| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
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| | | A. BUILDING 00<br>B. WING | 01/16/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| ASSISTED LIVING AT HARTSFIELD VILLAGE | 10002 COLUMBIA AVE<br>MUNSTER, IN 46321 |

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| R 0000<br><br>Bldg. 00 | This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00450986.<br><br>Complaint IN00450986 - State deficiencies related to the allegations are cited at R0052 and R0090.<br><br>Survey dates: January 15 and 16, 2025<br><br>Facility number: 010937<br><br>Residential Census: 69<br><br>These State Residential Findings are cited in accordance with 410 IAC 16.2-5. | R 0000 | | |
| R 0052<br><br>Bldg. 00 | 410 IAC 16.2-5-1.2(v)(1-6)<br>Residents' Rights - Offense<br><br>Based on record review and interview, the facility failed to protect the resident's right to be free from neglect when staff failed to initiate Cardiopulmonary Resuscitation (CPR) when a resident was found without a pulse and respirations for a resident who chose an advance directive for full resuscitation and failed to investigate or report a serious injury of unknown origin for 1 of 3 residents reviewed for death. (Resident B) This deficient practice resulted in the resident experiencing an open fracture of the right ankle and death.<br><br>Finding includes:<br><br>The closed record for Resident B was reviewed on 1/15/25 at 10:15 a.m. Diagnoses included, but were not limited to, high blood pressure, atrial | R 0052 | Assisted Living at Hartsfield Village<br>10002 Columbia Avenue<br>Munster, Indiana 46321<br><br>**This plan of correction represents the center's allegation of compliance. The following combined plan of correction and allegation of compliance is not an admission to any of the alleged deficiencies and is submitted at the request of the Indiana State Department of Health. Preparation and execution of this response and plan of correction does not constitute** | 02/14/2025 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Alyssa Fusco | Administrator | 02/03/2025 |

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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| | fibrillation (irregular heartbeat), edema, and breast cancer.<br><br>An Indiana Physician Orders for Scope of Treatment (POST) form, dated 3/6/24, indicated when the patient had no pulse and was not breathing, attempt resuscitation and CPR. The form was signed and dated by a Physician Assistant (PA) on 3/6/24.<br><br>A Service Plan, last reviewed/revised on 9/10/24, indicated the resident was a full code. The approach was the resident was to remain a full code unless changes were made to the advanced directive.<br><br>A Service Plan, last reviewed/revised on 9/10/24, indicated the resident would receive assistance with morning and evening care as needed. The approaches were to apply long socks to bilateral lower extremities, and then Velcro wraps over the socks for a.m. care and remove the wraps and long socks from bilateral lower extremities for p.m. care.<br><br>A Mini Mental Exam assessment, dated 9/15/24, indicated the resident was mildly cognitively intact for daily decision making.<br><br>The 12/2024 Physician Order Summary listed an order, dated 3/6/34, which indicated the resident was a full code.<br><br>A Release of Responsibility for a Resident Absence sign in and sign out sheet indicated the resident left the facility with family on 12/24/24 at 10:10 a.m., and arrived back to the facility on 12/28/24 at 11:05 a.m.<br><br>A resident log for meal consumption, dated 12/28/24, indicated the resident was out on pass | | **an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.**<br><br>**R052**<br>The facility failed to...initiate Cardiopulmonary Resuscitation (CPR) when a resident was found without a pulse and respirations…and failed to investigate or report a serious injury of unknown origin for 1 of 3 residents reviewed. (Resident B)<br><br>**Corrective action taken for residents found to have been affected by the deficient practice:**<br>Resident B no longer resides at this facility.<br><br>**Identification of other residents having the potential to be affected by the same deficient practice:**<br>All residents have the potential to be affected. An Advanced Directives audit was conducted of every resident currently in house to identify each resident's current Code Status.<br><br>**To ensure that proper practices continue:** | |

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| | for breakfast, refused lunch and was present in the dining room for dinner.<br><br>A Medication Administration Record (MAR), dated 12/2024, indicated the resident had received Eliquis (a medication used to thin blood) 2.5 milligrams (mg) and Metoprolol (a blood pressure medication) 75 mg before bed (7:00 p.m.-11:00 p.m.) The two medications were signed out as being administered on 12/28/24.<br><br>A Nursing Progress Note, dated 12/29/24 at 8:30 a.m., indicated staff had found the resident on the toilet unresponsive. The nurse was called to the room and at that time, the resident was without vital signs. The resident was not wearing the call pendant.<br><br>There was no documentation to indicate CPR was initiated immediately after staff had found the resident unresponsive and without vital signs.<br><br>There was no documentation in the clinical record or witness statements to indicate obvious clinical signs of irreversible death (e.g., rigor mortis, dependent lividity, decapitation, transection, or decomposition) were present to support the lack of CPR.<br><br>A Nursing Progress Note, dated 12/29/24, at 8:33 a.m., indicated 911 was called as well as the physician.<br><br>A Nursing Progress Note, dated 12/29/24 at 8:36 a.m., the ambulance arrived on scene and pronounced the resident deceased.<br><br>A Nursing Progress Note, dated 12/29/24 at 8:41 a.m., indicated the physician was aware of the death. | | In collaboration with the Executive Director/Vice President of Post-Acute Services, the Director of Clinical Operations and the Medical Director, facility Leadership developed and adopted the following new policies: Code Blue, Rapid Response.<br><br>The Director of Nursing/Designee will educate nursing staff (nurses, QMAs) on the new Code Blue policy and their associated responsibilities. The Director of Nursing/Designee will educate all facility staff on the new Rapid Response policy and their associated responsibilities.<br><br>The Director of Nursing/Designee will also educate nursing staff regarding unusual occurrences and/or a resident injury of unknown origin. Education will direct nursing staff to initiate an investigation form to include witness statements, etc. upon the identification of any unusual occurrence and/or resident injury of unknown origin.<br><br>The Director of Nursing/Designee will conduct weekly audits to review initiation of the following Code Status': Code Blue, Rapid Response to ensure compliance with facility policy/procedure. Additionally, the DON/Designee will conduct weekly audits to review all unusual occurrences | |

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| | A Nursing Progress Note, dated 12/29/24 at 9:00 a.m., indicated the resident's Power of Attorney (POA) was notified of the resident's death and would be in to see the resident and provide funeral home arrangements.<br><br>The last documented Nursing Progress Note was on 12/29/24 at 10:44 a.m., which indicated the POA had arrived and provided funeral home arrangements. The funeral home was notified and their estimated time of arrival was two hours.<br><br>There was no other documentation in the clinical record regarding any injuries the resident had sustained prior to or at the time of her death.<br><br>There was no documentation in the progress notes, dated between 12/29/24 and 12/30/24, to indicate the facility immediately began an investigation of the injury of unknown origin.<br><br>A witness statement, written by the Director of Nursing (DON) dated 12/29/24, no time documented, indicated "Writer informed by staff that resident [initials] was noted unresponsive on toilet in her apartment. Nurse on duty responded, 911 was called. Paramedics responded and police arrived onsite. Resident was noted to be in a sitting position on the toilet, no vitals observed by emergency response team. Paramedics did not perform CPR as there were no signs of life. Lead police officer stated there would be no further investigation. Post-mortem care provided by facility staff; staff observed a possible disfiguration to the resident's left lower extremity on the interior side. Writer spoke to resident's family to inform them and address any questions. No concerns voiced. Pre-determined funeral home was contacted and resident's physician also made | | and/or injuries of unknown origin to ensure compliance with this plan of correction. Each week an auditing tool will be completed to monitor compliance and/or identify trends to review with the facility's QAA Committee. After the fourth week, the QAA Committee will review all audit tools and will determine if the facility has achieved 100% compliance with practices at which time the monitoring will cease. If the QAA Committee determines that less than 100% compliance has been achieved, the monitoring tools will continue for another four-week period and will again be reviewed by the QAA Committee. This practice will continue until the facility has achieved at least 100% compliance. The systemic plan will be randomly initiating this audit tool again monthly throughout the next 3 months, to ensure that this deficient practice will not recur.<br><br>**Quality Assurance Plan to monitor compliance with this Plan of Correction:**<br>Identified concerns shall be reviewed by the facility's QAA Committee. Findings from all audit tools will continue to be reviewed monthly for the next 3 months. Recommendations for further corrective action will be discussed and implemented as needed. | |

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| | aware. Funeral home arrived and writer reviewed the sequence of events to include identification of the left lower extremity. Funeral home removed the resident's body. On the same date, writer was contacted by the Coroner. He requested to review the resident's current medications, which we did by telephone. No further documentation or information was requested from the facility at this time."<br><br>A witness statement, written by Housekeeper 1, dated 12/29/24 with no time documented, indicated "I was doing my rounds on the morning of December 29th. I arrived at the apartment door to collect the garbage. There was no answer, and when I knocked on the bathroom door there was also no answer. I opened the door to collect the garbage, and I saw the resident sitting on her toilet in the bathroom. I saw blood on the floor of the bathroom by her feet. She was not responding, and I used my walkie to notify the nurse right away. The nurse came running in the room and I stepped out."<br><br>A witness statement from LPN 1, written by the DON, dated 12/29/24 with no time documented, indicated "Nurse on duty was informed by housekeeping staff that a patient was nonresponsive on the toilet in her apartment. Nurse arrived to apartment and observed patient sitting on her toilet with her head resting back. Resident clearly showed no signs of life, unable to detect vitals. Blood was observed on the floor by the resident's foot. Nurse called 911; paramedics and police arrived onsite. Paramedics did not perform CPR as there were no signs of life. Director of Nursing also at facility and spoke to the police after as well as the funeral home. Funeral home arrived to transport the body." | | Completion Date: February 14, 2025 | |

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| | A Final Death Investigation Scene Report, dated 12/29/24 and provided by the county Coroner's office, indicated on 12/29/24 at 2:45 p.m., the coroner's office received a call from the funeral home director with reports of an unusual death. The funeral home reported the decedent (a person who has died) was a 95-year-old white female who resided at an assisted living facility. The funeral Home was called to pick up the decedent and upon arrival they observed the decedent lying supine in the living room with two blood-stained yellow towels wrapped around the right ankle. The nursing home staff reported the decedent had fallen and fractured her ankle. The funeral home removed the decedent from the nursing facility and upon arrival at the funeral home, staff unwrapped the decedent's ankle and noticed significant trauma. The coroner's office was then notified. The Chief Deputy along with another investigator responded to the funeral home. The decedent was lying supine on a gurney, was cool to the touch with rigor mortis and fixed lividity (a discoloration of the skin that occurred after death) present. The eyes were clear, and the pupils were fixed. Palpation of the head and neck revealed no signs of cranial trauma. There was an open fracture of the right ankle with fatty tissues and the tibia exposed. The tibia was completely severed from the ankle joint. The investigator photographed the scene, and the decedent was transported to the county coroner for processing. The Chief Deputy contacted the nursing facility and spoke with the Nursing Supervisor (DON). The DON indicated the housekeeper came into the decedent's room at approximately 7:45 a.m., and found the decedent slumped over the toilet in the bathroom with significant trauma to the right ankle and a large amount of blood on the floor. The nurse on duty called 911 and the emergency medical system responded to the scene. | | | |

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| | Paramedics pronounced the decedent dead on arrival and no lifesaving measures were attempted.<br><br>During an interview on 1/15/25 at 11:35 a.m. the DON indicated the resident was found by Housekeeper 1 who was doing his morning rounds and removing the garbage from resident rooms. After observing the resident on the toilet, he called the nurse who came down and dialed 911 from the resident's room. The nurse who responded determined the resident had already expired so she did not initiate or perform CPR. The DON was then notified, lived very close to the facility, and was able to get there very quickly. The police and paramedics were still at the facility, but shortly after she arrived the ambulance had left. The paramedics did not perform CPR, and the police ruled the death an accident. The DON was then asked if there were any unusual skin openings on the resident and she indicated "no, except around the inner side of the ankle and the resident's bone was protruding out." She indicated to her knowledge the resident did not have fragile skin but wore some kind of braces to her legs that staff had helped her put on and take off. She was unaware the last time any staff member had seen the resident, and it was not the facility's protocol to check on residents during the nighttime. They would only check on a resident if they were at risk for falls, had something that required staff to check on a resident, or the resident had asked to be checked on. The resident had a fall in May 2024 which was her last fall.<br><br>During an interview on 1/15/25 at 1:27 p.m., Housekeeper 1 indicated he was making his morning rounds like he does every morning to collect the garbage in resident rooms. He knocked on the door, and the resident did not answer, so he walked in, because he thought the resident was | | | |

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| | down eating breakfast. He then walked into the bathroom and saw the resident sitting on the toilet holding onto the rail. He indicated he immediately got on his walkie and called for the nurse to come to the room right away. The housekeeper indicated there was a "nice amount" of blood on the floor by the resident's feet. He was not CPR certified so he did not initiate CPR. After getting a hold of the nurse, he walked over to the kitchen and waited for the nurse to arrive.<br><br>Attempts were made to contact LPN 1 via telephone on 1/15/25 at 1:26 p.m., 1/15/25 at 2:00 p.m., and 1/16/25 at 10:06 a.m., but LPN 1 was not available for interview.<br><br>During an interview on 1/15/25 at 2:15 p.m., the Administrator indicated she was made aware the resident had expired on 12/29/24. She was also made aware of the injury to the right ankle and leg; however, she had focused on the death of the resident and not the injury, therefore, she did not report the incident to the State Agency. She was also aware staff did not initiate CPR, even though the resident was a full code. The nurse had indicated the resident had already expired when she arrived on scene. She did not investigate the significant trauma to the resident's right ankle and thought the DON had investigated it.<br><br>During an interview on 1/15/25 at 2:34 p.m., The DON indicated she did look around the room to see what had possibly happened and how the resident's bone was protruding out of her leg. No other staff who had worked on 12/28/24 and who were there on 12/29/24 were interviewed to see if anyone had seen the resident prior to the accident or death. No other residents who lived near the resident were interviewed to determine if she had met with anyone prior to the accident. The DON | | | |

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| | indicated she had only interviewed Housekeeper 1 and LPN 1 (the two staff that responded to the incident). There was no thorough and documented investigation completed for the significant injury with bone protrusion for the resident's fracture.<br><br>The Assisted Living Residency Agreement, signed by the resident, indicated "The provider shall provide personal assistance, lodging and meals as follows: Health Services: Assistance and Supervision; routine well-being checks during a 24-hour period."<br><br>The current 1/1/24 "Medical Emergency" policy, provided by the Administrator on 1/16/25 at 8:20 a.m., indicated "When there is a medical emergency not reported by the emergency call system, by a resident, visitor, or staff member, the first staff member on the scene will announce over the handheld communication device, "Code One and the location." Nurses will assess the resident, visitor, or staff member and provide basic first aid and/or call for emergency care needed. Nursing will continue to manage the emergency until the arrival of the emergency medical system team on site.<br><br>This citation relates to Complaint IN00450986. | | | |
| R 0090<br><br>Bldg. 00 | 410 IAC 16.2-5-1.3(g)(1-6)<br>Administration and Management - Deficiency<br><br>Based on record review and interview, the facility failed to ensure an unusual occurrence and/or an injury of unknown origin was reported to the State Agency for 1 of 3 residents reviewed for fractures. (Resident B)<br><br>Finding includes: | R 0090 | Assisted Living at Hartsfield Village<br>10002 Columbia Avenue<br>Munster, Indiana 46321<br><br>**This plan of correction represents the center's** | 02/14/2025 |

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| | The closed record for Resident B was reviewed on 1/15/25 at 10:15 a.m. Diagnoses included, but were not limited to, high blood pressure, atrial fibrillation (irregular heart beat), edema, and breast cancer.<br><br>A Nursing Progress Note, dated 12/29/24 at 8:30 a.m., indicated staff had found the resident on the toilet unresponsive. The nurse was called to the room and at that time, the resident was without vital signs. The resident was not wearing the call pendent. At 8:33 a.m., 911 was called as well as the physician and at 8:36 a.m., the ambulance arrived on scene and pronounced the resident deceased.<br><br>A witness statement from the Director of Nursing (DON), dated 12/29/24, indicated she was informed by staff that the resident was found unresponsive on the toilet in her apartment. The nurse on duty called 911 and the paramedics arrived onsite as well as the police. The paramedics did not perform CPR as there were no signs of life. Post-mortem care was provided by facility staff, and they observed a possible disfiguration to the resident's left lower extremity on the interior side.<br><br>A Final Death Investigation Scene Report from the Coroner's office, dated 12/29/24, indicated the resident had significant injuries of an open fracture of the right ankle with fatty tissues and the tibia (lower leg bone) exposed. The tibia was severed from ankle joint.<br><br>There was no documentation the Administrator or DON had notified the State Agency of the injury of unknown origin/unusual occurrence.<br><br>During an interview on 1/15/25 at 2:15 p.m., the | | **allegation of compliance. The following combined plan of correction and allegation of compliance is not an admission to any of the alleged deficiencies and is submitted at the request of the Indiana State Department of Health. Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.**<br><br>**R090**<br>The facility failed to ensure an unusual occurrence and/or an injury of unknown origin was reported to the State Agency for 1 of 3 residents reviewed for fractures. (Resident B)<br>**Corrective action taken for residents found to have been affected by the deficient practice:**<br>Resident B no longer resides at this facility.<br><br>**Identification of other residents having the potential to be affected by the same deficient practice:**<br>All residents with an unusual | |

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| | Administrator indicated she was made aware the resident had expired on 12/29/24. She was also made aware of the injury to the right ankle and leg, however, she had focused on the death of the resident and not the injury, therefore, she did not report the incident to the State Agency.<br><br>This citation relates to Complaint IN00450986. | | occurrence and/or an injury of unknown origin have the potential to be affected.<br><br>**To ensure that proper practices continue:**<br>The Director of Clinical Operations will educate the Administrator on the Indiana Department of Health Long Term Care incident reporting policy related to Residential Care facilities. Education will ensure the Administrator has a working understanding of their responsibilities as related to the Residential Care reporting requirements for unusual occurrences and/or an injury of unknown origin.<br><br>The Director of Nursing/Designee will educate nursing staff regarding unusual occurrences and/or a resident injury of unknown origin. Education will direct nursing staff to initiate an investigation form to include witness statements, etc. upon the identification of any unusual occurrence and/or resident injury of unknown origin.<br><br>The Administrator/Designee will conduct weekly audits of all unusual occurrences and/or injuries of unknown origin to ensure compliance with this plan of correction. Each week an auditing tool will be completed to monitor compliance and/or identify trends to review with the facility's | |

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| | | A. BUILDING 00<br>B. WING | 01/16/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| ASSISTED LIVING AT HARTSFIELD VILLAGE | 10002 COLUMBIA AVE<br>MUNSTER, IN 46321 |

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| | | | QAA Committee. After the fourth week, the QAA Committee will review all audit tools and will determine if the facility has achieved 100% compliance with practices at which time the monitoring will cease. If the QAA Committee determines that less than 100% compliance has been achieved, the monitoring tools will continue for another four-week period and will again be reviewed by the QAA Committee. This practice will continue until the facility has achieved at least 100% compliance. The systemic plan will be randomly initiating this audit tool again monthly throughout the next 3 months, to ensure that this deficient practice will not recur.<br><br>**Quality Assurance Plan to monitor compliance with this Plan of Correction:**<br>Identified concerns shall be reviewed by the facility's QAA Committee. Findings from all audit tools will continue to be reviewed monthly for the next 3 months. Recommendations for further corrective action will be discussed and implemented as needed.<br><br>**Completion Date:** February 14, 2025 | |
| R 0243<br><br>Bldg. 00 | 410 IAC 16.2-5-4(e)(3)<br>Health Services - Deficiency | | | |

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| | Based on record review and interview, the facility failed to ensure blood pressure medications were administered as ordered and held per blood pressure parameters for 1 of 8 sampled residents . (Resident 8) The facility also failed to ensure blood pressure monitoring was completed for a resident receiving a cardiac medication for which blood pressure parameters were ordered for 1 of 8 sampled residents. (Resident 6)<br><br>Findings include:<br><br>1. The record for Resident 8 was reviewed on 1/15/25 at 11:42 a.m. Diagnoses included, but were not limited to, heart failure, atherosclerotic heart disease, and atrial fibrillation (irregular heart rate).<br><br>Physician's Orders, dated 8/25/24, indicated the resident was to receive Diltiazem (a medication to treat high blood pressure) 60 milligrams (mg) three times a day and hold for a systolic blood pressure (top number) of less than 130; and Hydralazine 50 mg twice a day, hold for systolic blood pressure of less than 130.<br><br>The December 2024 Medication Administration Record (MAR) indicated the resident received the Diltiazem upon rising on 12/13/24 with a blood pressure of 129/60, and midday on 12/9/24 with a blood pressure of 98/72.<br><br>The December 2024 MAR, indicated the resident received the Hydralazine upon rising on 12/6/24 with a blood pressure of 118/64.<br><br>The January 2025 MAR, indicated the resident received both the Diltiazem and Hydralazine upon rising on 1/5/25 with a blood pressure of 123/64. | R 0243 | Assisted Living at Hartsfield Village<br>10002 Columbia Avenue<br>Munster, Indiana 46321<br><br>**This plan of correction represents the center's allegation of compliance. The following combined plan of correction and allegation of compliance is not an admission to any of the alleged deficiencies and is submitted at the request of the Indiana State Department of Health. Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.**<br><br>**R243**<br>The facility failed to ensure blood pressure medications were administered as ordered and held per blood pressure parameters for 1 of 8 sampled residents. (Resident 8)<br>The facility also failed to ensure blood pressure monitoring was completed for a resident receiving a cardiac medication for which blood pressure parameters were | 02/14/2025 |

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| ASSISTED LIVING AT HARTSFIELD VILLAGE | 10002 COLUMBIA AVE<br>MUNSTER, IN 46321 |

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| | During an interview on 1/15/25 at 4:00 p.m., the Director of Nursing indicated the resident's medications should have been held per the blood pressure parameters.<br><br>2. The record for Resident 6 was reviewed on 1/15/25 at 10:26 a.m. Diagnoses included, but were not limited to, hypertension and congestive heart failure.<br><br>A Physician's Order, dated 1/5/25, indicated the resident was to receive Metoprolol Tartrate (a medication used to treat high blood pressure and heart failure) 25 milligrams (mg) twice a day. The medication was to be held if the resident's systolic blood pressure (top number) was below 130.<br><br>The January 2025 Medication Administration Record (MAR), indicated the resident's blood pressure was not documented at the time of the medication administration for the evening dose on 1/5/25 through the upon rising dose on 1/15/25.<br><br>During an interview on 1/15/25 at 4:00 p.m., the Director of Nursing (DON) indicated she would have to see if the blood pressures were documented somewhere else.<br><br>During an interview on 1/16/25 at 8:30 a.m., the DON indicated she had no additional information to provide. | | ordered for 1 of 8 sampled residents. (Resident 6)<br><br>**Corrective action taken for residents found to have been affected by the deficient practice:**<br>The current MAR (Medication Administration Record) was reviewed by the Provider for Resident 8 with no new orders given. Resident 6 is now receiving hospice services and the cardiac medication identified has been discontinued. An audit was performed to identify all current residents with medication orders specifying blood pressure parameters/blood pressure monitoring. Resident medications are also reviewed upon admission.<br><br>**Identification of other residents having the potential to be affected by the same deficient practice:**<br>All current residents with medication orders specifying blood pressure parameters/blood pressure monitoring have the potential to be affected.<br><br>**To ensure that proper practices continue:**<br>The DON/Designee will re-educate nurses regarding adherence to medication orders with a focus on identification of specified parameters and/or the need for blood pressure monitoring. | |

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| | | | Education will stress the importance of both monitoring and documenting blood pressure(s) as ordered.<br><br>The DON/Designee will initiate and complete a monitoring tool and conduct patient chart audits weekly for residents with orders specifying blood pressure parameters/blood pressure monitoring. Each week, a minimum of 4 audits will be conducted to monitor compliance and/or identify trends to review with the facility's QAA Committee. After the fourth week, the QAA Committee will review all audit tools and will determine if the facility has achieved 100% compliance with practices at which time the monitoring will cease. If the QAA Committee determines that less than 100% compliance has been achieved, the monitoring tools will continue for another four-week period and will again be reviewed by the QAA Committee. This practice will continue until the facility has achieved at least 100% compliance. The systemic plan will be randomly initiating this audit tool again monthly throughout the next 3 months, to ensure that this deficient practice will not recur.<br><br>**Quality Assurance Plan to monitor compliance with this** | |

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| | | | **Plan of Correction:**<br>Identified concerns shall be reviewed by the facility's QAA Committee. Findings from all audit tools will continue to be reviewed monthly for the next 3 months. Recommendations for further corrective action will be discussed and implemented as needed.<br><br>**Completion Date:** February 14, 2025 | |