STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155472	A. BUILDING 00 B. WING	05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HOOSIER VILLAGE	9875 CHERRYLEAF DR INDIANAPOLIS, IN 46268

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a Non-Certified Comprehensive Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: May 9, 10, 11, and 12, 2023. Facility number: 000548 Provider number: 155472 Census Bed Type: SNF: 7 Residential: 232 NCC: 51 Total: 290 Census Payor Type: Medicare: 4 Other: 3 Total: 7 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Completed on May 25, 2023.	F 0000	Submission of this plan of correction shall not constitute or be construed as an admission that Hoosier Village provides anything other than a high quality of care to its residents. Hoosier Village considers itself to be a partner with the Indiana State Department of Health and other entities in an ongoing effort to continually improve the services provided in long term care facilities. We believe that any feedback provided to us should be taken very seriously, and we are committed to using our resources to make any adjustments necessary to achieve better outcomes for residents. As required, the facility submits the following plan of correction: Hoosier Village is requesting a desk review of the plans of corrections submitted.	
F 0655 SS=D Bldg. 00	483.21(a)(1)-(3) Baseline Care Plan §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional			

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

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	standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary.			
	Based on observation, interview, and record review, the facility failed to ensure baseline care plans were accurately completed for the immediate	F 0655	This deficiency was cited for baseline care plans lacking documentation of resident	06/15/2023

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	needs of resident medications monitoring for 2 of 5 residents reviewed for baseline care plans (Residents 2 and 117). Findings include: 1. On 5/9/23 at 10:34 a.m., Resident 2 was observed. He laid in bed and several small, irregular-shaped bruises were noted to his hand and forearms. He indicated he bruised easily. On 5/11/23 at 11:00 a.m., Resident 2's medical record was reviewed. He had active diagnoses which included, but were not limited to, atherosclerotic coronary artery heart disease (plaque buildup in the wall of the arteries that supply blood to the heart) and duodenitis (inflammation of the lining of the duodenum) with bleeding and chronic pain disease. He had physician's orders for the following black box medications: a. A black-box narcotic pain medication: Oxycontin, 10 milligrams (mg) twice a day. b. A black-box narcotic pain medication: Oxycodone-Acetaminophen 7.5mg-325mg c. A black box medication used to treat high blood pressure: Valsartan 80mg (a medication that works by blocking the action of certain natural substances that tighten the blood vessels, allowing the blood to flow more smoothly and the heart to pump more efficiently). His baseline care plan dated 4/26/23 lacked documentation of his regularly scheduled black-box medication use. Black-box warnings were the strictest type of warning the U.S. Food & Drug Administration (FDA) gives a medication. The purpose was to		medication monitoring. Resident #117 was discharged on 5-11-23. Resident #2 discharged on 5-17-23. An admission audit has been completed on current residents to validate baseline care plans and presented to each resident and/or responsible party. The IDT and nursing staff have been provided with the baseline care plan policy **(Attachment A)** and educated on initiating accurate baseline care plans at time of admission, presenting within 48 hours, and providing a copy of the care plan to the resident and/or responsible party. In order to monitor and prevent future occurrences, the Director of Nursing (DON)/designee will be responsible to conduct audits **(Attachment B)** of new admissions to validate the baseline care plans that have been completed and presented within 48 hours weekly for 4 weeks, and then monthly thereafter. Any issues identified will be immediately addressed, with 1:1 re-education provided. Further, The audits of the baseline care plan will be reviewed by the Quality Assurance and Performance Improvement (QAPI) Committee at the next 2 quarterly committee meetings or until the Committee deems substantial compliance has been achieved.	

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	bring attention to the major risks of a medication for additional supervision and monitoring of side effects and potential drug interactions. 2. On 5/9/23 at 11:08 a.m., Resident 117 was observed. She sat upright in a cushioned chair. Several areas of bruising were noted to her hands and forearms, and when asked about it, she indicated, her skin was paper thin, and she bruised very easily. On 5/10/23 at 2:00 p.m., Resident 117's medical record was reviewed. She had active diagnoses which included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction (muscle weakness/paralysis following a stroke), chronic congestive heart failure and chronic kidney disease. Her hospital discharge list of medications indicated she should continue taking Xarelto (an anticoagulant medications) 15 mg (milligrams). A nursing progress note, dated 4/30/23 at 6:56 a.m., indicated," ...Resident is a new admit following a short stay at the hospital where she was diagnosed with stroke...." A baseline care plan, dated 4/30/23 at 1:41 p.m., lacked documentation of Resident 117's anticoagulant medication, name, dose or frequency, therefore, also lacked documentation of monitoring parameters. A physician's order, dated 5/2/23, for Xarelto 15 mg daily was noted, but the physician orders also lacked documentation of anticoagulant medication monitoring. Resident 117's comprehensive care plans were			

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	reviewed. Although there was a care plan, which indicated Resident 117 was at risk for bleeding, the care plan was not revised to include person-centered documentation of her medication, dose, instructions and what, or how often to monitor for side effects. During an interview on 5/11/23 at 10:20 a.m., the DON indicated, baseline care plans were an important step of the admission process to ensure the most immediate needs of the resident are met, which includes noting high risk medications. At this time, she provided a copy of current facility policy titled, "Care Plans- Baseline," revised 12/2016. The policy indicated, " ...To assure that the resident's immediate care needs are mend and maintained, a baseline care plan will be developed withing forth-eight (48) hours of the resident's admission ... The interdisciplinary team will review the healthcare practitioner's orders (e.g., dietary needs, medication, routine treatments, etc.) and implement a baseline care plan to meet the resident's needs immediate care needs including, but not limited to: ... physician orders ...."			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services			

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	staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on observations, interview, and record review, the facility failed to ensure comprehensive care plans were reviewed/revised in a timely manner to support person-centered approaches for resident first care. This deficient practice had the potential to effect 3 of 7 residents reviewed for care plans, (Residents 2, 5 and 117). Findings include: 1. On 5/9/23 at 10:34 a.m., Resident 2 was observed. He laid in bed and several small, irregular-shaped bruises were noted to his hand and forearms. He indicated he bruised easily. On 5/11/23 at 11:00 a.m., Resident 2's medical record was reviewed. He had active diagnoses which included, but were not limited to, atherosclerotic coronary artery heart disease (plaque buildup in the wall of the arteries that supply blood to the heart) and duodenitis (inflammation of the lining of the duodenum) with bleeding and chronic pain disease.	F 0657	This deficiency was cited due to comprehensive care plans not being reviewed/revised in a timely manner. Resident #5 has been provided care plan meeting opportunities to discuss their revised written comprehensive care plans. Resident #117 discharged on 5-11-2023 and Resident #2 discharged on 5-17-2023. In order to identify other residents who may need an update to their plan of care, the facility will audit incident reports over the last 30 days to verify the care plan was updated. The community will also audit any new residents over the last 30 days to ensure their care plan is updated. IDT members have been educated on the policy comprehensive care plan timing and revision **(Attachment C)** specifically related to the MDS	06/15/2023

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	He had physician's orders for the following black box medications: a. A black-box narcotic pain medication: Oxycontin, 10 milligrams (mg) twice a day. b. A black-box narcotic pain medication: Oxycodone-Acetaminophen 7.5mg-325mg c. A black box medication used to treat high blood pressure: Valsartan 80mg (a medication that works by blocking the action of certain natural substances that tighten the blood vessels, allowing the blood to flow more smoothly and the heart to pump more efficiently). Black-box warnings were the strictest type of warning the U.S. Food & Drug Administration (FDA) gave a medication. Its purpose was to bring attention to the major risks of a medication for additional supervision and monitoring of side effects and potential drug interactions. His comprehensive care plans were reviewed and lacked person-centered revisions for monitoring the above high-class meds. 2. On 5/9/23 at 2:23 p.m., Resident 5 was initially observed. She was seated in a cushioned chair with her feet on the ground. Her ankles were observed to be swollen and the tops of her ankle socks were observed to be tight. When asked about her swelling and if her socks were too tight, she indicated it was normal, she took medication for the edema, but she did not like it because it make her need to use the restroom often. On 5/11/23 at 1:48 p.m., Resident 5 was observed in the main activity room. She was seated upright in a regular wheelchair and her feet rested on foot pedals and were observed to be covered with regular socks, and no shoes at that time. At that time, Resident 5 indicated she was not very happy		schedule. Nursing staff have been re-educated on the need to update the plan of care following incidents to reflect root cause analysis and new interventions to prevent further incidents. They have also been educated to update the plan of care with a new diagnosis or medication that requires monitoring. IDT will utilize a tracker located within PointClickCare as well as an external tracker provided by the MDS Coordinator to ensure care plans are completely timely according to the MDS schedule. In order to monitor and prevent future occurrences, the DON/Designee will audit care plans **(Attachment D)** weekly for 4 weeks, then monthly to ensure compliance. Any issues identified will be immediately addressed, with 1:1 re-education provided. The reviews of the comprehensive care plan audits will be reviewed by the QAPI Committee at the next 2 quarterly committee meetings or until the Committee deems substantial compliance has been achieved.	

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	because the previous night had been difficult. Her stomach had been upset, and she needed to use the restroom, and after dinner she often needed to use the bathroom more often because of her, "water pills." Although the aide came right away to get her to the bathroom, Resident 5 indicated, "they left me on the john forever." She was afraid to get back into the wheelchair herself because she did not want to fall, like before. On 5/11/23 at 11:45 a.m., Resident 5's medical record was reviewed. She admitted to the facility on 4/11/23 after an acute hospital stay and treatment for pneumonia. She had active diagnoses which included, but were not limited to, respiratory failure, heart failure, unspecified dementia and idiopathic neuropathy. She had a physician's order for Lasix (a diuretic medication) 20 mg (milligrams) dated 4/17/23. She had a physician's order for Lyrica (a controlled substance used to treat nerve pain) 25 mg dated 4/17/23. Her comprehensive care plans were reviewed and lacked person-centered revision to include goals and interventions to address her diagnosis of dementia. Her plan of care lacked revision for new fall interventions after a fall. Her plan of care lacked revision to include goals and interventions for maintaining and monitoring a diuretic medication. Her plan of care lacked revision to include goals			

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	and intervention for maintaining and monitoring a controlled substance. 3. On 5/9/23 at 11:08 a.m., Resident 117 was observed. She sat upright in a cushioned chair. Several areas of bruising were noted to her hands and forearms, and when asked about it, she indicated, her skin was paper thin, and she bruised very easily. On 5/10/23 at 2:00 p.m., Resident 117's medical record was reviewed. She had active diagnoses which included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction (muscle weakness/paralysis following a stroke), chronic congestive heart failure, and chronic kidney disease. Her hospital discharge list of medications indicated she should continue taking Xarelto (an anticoagulant medications) 15 mg (milligrams). Resident 117 experienced potential signs/symptoms related to anticoagulant use and was hospitalized twice after she had critical value labs related to her hemoglobin (HGB- low hemoglobin can be a sign/symptom of blood loss due to injury or illness). A nursing progress note, dated 5/8/23 at 2:12 p.m., indicated, Resident 117 had a critical lab value for her hemoglobin (HGB) at 6.9, and a new order was obtained to send her to the Emergency Department (ED) for evaluation and possible blood transfusion. A nursing progress note, dated 5/8/23 at 7:15 p.m., indicated, Resident 117 returned from the hospital. She had only been given intravenous fluids, but had not required a blood transfusion, as her HGB			

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	results at the hospital were 7.9. A nursing progress note, dated 5/10/23 at 2:07 p.m., indicated, Resident 117 has another critical HGB lab value at 6.6. A new order was obtained to send her to the ED for a possible transfusion. She had a physician's order, dated 5/2/23, for Xarelto 15 mg daily was noted, but the physician orders lacked documentation of anticoagulant medication monitoring. Resident 117's comprehensive care plans were reviewed. Although there was a care plan, which indicated Resident 117 was at risk for bleeding, the care plan was not revised to include person-centered documentation of her medication, dose, instructions and what, or how often to monitor for side effects. Further, Resident 117 began to exhibit increased signs/symptoms of anxiety and confusion such that a wander guard was placed on her ankle for resident safety as indicated by the following: A new physician's order was obtained on 5/2/23 to place a wanderguard on Resident 117's left ankle. On 5/2/23 nursing progress notes indicated, Resident 117's experienced an increase in anxiety and confusion and a Wanderguard was placed on her leg for resident safety as she made continued statements about wanting to go home. A nursing progress note dated 5/2/23 at 7:12 p.m., indicated, " ...She had followed the nurse, was observed walking around the nurse's station and into an empty room and her goal was to figure out a way to get to her home ... She was unable to			

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	comprehend about her needs of being here ...." A nursing progress note dated 5/6/23 at 12:14 a.m., indicated, " ...remains confused per baseline ...." Her most recent minimum data set (MDS) assessment was dated 5/3/23 and lacked indication that Resident 117 had exhibited symptoms of wandering in the 7-day look back period. Her comprehensive care plan lacked revision to includer person-centered approaches to address the use of a wanderguard. Resident 117 had a physician's order for a do not resuscitate, (DNR) advance directive status. This physician's order matched her Physician's Scop of Treatment (POST) form. A comprehensive care plan for Resident 117 had been added to honor her wishes for a DNR, however, the intervention was revised on 5/2/23 to change her code status to a full code. During an interview on 5/11/23 at 10:20 a.m., the DON indicated, Resident 117's care plan should have been revised immediately to include the use of a wanderguard and that she did not know why the care plan for her code status had been changed, but it was incorrect and should match the physician's order. On 5/11/23 at 10:20 a.m., the DON provided a copy of current facility policy title, "Care Plans, Comprehensive Person-Centered," revised 12/2016. The policy indicated, "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the			

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	resident's physical, psychosocial and functional needs is developed and implemented for each resident ... assessments of residents are ongoing and care plans are revised as information about the resident and the residents' conditions change ...." On 5/11/23 at 10:20 a.m., the DON provided a copy of current facility policy title, "Elopement Prevention & Intervention," dated 10/7/22. The policy indicated, " ...Residents who are assessed to be at-risk for elopement will have a wanderguard bracelet attached to their ankle ... the interdisciplinary team will develop and implement a place of care to protect residents who are assessed to be at-risk, or otherwise demonstrate exit seeking behavior ...." 3.1-35(d)(2)(B)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure medications were not left at bedside of a resident with confusion for 1 of 2 residents reviewed for accidents (Resident 117). Findings include:	F 0689	This deficiency was cited due to medications being left at the bedside of one resident. Resident #117 has been discharged home. LPN #10 received immediate education/counseling. Nursing staff have been educated	06/15/2023

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	During a random observation on 5/11/23 at 5/11/23 at 9:40 a.m., Resident 117 was observed in her room. She sat on the edge of her bed, and on over-the-bed side table was set in front of her. An individual pill cup was observed on the bedside table. 8 unidentified tablets/capsules were observed in the cup. Resident 117 indicated she did not know what they pills were, she just took what the nurse gave her. Resident 117 could not remember if she was supposed to have already taken the pills, or if she was supposed to wait. Licensed Practical Nurse, (LPN) 10 entered the room and indicated, she put the cup down for Resident 117, but had to leave the room to assist another resident. Resident 117's medical record was reviewed on 5/10/23 at 2:00 p.m. She had active diagnoses which included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction (muscle weakness/paralysis following a stroke), chronic congestive heart failure and chronic kidney disease. On 5/2/23 nursing progress notes indicated, Resident 117's experienced an increase in anxiety and confusion and a Wanderguard was placed on her leg for resident safety as she made continued statements about wanting to go home. A nursing progress note, dated 5/2/23 at 7:12 p.m., indicated, " ...She had followed the nurse, was observed walking around the nurse's station and into an empty room and her goal was to figure out a way to get to her home ... She was unable to comprehend about her needs of being here ...." A nursing progress note dated 5/6/23 at 12:14 a.m., indicated, " ...remains confused per baseline ...."		by the DON/designee regarding medication pass policy and procedure **(Attachment E)**, leaving medications unattended at bedside, in addition to staying with the resident while the medications are consumed. Also, nursing staff have been educated on the proper labeling and storage of medications policy and procedure. DON/Administration rounds will be completed routinely and any noncompliance will result in re-education/ performance improvement plans. The DON/Designee will round and audit **(Attachment F)** during medication pass times weekly x 3 weeks; and then monthly to ensure compliance. Any issues identified will be immediately addressed, with 1:1 re-education provided. Further, the reviews of the medication audits will be reviewed by the QAPI Committee at the next 2 quarterly committee meetings or until the Committee deems substantial compliance has been achieved.	

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	During an interview on 05/11/23 10:42 a.m., the DON indicated, medications should not be left by the bedside. If the nurse needed to respond to another resident, they should take the remaining pills out of the room. On 5/11/23 at 1:30 p.m., the DON provided a copy of current facility policy, titled, "Administering Medications," revised 12/2012. The policy indicated, " ...Medications shall be administered in a safe and timely manner, and as prescribed ...." 3.1-45(a)			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (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)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.			

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	Based on observation, interview, and record review, the facility failed to ensure appropriate care and maintenance of a G/J tube (gastrostomy-jejunostomy) for 1 of 1 resident reviewed for enteral feeding (Resident 167). Findings include: During a medication administration observation on 5/11/23 at 3:02 p.m., Licensed Practical Nurse, (LPN) 10 went into Resident 167's room to administer his ordered medications. LPN 10 washed her hands, donned gloves and obtained needed supplies. LPN 10 checked the Resident for tube placement by using her stethoscope. She used a piston syringe and pulled back on the syringe to check for residual, none was noted. LPN 10 administered Resident 167's medications. She finished by flushing his gastrostomy tube with 30 mL (milliliters) of water and then flushed his jejunostomy with 30 mL of water. A comprehensive record review was completed for Resident 167 on 5/11/23 at 4:03 p.m. Resident 167 had the following diagnoses, which included, but were not limited to GERD (gastro-esophageal reflux disease), BPH (benign prostatic hyperplasia), weakness, hearing loss, insufficient sleep syndrome, unspecified fall, and unspecified displaced fracture of seventh cervical vertebra. A review of Resident 167's orders was completed. His order indicated to flush 100 ml of water via pump 9:00 p.m.-9:00 a.m. and flush with 10-30 ml of water before and after medication pass via g-tube. The order lacked documentation for the maintenance of his j-tube. The medications and Jevity were ordered to be administered via g-tube. Resident's record lacked an order to check for	F 0693	This deficiency was cited due to not ensuring appropriate care and maintenance of a G/J tube when one nurse checked for residual from the J tube and flushed it with water without proper documentation of a physician's order. Resident #167 remains in facility without negative outcome. LPN #10 was required to perform G/J tube medication administration competency and received written education/performance improvement. G/J tube orders were reviewed, clarification obtained, and were revised immediately. (5.11.23). Care plan was reviewed and revised. There are no other residents with the potential to be affected. As a means to ensure this deficiency does not occur in the future, new admission orders will be reviewed in daily clinical meeting to ensure completeness. Licensed Nursing staff have been educated regarding G/J tube medication administration by DON/ Designee. In order to prevent future occurrences, the DON/Designee will audit documentation **(Attachment G)** and perform visual audits of G/J tube feedings/flushes completed as ordered weekly x4 weeks, then monthly thereafter. Further, the reviews of G/J tube audits will be reviewed by the QAPI Committee	06/15/2023

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	residual prior to administering medications, fluids and nutrition via tube. A policy was not provided at the time of survey exit. 3.1-44(a)(l)		at the next 2 quarterly committee meetings or until the Committee deems substantial compliance has been achieved.	
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 §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 observation, interview, and record review, the facility failed to ensure residents received appropriate monitoring for potential side effects related to their use of high risk medications for 4 of 5 residents reviewed for unnecessary medications (Residents 1, 168, 2 and 117).	F 0757	1, #168, #2 and #117 have been discharged. orders were reviewed to ensure that appropriate side effect monitoring are in place and their	07/05/2023

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	Finding include: 1. On 5/11/23 at 9:48 a.m., resident 1's discharge record was reviewed. She had diagnoses which included, but were not limited to, cerebral infarction (stoke), hypertension (high blood pressure), anxiety, hypothyroidism (underactive thyroid), repeated falls, back pain, and hyperlipidemia (higher than normal count of lipid cells). The Pharmacist completed a review of Resident 1's medications upon admission on 4/22/23 and recommended the nursing staff to monitor for drug-to-drug interactions for Resident 1's use of bupropion, (an antidepressant medication), and metoprolol (a medication used to treat high blood pressure). The recommendation indicated, bupropion may cause an increase in potential side effects of the metoprolol, and the metoprolol needed to be monitored for potential adverse reactions, which could include, but were not limited to, bradycardia and hypotension, during co-administration with bupropion. 2. On 5/10/23 at 1:22 p.m., Resident 168's medical record was reviewed. She had diagnoses which included, but were not limited to, aftercare following joint replacement surgery, disorder of the autonomic nervous system, hypertensive chronic kidney disease, atrial fibrillation (irregular heartbeat), anemia (low red blood cells), polyneuropathy (nerve numbness/pain/tingling), hyperlipidemia, hypertension, insomnia, and muscle weakness. Resident 168 was prescribed Eliquis (an anticoagulant medication) oral tablet 2.5mg two times daily as a blood thinner. The record lacked		care plans reflect side effect monitoring when necessary. regarding Medication Management policy, side effect monitoring, and care plans reflect that monitoring. Also, new licensed staff will be educated regarding side effect monitoring as part of the new hire orientation. meetings to ensure appropriate monitoring orders are in place and care plans updated accordingly. And all new admission orders will be reviewed in the clinical meeting to ensure appropriate monitoring for medications and that care plans are reflective of medication side effect monitoring. Further, Audits of new admission orders and daily new Physician orders will be reviewed with the Quality Assurance and Performance Improvement (QAPI) Committee at the next 2 quarterly committee meetings or until the committee deems substantial compliance has been achieved.	

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	documentation for monitoring parameters for the potential adverse effects of the medication, which could include, bleeding gums, bruising easily, nosebleeds and increase risk of bleeding. During an interview on 5/11/23 at 11:23 a.m., Director of Nursing, (DON) indicated, residents were monitored for medication side effects but there were no specific to monitor for adverse effects to high risks medications. The DON indicated she received the pharmacy request on 5/11/23 when she called the pharmacy to request the Pharmacist's comments upon initial admission review for irregularities. 3. On 5/9/23 at 10:34 a.m., Resident 2 was observed. He laid in bed and several small, irregular-shaped bruises were noted to his hand and forearms. He indicated he bruised easily. On 5/11/23 at 11:00 a.m., Resident 2's medical record was reviewed. He had active diagnoses which included, but were not limited to, atherosclerotic coronary artery heart disease (plaque buildup in the wall of the arteries that supply blood to the heart) and duodenitis (inflammation of the lining of the duodenum) with bleeding and chronic pain disease. He had physician's orders for the following black box medications: a. A black-box narcotic pain medication: Oxycontin, 10 mg twice a day. b. A black-box narcotic pain medication: Oxycodone-Acetaminophen 7.5mg-325mg c. A black box medication used to treat high blood pressure: Valsartan 80mg (a medication that works by blocking the action of certain natural substances that tighten the blood vessels, allowing the blood to flow more smoothly and the heart to pump more efficiently).			

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	Black-box warnings are the strictest type of warning the U.S. Food & Drug Administration (FDA) gives a medication. Its purpose is to bring attention to the major risks of a medication for additional supervision and monitoring of side effects and potential drug interactions. His physician's orders lacked documentation or instructions to monitor for the side effects of the above high-class drugs. His comprehensive care plans were reviewed and lacked person-centered revisions for monitoring the above high-class meds. 4. On 5/9/23 at 11:08 a.m., Resident 117 was observed. She sat upright in a cushioned chair. Several areas of bruising were noted to her hands and forearms, and when asked about it, she indicated, her skin was paper thin, and she bruised very easily. On 5/10/23 at 2:00 p.m., Resident 117's medical record was reviewed. She had active diagnoses which included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction (muscle weakness/paralysis following a stroke), chronic congestive heart failure and chronic kidney disease. Her hospital discharge list of medications indicated she should continue taking Xarelto (an anticoagulant medications) 15 mg (milligrams). A nursing progress note, dated 4/30/23 at 6:56 a.m., indicated," ...Resident is a new admit following a short stay at the hospital where she was diagnosed with stroke...."			

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	Resident 117 experienced potential signs/symptoms related to anticoagulant use and was hospitalized twice after she had critical value labs related to her hemoglobin (HGB- low hemoglobin can be a sign/symptom of blood loss due to injury or illness). A nursing progress note, dated 5/8/23 at 2:12 p.m., indicated, Resident 117 had a critical lab value for her hemoglobin (HGB) at 6.9, and a new order was obtained to send her to the Emergency Department (ED) for evaluation and possible blood transfusion. A nursing progress note, dated 5/8/23 at 7:15 p.m., indicated, Resident 117 returned from the hospital. She had only been given intravenous fluids, but had not required a blood transfusion, as her HGB results at the hospital were 7.9. A nursing progress note, dated 5/10/23 at 2:07 p.m., indicated, Resident 117 has another critical HGB lab value at 6.6. A new order was obtained to send her to the ED for a possible transfusion. She had a physician's order dated 5/2/23 for Xarelto 15 mg daily was noted, but the physician orders lacked documentation of anticoagulant medication monitoring. Resident 117's comprehensive care plans were reviewed. Although there was a care plan, which indicated Resident 117 was at risk for bleeding, the care plan was not revised to include person-centered documentation of her medication, dose, instructions and what, or how often to monitor for side effects. During an interview on 5/11/23 at 3:37 p.m., the DON indicated, she was not aware the			

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	medications did not have monitoring orders, but high-class drugs should be monitored in order to ensure no ill or unwanted side effects occurred. On 5/11/23 at 10:20 a.m., the Director of Nursing (DON) provided a copy of current facility policy titled, "Medication Monitoring and Management," dated 4/2017. The policy indicated, "In order to maintain the resident's highest level of practicable functioning and to prevent and minimize adverse consequences related to medication therapy, the facility establishes monitoring standards for certain medications to promote safe and effective use of the medications ...." 3.1-48(a)(3)			
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs			

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	listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview and record review, the facility failed to properly store medications in 2 of 3 medication rooms and failed to ensure appropriate labeling was placed on a bottle of over-the-counter vitamins for 1 of 7 residents reviewed for storage (Resident 168). Findings include: During a medication administration observation on 5/12/23 at 8:59 a.m., LPN 10 pulled a bottle of Ocuvite Eye Multivitamins out of the medication cart. The bottle indicated the resident's name (Resident 168) and a date the bottle was opened. It lacked the directions for use. At that time, LPN 10 indicated Resident 168 brought the medication from home. She indicated she was unaware the medication required a label with the directions for use. Medication Room on A wing was observed on 5/10/23 at 2:30 p.m. LPN 10 indicated the temperature log was last checked on 5/8/23. There was a bottle of lorazepam in the refrigerator. The lorazepam belonged to an unidentified resident. The bottle was sent on 12/16/22. The bottle was opened with no open date. A bottle of tuberculin serum was observed in the refrigerator. It lacked an open date on the bottle. LPN 10 indicated she would let the DON (Director of Nursing) know. Medication Room B was observed on 5/10/23 at 2:50 p.m. LPN 24 removed the medications from	F 0761	This deficiency was cited due to medications not properly stored and a bottle of over-the-counter vitamins lacking an appropriate label. Medications involved were removed and/or reordered. Medication carts and medication rooms were audited by DON/ Designee and medications found to be unlabeled or without date opened sticker were removed from the carts and replaced. Education provided to Licensed Nursing staff by DON/ Designee regarding medication storage, labeling/dating **(Attachment H)**. As a means of ensuring ongoing compliance, the DON/Designee will monitor and audit medication carts **(Attachment I)** and medication rooms **(Attachment J)** weekly x3 weeks and then monthly thereafter to ensure items are labeled appropriately and not expired. The reviews of storage and labeling of drugs and biologicals audits will be forwarded will be reviewed by the QAPI Committee at the next 2 quarterly committee meetings or until the Committee deems substantial compliance	06/15/2023

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	the refrigerator. Observed a bottle of tuberculin with some writing on the bottle but it was illegible. A bottle of lorazepam was observed opened with no date. The bottle belonged to an unidentified resident. The lorazepam was sent on 4/28/23 from Grandview Pharmacy. A bottle of lorazepam was observed sitting in a drinking cup with a EDK (Emergency Drug Kit) slip indicating the lorazepam was withdrawn from the EDK on 5/9/23. The cup had a name written on it. The bottle lacked a label to include a resident's name and directions for use. A bottle of lorazepam belonging to an unidentified resident was observed to be opened. It lacked a date when the bottle was opened. A bottle of lorazepam was observed belonging to an unidentified resident. The bottle was sent from the pharmacy on 3/29/23. The bottle lacked an open date to indicate when it was opened. A bottle of lorazepam belonging to an unidentified resident was opened and lacked a date to indicate when it was opened. The bottle was sent from the pharmacy on 12/2/22. A bottle of lorazepam belonging to an unidentified resident was observed to be opened and it lacked an open date. The bottle was sent from the pharmacy on 1/12/23. A policy titled, "Storage of Medications" was provided by the DON (Director of Nursing) on 5/12/23 at 9:43 a.m. It indicated, "...Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed...."		has been achieved.	

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	3.1-25(j) 3.1-25(m) 3.1-25(n)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of			

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	communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, interview, and record review, the facility failed to ensure appropriate hand hygiene was performed during a treatment	F 0880	This deficiency was due to one nurse not performing appropriate hand hygiene during a treatment	06/15/2023

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	155472	A. BUILDING 00 B. WING	05/12/2023

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	procedure for 1 of 1 resident (Resident 167) observed for Moisture-Associated Skin Damage (MASD). Findings include: On 5/10/23 at 11:06 a.m., a MASD treatment procedure was observed. Upon entrance into Resident 167's room, Licensed Practical Nurse (LPN) 10 failed to perform hand hygiene. Once in the room, LPN 10 closed the blinds for privacy and donned a pair of gloves without performing hand hygiene. She removed an old dressing from the resident's feeding tube site and failed to perform hand hygiene before replacing a new dressing. Next, Resident 167 stood up and faced his recliner so that LPN 10 could access the areas of MASD located on his left and right buttocks. The area was observed to be red with some chaffing and Resident 167 indicated the area burned. LPN 10 cleansed the area with a gauze pad and normal saline. After she cleansed the area, she failed to perform hand hygiene. She applied Neosporin ointment to the area with a gloved finger. When she was done, LPN 10 removed her gloves and failed to perform hand hygiene. During an interview at the end of the treatment, LPN 10 indicated she had not washed her hands because she was nervous during the observation and forgot. During an interview on 5/10/23 at 12:17 p.m., the		procedure on one resident. LPN #10 has received education / counseling. Residents who reside in the care area have the potential to be affected; LPN immediately educated and required to perform competencies related to Hand hygiene, including Handwashing, donning/ doffing of gloves, dressing change between clean and dirty. Nursing Staff education provided by DON/ Designee on Infection Control policies/ procedures for Hand hygiene, Handwashing, donning/doffing of gloves, dressing changes (ie. Clean / dirty surfaces), with return demonstrations required **(Attachments K**) Nursing/Administration to perform compliance audit rounds as related to:Hand washing/Hand hygiene, Appropriate donning/doffing of gloves, Dressing changes with return demonstration required. DON/Designee will perform infection control audit rounds **(Attachment L)** M-F x 1 week, then weekly for 3 weeks, then monthly thereafter for compliance with infection control standards. Immediate correction and education will occur for any concerns identified. The reviews of infection control audits will be reviewed by the QAPI Committee at the next 2	

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	Director of Nursing (DON) indicated LPN 10 should have performed hand hygiene upon entering and exiting the resident's room, as well as in between soiled and clean treatment, and in between treatment sites. A policy titled "Handwashing/Hand Hygiene" was provided by the DON (Director of Nursing) on 5/12/23 at 9:45 a.m. It indicated, " ...Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: before and after direct contact with residents, before handling clean or soiled dressings, gauze pads, etc., after contact with a resident's skin, and after removing gloves...." 3.1-18(b)(2)		quarterly committee meetings or until the Committee deems substantial compliance has been achieved.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a State Residential Licensure Survey. This visit included a Non-Certified Comprehensive Licensure Survey. Survey dates: May 9, 10, 11, and 12, 2023. Facility number: 000548 Residential Census: 232 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on May 25, 2023.	R 0000	Submission of this plan of correction shall not constitute or be construed as an admission that Hoosier Village provides anything other than a high quality of care to its residents. Hoosier Village considers itself to be a partner with the Indiana State Department of Health and other entities in an ongoing effort to continually improve the services provided in long term care facilities. We believe that any feedback provided to us should be taken very seriously, and we are committed to using our resources to make any adjustments necessary to achieve better outcomes for	

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			residents. As required, the facility submits the following plan of correction: Hoosier Village is requesting a desk review of the plans of corrections submitted.	
R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete			

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	a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on interview and record review, the facility failed to ensure a complete 2-step TB skin test and physical health assessment were completed for an employee prior to her employment for 1 of 5 residential employee records reviewed. Findings include: On 5/12/23 at 11:00 a.m., 5 random employee files were reviewed with the Human Resources Coordinator (HR). No Step 1 or Step 2 Tuberculous (TB) screening or health assessment was found for Qualified Medication Aid (QMA) 13 who was begun work on 10/12/22. On 5/12/23 at 3:32 p.m., the Associate Executive Director (AED) indicated the facility was unable to find a health assessment for QMA 13. A current policy, titled, " General Policy-Physical, Mantoux, TB assessment," was provided by the AED, on 5/12/23 at 1:57 p.m. A review of the policy indicated, " ...Hoosier Village will ensure required assessments and testing for communicable disease is completed on all staff, to ensure a safe environment in accordance with state and federal guidelines... At the time of employment, or within one month prior to	R 0121	This tag was cited due to a missed 2nd step PPD and health assessment being completed for 1 staff member. Staff member #13 has completed Step 1 PPD testing and has completed health assessment. Step 2 PPD testing has been scheduled for in 2 weeks. In order to identify other staff, a new audit tool will be utilized (**Attachment R-A**) for all new AL staff hires within the last 30 days to determine whether any other staff have incomplete documentation of their tuberculin skin tests and health assessments. If any others are identified, they will receive a 2 step test and health assessment. Facility self-Identified this issue back in October 2022 and a PIP was utilized. Changes to the PIP were made in March 2023 to better identify issues. (**Attachment R-B**) In order to prevent further occurrences, the facility will use a personnel file checklist for all new hires to verify that all	06/15/2023

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	employment, employees shall be screened for TB using the 2-step Mantoux method ... A physical examination shall be required within one month prior to employment...."		pre-employment and new hire requirements are met. These results will be reviewed with the Quality Assurance and Performance Improvement (QAPI) Committee quarterly for the next 2 committee meetings or until the committee deems substantial compliance has been achieved,	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the			

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	provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on interview and record review, the facility failed to ensure a resident's service plan was updated for self-administration of medications for 1 of 7 residents reviewed (Resident 42). Findings include: Resident 42's record was reviewed on 5/11/23 at 3:25 p.m. Her diagnoses included but were not limited to, hyponatremia (low sodium blood levels), prediabetes (elevated blood sugar levels), muscle weakness, and lumbago with sciatica (lower back pain with numbness and pain that radiates down the posterior legs). Her Senior Living Quarterly Assessment, dated 7/6/22, indicated she self-administered her own medication. Her Senior Living Quarterly Assessment, dated 1/10/23, indicated she cannot self-administer her own medication. Her medication services plan, dated 4/10/23, indicated Resident 42 was independent with self administration of medications. Her cognition service plan, dated 4/19/23, indicated Resident 42 had mild to moderate disorientation or difficulty recalled/retaining information, needed cueing, did no do well with routine, and needed reminders for medications. Her medications, included but were not limited to, multivitamin tablet 1 tablet once a day, Tums 200 mg calcium (500 mg) chewable tablet, cranberry	R 0217	This tag was cited due to a service plan not being updated for 1 resident regarding ability to self-administer medication in their service plan. Resident #42's service plan has been reviewed, updated, signed and provided to the resident. Nursing staff have been re-educated by the AED of Residential concerning the Service Plan Policy and importance of accuracy. In order to identify other residents who may need an update to their services plans, an audit (**Attachment R-C**) will be performed to ensure their service plan is updated. Further, in order to monitor and prevent future occurrences the AED of Residential will audit service plans (Attachment R-D) monthly for 6 months and will review results with the Quality Assurance and Performance Improvement (QAPI) Committee x2 or until the committee deems substantial compliance has been achieved.. Any issues identified will be immediately addressed, with 1:1 re-education provided.	06/15/2023

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	450 mg tablet BID (twice a day), Vitamin D3 (cholecalciferol - vitamin d3) 25 mcg capsule capsule once a day, aspirin 81 mg tablet delayed release 1 time daily, nitrofurantoin macrocrystal (prevents urinary tract infections UTI) 50 mg capsule take one capsule by mouth daily, amlodipine (treats high blood pressure) 10 mg tablet take 1 tablet daily, Tylenol Extra Strength 500 mg tablet take 1 tablet by mouth every eight hours as needed, and Cozaar (treats high blood pressure) 100 mg tablet take 1 tablet by mouth once a day. On 5/11/23 at 3:05 p.m., Resident 42 indicated she did not self-administer her own medications. The facility took all the medications away from her. She indicated there were no medications in her room. During an interview, on 5/12/23 at 10:00 a.m., the Assisted Living Director indicated Resident 42 was previously administering her own medications. In February, she and her daughter elected to have the facility do her medications for her. The change in her service plan was missed. A current policy titled, "Service Plan," with no date, was provided by the Assisted Living Director on 5/12/23 at 10:30 a.m. A review of the policy indicated, " ...It is the policy of BHI [Baptist Home Indiana] to provide a service plan for each resident in order to identify their person-centered needs and strategies for accomplishing...."			
R 0299 Bldg. 00	410 IAC 16.2-5-6(c)(3) Pharmaceutical Services - Noncompliance (3) The medication review, recommendations, and notification of the physician, if necessary, shall be documented in accordance with the facility ' s policy.			

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	Based on interview and record review, the facility failed to ensure a pharmacy recommendation was provided to a resident's personal physician with a response received for 1 of 7 residents reviewed after pharmacy reviews (Resident 19). Finding include: On 5/12/23 at 11:54 a.m., Resident 19's medical record was reviewed. A pharmacy review, dated 1/9/23, indicated Resident 19 was on the proton pump inhibitor (treats gastric reflux disease - GERD) (PPI) Protonix 40 milligrams (mg), twice a day (BID) since 12/18/22. The pharmacy recommendation was to change the Protonix 40 mg to once a day, in the morning. The rationale was if dosing a PPI more frequently than once daily it may increase the risk for adverse effects like an osteoporotic fracture (bone fracture cause by bone deterioration) and Clostridum difficile (C. Diff - a bowel bacteria that releases toxins and causes fever). The bottom of the pharmacy recommendation page was blank with no response from Resident 19's physician about whether he accepted or declined the recommendation and no physician's signature. A current physician order, started on 12/18/22, indicated to administer 1 pantoprazole sodium (Protonix) 40 mg delayed-release tablet by mouth, BID for GERD. His medication service plan, dated 4/10/23, indicated Resident 19 will be supported to take all medications safely and as ordered. He did not know the name, reason or time of the medications. He required daily supervision of medications. His cognition service plan, dated 4/10/23, indicated Resident 19 will be supported to make	R 0299	This tag was cited due to missing proof that an outside medical provider was notified of a pharmacy recommendation. The Nurse faxed Resident # 19's recommendation from the consultant pharmacist recommendation to the outside physician and also left a voicemail with the office on 5/12/23. New orders were written 5/15/23 in reference to the consultant pharmacist recommendation. An audit has been completed on current residents to validate that all pharmacy recommendations have been sent and reviewed by physicians with no further findings. Moving forward the Assisted living Nursing Supervisor will place a note in the residents chart when an attempt to contact that physician regarding a pharmacy recommendation has been made and will upload a signed copy of the recommendation into the electronic chart when returned. In order to monitor and prevent future occurrences the Administrator of Assisted Living will audit pharmacy recommendations (**attachment R-D**) monthly for 6 months and will review results with the Quality Assurance and Performance Improvement (QAPI) Committee for the next 2 meetings or until the committee deems substantial compliance has been achieved. Any issues identified will be	06/15/2023

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	appropriate decisions about his care and environment. He had mild to moderate disorientation or difficulty recalling/retaining information. He needed cueing. He did well with routine, but needed reminders for medications. His Senior Living Quarterly Assessment, dated 4/10/23, indicated he was unable to manage his own medication. On 5/12/23 at 2:08 p.m., the Assisted Living Director (ALD) indicated the pharmacy review was sent to his outside (personal) physician by FAX (electronically scanned and transmitted) and the facility did not get a response. She indication she would try to find the FAX for proof it was sent and find out if anyone followed up with his physician for a response. On 5/12/23 at 3:34 p.m., the ALD indicated the facility did not get a FAX report unless the FAX failed to go through. LPN 16 would follow up with Resident 19's personal physician regarding the pharmacy recommendation for Protonix. A current policy, titled, " Resident Rights," was provided after entrance conference on 5/10/23. A review of the policy indicated, " ...Notification of changes ...A facility must immediately inform the resident, consult with the resident's physician ...A need to alter treatment significantly, that is , a need to discontinue an existing form of treatment due to adverse consequences...."		immediately addressed.	