STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E683	A. BUILDING 00 B. WING	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MORGANTOWN WOODS OF JOURNEY	140 W WASHINGTON ST MORGANTOWN, IN 46160

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00434506. Complaint IN00434506 - No deficiencies related to the allegations are cited. Survey dates: June 26, 27, 28, July 1, and 2, 2024 Facility number: 000399 Provider number: 15E683 AIM number: 100289100 Census Bed Type: SNF/NF: 31 Total: 31 Census Payor Type: Medicaid: 25 Other: 6 Total: 31 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed July 9, 2024.	F 0000	This plan of correction is prepared and executed because it is required by the provisions of the state and federal regulations and citations listed on this statement of deficiencies. This plan of correction shall operate as Morgantown Woods' written credible allegation of compliance. Morgantown Woods respectfully requests paper compliance on the attached plan of correction.	
F 0604 SS=D Bldg. 00	483.10(e)(1), 483.12(a)(2) Right to be Free from Physical Restraints §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
DALE W. HARTMAN	HFA	07/25/2024

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

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	symptoms, consistent with §483.12(a)(2). §483.12 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, 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)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. Based on observation, interview, and record review, the facility failed to protect the residents right to be free from physical restraints for 3 of 5 residents reviewed for restraints. Documentation of releasing the restraint and repositioning was not completed and informed consent for the use of restraints was not completed prior to placing the resident in restraints. (Resident 3, Resident 16, Resident 27) Findings include: 1. On 6/26/24 at 2:11 p.m., Resident 16 was observed sitting in a broda chair asleep in the hallway with lap straps around her legs to prevent her from getting out of the chair.	F 0604	What corrective action will be accomplished for those residents found to have been affected by the deficient practice: · Order for resident #16 updated to reflect the use of leg straps with Broda chair. "Broda chair with leg straps or Geri chair with lap tray to be utilized while up due to inability to maintain erect torso related to diagnosis. Release and reposition every 2 hours or more frequently as needed. Evaluation conducted & consent to be obtained quarterly or as needed for continued usage."	07/22/2024

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	On 6/28/24 at 9:10 a.m., Resident 16 was observed sitting in the broda chair asleep in the hallway with leg straps around her legs to prevent her from getting out of the chair. On 6/28/24 at 10:24 a.m., Resident 16 was observed sitting in the broda chair asleep in her room with leg straps around her legs to prevent her from getting out of the chair. On 6/28/24 at 11:29 a.m., Resident 16 was observed sitting in the broda chair asleep in her room with leg straps around her legs to prevent her from getting out of the chair. On 6/28/24 at 12:28 p.m., Resident 16 was observed sitting in the broda chair awake in the hallway with leg straps around her legs to prevent her from getting out of the chair. On 6/28/24 at 2:00 p.m., Resident 16 was observed sitting in the broda chair awake in the hallway with leg straps around her legs to prevent her from getting out of the chair. On 7/1/24 at 10:19 a.m., Resident 16 was observed sitting in the broda chair awake in the hallway with leg straps around her legs to prevent her from getting out of the chair. On 7/1/24 at 12:12 p.m., Resident 16 was observed sitting in the broda chair awake in her room with leg straps around her legs to prevent her from getting out of the chair. On 7/1/24 at 2:56 p.m., Resident 16 was observed sitting in the broda chair awake in her room with leg straps around her legs to prevent her from getting out of the chair.		· ADL documentation initiated for removal of restraints and repositioning every 2 hours for residents #3, #16, and #27 · An in-service was completed with all staff on restraint compliance and safety, the definition of a restraint, and using the least restrictive option that is effective. · Nursing staff was educated on having completed consents from guardians for the use of restraints as well as a physician order in place before placing anything considered a restraint on a resident. · Facility restraint policy updated to indicate the requirement to document release of restraints and repositioning every 2 hours and to have an Informed Consent for Use of Restraint form signed prior to placing the resident in restraints. 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 residents with restraints have the potential to be affected · An additional audit was completed on all residents in the facility to verify that all residents with restraints are identified · The audit checked that all procedures have been followed, all ADL documentation is complete, all orders are in place and appropriate, and all are compliant. · All Informed Consent for Use of	

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	Resident 16's clinical record was reviewed on 6/28/24 at 9:30 a.m. The diagnoses included, but were not limited to, progressive supranuclear ophthalmoplegia (slow and difficult muscle movements) and anxiety disorder. Physician orders, dated 7/2/24, for Resident 16 indicated, "... broda/geri chair with tray while up due to leaning to sides and forward, unable to maintain direct torso ..." The physician orders did not indicate using leg restraints when resident was sitting in the broda chair. The Quarterly Minimum Data Set (MDS) assessment, dated 5/8/24, assessed Resident 16 as using limb restraints daily. A care plan, initiated on 8/9/23, and current through target date 6/12/24, for Resident 16 indicated, "... Problem: Resident requires use of broda chair with straps while up due to inability to maintain erect torso ... Goal: Resident will be free from negative outcomes or decline in functioning relative to restraint use ... Interventions: 9. Release every 2 hours and prn [as needed] to reposition and toilet ..." The Informed Consent for Use of Restraints form, dated 5/8/24, for Resident 16 indicated, "... broda chair with leg straps ... release and reposition every 2 hours and when toileting ..." A review of the clinical record for Resident 16 lacked documentation of where the resident was released and repositioned every 2 hours while up in the broda chair with leg straps. 2. On 6/27/24 at 10:43 a.m., Resident 3 was observed sitting in a broda chair awake in his room with lap straps around his legs to prevent		Restraint forms have been verified and are current. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. · A weekly audit x 8 weeks will be completed by the Director of Nursing and nursing staff to identify residents with restraints and that all orders, consents, ADL documentation, and care plans are in place to support their use. Any concerns found will be corrected immediately. · An in-service will be provided to nursing staff on the proper measures and orders to have in place for any resident that is determined to require a restraint in the future. Restraint procedure will be signed by all members of the nursing staff and posted at nurses' station. 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 in place. · On 7/22/2024 an AD HOC QAPI meeting was held to review facility plan of correction for concerns identified which included Administrator, Director of Nursing, and IDT · To monitor compliance, there will be on-going random audits of staff knowledge regarding the restraint policy to determine if further re-education is required. All audits	

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	him from getting out of the chair. On 6/28/24 at 9:12 a.m., Resident 3 was observed sitting in a broda chair asleep in his room with lap straps around his legs to prevent him from getting out of the chair. On 6/28/24 at 10:25 a.m., Resident 3 was observed sitting in a broda chair asleep in his room with lap straps around his legs to prevent him from getting out of the chair. On 6/28/24 at 11:28 a.m., Resident 3 was observed sitting in a broda chair asleep in his room with lap straps around his legs to prevent him from getting out of the chair. On 6/28/24 at 1:59 p.m., Resident 3 was observed sitting in a broda chair awake in his room with lap straps around his legs to prevent him from getting out of the chair. On 7/1/24 at 10:20 a.m., Resident 3 was observed sitting in a broda chair awake in his room with lap straps around his legs to prevent him from getting out of the chair. On 7/1/24 at 2:59 p.m., Resident 3 was observed sitting in a broda chair asleep in his room with lap straps around his legs to prevent him from getting out of the chair. Resident 3's clinical record was reviewed on 7/1/24 at 10:25 a.m. The diagnoses included, but were not limited to, Alzheimer's disease and traumatic brain injury. Physician orders, dated 7/2/24, for Resident 3 indicated, "... broda chair with straps to be utilized while up due to inability to maintain erect torso,		will be submitted to QAPI Committee for review and recommendations, which will be followed for at least a period of 6 months. The facility alleges substantial compliance on: 7/22/2024	

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	leans to side and forward ..." The Annual Minimum Data Set (MDS) assessment, dated 6/5/24, assessed Resident 3 as using limb restraints daily. A care plan, initiated on 9/1/23, and current through target date 5/13/24, for Resident 3 indicated, "... Problem: Resident requires use of broda chair while up due to inability to recall he is unable to bear his own weight ... Goal: Resident will be free from negative outcomes or decline in functioning relative to restraint use ... Interventions: 9. Release resident every 2 hours and prn for toileting and repositioning ..." The Informed Consent for Use of Restraints form, dated 6/29/24, for Resident 3 indicated, "... broda chair with straps ... release and reposition every 2 hours and when toileting ..." The consent form was dated after the resident was observed to be in a broda chair with leg restraints. A review of the clinical record for Resident 3 lacked documentation of where the resident was released and repositioned every 2 hours while up in the broda chair with leg straps. During an interview on 7/2/24 at 11:48 a.m., the Director of Nursing indicated the facility did not have a consent prior to the 6/29/24 date for Resident 3's use of restraints. 3. On the following dates, times, and locations, Resident 27 was observed sitting in a Broda wheelchair (a chaired designed to provide supportive positioning, decrease postural deviations, and enhance patient safety while facilitating safe, frequent repositioning) with restraining straps secured across the resident's			

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	upper legs. The straps were unable to be removed by the resident: - On 6/26/24 from 9:40 a.m. to 11:55 a.m., Resident 27 was observed to be straining against the restraints and emitting a high pitched vocal sound in her room. - On 6/26/24 from 1:20 p.m. to 3:30 p.m., in her room. - On 6/27/24 from 9:30 a.m. to 12:15 p.m., Resident 27 was observed to be straining against the restraints in her room. - On 6/28/24 from 10:00 a.m. to 12:35 p.m., in her room. - On 6/28/24 from 2:05 p.m. to 3:25 p.m., Resident 27 was observed to be straining against the restraints and emitting a high pitched vocal sound in her room. - On 7/1/24 from 9:31 a.m. to 11:47 a.m., in her room. - On 7/1/24 from 1:00 p.m. to 3:15 p.m., in her room. - On 7/2/24 at 9:05 a.m., in the dining room. - On 7/2/24 at 11:40 a.m., Resident 27 was observed to be straining against the restraints and emitting a high pitched vocal sound in her room. There were no observations of the resident being removed from restraints or pacing during the survey time period. On 7/1/24 at 11:50 a.m., Resident 27's clinical record was reviewed. The diagnoses included, but were not limited to, unspecified mood disorder and dementia. Physician's orders with a start date of 5/31/24 through the current date indicated, "Broda chair with straps while up for safety and positioning, unable to maintain erect torso. Paces to the point of exhaustion and unaware of her environment.			

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	Release and reposition every two hours and as needed". There was no documentation indicating the resident was released from the restraint every 2 hours and there was no documentation identifying any type of specific direct monitoring and supervision provided during the use of the restraint. A care plan with a review start date of 6/14/24 and a target date of 7/6/24 indicated the resident was to be released from the restraint and repositioned every 2 hours. During an interview on 7/2/24 at 9:00 a.m., CNA 1 indicated she was not certain how often the resident was to be out of the restraint but believed it was fairly frequently. During an interview on 7/2/24 at 9:30 a.m., CNA 2 indicated she was not certain how often the resident was to be out of the restraint, and on evening shift staff released the restraint and walked with the resident, as the resident enjoyed walking. During an interview on 7/2/24 at 1:16 p.m., the DON indicated the clinical record did not indicate Resident 3, Resident 16, and Resident 27 were released from their restraints and repositioned every 2 hours. On 7/1/24 at 1:15 p.m., the Administrator provided the facility's policy,"Restraint Free Environment" dated 3/1/24, and indicated it was the policy currently being used by the facility. A review of the policy did not indicate to complete documentation of where the resident was repositioned or released every 2 hours while in restraints nor having an Informed Consent for Use of Restraint formed signed prior to placing the			

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	resident in restraints. 3.1-26(h)			
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention			

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	requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation and interview, the facility failed to ensure the daily posted nurse staffing reflected the actual hours worked by staff for 5 of 5 days of daily posted nurse staffing reviewed. Findings include: On 6/26/24 at 11:42 a.m., the Posted Nurse Staffing was observed. The Posted Nurse Staffing lacked the actual hours worked. On 6/27/24 at 10:26 a.m., the Posted Nurse Staffing was observed. The Posted Nurse Staffing lacked the actual hours worked. On 6/28/24 at 9:28 a.m., the Posted Nurse Staffing was observed. The Posted Nurse Staffing lacked the actual hours worked. On 7/1/24 at 10:49 a.m., the Posted Nurse Staffing was observed. The Posted Nurse Staffing lacked the actual hours worked. On 7/2/24 at 10:20 a.m., the Posted Nurse Staffing was observed. The Posted Nurse Staffing lacked the actual hours worked. During an interview on 7/2/24 at 11:37 a.m., the Clinical Support Nurse indicated the facility should be including actual hours worked on the staffing sheet and be updated the following day to reflect the actual hours worked by licensed staff. They indicated the facility did not have a policy in regard to specific requirements on the nurse staffing sheets.	F 0732	What corrective action will be accomplished for those residents found to have been affected by the deficient practice: · No residents were named or affected by the deficient practice How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. · No residents have the potential to be affected by the deficient practice. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. · A new standardized staffing sheet was created in a clear and readable format to include i. Facility name ii. The current date iii. The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: A. Registered nurses B. Licensed practical nurses or licensed vocational nurses (as defined under State Law) C. Certified nurses aides D. Resident census · The new staffing sheet	07/22/2024

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			referenced prior will be posted daily at the beginning of each shift above the time clock by the back door of the building which is readily available for all visitors and residents · Staff members responsible for posting the staffing sheet were trained on how to complete the staffing sheet and what is required to be posted each day 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 in place. · On 7/22/2024 an AD HOC QAPI meeting was held to review facility plan of correction for concerns identified which included Administrator, Director of Nursing, and IDT. · The Director of Nursing/designee/Administrator will review the staffing sheet daily for at least a period of 6 months. The NHA and DON are responsible for ensuring implementation of the plan of correction and that compliance is maintained. The facility alleges substantial compliance on: 7/22/2024	
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated			

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	with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic			

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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
	drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on observation, interview, and record review, the facility failed to ensure residents were free from unnecessary medications for 1 of 5 residents reviewed. As needed antipsychotic medications were prescribed for longer than 14 days, gradual dose reductions (GDR) were not completed, and antipsychotic medications did not have an adequate diagnosis. (Resident 3) Findings include: During an observation on 6/27/24 at 9:49 a.m., Resident 3 was observed sitting upright in a broda chair with lower limb restrains in place. The resident repeatedly shouted, "Come here!," in a loud and intelligible voice. On 6/27/24 at 10:17 a.m., Resident 3's clinical record was reviewed. The diagnoses included, but were not limited to, Alzheimer's disease, personal history of traumatic brain injury, insomnia, and anxiety. A 5/9/24 physician's order indicated the resident was prescribed olanzapine (antipsychotic medication) 2.5 milligrams, two times a day, related to Alzheimer's disease and prochlorperazine maleate (antiemetic and antipsychotic medication) 1 tablet by mouth every six hours as needed for nausea and vomiting. An Annual Minimum Data Set (MDS) assessment, dated 6/5/24, indicated the resident had a diagnosis of Alzheimer's disease and used antipsychotic medication. The MDS assessment also indicated a GDR was not attempted and was	F 0758	What corrective action will be accomplished for those residents found to have been affected by the deficient practice: · Resident #3's clinical record was reviewed. When the facility transitioned from paper charting to an electronic medical record, some information was not transferred appropriately. This resident has an existing diagnosis of F02.B2 dementia with psychotic disturbance for which olanzapine is ordered to manage psychosis. · Resident #3's medical diagnosis list was audited by the Director of nursing and medical providers and corrected to reflect his medical records. · The olanzapine order for resident #3 was corrected to reflect that it is ordered for the diagnosis of F02.B2 Dementia with psychotic disturbance and to manage psychosis · A review was completed on Resident #3's order for Prochlorperazine maleate 10mg every 6 hours as needed for nausea and vomiting. It was determined that there is no longer a need for this PRN medication as the resident does not currently exhibit symptoms of nausea and/or vomiting. The resident has not received the PRN medication	07/22/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E683	A. BUILDING 00 B. WING	07/02/2024

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	not clinically documented as contraindicated. A Psychotropic and Sedative/Hypnotic Utilization by Resident, for records updated between 2/1/24 and 2/8/24, included, but was not limited to: - Zyprexa (olanzapine) 2.5 mg twice a day for dementia diagnosis ordered 4/18/22, next evaluation 2/2024. - Prochlorperazine maleate 10 mg every six hours as needed for nausea and vomiting, ordered 10/4/23, next evaluation 1/2024. The clinical record lacked an evaluation for the continued use of as needed antipsychotics, adequate diagnosis for antipsychotics, and attempted GDR for psychotropic medications. During an interview on 7/2/24 at 2:30 p.m., the Clinical Support Nurse indicated resident should not have a antipsychotic medication for dementia without behaviors. She further indicated she believed the resident's hospice care would be an indicator for not attempting a GDR for as needed antipsychotics. On 7/2/24 at 3:30 p.m., the Administrator provided the facility policy, "Gradual Dose Reduction of Psychotropic Drugs," revised on 2/14/24, and indicated it was the policy currently being used. A review of the policy indicated, "... GDR is the stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued. Psychotropic Drug is defined as any drug that affects brain activities associated with mental process and behavior ... 4. The timeframes and duration of attempts to taper any medication ... c. Opportunities during the care process to consider whether the medications should be continued, reduced, discontinued, or		since 5/8/2024. This medication was discontinued due to non-use. · A review of the resident's medication orders revealed no other psychotropic medications that are out of compliance. 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 residents have the potential to be affected. · CMS compliance related to duration of PRN medications, GDR attempts, appropriate diagnosis, and any other contraindications will be identified from reports submitted during the monthly medication audit completed by the pharmacist · Monthly medication recommendations by the pharmacist will be addressed by the Director of Nursing and attending providers immediately when identified · The Director of Nursing discussed CMS compliance with psychotropic drugs with the facility's psychiatric providers. Both providers will review the residents' medications to verify medication changes. These changes will be addressed immediately. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.	

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	otherwise modified include: i. During the monthly medication regime review by the pharmacist. ii. When the physician or prescribing practitioner evaluated the resident's progress..." 3.1-48(a)(3) 3.1-48(b)(2)		· An in-service training was completed with all QMAs, RN's, LPN's and providers on medication administration, medication safety, duration of PRN psychotropic medication, GDR requirements, and using medications for an appropriate diagnosis. · Monthly medication recommendations by the pharmacist will be addressed immediately upon receipt by the DON and attending providers. · The DON and psychiatric providers will meet to review and discuss all plans of care, resident progress, and all psychotropic drugs prescribed for each visited resident biweekly. GDR due dates and attempts will be documented. Any necessary medication interventions will be addressed immediately by the DON and psychiatric providers. 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 in place. · On 7/22/2024 an AD HOC QAPI meeting was held to review facility plan of correction for concerns identified which included Administrator, Director of Nursing, and IDT. All recommendations to be followed for at least a period of 6 months. · The DON will be responsible for monitoring the use of psychotropic medications through monthly	

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			pharmacy audit reports and daily audits of the resident dashboard on the electronic medical record. The facility alleges substantial compliance on: 7/22/2024	