anxiety), 1 tablet by mouth every 6 hours prn (as needed) for anxiety/agitation for 14 days. A physician's order, dated 3/7/23, indicated to give Ativan (Lorazepam) oral tablet 0.5 mg. by mouth at bedtime related to anxiety disorder, unspecified. A physician's order, dated 3/15/23, indicated Resident 3 received anti-anxiety medication, to monitor for drowsiness, slurred speech, dizziness, nausea, aggressive/impulsive behavior. If any signs or symptoms observed, note findings in a progress note every shift. There was no order to monitor Resident 3 for side effects of anti-anxiety medication prior to 3/15/23.		orders to monitor for side effects. Should 100% compliance not be achieved, findings will be presented to QA Committee for further interventions.	

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	A current care plan, titled Behavior Management Program, dated 2/17/23, indicated Resident 3 had episodes of verbal aggression (talk in a threatening manner) and would yell at, curse, belittle (make feel unimportant) staff when upset or during care. Resident 3 would refuse care at times, refuse to take medication, refuse to wear a gait belt (belt used to aid in safe movement when transferring or walking) for walking or transfers, refuse to change positions in bed, refuse to change his clothes, would threaten to be on his call light all day if things weren't done correctly. Resident 3 has episodes of smacking at and hitting at staff during care when agitated and/or anxious. Resident 3 had a diagnosis of anxiety and was taking an anti-anxiety medication. The goal indicated Resident 3 would accept care from staff and would refrain from negative, aggressive and/or demeaning (negative) remarks toward staff when he was upset. The interventions included: educate Resident 3 on the purpose and safety risks for using the gait belt verses not using the gait belt, encourage Resident 3 to participate in activities of daily living (ADLs) (dressing, bathing, etc.) as much as he was able to, explain the behavior was inappropriate and ask calmly for Resident 3 to stop, explain the care you would like to provide prior to giving the care , engage in conversation with Resident 3 during and prior to the care being given, and Resident 3 would receive his medication as ordered. This care plan did not indicate to monitor Resident 3 for adverse side effects of anti-anxiety medication. A current care plan, dated 2/8/23, indicated Resident 3 used anti-anxiety medication. The goals indicated Resident 3 would be free from discomfort or adverse (harmful) reactions related to anti-anxiety therapy through the review. The interventions included: administer anti-anxiety			

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	medications as ordered by the physician, monitor for side effects and effectiveness every shift. Monitor, document, and report as needed any adverse reactions to anti-anxiety therapy: drowsiness, lack of energy, clumsiness, slow reflexes, slurred speech, confusion and disorientation, depression, dizziness, lightheadedness, impaired thinking and judgment, memory loss, forgetfulness, nausea, stomach upset, blurred or double vision, unexpected side effects: mania (extremely elevated and excitable mood), hostility (unfriendly behavior), rage (uncontrollable anger), aggressive (ready or likely to attack) or impulsive (done without thought) behavior, and hallucinations (where you hear, see, smell, taste, or feel things that appear to be real but are not). A progress note, dated 3/5/23 at 7:38 PM, indicated Resident 3's prn Ativan remained effective with no adverse drug reactions indicated. A progress note, dated 3/6/23 at 4:08 PM, indicated Resident 3 was very drowsy and unable to perform normal tasks such as drinking his own Boost. Resident 3's Ativan order was decreased to 0.5mg every 6 hours as needed per hospice and the Nurse Practitioner due to confusion and drowsiness. A progress note, dated 3/13/23 at 3:30 PM, indicated Resident 3 did have drowsiness after taking Ativan. No other adverse drug reactions were noted from the medication. There were no other progress notes to indicate Resident 3 was monitored for adverse side effects of the anti-anxiety medication he was receiving.			

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	Resident 3's Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated March 2023, indicated Resident 3 was given the medication, Ativan (Lorazepam) oral tablet 0.5mg, 1 tablet by mouth every 6 hours as needed (prn) for anxiety/agitation for 14 days (start date 2/27/23 at 10:30 AM, discontinued on 3/4/23 at 5:27 PM) on 3/2/23 at 12:57 AM and 3/4/23 at 10:15 AM. Resident 3's MAR and TAR, dated March 2023, indicated Resident 3 was given the medication, Ativan (Lorazepam) oral tablet 0.5mg, 2 tablet by mouth every 6 hours as needed (prn) for anxiety/agitation for 14 days (start date 3/4/23 at 5:30PM, discontinued on 3/6/23 at 12:14 PM) on 3/4/23 5:34 PM and 3/5/23 at 8:03 PM. Resident 3's MAR and TAR, dated March 2023, indicated Resident 3 was given the medication, Ativan (Lorazepam) oral tablet 0.5mg, 1 tablet by mouth every 6 hours as needed (prn) for anxiety/agitation for 14 days (start date 3/6/23 at 12:15 PM) on 3/7/23 at 12:30 AM, 3/9/23 at 10:48 AM, 3/12/23 at 9:53 AM and 6:39 PM, and 3/13/23 at 6:58 AM. Resident 3's MAR and TAR, dated March 2023, indicated Resident 3 was given the medication, Ativan (Lorazepam) 0.5mg oral tablet, 0.5mg by mouth at bedtime related to anxiety disorder, unspecified (start date 3/7/23 at 9:00 PM) on 3/7/23, 3/8/23. 3/9/23, 3/10/23, 3/11/23, 3/12/23, 3/13/23, and 3/14/23. Resident 3's MAR and TAR, dated March 2023, indicated Resident 3 received an anti-anxiety medication. Resident 3 was to be monitored for drowsiness, slurred speech, dizziness, nausea, or aggressive/impulsive behavior. If any signs or			

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	symptoms were observed, findings were to be noted in a progress note every shift. The start date was 3/15/23. There was no documentation on this date. There was no other documentation on the MAR or TAR to indicate Resident 3 was monitored for adverse side effects of anti-anxiety medication. In an interview on 3/16/23 at 10:20 AM, RN 9 indicated she monitored for adverse side effects when a resident received blood pressure medication, any new medication, and any behavior medication. RN 9 indicated an order or alert note would indicate a resident needed monitored for side effects of a medication. RN 9 indicated residents were monitored for adverse side effects every shift. Documentation of the monitoring for adverse side effects was done on the MAR and TAR and any specific observations of adverse side effects were documented in a health status progress note. In an interview on 3/16/23 at 11:00 AM, LPN 3 indicated residents were monitored for adverse side effects if they received antianxiety medication (relieve/control anxiousness), antipsychotic medication (relieve/control symptoms of hallucinations-thinking something is present when it's not, paranoia- unjustified suspicion or mistrust , hearing voices, delusion-false beliefs, anxiety) , an anticoagulant (blood thinner), a sedative (cause sleepiness), a hypnotic (cause sleepiness), an antidepressant (control anxiety and feeling severe sadness), a diuretic (used to get rid of excess fluid in the body, "water pill"), or insulin (used to treat high blood sugar). LPN 3 indicated there were templates on the computer program to indicate a resident needed to be monitored for adverse side effects of a medication. These templates needed to be added to the orders			

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	by the nurse when the order for the medication was entered. LPN 3 indicated there was a reference guide in the narcotic books listing the medications that required a resident to be monitored for adverse side effects. Documentation was done on the MAR and TAR to indicate the resident was being monitored for adverse side effects of the medication. Documentation of the observed adverse side effects was done in a progress note and the doctor or Nurse Practitioner (NP) would be notified. A current policy, titled Antipsychotic Medications, dated 1/2020, was provided by the Executive Director on 3/16/23 at 11:10 AM. The policy indicated " ...Antipsychotic medication must be used with great caution in residents as they can cause adverse effects ...Prior to use of Antipsychotics ...Must evaluate the effectiveness of the medication and monitor for adverse consequences (i.e., Increased confusion or over sedation) ...Monitoring and Follow-up-up: 2. The Behavior Management Team will ...Detect emergence or presence of adverse consequences: a. Anticholinergic effects (dry mouth, constipation, urinary retention (urine remaining in the bladder), bowel obstruction (blockage), dilated pupils (pupils looking large), blurred vision, increased heart rate and decreased sweating), b. signs and symptoms of Cardiac Arrythmias (abnormal heart rhythm) c. Metabolic Effects (increased blood pressure, high blood sugar, excess fat around the waist, and abnormal cholesterol or triglyceride levels), d. Neurological effects (paralysis, muscle weakness, poor coordination, loss of sensation, seizures, confusion, pain and altered levels of consciousness), e. Individualized monitoring parameters, 3. Concerns that are identified related			

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	to the effectiveness or potential and/or actual adverse consequences of a resident's medical regimen must be relayed to the physician and must respond with changes as necessary. 4. If the physician does not provide a timely and appropriate response to the notification, staff must contact the medical director and the Director of Nursing for further review and intervention ...Monitoring for Continued Use at Least Quarterly: Document rationale for continuing medication, including evidence the following was evaluated ...c. whether the resident experienced any medication-related adverse consequences during the previous quarter ...." This policy did not indicate specific guidelines for monitoring a resident receiving an anti-anxiety or anti-depresant medication for adverse side effects. A current policy, titled Antipsychotic Medications in Residents with Dementia, dated 1/2020, was provided by the Executive Director on 3/16/23 at 11:10 AM. The policy indicated " ...Antipsychotic medication must be used with great caution in residents with dementia as they can cause adverse effects ... Prior to use of Antipsychotics ...3. Must evaluate the effectiveness of the medication and monitor for adverse consequences (i.e., Increased confusion or over sedation) ... Monitoring and Follow-up: 2. The Behavior Management Team will ...Detect emergence or presence of adverse consequences: a. Anticholinergic effects (dry mouth, constipation, urinary retention, bowel obstruction, dilated pupils, blurred vision, increased heart rate and decreased sweating), b. signs and symptoms of Cardiac Arrythmias (abnormal heart rhythm) c. Metabolic Effects (increased blood pressure, high blood sugar, excess fat around the waist, and abnormal cholesterol or triglyceride levels), d. Neurological effects (paralysis, muscle weakness,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155828	A. BUILDING 00 B. WING	03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	poor coordination, loss of sensation, seizures, confusion, pain and altered levels of consciousness), e. Individualized monitoring parameters, , 3. Concerns that are identified related to the effectiveness or potential and/or actual adverse consequences of a resident's medical regimen must be relayed to the physician and must respond with changes as necessary. 4. If the physician does not provide a timely and appropriate response to the notification, staff must contact the medical director and the Director of Nursing for further review and intervention ... Monitoring for Continued Use at Least Quarterly: Document rationale for continuing medication, including evidence the following was evaluated ...c. whether the resident experienced any medication-related adverse consequences during the previous quarter ...." This policy did not indicate specific guidelines for monitoring a resident receiving an anti-anxiety or anti-depressant medication for adverse side effects. 3.1-48(a)(3)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. This visit was in conjunction with the Investigation of Complaint IN00400592. Survey dates: March 13, 14, 15, 16, and 17, 2023 Facility number: 012931 Residential Census: 23	R 0000	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible	

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	Heritage Pointe of Fort Wayne was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality reivew completed March 20, 2023 .		allegation of compliance. The Facility respectfully requests paper compliance for this citation.	