STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING 00 B. WING	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION ST LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: March 21, 22, 23, 24, 27 and 28, 2023 Facility number: 000051 Provider number: 155121 AIM number: 100275490 Census Bed Type: SNF/NF: 102 Total: 102 Census Payor Type: Medicare: 5 Medicaid: 86 Other: 11 Total: 102 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 3, 2023.	F 0000	Rosewalk Village of Lafayette respectfully requests desk review for this deficiency.	
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must			

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

Nathan Anderson | Executive Director | 04/13/2023

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	ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, interview, and record review, the facility failed to ensure a resident was provided thorough washing of all areas for 1 of 1 residents being observed for catheter care (Resident 2). Findings include: During an observation, on 3/27/23 at 11:21 a.m., LPN 3 and the Assistance Director of Nursing(ADON) were providing catheter care for Resident 2. LPN 3 gathered water from the bathroom and had wash cloths on the bedside table. LPN 3 started cleaning the resident's tubing attached to the catheter bag. LPN 3 did not wash	F 0690	**F690- Bowel/Bladder Incontinence, Catheter** It is the practice of this facility to ensure residents with catheters receive appropriate treatment and services. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 2 immediately had catheter care performed correctly, including cleaning peri area and 4 inches of the tubing where it entered the meatus.	04/21/2023

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	the resident's peri area or clean the catheter in a circular motion for about 4 inches and did not start cleansing where the catheter entered the meatus and down the drainage tub. Resident 2's peri area appeared very red. Resident 2's record was reviewed on 3/24/23 at 4:23 p.m. Diagnoses included, but where not limited to, pressure ulcer of left buttock, epilepsy, hypertension, depressive episode and traumatic brain injury and artificial knee joints. A facility form, titled, "Procedure Steps for Catheter Care (urinary)," dated 2/2023, indicated to use the non-dominant hand and grasp the catheter tubing where it entered the meatus; use the dominant hand to retrieve a wet soaped washcloth, cleanse catheter in a circular motion for about 4 inches; and start cleanse where the catheter entered the meatus and down the draining tube. A Care Plan, dated 8/12/22, indicated Resident 2 required an indwelling urinary catheter due to a wound to the buttock. Approaches included, but were not limited to, provide assistance for catheter care per shift, report signs of urinary tract infection, and keep catheter system closed as much as possible. A Physician's order, dated 11/10/22, indicated Resident 2's urinary catheter was to have catheter care every shift and to record the output every shift. A quarterly Minimal Data Set (MDS), dated 12/10/22, indicated Resident 2 had a catheter and was a two person extensive assist with toileting. It also indicated the resident's Brief Interview for Mental Status (BIMS) score was 15 which		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Any resident receiving catheter care has the potential to be affected by this finding. A facility audit will be completed by DNS/designee for all residents with catheters. All residents identified in this audit will be reviewed and ensure that catheter care is completed correctly. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The DNS/designee will in-service nurses on Catheter Care on or before 4/21/23. DNS/designee will conduct daily rounds to ensure catheter care is performed correctly. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool “Catheter Care”	

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	indicated the resident was cognitively intact. During an interview, on 3/27/23 at 11:04 a.m., the Assistant Director of Nursing (ADON) indicated the procedure steps should be followed during catheter care. During an interview, on 3/27/23 at 2:14 p.m., the Executive Director indicated they did not have a Catheter Care policy. The facility form titled, "Procedure Steps for Catheter Care (urinary)," dated 2/2023, was the policy catheter care. The facility did not have a Catheter Care policy. 3.1-41(a)(1)		weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up **By what date the systemic changes will be completed:** Compliance Date: 4/21/23	
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-			

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	§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on observation, interview, and record review, the facility failed to ensure lorazepam (an anti-anxiety medication) was not administered after the expiration date and to reconcile the controlled substance record for 1 out of 3 medication carts observed for medication storage (Resident 24). Findings include: 1. During a medication storage observation on 03/24/23 at 11:30 a.m., a bottle of lorazepam for Resident 24 was dated as opened on 12/21/22. The lorazepam should have been discarded on 3/21/23. The record for Resident 24 was reviewed on 3/24/22 at 11:30 a.m. Diagnoses included, but were limited to, unspecified dementia, unspecified severity, with other behavioral disturbance. A physician's order, dated 3/16/23, indicated lorazepam intensol 2 milligrams/milliliters give 0.5 milliliters every 4 hours as needed. A medication administration record, dated 3/1/23 to 3/23/23, lorazepam intensol 2 milligrams/milliliter	F 0755	**F755 Pharmacy Services/Procedures/Records** It is the practice of this facility to keep drug records in order and that an account of all controlled drugs is maintained and reconciled. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The expired lorazepam was immediately discarded. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this finding. A facility audit will be completed by DNS/designee for all medication storage areas to ensure all medications are stored, labeled, dated correctly and that narcotic	04/21/2023

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	give 0.5 milliliters was administered on 3/22/23 at 10:53 a.m. for a behavior issue. 2. During a medication storage observation on 03/24/23 at 11:30 a.m., a bottle of lorazepam intensol contained 14 milliliters of the medication. A controlled substance record indicated 7.5 milliliters of the medication remained in the bottle. A controlled substance record for lorazepam 2 milligrams/milliliter indicated 27 doses were administered from 12/21/23 to 3/22/23 resulting in 7.5 milliliters being left in the bottle. A medication administration record, dated 1/1/23 to 1/31/23, indicated one dose of lorazepam was administered. A medication administration record, dated 2/1/23 to 2/28/23, indicated 2 doses of lorazepam was administered. A medication administration record, dated 3/1/23 to 3/23/23, indicated 14 doses of lorazepam were administrated. This was a total of 17 doses of lorazepam doses administered. The dates of administration on the medication administration record did not coincide with the dates of administration on the controlled substance record. The shift change records for the memory care unit were reviewed on 3/24/2023 at 12:30 p.m., the records indicated the medication amount was checked and verified by staff every shift. During an interview on 3/24/23 at 12:35 p.m.,		count sheets are accurate. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The DNS/designee will in-service nurses on Medication Storage on or before 4/21/23. DNS/designee will conduct daily rounds to ensure medications are stored and counted correctly. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool "Medication Storage" weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up **By what date the systemic changes will be completed:** Compliance Date: 4/21/23	

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	Nurse 4 indicated she was not aware of an expiration date for the lorazepam, and she did not notice when she verified narcotic medications in cart and refrigerator. There was an error in the amount listed on the controlled substance record and in the actual medication bottle. A current manufacturer's insert, Pharmaceutical Associates Inc., indicated to discard opened bottles of lorazepam after 90 days. A current policy, titled, "Storage and Expiration of Medications, Biologicals, Syringes and Needles," indicated, dated 10/31/16, received from the executive director on 3/23/23 "..facility should ensure that medications and biologicals that...have an expired date on the label... have been retained longer than recommended by manufacturer or supplier guidelines...." A current policy, titled, "Inventory Control of Controlled Substances, dated 1/1/13, received from the executive director, on 3/23/23 at 3:46 p.m., indicated "...facility should maintain a separate individual controlled substance records...facility should ensure that facility staff count all schedule III and IV controlled substances in accordance with facility policy and applicable law... a facility representative should regularly check the inventory records to reconcile inventory...." 3.1-25(e)(2) 3.1-25(o)			
F 0756 SS=D Bldg. 00	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a			

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	month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. Based on interview and record review, the facility	F 0756	**F756 Drug Regimen Review**	04/21/2023

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	failed to ensure a pharmacy recommendation was addressed by the prescriber within 30 days for 1 of 5 residents reviewed for unnecessary medications (Resident 85). Finding includes: The record for Resident 85 was reviewed on 3/24/23 at 3:49 p.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance, anxiety disorder, major depressive disorder and a sleep disorder. A pharmacy consultation, dated 6/8/22, indicated the resident received an antidepressant, sertraline 100 milligrams (mg), at bedtime which may interfere with sleep. The resident was receiving melatonin (a hormone which affects sleep) 3 mg once a day at bedtime as a sleep aid. Recommended to change the administration time of the sertraline to the morning and reassess the continued need for the melatonin. The Nurse Practitioner (NP) responded to the recommendation on 7/25/22 and indicated to adjust the sertraline dosing to every morning. The NP response was 47 days after the pharmacy recommendation. During an interview, on 3/28/23 at 11:44 a.m., the Executive Director (ED) indicated there was no answer why the NP had the delayed response to the pharmacy recommendation on 6/8/22. A current Nursing Drug book, indicated the adverse reactions of sertraline included, but were not limited to, insomnia. A current policy, titled, "Medication Regimen Reviews and Pharmacy Recommendation",		It is the practice of this facility to ensure the drug regimen of each resident is reviewed at least once a month by a licensed pharmacist. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 85 had current medication regimen reviewed by a licensed pharmacist and the physician was notified of any recommendations, no changes were made. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this finding. A facility audit of the last 30 days will be completed by DNS/designee for all residents to ensure a pharmacy reviews have been completed. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The ED/designee will in-service nurse practitioners and medical directors on responding to drug regimen reviews within 30 days on or before 4/21/23. All pharmacy recommendations will be reviewed by DNS/IDT monthly to ensure	

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	revised on 10/2018 and received from the executive director on 3/28/23 at 12;27 p.m., indicated, "...It is the policy of ASC that the facility maintains the resident's highest practicable level of physical, mental and psychosocial well-being and prevents or minimized adverse consequences related to medication therapy to the extent possible by providing oversight by a licensed pharmacist, Attending Physician, Medical Director, and Director of Nursing...The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The drug regimen review must include a review of the resident's medical chart...The Consultant Pharmacist recommendations will be reviewed by the Director of Nursing and the Attending Physician will be notified promptly of any recommendation needing immediate attention...Pharmacy recommendations should be reviewed with follow up by the physician within 30 days of the facility receiving...." 3.1-25(i)		providers are responding to recommendations within 30 days. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool “Pharmacy Services” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up **By what date the systemic changes will be completed:** Compliance Date: 4/21/23	
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic;			

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	(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 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.			

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	Based on interview and record review, the facility failed to ensure the prescribed antianxiety medication had documentation to show the clinical rationale for being prescribed and to ensure the continued need for the use of the medication was assessed for 1 of 5 residents reviewed for unnecessary medications (Resident 4), and to provide a clinical rationale for not accepting a gradual dose reduction (GDR) recommendation for 1 of 5 residents reviewed for unnecessary medications (Resident 48). Findings include: 1. The Record for Resident 4 was reviewed on 3/23/23 at 12:25 p.m. Diagnoses included, but were not limited to, Alzheimer's disease with late onset, unspecified dementia with psychotic disturbance, psychotic disorder with hallucinations due to a known physiological condition, moderate intellectual disabilities, recurrent major depression and a lack of coordination. The diagnoses did not include anxiety. A physician's order, dated 9/6/23, indicated to give buspirone (an anxiolytic to treat anxiety) 7.5 milligrams (mg) twice a day for depression. A care plan, dated 9/7/22, indicated the resident was at a risk for signs/symptoms of depression. The resident had a diagnosis of major depressive disorder and utilized an antianxiety medication. The interventions included, but were not limited to, allow the resident to express feelings and frustration, encourage activities of interest and medications as ordered. A care plan, dated 9/7/22, indicated the resident was at a risk for adverse side effects related to the	F 0758	**F758 Free from Unnecessary Medication** It is the practice of this facility to provide the resident an environment free of unnecessary psychotropic medication. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 4 had current medication regimen reviewed by the physician and a diagnosis of anxiety was added. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this finding. A facility audit will be completed by DNS/designee for all residents to ensure pharmacy review for the last 30 days have been completed and psychotropic medication has a clinical rational. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The DNS/designee will in-service social services and nurse practitioner on unnecessary medications on or before 4/21/23. All orders will be reviewed by DNS/IDT in daily meeting to	04/21/2023

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	155121	A. BUILDING 00 B. WING	03/28/2023

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	use of psychotropic medication, an antidepressant and antianxiety medication. The resident had a diagnosis of major depression, dementia with behavioral disturbance and a psychotic disorder with hallucinations due to a known physiological condition. The care plans did not include the resident was at a risk for anxiety. A psychiatric progress note, dated 2/6/23, indicated the diagnoses and plan included: a. Alzheimer's disease with late onset to continue the Aricept and Namenda (memory medications). b. Major depressive disorder to continue the sertraline (an antidepressant). c. Other sleep disorder to continue the melatonin (a hormone which helps with sleep). d. Psychotic disorder with hallucinations due to a known physiological condition to continue the olanzapine (an antipsychotic medication) e. Other sexual dysfunction not due to a substance of known physiological condition to continue the sertraline. The diagnoses and plan did not include anxiety or the medication buspirone. A psychiatric progress note, dated 2/22/23, indicated the diagnoses and plan included: a. Alzheimer's disease with late onset to continue the Aricept and Namenda. b. Major depressive disorder to continue the sertraline. c. Other sleep disorder to continue the melatonin. d. Psychotic disorder with hallucinations due to a know physiological condition to continue the olanzapine. e. Sexual dysfunction not due to a substance or known physiological condition to continue the		ensure correct diagnosis and clinical rational are documented. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool “Pharmacy Services” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up **By what date the systemic changes will be completed:** Compliance Date: 4/21/23	

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	sertraline. The diagnoses and plan did not include anxiety or the medication buspirone. A psychiatric progress note, dated 3/6/23, indicated the diagnoses and plan included: a. Dementia which was moderately stable. b. Major depressive disorder to continue the antidepressant sertraline 150 mg. c. Other sleep disorder to continue melatonin 5 mg each evening. d. Sexual dysfunction not due to a substance or known physiological condition to continue the sertraline. e. Psychotic disorder with delusions due to a known physiological condition to continue olanzapine. The diagnoses and plan did not include anxiety or the buspirone. An Pharmacy consultation report, dated 3/14/23, indicated the resident had received buspirone 7.5 mg twice daily for major depressive disorder since 9/2022. For the initial attempt at a GDR, please reduce the buspirone to 5 mg twice daily. Please provide patient specific rationale desscribing why a GDR attempt was likely to impair function or cuase psychiatric instability. The NP response included the GDR was declined due to being clinically contraindicated. The NP signed the form on 3/20/23 and did not provide a clinical rationale for declining the GDR as requested on the form. During an interview, on 3/27/23 at 12:34 p.m., The DON indicated the NP was prescribing the buspirone even though he did not document the medication in any of the psychiatric progress notes. The NP was changing the diagnosis to			

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	anxiety for the use of the buspirone. During an interview, on 3/28/23 at 12:26 p.m., the Executive Director (ED) indicated the NP changed the diagnosis for the use of the buspirone to generalized anxiety disorder. The medication was documented as being given for depression prior to 3/28/23. The ED indicated once the diagnosis was changed to generalized anxiety disorder then the depression diagnosis would not show in the history on the electronic health record in the physician's orders. The copy of the physician's order provided by the facility would not show the original order had the diagnosis of depression. 2. The record for Resident 48 was reviewed on 03/23/23 at 09:29 a.m. Diagnoses included, but were not limited to, major depressive disorder, delusional disorders, generalized anxiety disorder, and psychotic disorder with delusions due to known physiological condition. A physician's order, dated 1/23/23, indicated Lexapro (an antidepressant) 10 mg daily. A pharmacy recommendation, dated 9/19/22, indicated the resident had received an antidepressant, lexapro 5 milligrams once daily for the management of major depressive disorder since 3/2022. The recommendation was to consider documenting that a gradual dose reduction was clinically contraindicated. A patient-specific rationale describing why a gradual dose reduction attempt is likely to impair function or cause psychiatric instability in the individual. The physicians response, dated 9/19/12, indicated the escitalopram was an ongoing need and the GDR was declined. The physician response did not include the clinical rationale for declining the gradual dose			

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	reduction. A current policy, titled, "Psychotropic Management," last revised on 7/22 and received from the Executive Director on 3/28/23 at 12:14 p.m., indicated, "...It is the policy of American Senior Communities to ensure that a resident's psychotropic medication regimen helps promote the resident's highest practicable mental, physical and psychosocial well-being with person centered intervention and assessment. These medications are managed in collaboration with professional services and facility staff to include no pharmacological interventions, assessment and reduction as applicable...A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories...Anti-psychotic...Anti-depressant...An ti-anxiety...Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition as diagnoses, and this is documented in the medical record. Each resident receiving psychotropic medication will have an adequate indication for use and supporting diagnosis for use which is documented in the clinical record...Gradual dose reductions [GDR] and use of no pharmacological intervention will occur for residents receiving psychotropic medication unless contraindicated by the prescriber with specific rationale why reduction is not indicated...Periodic re-evaluation of the medication regimen is necessary to determine whether continued use of a mediation is indicated...Prescribers will evaluate the efficacy and risks for psychotropic medications and document their assessment in the medical record... The prescriber may reduce the medication or clinically contradict the GDR based on relevant			

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	clinical standards of practice. All rationale must be documented in the medical record...." 3.1-48(a)(3) 3.1-48(a)(4)			
F 0761 SS=D 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 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 ensure insulin pens were dated when opened and unopened insulin was in the refrigerator for 1 out of 3 medication	F 0761	**F761 Label/Storage Drugs and Biologicals** It is the practice of this facility to label drugs and biologicals used in	04/21/2023

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	carts observed for medication storage (Residents 52 and 156). Findings include: During an observation, on 03/24/23 at 10:07 a.m., insulin lispro (a short acting insulin) 100 units/milliliter pens were in the medication cart without open dates. Another insulin pen was not open and was stored in the medication cart. The insulin pens belonged to Residents 52 and 156. The record for Resident 52 was reviewed on 3/24/23 at 11:00 a.m. Diagnoses included but were not limited to type 2 diabetes mellitus. The record for Resident 156 was reviewed on 3/24/23 at 11:00 a.m. Diagnoses included but were not limited to type 2 diabetes mellitus. During an interview on 3/23/23 at 4:15 p.m. LPN 3 indicated the insulin pens should have been dated when they were opened, and the unopened insulin should have been stored in the refrigerator. A current policy, titled, "Storage and Expiration of Medication, Biologicals, Syringes and Needles," indicated "...once a medication or biological package is opened, the facility should follow manufacturer/supplier guidelines with respect to expiration dates, for opened medications...facility staff should record the date opened on the medication container when the medication container when the medication has a shortened expiration date...the facility should ensure the medications and biologicals are stored at their appropriate temperatures according to the United States Pharmacopeia guidelines for temperature ranges...."		the facility in accordance with currently accepted professional principles. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** All incorrectly labeled, dated, expired medications were disposed of in accordance with the pharmacy policies. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this finding. A facility audit will be completed by DNS/designee for all medication storage areas to ensure all medications are stored, labeled, and dated correctly. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The DNS/designee will in-service nurses on Medication Storage on or before 4/21/23. DNS/designee will conduct daily rounds to ensure medications are stored correctly. **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**	

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	3.1-25(m)		**into place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool "Medication Storage" weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up **By what date the systemic changes will be completed:** Compliance Date: 4/21/23	
F 0804 SS=E Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to ensure pureed foods were at the regulated temperature for hot and cold foods and to ensure the food was at a pudding thick consistency which had the potential to	F 0804	**F804 Food Procurement, Storage/Prepare/Serve-Sanitar y** It is the practice of this facility to ensure that food and drink is	04/21/2023

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	affect 18 of 18 residents who were on a pureed diet. Findings include: 1. During an observation, on 3/23/23 at 1:17 p.m., the Executive Director(ED) and Registered Dietitian (RD) were asked to take temperatures of the puree food served on the dementia unit. The RD took the 12th tray and removed the plate cover. The plate contained two white scoops and a large orangish/yellow liquid item covering half the plate and touching the two white scoops. The RD indicated the plate contained cauliflower, bread, and chicken pot pie. The cauliflower had an area of about 1/2 inch of clear liquid surrounding the scoop and the chicken pot pie had a liquid consistency. The RD placed the thermometer into the cauliflower and the temperature was 126.1 Fahrenheit (F). The temperature of the bread was 111.3 F. The RD took the thermometer and put the tip into the liquid chicken pot pie. The RD stated the chicken pot pie was normally served in a bowl. The chicken pot pie had a temperature of 110.2 F degrees. The RD temped the bowl of pureed pears and the temperature was 68.6 F. During an interview, on 3/22/23 at 12:18 p.m., the RD indicated every food item served hot needs to be 135 F or above and cold foods need to be 41 F or below. During an interview, on 3/23/23 at 3:02 p.m., the Executive Director(ED) indicated the chicken pot pie was covering half the plate and was normally served in a bowl. The [name of company] recipe for pureed chicken pot pie for a serving size of 25 indicated add		palatable, attractive and at a safe and appetizing temperature. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The puree food was brought to the correct temperate prior to serving. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents who receive a puree diet have the potential to be affected by this finding. An audit of puree foods will be completed by RD/designee and any findings will be immediately corrected. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The RD/designee will in-service culinary cooks on Puree Diets on or before 4/21/23. CDM/designee will conduct daily observations to ensure puree meals are served at correct temperature and texture. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored	

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	twenty-five 8 oz ladles of chicken pot pie, 1 tablespoon and 3/4 teaspoon of low-sodium chicken broth, 1 1/4 quart of hot water. Prepare the chicken pot pie as directed and add to the food processor. Process until fine in consistency. Gradually add hot broth to mixture while processing. All liquid may not be required. Hot food held for later service must maintain a minimum internal temperature of 140 F. Place cooked green beans in food processor, add melted margarine and a food thickener. Process briefly until mixed. 2. During a kitchen test tray observation on 3/22/23 at 12:38 p.m., the pureed bun tasted gooey and had no flavor of bread, the pureed hamburger still had little chunks of meat and was not a smooth texture and was not the flavor of a typical hamburger. During an interview, on 3/22/23 at 12:43 p.m., the kitchen staff indicated the test tray did not include the bun only the pureed French fries and they would bring a test tray with the pureed bun and pureed French fries. During a kitchen test tray observation on 3/22/23 at 12:44 p.m., the new test tray with the pureed hamburger and the pureed bun mixed together, the pureed hamburger still had a bitter taste. The pureed French fries had a gooey texture and tasted like starch and water. The flavor was not the taste of French fries. 3. During an interview, on 3/23/23 at 11:21 a.m., Resident 82's family indicated the pureed food had to be "stiffened up" because it was too runny. He showed a picture of two different colored pureed foods which were runny and had spread across the plate blending the two foods. The foods were not in a scoop form and were very flat on the		through the facility Quality Assurance and Performance Improvement Program (QAPI). The ED/designee will be responsible for completing the QAPI Audit tool “Puree Diets” daily for 2 weeks, weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. **By what date the systemic changes will be completed:** Compliance Date: 4/21/23	

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	plate. The pureed food was also cold, and the family warmed the food in the microwave before serving it to the resident. The record for Resident 82 was reviewed on 3/28/23 at 4:00 p.m. Diagnoses included, but were not limited to, Alzheimer's disease and dysphagia (difficulty swallowing). A physician's order, dated 1/23/23, indicated pureed diet with nectar thick/mildly thick liquids. 4. During an interview, on 3/23/23 at 11:28 a.m. Resident 22's family member indicated the pureed foods should be the correct consistency for residents who have swallowing problems. The family brought in their own thickener because the pureed foods had water all over the plate and were not thick. The record for Resident 22 was reviewed on 3/23/23 at 4:12 p.m. Diagnoses included, but were not limited to, unspecified dementia, dysphagia and adult failure to thrive. A physician's order, dated 2/25/23, indicated pureed diet with nectar thick/mildly thick liquids and 2 times the dessert at dinner. During an interview on 3/23/23 at 11:46 a.m., the Social Services Director (SSD) indicated he had observed the pureed foods to be runny on the plate and he would file a grievance when the pureed food was runny. He did turn in a grievance on 3/22/23 for the pureed foods being a runny consistency. During an interview, on 3/23/23 at 3:02 p.m., the Executive Director indicated the pureed chicken pot pie should have been served in a bowl since it			

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	had expanded onto the other food on the plate. It was hard to puree chicken pot pie and he was not sure if the kitchen staff had added thickener to the pot pie. A current policy titled, "Food Temperatures", revised 10/2022, received by the Executive Director on 3/23/23 at 3:46 p.m., indicated, " ...The facility proper temperature control to prevent food borne illness. 1. Hot foods that are potentially hazardous will be held for a serve at or above 135 F(Fahrenheit), and cold foods at or below 41 F. 2. All hot and cold food items will be served to the resident at a temperature that is considered palatable at the time the resident receives the food. 5. Temperatures should be taken with a sanitized and calibrated thermometer. Should this thermometer have a tube or sheath type cover, it must also be sanitized. 6. To take hot food temperatures, insert the thermometer into the thickest portion of the food item while avoiding bones, if present. 9. Hot food will be held at or above 135 F. If minimum temperature requirements are not maintained, food will need to be reheated to a minimum of 165 F for 15 seconds before serving. 10. Cold food will be held at or below 41 F. If cold food temperature is not maintained, food item will need to be chilled at < F before serving...." A current policy titled, "Protocol for Altered Diet Consistency/Thickened Liquids," undated, received by the Executive Director on 3/23/23 at 4:29 p.m., indicated, " ...Speech Therapist determines an altered diet consistency and/or thickened liquids are necessary. Reasons for the altered diet consistency and/or thickened liquids order i.e. chewing/swallowing difficulties, risk for aspiration...An altered consistency diet is any diet consistency that is not a regular consistency.			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION ST LAFAYETTE, IN 47904

(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
	Mech Soft, Ground or Chopped Meat, Puree, etc...." 3.1-21(a)(1) 3.1-21(a)(2)			