STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155377	A. BUILDING 00 B. WING	01/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SEYMOUR CROSSING	707 S JACKSON PARK DR SEYMOUR, IN 47274

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00424028. Complaint IN00424028 - No deficiencies related to the allegations are cited. Survey dates: January 16, 17, 18, 22, and 23, 2024 Facility number: 000272 Provider number: 155377 AIM number: 100274710 Census Bed Type: SNF/NF: 73 Total: 73 Census Payor Type: Medicare: 2 Medicaid: 54 Other: 17 Total: 73 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on January 29, 2024.	F 0000	This Plan of Correction constitutes the facility's written allegation of compliance for the deficiencies cited. This submission of this Plan of Correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report. We respectfully request a desk review and ask that your office accept this plan as our facility's compliance. [Please review the attachments provided with this plan of correction, which include audit and re-education tools.] Please feel free to contact Jay Myers, Executive Director, should you need any additional information to support the desk review at 812-522-2419. Thank you for your consideration.	
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment,			

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

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	involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on record review and interview, the facility failed to ensure a resident was free from verbal abuse for 1 of 24 residents reviewed. (Resident 51) Findings include: The clinical record for Resident 51 was reviewed on 01/18/24 at 9:11 A.M. A Significant Change MDS (Minimum Data Set) assessment, dated 12/11/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, dementia, hypokalemia, renal insufficiency, and hemiplegia. During an interview on 01/22/24 at 10:32 A.M., LPN (Licensed Practical Nurse) 3 indicated there had been an incident involving the resident during wound care. CNA (Certified Nurse Aide) 4 was assisting the LPN by holding the resident on his side while the LPN provided a wound treatment to the resident's leg. During the procedure, the CNA yelled out something to the affect, "don't scratch me or I will hit you in the face." The LPN was unsure of the exact wording but indicated her statement in the written report was correct. It happened very quickly. She did not see the resident scratch the CNA, but the resident had a history of combativeness. The LPN immediately had the CNA leave the room. Management was there in the building. The LPN got the CNA away from all the residents and	F 0600	This tage was pass noncopliance	02/09/2024

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	management staff took control of the situation. During an interview on 01/22/24 at 10:39 A.M., the DON (Director of Nursing) indicated LPN 6 immediately walked the employee to the time clock and out of the facility following the incident. Then the DON, LPN 6, the IP (Infection Preventionist), and the Administrator started the investigation. The SSD (Social Services Director) started interviewing residents, a head to toe assessment was completed on Resident 51 and all other residents with low cognition levels. There were no other findings with any of the other residents. During an interview on 01/18/24 at 9:02 A.M., the Administrator and IP indicated the resident was aggressive at times. CNA 4 had only worked there a couple of months and had not had any inappropriate encounters verbally or physically with any of the residents prior to the incident on 11/11/23 at 12:29 P.M. Staff were in-serviced and re-educated following the incident. During an interview on 01/18/24 at 12:41 P.M., CNA 8 indicated they had not seen or heard staff members be abusive to residents. They were in-serviced and re-educated on abuse regularly. They were in-serviced about a week and a half ago. The employee record for CNA 4 (involved in the incident) was reviewed on 01/18/24 at 9:18 A.M., and indicated they were educated on abuse and had received 100% on the test dated 07/28/23. They were educated on "Code of Conduct", the "Elder Justice Act Policy", and had completed the required six hours of dementia training for 2023. Their criminal background check was completed and clear.			

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	The signed statement from LPN 3, following the incident, dated 11/11/23 at 12:29 P.M., was provided by the Administrator on 01/22/24 at 11:00 A.M. The record indicated the LPN had asked CNA 4 to help her with Resident 51 while she administered his treatment. The CNA turned the resident to his right side. As the LPN was applying a dressing to the resident, she felt the CNA's arm jerk away from the resident as the CNA repeated twice, "If you scratch me again, I will punch you in the face." The LPN stopped the procedure and immediately escorted the CNA to the nurse's station, notified management, and management led the CNA away from the nurse's station. The current "Abuse Prohibition, Reporting, and Investigation" policy, with a revised date of June 2023, was provided following the Entrance Conference. The policy indicated, "...It is the policy of American Senior Communities to provide each resident with an environment that is free from abuse...This includes but is not limited to verbal abuse...American Senior Communities will not permit residents to be subjected to abuse by anyone, including employees..." The Past noncompliance began on 11/11/23 and the deficient practice was corrected on 11/17/23 prior to the start of the survey. The facility implemented a systemic plan that included the following actions: The facility completed staff education on the resident abuse and neglect policy, facility wide resident re-assessments completed for abuse, and a Resident Council Meeting in which staff reviewed the process of filing grievances, the types of abuse and the process for reporting. 3.1-27(b)			

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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, observation, and record review, the facility failed to ensure surgical wound treatments were administered appropriately and follow physician's orders related to hold parameters for cardiac medications for 3 of 18 residents reviewed for quality of care. (Residents 71, 14, 59) Findings include: 1. During an interview on 01/16/24 at 2:44 P.M., Resident 71 indicated she had bilateral nephrostomies (a surgical procedure where a tube was inserted into the kidney to drain urine) last month. The tube in the right kidney leaked urine all the time. Nursing staff didn't change the dressings at the insertion sites with any regularity. Recently, they had a meeting and she asked them to increase the dressing changes from once a day to twice a day. They still didn't always do it when they were supposed to. The resident's clothing on the right side was observed, with an area approximately four inches in diameter that appeared to be wet. The resident lifted her sweatshirt and the nephrostomy tubing on the right was observed. The tubing was wet, with urine dripping down the outside of the tube. The surgical site dressing was unable to be visualized.	F 0684	**F 684** **It is the standard of this facility to follow the physicians orders and to ensure surgical wound treatments are administered appropriately.** **1)** **What corrective action will be accomplished for those residents found to have been affected by the deficient practic e?** Resident #14's EMARs were reviewed on 2/13/24 at which time physician was contacted and notified of Metoprolol Tartrate being given outside hold parameter orders on1/1/24, 1/2/24, 1/8/24, 1/9/24, 1/11/24, 1/20/24, & 1/21/24. Resident #59's EMARs were reviewed on 2/13/24 at which time physician was contacted and notified of Metoprolol Tartrate being given outside hold parameter orders on 11/11/23, 11/14/23, 11/23,23, 11/25/23, 12/7/23, 12/8/23, 12/16/23, 12/17/23,	02/16/2024

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	The resident's clinical record was reviewed on 01/22/24 at 3:25 P.M. An Admission MDS (Minimum Data Set) assessment, dated 12/13/23, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, heart failure, kidney disease, and malnutrition. The resident's current physician's orders included an open-ended order, with a start date of 01/15/24, staff were to cleanse both nephrostomy tube sites with normal saline, pat dry, apply a drain sponge, and cover with a transparent dressing, twice a day. On 01/18/24 at 12:43 P.M., the resident was observed in her room eating lunch. The resident indicated her nephrostomy tube on the right side did not leak in bed the night before, however, staff were supposed to change the dressings twice a day and they hadn't been changed since the day before yesterday. A wet area approximately two inches in diameter was observed on the resident's sweatshirt near the tube insertion site. The resident's dressings were observed on 01/18/24 at 2:36 P.M., with LPN (Licensed Practical Nurse) 2. The dressing on the left was clean, dry, and intact. The dressing on the right was intact, but soaked through, with a dark yellow/brown area approximately 2 by 2 inches visible through the dressing. Neither dressings were dated or initialed. LPN 2 removed the old dressings and cleansed the tube insertion sites. Both insertion sites were observed and were without signs of infection. The skin around the right insertion site was slightly reddened where the dressing had been in place. LPN 2 indicated she forgot to date and initial the dressings when she last changed		12/29/23, 15/24, 1/6/24, 1/11/24, and 1/12/24. Resident #71's EMAR and Nephrostomy tube orders were reviewed on 2/13/24 at which time the physician was contacted and notified of missing date/initial on new dressings. **2)** **How other residents having the potential to be affected by t he** **same deficient practice will be identified and what corrective action(s) will be taken.** All residents having hold parameters related to their blood pressure medication and nephrostomy tubes have the potential to be affected by the alleged deficient practice. A hold parameters audit was completed on all resident who have hold parameters for the last 30 days to ensure they were followed. A surgical wound audit was completed on all resident who have Nephrostomy tubes to ensure dressing changes are occurring as well has being dated on initialed. Audit were completed on 2/9/24, with no findings. **3)** **What measures will be put into place or what systemic changes will be made to ensur e** **that the deficient practice does not recur?** The DON or designee in-serviced	

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	them. The LPN indicated she last changed the resident's dressing the day before (yesterday). The LPN cleansed the sites and applied new dressings. The current facility policy, titled "Dressing Change Clean Technique (Incision or Wound)", with a most recent revision date of 07/2023, was provided by the DON (Director of Nursing) on 01/23/24 at 1:59 P.M. The policy indicated, "...Apply treatment...Date and initial new dressing..." 2. The clinical record for Resident 14 was reviewed on 01/22/24 at 2:05 P.M. A Quarterly MDS assessment, dated 12/05/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, hypertension, diabetes, and dementia. The EMAR/ETAR (Electronic Medication Administration Record/Treatment Administration Record) for January 2024, was provided by the DON on 01/23/24 at 2:34 P.M. The record included, but was not limited to, the following current, open-ended physician's order, with a start date of 07/25/23, staff were to administer Metoprolol Tartrate 12.5 mg (milligrams), every 12 hours. The medication was to be held if the resident's systolic blood pressure (top number) was less than 100 or the pulse was less than 60. The record indicated the medication was given on the following dates and times when the systolic blood pressure was less than 100 or the pulse was less than 60: - 01/01/24 from 6:00 P.M. to 10:00 P.M., when the pulse was 56, - 01/02/24 from 11:00 A.M. to 2:00 P.M., when the pulse was 57 and the blood pressure was 90/50, - 01/08/24 from 6:00 P.M. to 10:00 P.M., when the		facility nurses on following physicians orders related to hold parameters for blood pressure medication and on Dressing Change Clean Technique skills validation. The DON or designee will review blood pressure medications with hold parameters daily during the clinical meeting. The DON or designee will completed a review of the dressings during wound rounds weekly. **4)** **How the corrective action(s) will be monitored to ensure the** **deficient practice will not recur , i.e. what quality assurance program will be put into place?** **.** To ensure compliance the DNS/Designee will complete blood pressure medication reviews if they include hold parameters & wound & skin prevention CQI audit tool, weekly x 4 weeks, then monthly x 6 months, and quarterly thereafter. CQI committee will determine need for further review. The results of these audits will be reviewed by the CQI Committee, if threshold of 100% is not achieved an action plan will be completed. Deficiency in this practice will result in disciplinary action up to and including termination.	

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	pulse was 50, - 01/09/24 from 6:00 P.M. to 10:00 P.M., when the pulse was 58, - 01/11/24 from 11:00 A.M. to 2:00 P.M., when the pulse was 54, - 01/20/24 from 11:00 A.M. to 2:00 P.M., when the pulse was 58, and - 01/21/24 from 11:00 A.M. to 2:00 P.M., when the pulse was 58. The Progress Notes were provided by the DON on 01/23/24 at 2:34 P.M. The record lacked documentation the medication was held on the above listed dates. 3. The clinical record for Resident 59 was reviewed on 01/22/24 at 3:54 P.M. A Quarterly MDS assessment, dated 11/17/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, anemia, hypertension, non-Alzheimer's dementia, anxiety, and depression. A current, open-ended physician's order, with a start date of 05/26/23, indicated the staff were to administer metoprolol tartrate 25 mg, every 12 hours. The medication was to be held if the systolic blood pressure was less than 110 or the pulse was less than 60. The November, December 2023, and January 2024 EMAR/ETAR indicated the medication was given the following dates and times when the systolic blood pressure was less than 110 or the pulse was less than 60: - 11/11/23 at 8:00 P.M., when the blood pressure was 106/58, - 11/14/23 at 8:00 A.M., when the blood pressure was 106/89 and the pulse was 55, - 11/23/23 at 8:00 P.M., when the blood pressure			

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	was 106/80, - 11/25/23 at 8:00 A.M., when the blood pressure was 110/63 and the pulse was 52, and at 8:00 P.M., when the blood pressure was 100/56 and the pulse was 56, - 12/07/23 at 8:00 A.M., when the pulse was 56, - 12/08/23 at 8:00 A.M., when the pulse was 57, - 12/16/23 at 8:00 A.M., when the pulse was 56, - 12/17/23 at 8:00 A.M., when the pulse was 59, - 12/29/23 at 8:00 P.M., when the blood pressure was 98/64, - 01/05/24 at 8:00 P.M., when the blood pressure was 106/64, - 01/06/24 at 8:00 P.M., when the blood pressure was 104/65, - 01/11/24 at 8:00 A.M., when the blood pressure was 108/59, and - 01/12/24 at 8:00 A.M., when the pulse was 59. During an interview on 01/23/24, RN 7 indicated when a resident had a medication that required a blood pressure or pulse checked prior to administering, she would obtain the blood pressure and pulse. If the vitals were out of the range required for the medication to be given the medication would be held, and she would document "not administered" in the EMAR. During an interview on 01/23/24 at 4:13 P.M., the Administrator indicated the facility did not have a policy for following physician's orders. It was a standard practice. 3.1-37(a)			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services,			

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	consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, interview, and record review, the facility failed to implement a dressing change for a resident with a central line for 1 of 2 residents reviewed for dialysis. (Resident 49) Findings include: During an interview and observation on 01/16/24 at 12:03 P.M., Resident 49 had a dressing to his right upper chest. The bottom part of the dressing was cut, with the bottom of the dressing open and the central line ports were hanging out the bottom. The dressing was undated. The resident indicated the central line ports were used in the past for dialysis. During an observation on 01/18/24 at 9:34 A.M., the resident was lying in bed, asleep. There was a dressing visible to the right upper chest that was cut at the bottom. The bottom of the dressing was open and the central line ports were hanging out the bottom. The dressing was undated. During an observation on 01/18/24 at 12:34 P.M., the resident was lying in bed. There was a dressing visible to the right upper chest that was cut at the bottom. The bottom of the dressing was open and the central line ports were hanging out the bottom. The dressing was undated. During an interview on 01/23/24 at 9:19 A.M., LPN (Licensed Practical Nurse) 9 indicated the resident had a port in the right upper chest for dialysis. They were working on getting it removed as the resident didn't need to receive dialysis anymore. The port was monitored every shift.	F 0698	**F 698** **It is the standard of this facility to implement a dressing change for a resident with a central line.** **1) What corrective action(s) will be accomplished for the residents found to be affected by the deficient practice?** Resident #49's dialysis orders were reviewed on 2/13/24 at which time the physician was contacted and order received to change central line every 7 days and PRN. **2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** All dialysis residents admitted with central lines had the potential to be affected by the alleged deficiency. An order review was completed on all dialysis residents to ensure treatment orders are in place to change central line dressings every 7 days and PRN. The DNS or designee re-educated the facility nurses on the Dialysis policy with Central Line Sterile Dressing Change skill validations being completed. **3) What measures will be put into place or what systemic changes you will make to**	02/16/2024

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	They made sure the dressing was clean, dry, and intact. There should have been an order to change the dressing since the resident's dialysis was discontinued on January 5th. The clinical record for Resident 49 was reviewed on 01/22/24 at 2:57 P.M. An Admission MDS (Minimum Data Set) assessment, dated 12/116/23, indicated the resident was moderately cognitively intact. The diagnoses included, but were not limited to, heart failure, anemia, heart failure, hypertension, renal insufficiency, diabetes, anxiety, depression, and schizophrenia. The resident received dialysis while a resident. A Hot Charting Event, dated 01/08/24, indicated the resident's dialysis was discontinued. The clinical record lacked indication the resident had orders to change the dressing to the central line since the resident was discharged from dialysis on 01/08/24. The Complete Care Plan, was provided by the Administrator on 01/23/24 at 9:48 A.M. A Care Plan, with a start date of 12/11/23, indicated the resident was receiving hemodialysis. The interventions included, but were not limited to, treatment as ordered. The current facility policy titled, "Dialysis" with a revision date of 11/2017, was provided by the Administrator on 01/23/24 at 9:38 A.M. The policy indicated, "...to ensure that residents requiring dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care, and the residents' goals and preferences. The facility will assure that each resident receives care and services for the provision of hemodialysis and/or		**ensure that the deficient practice does not recur?** The DNS or designee re-educated the facility nurses on the Dialysis policy with Central Line Sterile Dressing Change skill validations being completed. When a resident admits to the facility or has a change in their dialysis status, orders will be obtained for the facility to complete central line dressing changes. The DNS or designee will review the facility activity report daily in clinical meeting to ensure there has been no change in dialysis status/dialysis order changes. The DNS or designee will complete a review of central line dressing changes during the wound rounds. **4)How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** To ensure compliance the DNS or designee will complete dialysis CQI audit tool weekly x 4 weeks, then monthly x 6 months, and quarterly thereafter. CQI committee will determine need for further review. The results of these audits will be reviewed by the CQI Committee, if threshold of 100% is not achieved an action plan will be completed. Deficiency in this practice will result in disciplinary action up to	

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(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
	peritoneal dialysis consistent with professional standards of practice...PROCEDURE...Physician Orders will be received at time if admission specific to the resident...dialysis access care...Access sites are clean, dry, and dressing is changed with clean technique per physician order..." The current facility policy titled, "Central Line Sterile Dressing Change", with a review date of 08/2017, was provided by the Administrator on 01/23/24 at 9:48 A.M. The policy indicated, "...Verify physician's order..."Label the dressing with the date, time and initials...Document the dressing change and other pertinent information..." 3.1-37(a)		and including termination.	
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 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 record review and interview that facility failed to follow the physician's orders, related to medications, for a resident with increased behaviors for 1 of 7 residents reviewed for unnecessary medications. (Resident 59)	F 0742	**F 742** **It is the standard of this facility to follow the physicians orders related to medications.** **1) What corrective action will be accomplished for those**	02/16/2024

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	155377	A. BUILDING 00 B. WING	01/23/2024

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	Findings include: The clinical record for Resident 59 was reviewed on 01/22/24 at 3:54 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 11/17/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, anemia, hypertension, non-Alzheimer's dementia, anxiety, and depression. A Psychiatry Initial Consult, dated 05/31/23, indicated the resident was seen in his room with his partner of 25 years. She provided much of the history as the resident was a poor historian. He was alert and pleasantly confused at the time. He stated he slept and ate well. He did endorse anxiety and depression but could not elaborate on the cause. The plan was to discontinue the resident's Lexapro (an antidepressant medication) and start Zoloft (an antidepressant) 50 mg (milligrams) daily x 2 weeks then increase to 100 mg A physician's order, dated 05/31/23 through 06/28/23, indicated the resident was to take Zoloft 50 mg, once a day. A Progress Note, dated 06/14/23 at 12:21 P.M., indicated the resident continued to have episodes of combative episodes of hitting staff with care. A Progress Note, dated 06/16/23 at 9:49 P.M., indicated the resident was noted to be in bed per his choice. He was noted to be yelling out off and on that evening. A Progress Note, dated 06/17/23, at 8:18 A.M., indicated the resident was combative with care. He was hitting and scratching staff, screaming and calling out.		**residents found to have been affected by the deficient practic e?** Resident #59's EMARs were reviewed on 2/13/24 at which time the physician was notified of orders 5/31/23 being transcribed incorrectly. No changes to current medication regime **2)** **How other residents having the potential to be affected by t he** **same deficient practice will be identified and what corrective action(s) will be taken.** All residents having psychotropic medications have the potential to be affected by the alleged deficient practice. A psychotropic medication audit was completed on 2/13/24 to ensure all order were transcribed properly for the last 30 days. The DNS or designee re-educated the facility nurses on the Psychotropic Management Policy. **3)** **What measures will be put into place or what systemic changes will be made to ensur e** **that the deficient practice does not recur?** The DNS or designee in-serviced facility nurses on the Psychotropic Management policy. The DNS or designee will review all new orders daily during morning meeting to ensure proper transcription.	

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	A Psychiatry Progress Note, dated 06/28/23, indicated the resident was seen that day. His partner was present, and she stated the resident was still combative with staff at times. The staff reported he always had delusions, thinking that someone would hurt him, but he was being treated for a UTI (Urinary Tract Infection) at the time too. The Zoloft was never increased to 100 mg as ordered. A physician's order, dated 06/28/23 through 08/30/23, indicated the resident was to take Zoloft 100 mg, once a day. A Progress Note, dated 06/28/23 at 11:43 A.M., indicated the resident was seen by the Psychiatric NP (Nurse Practitioner). A new order was obtained to increase the resident's Zoloft to 100 mg, daily. During an interview on 01/23/24 at 2:40 P.M., the IP (Infection Preventionist) indicated the resident's Zoloft medication should have been increased per the physician's order. The order was not transcribed correctly. During an interview on 01/23/24 at 4:13 P.M., the Administrator indicated the facility did not have a policy for following physician's orders. It was a standard practice. The current facility policy titled, "Psychotropic Management", wit a revised date of 7/22, was provided by the Administrator on 01/23/24 at 3:37 P.M. The policy indicated, "...to ensure that a resident's psychotropic medication regimen helps promote the resident's highest practicable mental, physical, and psychosocial well-being with person centered interventions and assessment..."		**4)** **How the corrective action(s) will be monitored to ensure the** **deficient practice will not recur , i.e. what quality assurance program will be put into place?** To ensure compliance the DNS/Designee will complete the Psychotropic management CQI audit tool, weekly x 4 weeks, then monthly x 6 months, and quarterly thereafter. CQI committee will determine need for further review. The results of these audits will be reviewed by the CQI Committee, if threshold of 100% is not achieved an action plan will be completed. Deficiency in this practice will result in disciplinary action up to and including termination.	

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	3.1-37(a)			
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on record review and interview, the facility failed to follow the physician's orders related to dementia care for 1 of 3 residents reviewed for Dementia Care. (Resident 59) Findings include: The clinical record for Resident 59 was reviewed on 01/22/24 at 3:54 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 11/17/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, anemia, hypertension, non-Alzheimer's dementia, anxiety, and depression. A Psychiatry Progress Note, dated 07/05/23, indicated the resident was seen in his room. The staff reported increased incidents of the resident calling out for his family member when his partner was not there. He was screaming and yelling throughout the day and night, begging the staff to stay with him and not leave him. A new order was obtained to start Namenda (cognition-enhancing medication) 5 mg (milligrams), twice a day for moderate vascular dementia with mood disturbances. The July and August EMAR/ETAR (Electronic Medication Administration Record/Electronic	F 0744	**It is the standard of this facility to follow the physicians orders related to Dementia Care.** **1) What corrective action will be accomplished for those residents found to have been affected by the deficient practic e?** Resident #59 EMARs were reviewed on 2/13/24 at which time the physician was notified of orders 7/5/23 not being initiated per MD order. **2)** **How other residents having the potential to be affected by t he** **same deficient practice will be identified and what corrective action(s) will be taken.** All residents having dementia medications have the potential to be affected by the alleged deficient practice. A medication audit was completed on 2/13/24 to ensure all order were transcribed properly for the last 30 days. The DNS or designee re-educated the facility	02/16/2024

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	Treatment Administration Record) indicated the resident received Namenda 5 mg daily. The clinical record indicated the medication was not increased until 08/30/23, for the Namenda 5 mg, to be given twice a day instead of once a day. During an interview on 01/23/24 at 2:40 P.M., the IP (Infection Preventionist) indicated the resident's Namenda medication should have been started at twice a day in July per the Nurse Practitioner's order. During an interview on 01/23/24 at 4:13 P.M., the Administrator indicated the facility did not have a policy for following physician's orders. It was a standard practice. 3.1-37(a)		nurses on the following physician orders. **3)** **What measures will be put into place or what systemic changes will be made to ensur e** **that the deficient practice does not recur?** The DNS or designee in-serviced facility nurses on following physician orders. The DNS or designee will review all new orders daily during morning meeting **4)** **How the corrective action(s) will be monitored to ensure the** **deficient practice will not recur , i.e. what quality assurance program will be put into place?** To ensure compliance the DNS/Designee will complete the MatrixCare physician orders CQI audit tool, weekly x 4 weeks, then monthly x 6 months, and quarterly thereafter. CQI committee will determine need for further review. The results of these audits will be reviewed by the CQI Committee, if threshold of 100% is not achieved an action plan will be completed. Deficiency in this practice will result in disciplinary action up to and including termination.	
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services			

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	The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on record review and interview, the facility failed to accurately reconcile residents' medications upon admission and readmission to the facility for 2 of 7 residents reviewed for unnecessary medications. (Residents 43 and 59) Findings include:	F 0755	**It is the standard of this facility to follow the physicians orders related to medication reconciliation related to admissions and readmissions.** **1** **What corrective action will be accomplished for those**	02/16/2024

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	1. The clinical record for Resident 43 was reviewed on 01/22/24 at 12:21 P.M. The Admission MDS (Minimum Data Set) assessment, dated 12/20/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, fracture, atrial fibrillation, heart failure, and hypertension. The resident was admitted to the facility from the hospital on 12/13/23. The EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) for December 2023 and January 2024 was provided by the DON (Director of Nursing) on 01/23/24 at 2:34 P.M., and included, but was not limited to, the following current physician's order: - Metoprolol Tartrate (a blood pressure medication) 12.5 mg (milligrams) every 12 hours for hypertension. Hold if the systolic blood pressure (top number) is less than 60. During an interview on 01/23/24 at 2:18 P.M., LPN (Licensed Practical Nurse) 6 indicated when a resident was admitted to the facility, the admitting nurse on the floor would put the physician's orders in the EHR (Electronic Health Record). She would review the orders when she came in to work on the following morning. They have a morning meeting with the nursing management team that included the IP (Infection Preventionist) /CEC (Clinical Education Coordinator), the DON, the ADON (Assistant Director of Nursing), the MDS coordinator, Medical Records, and the Unit Managers. They reviewed the entire admission packet that included, but was not limited to, the physician's orders. Resident 43's physician's orders came from his hospital discharge records, dated 12/13/23. If there were questions about the admitting orders, the admitting nurse would follow		**residents found to have been affected by the deficient practic e?** Resident #43's EMARs were reviewed on 2/13/24 at which time physician was contacted and notified of Metoprolol Tartrate being given outside hold parameter orders 12/20/23, 12/29/23, 01/02/24, 01/03/24, 01/04/24, 01/06/24, 01/14/24, & 01/15/24. Resident #59's EMARs were reviewed on 2/13/24 at which time physician was contacted and notified of residents return from the hospital 10/18/23 with a new medication dose for residents Trazodone. **2)** **How other residents having the potential to be affected by t he** **same deficient practice will be identified and what corrective action(s) will be taken.** All residents having hold parameters related to their blood pressure medication and those residents readmitting to the hospital have the potential to be affected by the alleged deficient practice. A hold parameters audit was completed on all resident who have hold parameters for the last 30 days to ensure they were followed. A readmission review will be completed for residents readmitting in the last 30 days to	

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	up with NP (Nurse Practioner) 10, who was over the building. When reviewing the Metoprolol order on the resident's EHR, LPN 6 did not want to comment on the physician's order because she did not enter the order into the computer, she indicated the IP had. LPN 6 reviewed the Progress Notes and could not find a note related to the order. During an interview on 01/23/24 at 2:28 P.M., the IP indicated the order was inappropriate and should have been to hold the medication for a heart rate under 60 beats per minute. The medication was given on the following dates and times when the heart rate was out of range: - 12/20/23 at 8:00 P.M., the heart rate was 51, - 12/29/23 at 8:00 A.M., the heart rate was 57, - 01/02/24 at 8:00 A.M., the heart rate was 58, - 01/03/24 at 8:00 A.M., the heart rate was 59, - 01/04/24 at 8:00 A.M., the heart rate was 58, - 01/06/24 at 8:00 A.M., the heart rate was 58, - 01/14/24 at 8:00 P.M., the heart rate was 58, and - 01/15/24 at 8:00 A.M., the heart rate was 54. The current "Admission Medication Regimen Review" policy, with a revised date of 10/01/18, was provided by the Administrator on 01/23/24 at 4:13 P.M. The policy indicated, "...An electronic medication regimen review...will be performed within 72 hours of an agreed upon timeframe of admission by a licensed pharmacist per written authorization from the facility..." 2. The clinical record for Resident 59 was reviewed on 01/22/24 at 3:54 P.M. A Quarterly MDS assessment, dated 11/17/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, anemia, hypertension, non-Alzheimer's dementia, anxiety,		ensure no medication change was made without MD clarification being made. The DNS or designee will in-service facility nurses on the MatrixCare Physician Order Policy. **3)** **What measures will be put into place or what systemic changes will be made to ensur e** **that the deficient practice does not recur?** The DNS or designee in-serviced facility nurses on the MatrixCare Physician Order Policy. The DNS or designee will complete a review of hold parameters and Admission and Readmissions IDT reviews daily during morning meeting. **4)** **How the corrective action(s) will be monitored to ensure the** **deficient practice will not recur , i.e. what quality assurance program will be put into place?** To ensure compliance the DNS/Designee will complete Admission/Readmission CQI audit tool, weekly x 4 weeks, then monthly x 6 months, and quarterly thereafter. CQI committee will determine need for further review. The results of these audits will be reviewed by the CQI Committee, if threshold of 100% is not achieved an action plan will be completed. Deficiency in this practice will	

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	and depression. A physician's order, dated 05/26/23 through 10/18/23, indicated the resident was to receive trazodone (an antidepressant) 150 mg (milligrams). Staff were to administer 75 mg (1/2 of the tablet), at bedtime for insomnia. The resident was discharged to the hospital on 10/17/23. The resident returned to the facility on 10/18/23. A current, open-ended physician's order, with a start date of 10/18/23, indicated the resident was to receive trazodone 150 mg, every evening at bedtime. A Psychiatry Progress Note, dated 01/17/24, indicated the resident's medication list included, but were not limited to, trazodone 150 mg, 1/2 tablet at bedtime to total 75 mg. During an interview on 01/23/24 at 2:54 P.M., the Social Service Director indicated when the Psychiatric NP (Nurse Practitioner) came to the building she would review the resident's medications. During an interview on 01/23/24 at 4:07 P.M., the DON (Director of Nursing) indicated the resident's trazodone order should have been addressed when he returned from the hospital to determine if it needed to stay at 150 mg or lowered back to the 75 mg. The current facility policy titled, "MatrixCare Physician Order Policy", with a revised date of 8/2019, was provided by Medical Records on 01/23/24 at 4:38 P.M. The policy indicated, "...Nursing managers and/or designated nurses		result in disciplinary action up to and including termination.	

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	will review the physician order report [re-caps] for accuracy, order omissions, and obtain any necessary order clarifications...For readmissions, if the resident has been out of facility less than 7 days, reconcile existing orders in MatrixCare with hospital re-admission orders. Make any necessary additions, subtractions, i.e., add any new orders, d/c [discontinue] orders that are not included in readmission orders..." 3.1-37(a) 3.1-48(a)(1)			
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			

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	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 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 record review and interview, the facility failed to address Pharmacy Recommendations in a timely manner for 3 of 7 residents reviewed for unnecessary medications. (Residents 51, 59, and 46) Findings include: 1. The clinical record for Resident 51 was reviewed on 01/18/24 at 9:11 A.M. A Significant Change MDS (Minimum Data Set) assessment, dated 12/11/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, dementia, hypokalemia, renal insufficiency, and hemiplegia. A Pharmacy Consultation Report, issued on 12/06/23, was provided by the Administrator on 01/23/24 at 1:20 P.M. The report indicated the resident's recent lab results showed a low concentration of potassium, 2.6 on 11/20/23, and 2.7 on 10/27/23. The recommendation was to,	F 0756	**It is the standard of this facility to follow address Pharmacy Recommendations in a timely manner.** **1** **What corrective action will be accomplished for those residents found to have been affected by the deficient practic e?** Resident #51, #59, & #46s December's Pharmacy Recommendations were reviewed on 2/13/24 at which time physician was contacted and notified of the delay in the recommendation being addressed and orders entered in MatrixCare. **2)** **How other residents having the potential to be affected by t he**	02/16/2024

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	"Please consider adding potassium chloride 20 MEQ (Milliequivelents) daily and repeating potassium level on 12/13/23. The recommendation was signed by the pharmacist on 12/06/23. The physician responded to the recommendation on 01/02/24. The potassium level was not checked until 01/15/24, when it was 3.1, and out of the preferred range of 3.4 to 5.1. The EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) for December 2023 and January 2024, indicated the resident's recommended potassium was not started until 01/09/24. The Progress Notes for December 2023 and January 2024, indicated the NP (Nurse Practitioner), dated 01/09/24 at 6:31 A.M., indicated the NP addressed the Pharmacy Recommendation, dated 12/06/23, and ordered the potassium, 20 MEQ daily. During an interview on 01/23/24 at 12:55 P.M., the IP (Infection Preventionist) indicated she oversaw the pharmacy recommendations. Someone should have followed up on the pharmacy recommendation if she was not there. The resident's potassium level was not drawn on 12/13/23 per the pharmacy recommendation. She was unsure as to why the pharmacy recommendation was not addressed sooner. 2. The clinical record for Resident 59 was reviewed on 01/22/24 at 3:54 P.M. A Quarterly MDS assessment, dated 11/17/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, anemia, hypertension, non-Alzheimer's dementia, anxiety, and depression.		**same deficient practice will be identified and what corrective action(s) will be taken.** All residents having pharmacy recommendations have the potential to be affected by the alleged deficient practice. A pharmacy recommendation audit was completed on all resident who have had recommendations in the last 30 days was completed to ensure they were addressed timely. The DNS or designee will in-service facility nurses on the Medication Regimen Review Policy. **3)** **What measures will be put into place or what systemic changes will be made to ensur e** **that the deficient practice does not recur?** The DNS or designee in-serviced facility nurses on the Medication Regimen Review Policy. The DNS or designee will review pharmacy recommendation daily during morning meeting to ensure timely completion. **4)** **How the corrective action(s) will be monitored to ensure the** **deficient practice will not recur , i.e. what quality assurance program will be put into place?** To ensure compliance the DNS/Designee will complete Pharmacy Services and	

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	155377	A. BUILDING 00 B. WING	01/23/2024

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	A Pharmacy Consultation Report for Resident 59, was dated 12/06/23. The report indicated, " the resident had a diagnoses of diabetes and hypertension, but does not receive an antihypertensive associated with improved kidney and cardiovascular outcomes. This individual received the following antihypertensive medications: metoprolol 25 mg every 12 hours, the blood pressure readings are consistently elevated. Recommendation: Please consider adding lisinopril 10 mg daily." The physician accepted the recommendation with a following modification: lisinopril 2.5 mg daily. The recommendation was signed by the NP (Nurse Practitioner) on 01/04/24. The clinical record indicated the resident started the lisinopril medication on 01/09/24. During an interview on 01/23/24 at 12:58 P.M., Infection Preventionist indicated for pharmacy recommendations she would get a report and could check it everyday. She would make a copy of the recommendation and put the rest of them in the binder for the NP. If she didn't hear a response back within a couple of days then she would check with the NP about the recommendations. If she was off work the DON (Director of Nursing) had access to the reports. The NP was in the building Monday through Friday and should have reviewed within 1 week. The recommendation dated 12/06/23, should have been reviewed and signed before 01/04/24. 3. The clinical record for Resident 46 was reviewed on 01/22/24 at 3:45 P.M. An Admission MDS assessment, dated 12/18/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, hypertension, stroke, anxiety, and diabetes. A Pharmacy Consultation Report, dated on		recommendations CQI audit tool, weekly x 4 weeks, then monthly x 6 months, and quarterly thereafter. CQI committee will determine need for further review. The results of these audits will be reviewed by the CQI Committee, if threshold of 100% is not achieved an action plan will be completed. Deficiency in this practice will result in disciplinary action up to and including termination.	

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	12/13/23, indicated the resident received medroxyprogesterone (a hormone used for birth control). The medication had a "BOXED WARNING" describing increased risk of stroke, deep vein thrombosis, pulmonary embolism, coronary events, dementia, breast cancer, and endometrial cancer. The Beers criteria recommended avoiding estrogen (oral and transdermal) in older women due to risk of cancer and a lack of cardioprotective and cognitive protective effect. The recommendation was to please reevaluate the use of medroxyprogesterone. The recommendation was signed by the pharmacist on 12/13/23. The physician responded on 01/11/24 and indicated they wanted to discontinue the medication. During an interview on 01/23/24 at 1:09 P.M., The IP Nurse indicated she did have to discuss that recommendation with the NP (Nurse Practitioner). The NP wasn't sure about discontinuing the birth control because the resident came to the facility with the order. Usually, the turnaround time for the NP or MD to respond to the pharmacy recommendations was so fast that they didn't need to make a progress note that indicated they were working on addressing a recommendation. The clinical record lacked documentation the recommendation was addressed before 01/11/24 when the medication was discontinued. The recommendation should have been addressed sooner. The current facility policy, titled "Medication Regimen Review", dated January 2022, was provided by the Administrator on 01/23/24 at 4:13 P.M. The policy indicated, "...The Consultant Pharmacist will make recommendations...on the date of the review...the Director of Nursing or designee...will notify the resident's			

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	physician/prescriber for review and consideration..." 3.1-25(i)			