STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155724	A. BUILDING 00 B. WING	01/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODBRIDGE HEALTH CAMPUS	602 WOODBRIDGE AVE LOGANSPORT, IN 46947

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: January 18, 19, 20, 23, 24, 25 and 26, 2023. Facility number: 003691 Provider number: 155724 AIM number: 200456230 Census Bed Type: SNF/NF: 34 SNF: 30 Residential: 24 Total: 88 Census Payor Type: Medicare: 22 Medicaid: 21 Other: 21 Total: 64 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on February 2, 2023.	F 0000		
F 0644 SS=D Bldg. 00	483.20(e)(1)(2) Coordination of PASARR and Assessments §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Alma Nieves	Executive Director	02/21/2023

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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	effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. Based on record review and interview, the facility failed to complete a new Preadmission Screening and Resident Review (PASARR) for a resident who was prescribed an antipsychotic medication for 1 of 1 resident reviewed for PASARR. (Resident 42) Finding includes: The record for Resident 42 was reviewed on 1/23/23 at 3:52 p.m. Diagnoses included, but were not limited to, unspecified dementia with behavioral disturbances, Alzheimer's disease with late onset and major depressive disorder. A PASARR Level I screen, dated 5/9/22, indicated the resident's mental health condition was anxiety. The resident had a diagnosis of dementia and had not received any mental health services in the past. The medication used for the anxiety was Ativan (a benzodiazepine used to treat anxiety). The Level I screen indicated there was no evidence of a serious behavioral health condition and if changes occurred or new information refuted the findings, a new screen must be submitted.	F 0644	1. Resident 42 was affected. PASARR for medication has been completed. No adverse effects noted. 2. All new admits and readmits on Antipsychotic medications have the potential to be affected. All have been reviewed for completion of PASARR. Educated Social Service Director on ensuring PASARR is completed for all new admits and readmits if on an antipsychotic medication. 3. All referrals will be assessed for a need of a PASARR on admission and will be completed timely per regulations. Any residents with new orders for antipsychotics will have a PASARR completed and ensure they have an appropriate dx for the medication(s). As a measure of ongoing compliance, SSD will review 5 residents 3 times a week for 4 weeks, then 2 times a week for 4 weeks, then weekly x 4	02/09/2023

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	A physician's order, dated 11/7/22, indicated to give Zyprexa Zydis (an antipsychotic in orally disintegrating tablets) 7.5 mg (milligram) twice a day for unspecified dementia with behavioral disturbance. A physician's order, dated 11/8/22, indicated to give Zyprexa (an antipsychotic not orally disintegrating) 7.5 mg twice a day. During an interview, on 1/24/23 at 2:34 p.m., the SSD (Social Services Director) indicated the resident only had one PASARR completed and should have had another one completed when the Zyprexa was added. A current policy, titled "Indiana PASRR," not dated and received from the Clinical Support Nurse on 1/24/23 at 4:20 p.m., indicated "...Preadmission Screening and Resident Review [PASRR] is a federal requirement to help ensure that individuals are appropriately placed in nursing facilities for long-term care. PASRR requires...all applicants to a Medicaid-certified nursing facility be evaluated for serious mental illness...and/or intellectual disability...be offered the most appropriate setting for their needs...and the services they need in those settings...PASRR Level I complete for change in status...." 3.1-16(d)(1)(B)		weeks, then monthly x 3 months or until 100% compliance is maintained. 4. As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the			

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	facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview and record review, the facility failed to assess for edema and notify the physician of a significant weight gain for 1 of 6 residents reviewed for quality of care. (Resident 155) Finding includes: During a wound care observation, with RN 3 on 1/24/23 at 3:11 p.m., Resident 155's legs were elevated on a pillow and appeared swollen. RN 3 indicated the resident had edema off and on in the past. The record for Resident 155 was reviewed on 1/20/23 at 3:16 p.m. Diagnoses included, but were not limited to, dementia unspecified severity, depressive disorder, and hypertension. A physician's order, dated 1/4/23, indicated the resident was to be weighed every Monday between 6:00 a.m., and 10:00 a.m. A care plan, dated 1/11/23, indicated the resident was at risk for malnutrition due to inadequate nutrients. The interventions included, but were not limited to, assist with meals, and obtain weights as ordered. The resident had the following weights: a. On 1/4/23, the weight was 163.8 pounds. b. On 1/9/23, the weight was 168.0 pounds. c. On 1/16/23, the weight was 175.8 pounds which was a significant weight gain of 6.84% from 1/4/23 in 12 days.	F 0684	1. Resident 155 was affected by missed evaluation of weight gain. Assessment completed immediately. No adverse reactions noted from missed evaluation of weight gain. MD was notified. 2. All residents with significant weight change have the potential to be affected. All nurses educated on timely assessments after significant weight change. All residents with current significant weight change have been reviewed and are being monitored. 3. As a measure of on-going compliance, the Director of Health Services, or designee, will complete audits of 3 residents to ensure significant weight change assessments/events have been completed accurately and timely 3x weekly for 4 weeks, then weekly x 4 weeks, then every other week x4 weeks, then monthly x 3 months. 4. The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained. The plan will be reviewed and updated as warranted and will continue until	02/09/2023

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	d. On 1/23/23, the weight was 180.2 pounds which was a significant weight gain of 10.1% from 1/4/23 in 19 days. e. On 1/24/23, the weight was 187 pounds which was a significant weight gain of 14.16% from 1/4/23 in 20 days. The physician was not notified of the resident's edema or the significant weight gain. During an interview, on 1/20/23 at 3:06 p.m., RN 4 indicated the resident had edema and was elevating her legs. During an interview, on 1/24/23 at 4:54 p.m., the Director of Nursing indicated the management team discussed Resident 155's weight on 1/16/23. The physician was not notified, and no new interventions were started for the resident's weight gain. The physician should have been notified of the edema and weight gain. A current policy, titled "Guidelines for Weight Tracking," dated as revised on 1/16/21 and received from the Clinical Support Nurse on 1/23/23 at 2:30 p.m., indicated "...To ensure resident weight is monitored for weight gain and/or loss to prevent complications arising from compromised nutrition/hydration...Resident will have their weight taken and recorded upon admission to establish a baseline...The facility dietitian or representative will review the resident's nutritional status, usual body weight and current weight to implement a nutritional program when warranted...Residents who have a weight that seem out of normal range shall be re-weighed to determine the accuracy of the original weight...The physician, resident representative and dietitian shall be notified of a weight variance of 5% in 30 days, 7.5% in 90 days,		100% compliance is maintained	

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	and 10% in 180 days (unless on a planned weight loss or gain program)...Residents with a significant weight change can be added to Clinically At Risk...." A current policy, titled "Physician-Provider Notification Guidelines," dated as revised on 9/12/17 and received from the Clinical Support Nurse on 1/23/23 at 2:13 p.m., indicated "...To ensure the resident's physician or practitioner (may include NP, PA, or clinical nurse specialist) is aware of all diagnostic testing results or change in condition in a timely manner to evaluate condition for need of provision of appropriate interventions for care...Resident assessments for change in condition, suspected injury, event of unknown or ordered lab and/or other diagnostic tests should be completed in a timely manner...Attempts to notify the physician/provider and their response should be documented in the resident electronic health record...The 24 Hour report shall be utilized for nurse to nurse communication regarding the status of notification and response back...." 3.1-37(a)			
F 0756 SS=D Bldg. 00	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician			

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	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 failed to ensure the consultant pharmacist made recommendations for irregularities in diagnoses and medications prescribed for 1 of 2 residents reviewed for unnecessary psychotropic medications. (Resident 42) Finding includes:	F 0756	1. Resident 42 was affected. No adverse effects noted. All residents reviewed for irregularities in diagnosis and medications prescribed reviewed for unnecessary psychotropic medications. 2. All residents on	02/09/2023

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	The record for Resident 42 was reviewed on 1/23/22 at 3:52 p.m. Diagnoses included, but were not limited to, unspecified dementia with behavioral disturbance, Alzheimer's disease with late onset, restlessness and agitation, major depressive disorder, chronic kidney disease stage 3, and anxiety disorder. A physician's order, dated 11/7/22 through 11/29/22, indicated to give lithium carbonate (used to treat bipolar disorder) 300 mg (milligram) once a day for unspecified dementia with behavioral disturbance. A physician's order, dated 11/29/22 through 12/2/22, indicated to give lithium carbonate 300 mg once a day on Sundays, Tuesdays, Wednesdays, Fridays, and Saturdays for unspecified dementia with behavioral disturbance. A physician's order, dated 11/8/22, indicated to give Zyprexa (an antipsychotic not orally disintegrating) 7.5 mg twice a day. A pharmacy review, dated 11/11/22, indicated the medication review was completed. There were no recommendations with the pharmacy review. During an interview, on 1/26/23 at 11:42 a.m., the Consultant Pharmacist indicated the Zyprexa was ordered for dementia with behaviors. The diagnosis was not appropriate although it was ordered at the psychiatric hospital. The indication for the use of lithium was depression although the medication was ordered for dementia with behaviors. The pharmacist did not make recommendations to the facility for the		antipsychotic medications have the potential to be affected. Pharmacists and Social Service Director to be educated on importance of timely reviews of antipsychotic medications and proper diagnosis. 3. As a measure of on-going compliance, the Social Service Director, or designee, will complete audits of 3 residents to ensure timely pharmacy reviews of antipsychotic medications with proper diagnosis have been completed accurately and timely 3x weekly for 4 weeks, then weekly x 4 weeks, then every other week x4 weeks, then monthly x 3 months. The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained	

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	inappropriate diagnoses for the medications. A Nursing Drug Handbook 2023 indicated lithium was used to treat bipolar disorder. The contraindications for the use of the medication included severe renal disease and the elderly. A Nursing Drug Handbook 2023 indicated Zyprexa was indicated for the treatment of schizophrenia, short term treatment of manic episodes with bipolar disorder and treatment resistant depression. The black box warning included the drug may increase the risk of death in elderly patients with dementia. The drug was not approved to treat patients with dementia-related psychosis. A Consultant Services Provider Requirements, dated as revised 11/18 and received from the Clinical Support Nurse on 1/24/23 at 4:59 p.m., indicated "...The Consultant Pharmacist and/or pharmacy representative provide consultation of all aspects of the provision of pharmacy services in the facility. In collaboration with facility personnel, the Consultant Pharmacist helps to identify, communicate, address, and resolve concerns and issues related to provision of pharmaceutical services. This may include, but is not limited to...Identifying one or more current medication references to facilitate the identification of medications and information on contraindications, side effects and/or adverse effects, dosage levels and other pertinent information...Reviewing the medication regimen [medication regimen review] of each resident at least monthly or more frequently under certain conditions...incorporating federally mandated standards of care in addition to other applicable professional standards...and documenting the review and findings in the resident's medical			

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	record or in a readily retrievable format...Communicating to the responsible prescriber and the facility leadership potential or actual problems detected and other findings relating to medication therapy orders including recommendations for changes in medication therapy and monitoring of medication therapy as well as regulatory compliance issues...." A current policy, titled "Psychotropic medication Usage and Gradual Dose Reduction," dated as revised on 11/7/22 and received from the Clinical Support Nurse on 1/24/23, indicated "...To ensure every effort is made for residents receiving psychoactive medications to obtain the maximum benefit with minimal unwanted side effects through appropriate use, evaluation and monitoring by the interdisciplinary team...Resident shall receive psychotropic medications only if designated medically necessary by the prescriber, with appropriate diagnosis or documentation to support its usage. The medical necessity will be documented in the resident's medical record and in the care planning process...Regular monthly review of antipsychotics in CAR [clinically at risk] for continued need, appropriate dosage, side effects, risks and/or benefits will be conducted, to ensure the use of psychopharmacologic medications are therapeutic and remain beneficial to the resident...Reviews of medication use will be conducted by the consultant pharmacist monthly and will...." 3.1-25(i)			
F 0757 SS=D 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			

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	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 interview and record review, the facility failed to ensure a physician's order for antibiotics was followed for 1 of 5 residents reviewed for unnecessary medications. (Resident 19) Finding includes: The record for Resident 19 was reviewed on 1/23/23 at 10:37 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, type 2 diabetes mellitus, and Parkinson's disease. An emergency department note, dated 10/26/22, indicated the resident had redness and swelling to the right lower leg. The assessment/plan indicated cephalexin (an antibiotic) 500 mg (milligram) every 12 hours for 20 doses and doxycycline (an antibiotic) 100 mg twice daily for 20 doses.	F 0757	1. Resident 19 was affected. No adverse effects noted. All residents reviewed for excessive antibiotic use. 2. All residents with antibiotic use have the potential to be affected. Infection Preventionist educated on excessive antibiotic use. All residents with infections have been reviewed and are being monitored. 3. As a measure of on-going compliance, the Infection Preventionist, or designee, will complete audits of 3 residents to ensure all antibiotic usage are compliance with McGreer criteria have been completed accurately 3x weekly for 4 weeks, then	02/09/2023

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	A physician's order, dated 10/27/22 through 11/5/22, indicated to give cephalexin 500 mg every 12 hours for cellulitis. A physician's order, dated 10/27/22 through 11/5/22, indicated to give doxycycline 100 mg twice daily for cellulitis. A physician's clinic note, dated 10/27/22, indicated the resident was seen in the nursing home by the physician. The resident was seen in the emergency room for cellulitis. The resident was on cephalexin. The assessment/plan indicated to complete outpatient antibiotic therapy with cephalexin. The physician's clinic note did not include the continuing use of the doxycycline. A progress note, dated 10/27/22, indicated the interdisciplinary team (IDT) reviewed the associated infection event. The resident had returned to the facility from the emergency department with a diagnosis of lower extremity cellulitis and new order for antibiotics for 10 days. A progress note, dated 10/29/22 at 12:49 p.m., indicated the resident continued doxycycline and cephalexin as ordered. During an interview, on 1/24/23 at 4:20 p.m., the Clinical Support Nurse indicated the resident's physician only included to continue the cephalexin. The facility continued to administer the doxycycline along with the cephalexin and did not clarify this order. A current policy, titled "Antibiotic Stewardship Guidelines," dated as last reviewed on 12/01/2021 and received from the Clinical Support Nurse on		weekly x 4 weeks, then every other week x4 weeks, then monthly x 3 months. 4. The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained	

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	1/24/23 at 4:20 p.m., indicated "...Optimize the treatment of infections by ensuring that residents who require an antibiotic, are prescribed the appropriate antibiotic. Reduce the risk of adverse events, including the development of antibiotic-resistant organisms, from unnecessary or inappropriate antibiotic use. Encompass a facility-wide system to monitor the use of antibiotics...New orders for antibiotic usage will be reviewed during the campus Clinical Care Meeting on regular business days...Pharmacy provider will assist in review of all antibiotic usage for appropriateness...." 3.1-48(a)(1)			
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; (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			

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	155724	A. BUILDING 00 B. WING	01/26/2023

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	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. Based on interview and record review, the facility failed to ensure a resident with dementia had an appropriate diagnosis for the use of an antipsychotic medication and a mood stabilizing medication and to ensure recommendations for parameters of laboratory levels were followed for 1 of 2 residents reviewed for unnecessary psychotropic medications. (Resident 42) Finding includes: The record for Resident 42 was reviewed on 1/23/22 at 3:52 p.m. Diagnoses included, but were not limited to, unspecified dementia with	F 0758	1. Resident 42 was affected. No adverse effects noted. All residents reviewed for correct diagnosis of antipsychotics and correct parameters followed. 2. All residents on antipsychotic medications have the potential to be affected. Social Service Director and all nurses to be educated on importance of timely reviews of antipsychotic medications with proper diagnosis and correct lab parameters. 3. As a measure of on-going	02/09/2023

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	behavioral disturbance, Alzheimer's disease with late onset, restlessness and agitation, major depressive disorder, chronic kidney disease stage 3, and anxiety disorder. A discharge summary from the inpatient psychiatric facility, dated 11/7/22, indicated the resident was admitted to the psychiatric facility, on 10/23/22, due to increased behaviors of physical aggression over a 72-hour time period. The resident was prescribed Zyprexa for dementia with behaviors and lithium for dementia with behaviors. The goal was to keep the lithium level less than 0.6 due to the resident's advanced age and debility. A physician's order, dated 11/7/22 through 11/29/22, indicated to give lithium carbonate (used to treat bipolar disorder) 300 mg (milligrams) once a day for unspecified dementia with behavioral disturbance. A physician's order, dated 11/8/22, indicated to give Zyprexa (an antipsychotic) 7.5 mg twice a day. A pharmacy review, dated 11/11/22, indicated the medication review was completed. There were no recommendations regarding the inappropriate diagnoses for the use of Zyprexa and lithium with the pharmacy review. A physician's order, dated 11/16/22 through 11/18/22, indicated a CMP (comprehensive metabolic panel) and lithium level weekly on Thursday due to the lithium use. The physician's order did not include the parameters of a lithium level of less than 0.6 as		compliance, the Social Service Director and Director of Health Services, or designee, will complete audits of 3 residents to ensure timely antipsychotic medications with proper diagnosis and correct lab parameters are being followed 3x weekly for 4 weeks, then weekly x 4 weeks, then every other week x4 weeks, then monthly x 3 months. 4. The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained	

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	indicated by the inpatient psychiatric discharge notes. A lab report, dated as received on 11/17/22 and reported on 11/18/22, indicated the resident had a lithium level of 1.2 with a reference range of 0.5-1.2. This was out of the range of less than 0.6 as recommended by the inpatient psychiatric facility. The lithium dosage was not changed. A physician's order, dated 11/18/22 through 12/13/22, indicated a CMP and lithium level weekly on Tuesday due to lithium use. A lab report, dated as received on 11/22/22 and reported on 11/23/22, indicated the lithium level was 1.0. This was out of the range of less than 0.6 as recommended by the inpatient psychiatric facility. A physician's order, dated 11/29/22 through 12/2/22, indicated to give lithium carbonate 300 mg once a day on Sundays, Tuesdays, Wednesdays, Fridays, and Saturdays for unspecified dementia with behavioral disturbance. A NP (Nurse Practitioner) progress note, dated 12/1/22 at 10:17 a.m., indicated the resident was currently on lithium and olanzapine (Zyprexa) after an inpatient psychiatric stay. The resident seemed to have a general decline after starting those medications. The resident was drooling, her gait was not steady, and she was not sleeping well at night. The available labs were reviewed and some of the labs were still pending. The assessment/plan included an altered mental status, unsteady gait, general decline, and			

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	drooling. The drooling was likely related to the antipsychotics and the Zyprexa was decreased to 5 mg daily. The labs were pending. The dose of Zyprexa was not decreased until after the resident had a decline of condition. A progress note, dated 12/2/22 at 10:39 a.m., indicated the CMP results were sent to the NP and the lithium level was not available. A progress note, dated 12/2/22 at 2:25 p.m., indicated the lab called with a critical lithium level of 1.5 and the NP was notified. A new order to discontinue the lithium was received. A facility psychiatry progress note, dated 12/13/22, indicated the resident's lithium had been discontinued since the last visit. The lithium level had gone up to 1.8 which was considered a toxic level. The family disclosed the resident only had one kidney and had renal impairment. The primary care physician also decreased the Zyprexa to 5 mg daily. The resident had remained stable without any mood or behavioral issues reported. The plan included to continue the Zyprexa with a diagnosis of psychotic disorder with delusions due to a known physiological cause. There were no reported distressing delusions. The facility did not change the diagnosis for the use of the Zyprexa to a psychotic disorder with delusions due to a known physiological cause as indicated in the facility psychiatry progress note. During an interview, on 1/26/23 at 11:42 a.m., the Consultant Pharmacist indicated the lithium and Zyprexa were ordered for dementia with behaviors. The diagnosis was not appropriate although it was ordered at the psychiatric			

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	hospital. The lithium could be used for depression and the resident had a diagnosis for depression, so she did not recommend the facility look at the diagnosis for the medication since the diagnosis was listed somewhere. If a resident with chronic kidney disease was prescribed lithium, usually a lower dose would be ordered, and the kidney function and lithium levels would be monitored weekly for a few months. She did not have a chance to make the recommendation for the weekly labs since they were already ordered. The resident returned to the facility, on 11/7/22, and she did the pharmacy review on 11/11/22 with no recommendations. She did not include recommendations about lithium use with decreased kidney function. The facility had already completed one lithium level. The lithium was discontinued on 12/2/22 due to a high lithium level. A Nursing Drug Handbook 2023 indicated lithium was used to treat bipolar disorder. The contraindications for the use of the medication included severe renal disease and elderly. The adverse reactions were drowsiness, confusion, incoordination (lack of coordination) and hand tremor. A black box warning indicated lithium toxicity could occur at doses close to therapeutic levels. Provisions for prompt and accurate determination of serum lithium levels should be available before the start of therapy. Monitor and discontinue drug for signs and symptoms of lithium toxicity which include ataxia (impaired balance or coordination), drowsiness, weakness, tremor, and vomiting. The overdosage signs and symptoms included drowsiness, muscular weakness, lack of coordination, ataxia, slurred speech, myoclonic (involuntary twitching or jerking) limb movements.			

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	A Nursing Drug Handbook 2023 indicated Zyprexa was indicated for the treatment of schizophrenia, short term treatment of manic episodes with bipolar disorder and treatment resistant depression. The black box warning included the drug may increase the risk of death in elderly patients with dementia. The drug was not approved to treat patients with dementia-related psychosis. A current policy, titled "Psychotropic medication Usage and Gradual Dose Reduction," dated as revised on 11/7/22 and received from the Clinical Support Nurse on 1/24/23, indicated "...To ensure every effort is made for residents receiving psychoactive medications to obtain the maximum benefit with minimal unwanted side effects through appropriate use, evaluation and monitoring by the interdisciplinary team...Resident shall receive psychotropic medications only if designated medically necessary by the prescriber, with appropriate diagnosis or documentation to support its usage. The medical necessity will be documented in the resident's medical record and in the care planning process...Regular monthly review of antipsychotics in CAR [clinically at risk] for continued need, appropriate dosage, side effects, risks and/or benefits will be conducted, to ensure the use of psychopharmacologic medications are therapeutic and remain beneficial to the resident...Efforts to reduce dosage or discontinue psychotropic medications will be ongoing...Reviews of medication use will be conducted by the consultant pharmacist monthly and will...Monitor psychotropic drug use in the campus to ensure that medications are not used in excessive doses or for excessive duration...." 3.1-48(a)(3) 3.1-48(a)(4)			

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R 0000 Bldg. 00	3.1-48(a)(5) This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: January 18, 19, 20, 23, 24, 25 and 26, 2023. Facility number: 003691 Residential Census: 24 Woodbridge Health Campus was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review was completed on February 2, 2023.	R 0000		