STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155120	A. BUILDING 00 B. WING	01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - BRANDYWINE CARE CENTER	745 N SWOPE ST GREENFIELD, IN 46140

(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 a Recertification and State Licensure Survey. Survey dates: January 2, 3, 4, 5, 8, and 9, 2024 Facility number: 000050 Provider number: 155120 AIM number: 100266170 Census Bed Type: SNF/NF: 106 Total: 106 Census Payor Type: Medicare: 12 Medicaid: 75 Other: 19 Total: 106 This deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on January 11, 2024	F 0000	Preparation, submission and implementation of this Plan of Correction does not constitute an admission or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction was prepared and executed as a means to continuously improve the quality of care and comply with all applicable federal and state requirements. The facility respectfully requests a desk review of our responses to this survey.	
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on interview and record review, the facility failed to honor the time of bathing preferences for	F 0558	F 558: Reasonable Accommodations Needs/Preferences	01/25/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Colleen McCreary-Warnick	Executive Director	01/25/2024

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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	2 of 4 residents reviewed for bathing needs. (Resident 30 and 32) Findings include: 1. The clinical record for Resident 30 was reviewed on 11/8/2024 at 10:48 a.m. The medical diagnosis included dementia. A Quarterly Minimum Data Set (MDS) Assessment, dated 11/6/2023, indicated Resident 30 was cognitively impaired and did not reject care. A resident preference evaluation, dated 11/16/2023, indicated that Resident 30 preferred to take showers in the morning. The facility task documentation indicated to offer Resident 30 showers two times a week on Tuesday and Friday evenings. 2. The clinical record for Resident 32 was reviewed on 1/9/2024 at 10:26 a.m. The medical diagnosis included Alzheimer's disease. A Quarterly MDS Assessment, dated for 12/20/2023, indicated Resident 32 was cognitively intact and did not reject care. An interview with Resident 32 on 1/3/2023 at 11:58 a.m. indicated that she does not get her showers when she would like them. She stated her preference was to have her showers around 3 p.m., but the staff often do not offer it until right before bed (around 8-10 p.m.) She indicated she often tells the direct care staff she wants her showers earlier and they will tell her they are too busy earlier in the shift to give her a shower.		What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident 30: Clinical record was reviewed and plan of care and Kardex was updated to include preference for shower/bathing. Resident 32: No longer resides at the facility How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken Initial audit : The facility reviewed all residents clinical records to ensure their plan of care and Kardex honored their time of bathing/shower preferences. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur Education : Clinical staff were educated on the Guideline Promoting/Maintaining Resident Self-Determination to include but not limited to honoring the residents choice and preferences for bathing/shower times. On-going monitoring : The DNS or designee will interview or observe 4 residents per day to ensure residents preference regarding bathing/showering is honored and any updates or changes needed to the clinical record are done timely. These reviews to be conducted 5 times weekly x 4 weeks, then 3	

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	An interview with Resident 32 on 1/5/2024 at 11:24 a.m. indicated she had refused her shower on Wednesday (1/3/2024) because they tried to give it right before bed. A resident preference assessment, dated for 4/4/2023, indicated it was very important for Resident 32 to decide her bathing preferences. Review of shower documentation for Resident 32 indicated she refused showers offered on 12/3/2023 at 8:42 p.m., 12/6/2023 at 9:18 p.m., 12/13/2023 at 9:21 p.m., 12/17/2023 at 9:30 p.m., and 1/3/2024 at 8:25 p.m. A policy entitled, "Promoting/Maintaining Resident Self-Determination", was provided by the Director of Clinical Operations on 1/8/2024 at 11:00 a.m. The policy indicated, " ...Each resident has the right to choose their schedules (including sleeping, eating, bathing, and waking times) ..." 3.1-3(v)(1)		times weekly x 4 weeks, then weekly x 4 months. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations. If issues/trends are identified, then will continue audits based on QAPI recommendation. If none noted, then will complete audits based on a prn basis.	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview and record review the facility failed to provide nail care for a dependent resident with bilateral hand contractures for 1 of 5 residents reviewed for Activities Of Daily Living (ADL) (Resident 29). Finding include:	F 0677	F 677 D : ADL Care Provided for Dependent Residents What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident 29: Clinical record was reviewed and updated to reflect residents current ADL needs to	01/25/2024

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	During an observation on 1/03/24 at 11:18 a.m.,. Resident 29 had long fingernails on both hands with peeling fingernail polish, the resident had bilateral hand contractures and the resident's fingernails were pressing into the palms of her hands. During an interview with Resident 29's family member on 1/03/24 at 11:40 a.m., indicated Resident 29's fingernails were too long and needed to be trimmed. . During an observation on 1/04/24 at 1:04 p.m., Resident 29 had long fingernails on both hands with peeling fingernail polish, the resident had bilateral hand contractures and the resident's fingernails were pressing into the palms of her hands. During on observation on 1/05/24 at 10:38 a.m., Resident 29 had long fingernails on both hands with peeling fingernail polish, the resident had bilateral hand contractures and the resident's fingernails were pressing into the palms of her hands. Review of the record of Resident 29 on 1/8/24 at 1:40 p.m., indicated the resident's diagnoses included, but were not limited to, dementia, psychotic disorder with delusions, weakness and joint stiffness and bilateral hand contractures. The plan of care for Resident 29, dated 7/12/23, indicated the resident had physical functioning/self care deficit secondary to dementia. The resident required assistance with personal hygiene and grooming. The interventions included, but were not limited to, was dependent on one person for assistance with personal hygiene.		include nail care completed. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken Initial audit : Resident with hand contractures were reviewed and clinical record reflects residents current ADL needs to include nail care. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur Education : Clinical staff were educated on the guideline for Nail care to include but not limited to completing routine nail inspection and care during ADL/Grooming and Hygiene care. On-going monitoring : DNS or designee will observe 4 residents daily to ensure nail care or inspection has been completed. These reviews to be conducted 5 times weekly x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 months. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations. If issues/trends are identified, then will continue audits based on	

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	The Quarterly Minimum Data (MDS) assessment for Resident 29, dated 12/26/23, indicated the resident was severely impaired for daily decision. The resident was dependent on staff for personal hygiene. During an interview with the Director Of Nursing on 1/8/24 at 2:45 p.m., indicated it was the responsibility of the CNA's to ensure Resident 29 was provided nail care. The nail care policy provided by the Director Of Clinical Operations on 1/9/24 at 10:45 a.m., indicated the purpose was to provide guidelines for the provision of care to a resident's nails for good grooming and health. Routine cleaning and inspection of nails would be provided during ADL care on an ongoing basis. 3.1-38(a)(3)(E)		QAPI recommendation. If none noted, then will complete audits based on a prn basis.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review the facility failed to obtain daily weights as ordered by the physician for Congestive Heart Failure (CHF), failed to follow the physician order to hold blood pressure medications per parameters and failed to	F 0684	F 684 D : Quality of Care What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?	01/25/2024

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	obtain Foley catheter and catheter care orders for 3 of 3 residents reviewed for quality of care (Resident 61, Resident 14 and Resident 9). Findings include: 1.) Review of the record of Resident 61 on 1/8/23 at 11:40 a.m., indicated the resident's diagnosis included, but were not limited to, congestive heart failure. The January 2024 physician Recapitulation order for Resident 61, (original order date 2/23/23), indicated the resident was to have daily weights completed due to congestive heart failure. The facility was to notify the physician/Nurse Practitioner if the resident has 3 pounds or greater gain in 1 day or 5 pounds or more in a week. The Medication Administration Record (MAR) for Resident 61, dated December 2023, indicated the resident weight was 105.8 pounds on 12/23/23, the resident's weight was not completed on 12/24/23, 12/25/23 or 12/26/23. The resident's weight was 118 pounds on 12/27/23, this indicated a 12.2 pound weight gain. During an interview with the Director Of Nursing (DON) on 1/8/23 at 2:48 p.m., indicated it was the responsibility of the nurse and CNA to obtain Resident 61's daily weights as ordered by the physician on 12/24/23, 12/25/23 and 12/26/23. 2. The clinical record for Resident 9 was reviewed on 1/5/2023 at 2:40 p.m. The medical diagnoses included stroke and Alzheimer's disease. An Admission Minimum Data Set Assessment, dated for 12/8/2023, indicated that Resident 9 had both short- and long-term memory problems, was dependent on staff for activities of daily living,		Resident 61: Clinical record was reviewed for completion of physician orders regarding daily weights. Resident 14: Clinical record was reviewed for completion of physician orders and following parameters for medication administration. Resident 9: Clinical record was reviewed and include orders for use and care of foley catheter. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken Initial audit: Clinical records were reviewed for the following: Residents with orders for daily weights were reviewed to include documentation of weights and Provider notification when needed per parameters. Residents with orders to obtain blood pressure prior to administering medication have parameters followed and Provider notification when indicated. Residents with indwelling foley catheters have orders for use and care. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur Education : Nurses were educated on the guideline for Foley Catheter and Catheter Care to include but not limited to orders for use and	

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	utilized an indwelling urinary catheter, was at risk for pressure areas, and currently had three pressure areas. A urinary catheter care plan, dated for 12/11/2023, indicated Resident 9 utilized an indwelling urinary catheter. Physician orders for catheter sizing and care were added to Resident 9's medical chart on 12/18/2023. An interview with the Director of Nursing on 1/8/2024 at 1:30 p.m. indicated that the clinical staff review the admission orders on the next business day for completeness and accuracy. 3. The clinical record for Resident 14 was reviewed on 1/9/2024 at 10:32 a.m. The medical diagnoses included anxiety and disorganized schizophrenia. A Quarterly Minimum Data Set Assessment, dated 1/2/2024, indicated Resident 14 cognitively intact. A physician order, dated for 6/23/2023, indicated to obtain blood pressure for Resident 14 prior to medication administration and to hold blood pressure medication if systolic blood pressure (top number) is under 110 or diastolic blood pressure (bottom number) is less than 60. Review of the December medication administration record (MAR) for Resident 14 indicated the following blood pressures with a diastolic blood pressure less than 60: 12/9/2023 - 150/53 12/10/2023 - 142/59 12/23/2023 - 136/47 12/24/2023 - 148/37 Further review of the December MAR indicated		care. Nurses (QMA included) were educated on following Physician orders to include medications with parameters are followed and medications held when indicated. Weights are obtained per physician orders and Provider notified when indicated. On-going monitoring : DNS or designee will review the clinical record for new admissions or residents with newly placed indwelling catheter to ensure record includes orders for use and care. DNS or designee will review clinical record for 5 residents with orders for daily weights and/or blood pressure medication with parameters for completion per physician orders. These reviews to be conducted 5 times weekly x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 months. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations. If issues/trends are identified, then will continue audits based on QAPI recommendation. If none noted, then will complete audits based on a prn basis.	

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	Resident 14 received blood pressure medications on 12/9/2023, 12/10/2023, 12/23/2023, and 12/24/2023 without notification to the physician of the out-of-range blood pressure readings. An interview with the Director of Clinical Operations on 1/8/2024 at 11:08 a.m. indicated the expectation is that nursing staff will follow physician orders as written or to notify physician of discrepancy. A policy entitled, "Admission Orders", was provided by the Director of Clinical Operations on 1/8/2024 at 11:00 a.m. indicated at the time of admission, orders should include at a minimum routine care orders that should allow facility staff to provide essential care to the resident consistent with their physical status. 3.1-37(a)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.	F 0686	F 686 D : Treatment/Services to	01/25/2024

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	Based on interview, record review, and observations, the facility failed to utilize pressure relieving boots for a dependent resident at risk for developing pressure areas for 1 of 1 residents reviewed for pressure areas. (Resident 9) Findings include: The clinical record for Resident 9 was reviewed on 1/5/2023 at 2:40 p.m. The medical diagnoses included stroke and Alzheimer's disease. An Admission Minimum Data Set Assessment, dated for 12/8/2023, indicated that Resident 9 had both short- and long-term memory problems, was dependent on staff for activities of daily living, utilized an indwelling urinary catheter, was at risk for pressure areas, and currently had three pressure areas. A pressure area care plan, dated for 12/11/2023, indicated for Resident 9 to utilized prevalon boots, a type of pressure reliving boots. An observation on 1/2/2024 at 11:45 a.m. indicated Resident 9 laying in bed with a low air loss mattress in place. Her prevalon boots were sitting next to her bed in a chair. An observation on 1/2/2024 at 1:40 p.m. indicated Resident 9 laying in bed with a low air loss mattress in place. Her prevalon boots were sitting next to her bed in a chair. An interview with the Assistant Director of Nursing on 1/8/2024 at 1:00 p.m. indicated that Resident 9 does not refuse care and it is the responsibility of her direct care staff to ensure pressure relieving measures were in place.		Prevent/Heal Pressure Ulcers What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Residents 9: Clinical Record was reviewed and orders, care plan and Kardex reflect residents current care needs. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken Initial audit : Residents that have orders for Boots or heel offloading devices have boots/device available and in use per plan of care or orders. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur Education : Clinical Staff were educated on the guideline for Pressure Injury Prevention and Management to include but not limited to following physician orders and plan of care for use of pressure reducing devices. On-going monitoring : DNS or designee will round on a sampling of residents that have offloading devices in place to ensure the residents plan of care is followed. These reviews to be conducted 5 times weekly x 2 weeks, then 3 times weekly x 6 weeks, then weekly x 4 months. How the corrective action will be	

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	A policy entitled, "Pressure Injury Prevention and Management", was provided by the Director of Nursing on 1/8/2024 at 1:30 p.m. the policy indicated, " ...The facility is committed to the prevention of avoidable pressure injuries ..." 3.1-40(a)(2)		monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations. If issues/trends are identified, then will continue audits based on QAPI recommendation. If none noted, then will complete audits based on a prn basis.	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, interview and record	F 0692	F 692 D: Nutrition/Hydration Status Maintenance	01/25/2024

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	review the facility failed to provide fortified pudding at lunch as ordered by the physician for a resident with a history of significant weight loss for 1 of 5 residents reviewed for nutrition (Resident 61). Finding include: During an observation on 1/03/24 at 12:33 p.m., Resident 61 was thin in appearance. During an observation on 1/04/24 at 1:02 p.m., Resident 61 was eating lunch in her room, the resident did not have fortified pudding on her tray. During an observation and interview on 1/05/24 at 12:52 p.m., Resident 61 was eating lunch in her room, the resident did not have fortified pudding on her tray. The resident's tray card indicated she was to have fortified pudding. Resident 61 indicated sometimes she received her fortified pudding and sometimes she did not. Review of the record of Resident 61 on 1/8/23 at 11:40 a.m., indicated the resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease, congestive heart failure, hypertension, muscle weakness, gastro-esophageal reflux and chronic kidney disease. The plan of care for Resident 61, dated 12/26/23, indicated the resident was malnourished and had a Body Mass Index (BMI) less than 22. The resident had a weight loss of 5% in the last month (11/23/23). The interventions included, but were not limited to, fortified pudding with lunch (12/14/23).		What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident 61: Clinical record was reviewed. Facility ensured physician orders are followed for providing fortified supplement on meal tray. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken Initial audit : Resident with orders for fortified supplements to be provided on meal tray were reviewed to ensure supplement is provided by dietary staff on the meal tray as ordered. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur Education : Dietary staff and Clinical staff were educated on the guideline for Weight Monitoring to include but not limited to providing interventions as ordered and per the plan of care. On-going monitoring : Dietary Manager or designee will review 5 meal trays to ensure residents with orders for fortified supplements with meals receive them per their plan of care. These reviews to be conducted 5 times weekly x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 months. To include	

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	155120	A. BUILDING 00 B. WING	01/09/2024

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	The Interdisciplinary Team (IDT) Nutrition at Risk progress note for Resident 61, dated 12/21/23, indicated the resident's weight was down 10.9% in 30 days. The resident's Body Mass Index (BMI) was 18.7 and she was underweight range with inadequate oral intake. The resident's weight was 105.8 pounds. The intervention included, but were not limited to, fortified pudding with lunch. The Interdisciplinary Team (IDT) Nutrition at Risk progress note for Resident 61, dated 1/4/24, indicated the resident's weight had improved and the resident's weight was 113 pounds. The intervention in place included, but were not limited to, fortified pudding at lunch. The January 2024 physician Recapitulation order for Resident 61, (original order date 12/14/23), indicated the resident was ordered to have fortified pudding at lunch. The Significant Change Minimum Data Set (MDS) for Resident 61, dated 12/11/23, indicated the resident was cognitively intact for daily decision making. The resident had a weight loss of 5% or more in the last month or loss of 10% in six months that was not a prescribed weight loss regimen. During an interview with the Dietary Manager on 1/8/23 at 1:25 p.m., indicated the Dietary Aide was was responsible to ensure Resident 61 receives her fortified pudding at lunch. The weight monitoring policy provided by the Director Of Nursing (DON) on 1/8/24 at 1:30 p.m., indicated the based on the resident's comprehensive assessment, the facility would ensure that all residents maintain acceptable parameters of nutritional status. The plan would		observation of breakfast, lunch and dinner during the week. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations. If issues/trends are identified, then will continue audits based on QAPI recommendation. If none noted, then will complete audits based on a prn basis.	

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	include, but were not limited to, identify resident specific interventions. Interventions would be identified, implemented, and monitored. 3.1-46(a)(1) 3.146(a)(2)			
F 0756 SS=D Bldg. 00	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to			

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	address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. Based on interview and record review, the facility failed to ensure the attending physician reviewed and signed medication regimen reviews (MRR) for 2 of 5 residents reviewed for unnecessary medications. (Resident 14 and 50) Findings include: 1. The clinical record for Resident 14 was reviewed on 1/9/2024 at 10:32 a.m. The medical diagnoses included anxiety and disorganized schizophrenia. A Quarterly Minimum Data Set Assessment, dated 1/2/2024, indicated Resident 14 was cognitively intact. A MRR review, dated for 6/28/2023, indicated a recommendation for a gradual dose reduction (GDR) for Zoloft or guidance to document a contraindication to the GDR. This MRR was not signed by a provided until 8/28/2023 to reflect to attempt the GDR for Resident 14's Zoloft. The attending physician visited Resident 14 on 7/8/2023.	F 0756	F 756 D: Drug Regimen Review, Report Irregular, Act on What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident 50: Clinical record was reviewed all drug regimen reviews and have been addressed by provider. Resident 14: Clinical record was reviewed all drug regimen reviews and have been addressed by provider. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken Initial audit : A 15 day look back was completed of all current residents that had a drug regimen review completed to ensure they were reviewed by the provider on their next visit with the resident. What measures will be put into place and what systemic changes	01/25/2024

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	The psychiatric nurse practitioner visited Resident 14 on 7/13/2023. 2. Resident 50's record was reviewed on 1/04/24 at 11:10 a.m. The record indicated Resident 50 had diagnoses that included, but were not limited to, dementia with psychotic disturbance, anxiety, high blood pressure, depression, type 2 diabetes mellitus, diverticulosis of intestine, tremor, Parkinsonism, and generalized muscle weakness. An Annual Minimum Data Set assessment, dated 11/10/23, indicated Resident 50 was severely impaired in cognitive skills for daily decision making, had dementia, and received insulin, antipsychotic medications, and diuretics. A Medication Regimen Review (MRR), dated 5/21/23, indicated a recommendation for: "Current order: Latuda 20 mg (milligrams) qd (every day). Within the first year a resident is admitted on an antipsychotic medication, or after an antipsychotic medication has been initiated in the facility, a gradual dose reduction (GDR) must be attempted in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, a GDR must be attempted annually, unless clinically contraindicated. Recommendation: Please consider reducing or dcing (discontinuing) medication. If a GDR is clinically contraindicated at this time, pleas document the clinical rationale. This must address the reason(s) why an attempted dose reduction would likely impair function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder." The physician did not follow up on this recommendation until 7/4/23.		will be made to ensure that the deficient practice does not recur Education : Clinical staff (Nurses, Social Services, Medical Records) were educated on the guideline for Addressing Medication Regimen Review Irregularities to include timely review by the provider to address recommendations. On-going monitoring : DNS or designee will review the monthly Medication Regimen Reviews received by the pharmacist and ensure they are addressed by the Provider on their next visit to the facility. Reviews to be conducted twice a month following the pharmacist visit and review and ongoing for six months. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations. If issues/trends are identified, then will continue audits based on QAPI recommendation. If none noted, then will complete audits based on a prn basis.	

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	An MRR, dated 6/27/23, indicated a recommendation for: "Current order: Omeprazole 20 mg qd. This patient has been receiving the above PPI (proton pump inhibitor) for GERD (gastro-esophageal reflux disease)...Recommendations: Please evaluate and consider discontinuing this PPI and attempting a trial of...famotidine 40 mg po (by mouth) hs (bedtime) or DC (discontinue) the PPI, if clinically appropriate." The physician did not follow up on the recommendation until 8/17/23. An MRR, dated 6/27/23, indicated a recommendation for: "CMS (Centers for Medicare and Medicaid Services) guidelines require periodic evaluation of antidepressants for potential reductions in dose to determine if the symptoms can be controlled utilizing a lower dose of if the antidepressant can be discontinued. Please evaluate if a dose reduction may be clinically appropriate. If a gradual dose reduction is clinically contraindicated at this time, please document the clinical rational below. The following information may assist with documentation. 1)____Attempt a dose reduction: D/C. 2)____A GDR is not clinically appropriate at this time, The risk vs. benefit has been evaluated and the attempt would likely impair the resident's function, exacerbate the underlying psychiatric/medical condition or increase the residents expression and/or indications of distress. 3)____Other:_____." The physician did not follow up on the recommendation until 8/17/23. A policy for "Addressing Medication Regimen			

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	Review Irregularities" was provided by the Director of Nursing on 1/8/24 at 1:30 p.m. The policy included, but was not limited to, "It is the policy of this facility to provide a Medication Regimen Review (MRR) for each resident in order to identify irregularities and respond to those irregularities in a timely manner to prevent the occurrence of an adverse drug event...4. The pharmacist must report any irregularities to the attending physician, the facility's medical director and director of nursing, and the reports must be acted upon...5. The report should be submitted to the DON within 10 working days of the review...." On 1/09/24, at 11:02 a.m., the Director of Clinical Operations indicated their policy doesn't talk about a time frame and provided the state regulation. 3.1-25(i)			