STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155230	A. BUILDING 00 B. WING	02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROSEBUD VILLAGE	2050 CHESTER BLVD RICHMOND, IN 47374

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: February 14, 15, 16, 17, 18, & 21 2022 Facility number: 000135 Provider number: 155230 AIM number: 100266820 Census Bed Type: SNF/NF: 75 SNF: 8 Total: 83 Census Payor Type: Medicare: 10 Medicaid: 66 Other: 7 Total: 83 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 24, 2022	F 0000	Dear Brenda Buroker, Attached is Rosebud Village's plan of correction for annual survey completed on 2/21/2022. Rosebud Village is requesting paper compliance for all deficiencies written in the 2567. Please accept the plan of correction as written. Thank you, Kari Alcorn, HFA Executive Director Rosebud Village	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for			

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

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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	each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.			
	Based on observation, interview, and record review, the facility failed to promote dignity by covering the contents of a urinary catheter bag for 1 of 2 residents reviewed for urinary catheters. (Resident 40) Findings include:	F 0550	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** · Resident 40 has received the appropriate urinary dignity bag.	03/15/2022

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	The medical record for Resident 40 was reviewed on 2/17/2022 at 12:45 p.m. Diagnoses included, but were not limited to, cognitive communication deficit and neuromuscular dysfunction of the bladder. A Significant Change Minimum Data Set, dated 12/8/2021, indicated that Resident 40 had memory issue, had a urinary catheter, and needed assistance of 2 staff members for toileting needs. A care plan for Resident 40, dated 5/29/2020, indicated indwelling catheter used for urinary retention related to neurogenic bladder. An intervention indicated to keep the urinary collection bag inside a protective pouch. During an observation on 2/14/2022 at 1:32 p.m., Resident 40's urinary collection bag was visible from the doorway with the dignity bag bunched at the top of the bag. Contents of the urinary collection bag were visible. During an observation on 2/17/2022 at 10:43 a.m., Resident 40's urinary collection bag was visible from the doorway with the dignity bag bunched at the top of the bag. Contents of the urinary collection bag were visible. An interview with the Administrator on 2/17/2022 at 3:49 p.m., indicated it was the expectation that Resident 40's urinary catheter bag would be covered with a urinary dignity bag. 3.1-3(t)		**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 with urinary catheters have the potential to be affected by the alleged deficient practice. · Residents with urinary catheters have been reviewed for appropriate dignity bags by 3/7/22. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** · IDT to be educated on resident rights and appropriate urinary dignity bags. · Education provided by DNS/designee to all staff regarding resident rights and specifically urinary dignity bags by 3/15/22. · Charge nurse will observe for proper urinary dignity bags every shift during care rounds. · Nurse managers will observe for proper urinary dignity bags daily during care rounds. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance**	

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			program will be put into place; · On going compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. · Dignity and Privacy QAPI tool will be completed weekly x 4 weeks, monthly x 6 months, and quarterly there after until compliance is achieved. · If Threshold of 90% is not met, an action plan will be developed to ensure compliance. **By what date the systemic changes will be completed;· Completion date: 3/15/22**	
F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.			
	Based on observation, interview and record review the facility failed to provide an ongoing activity program for 1 of 1 resident's reviewed for activities (Resident 66).	F 0679	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** · Resident 66 is	03/15/2022

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	Finding include: During an observation on 2/15/22 at 11:21 a.m., Resident 66 was sitting in his room in the dark in a wheelchair. There was no music playing, no TV on or any type of activity for the resident. During an observation on 2/16/22 at 1:26 p.m., Resident 66 was laying in bed, there was no music playing and no TV on. During an observation on 2/17/22 at 11:04 a.m., Resident 66 was in the common area sitting in his wheelchair with two other residents sitting in their wheelchair. There was a TV on playing a religious program. None of three residents were engaged in the TV program. During an observation on 2/17/22 at 2:10 p.m., the facility was having bingo in the main dining room, Resident 66 was sitting in his wheelchair in the hallway. During an observation on 2/18/22 at 10:30 a.m., Resident 66 was sitting in his room in the dark in a wheelchair. There was no music playing, no TV or any type of activity for the resident. During an observation on 2/18/22 at 2:10 p.m., Resident 66 was laying in bed with no music playing and no TV on. The resident indicated the Director Of Nursing Services (DNS) that he would like to get out of bed. During an observation on 2/21/22 at 11:30 a.m., Resident 66 was sitting in front of the nursing station in his wheelchair. The resident was not engaged in any conversation and did not have on head phones to listen to music.		offered/provided activities per preference on a daily basis.· Activity observations for resident 66 has been updated. · Care plan for resident 66 has been updated to reflect activity preferences. **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 the alleged deficient practice. ∸All resident activity preferences were reviewed to ensure residents are participating in activities per preference and choice.∸Activity assessments were completed, and care plans updated for activities of choice and preferences.**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** ∸ED/Designee will conduct rounds each day to ensure residents are participating in activities of choice and preference per care plan. ·Education provided by Executive Director/designee to all social enrichment staff regarding activity policy including preferences for daily routines by 3/15/22.**How the corrective action(s) will be monitored to ensure the deficient practice will not**	

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	Review of the record of Resident 66 on 2/18/22 at 1:30 p.m., indicated the resident's diagnoses included, but were not limited to, dementia with Lewy bodies, Parkinson's disease, hypertensive heart disease with heart failure, physical debility, generalized anxiety disorder, contracture of the left hand, muscle weakness, traumatic brain injury and reduced mobility. The plan of care, revision date 1/24/22, indicated the resident enjoyed watching TV, being outdoors and listening to music. The resident frequently sits in TV room and enjoyed listening to his headphones in this area. The Significant Change Minimum Data Set (MDS) assessment, dated 1/28/22, indicated the resident was moderately impaired for daily decision making and required cues/supervision. The resident required extensive assistance of two people for transfers, did not ambulate and was totally dependent of one person for locomotion on and off the unit. The resident felt it was very important to listen to music, be around pets, join in group activities and go outside and to religious services. During an interview with the Administrator on 2/21/22 at 10:25 a.m., indicated Resident 66 had not participated in activities in January 2022 or February 2022, the resident only attended one activity in December 2021 which was the facility Christmas party. The Activity Director was new to this role and the facility had difficulty keeping activity aides. The Administrator indicated it was the activity staff and nursing staff who were responsible to ensure the resident had his head phones, TV on and whatever else his activity preference was. The Administrator had requested for the Activity Director to review his care plans and preferences with the resident today.		**recur, what quality assurance program will be put into place.**· Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director.· Social Wellness and Enrichment Program QAPI tool will be completed weekly x 4 weeks, monthly x 6 months, and quarterly there after until compliance is achieved. · If Threshold of 90% is not met, an action plan will be developed to ensure compliance. **By what date the systemic changes will be completed.**· **Completion date: 3/15/22**	

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	During an interview with Resident 66's family on 2/21/22 at 11:15 a.m., indicated his family member always liked being in groups of people and was was always social. The resident enjoyed playing cards, listening to music, watching TV, loved basketball, going outside and being around animals. The activity policy provided by the Administrator on 2/21/22 at 10:38 a.m., indicated the facility was to provide an ongoing program of activities designed to meet the interests and the physical, mental, and psychosocial well being of each resident. 3.1-33(a)			
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 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			

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	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 interview, observation, and record review, the facility failed to completely administer a course of antibiotics as ordered by a physician to treat a urinary tract infection for 1 of 3 residents reviewed for urinary tract infections. (Resident 72) Findings include: The medical record for Resident 72 was reviewed on 12/18/2022 at 2:09 p.m. The diagnoses included, but were not limited to, hemiplegia and dementia. A Quarterly Minimum Data Set, dated 11/5/2021, indicated Resident 72 was cognitively impaired and needed total assistance with toileting and hygiene tasks. A urinary incontinence care plan, dated 5/4/2015, indicated an intervention for staff to observe Resident 72 of signs or symptoms of a urinary tract infection, including but not limited to, abdominal pain, painful urination, and change in mental status.	F 0690	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** · Resident 72 was assessed by nursing staff, a new urine analysis was completed and reviewed by nurse practitioner with no new orders. **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 with urinary tract infections have the potential to be affected by the alleged deficient practice. · Residents with urinary tract infections who are prescribed antibiotics have been reviewed to ensure residents are receiving antibiotics as	03/15/2022

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	A physician order for Resident 72, dated 1/10/2022, indicated to give tetracycline capsule (antibiotic) 500 mg (milligrams) by mouth every 6 hours for 40 doses. The medication administration record for Resident 72 indicated she had received 28 of the 40 prescribed doses of tetracycline in January 2022. During an observation on 2/18/2022 at 1:43 p.m., Resident 72 stated "it stings a little" when asked if she had pain during urination. A policy last entitled, General Dose Preparation and Medication Administration, was provided by the Director of Nursing Services on 2/18/2022 at 10:30 a.m. The policy, last revised on 1/1/2013, indicated that staff were to document when medications were administered. A policy last entitled, Antibiotic Stewardship Program, was provided by the Director of Nursing Services on 2/18/2022 at 10:30 a.m. The policy, dated Nov. 2017, indicated the facility was to monitor and manage antibiotic use in the commitment to optimize treatments of infections with reducing the adverse events associated with antibiotic use. 3.1-41(a)(2)		prescribed. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** · IDT to be educated on antibiotic stewardship and general dose preparation and medication administration · Education provided by DNS/designee to all licensed/registered nurses regarding antibiotic stewardship and general dose preparation and medication administration by 3/15/22. · IDT to review all residents at the completion of antibiotic therapy to ensure all doses have been completed and that resident is free from s/sx of infection. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place;** · On going compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. · Antibiotic Therapy QAPI tool will be completed weekly x 4 weeks,	

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			monthly x 6 months, and quarterly there after until compliance is achieved. · If Threshold of 90% is not met, an action plan will be developed to ensure compliance. **By what date the systemic changes will be completed;· Completion date: 3/15/22**	
F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on interview and record review, the facility failed to monitor residents' severity of pain when administering PRN (as needed) pain medications, failed to complete MAR (mediation administration record) documentation for PRN pain medications, and failed to ensure a licensed nurse documented the effectiveness of the PRN pain medication. This affected 2 of 6 residents reviewed for unnecessary medications related to pain medication use. (Resident 61 and 48) Findings include: 1. Resident 61's record was reviewed on 2/21/22 at 10:21 a.m. The record indicated Resident 61 had diagnoses that included, but were limited to, wedge compression fracture of second thoracic vertebra with routine healing, dementia, multiple	F 0697	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** ·Residents 48, 49, and 61 have been assessed for pain. Pain medication is being administered per pain assessment and documented in the MAR. **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 are prescribed pain medications have the potential to be	03/15/2022

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	fractures of ribs with routine healing, fracture of sternum with routine healing, wedge compression fracture of T5-T6 vertebra with routine healing, cervical disc degeneration, age-related physical debility, pain in right ankle and joints of right foot. An Annual Minimum Data Set assessment, dated 1/14/22, indicated Resident 61 had occasional pain and received scheduled and PRN pain meds. A Quarterly Minimum Data Set assessment, dated 11/10/21, indicated Resident 61 was moderately cognitively impaired and had a pain assessment that indicated no pain. Physician's orders included, but were not limited to: Oxycodone - Schedule II, tablet; 5 mg; amount: 10 mg; oral Indications: severe pain (7 out of 10) Every 4 Hours - PRN Date started: 2/05/2022 Monitor for effectiveness of routine pain medication every shift. If not effective, complete a pain assessment and notify MD and/or Hospice for every shift. Date started: 2/05/2022 and ended on 2/12/22 Review of February 2022 MARs indicated the following days the oxycodone was given without monitoring the severity of the pain: 2/6/22 at 3:50 a.m., 9:37 a.m., 3:17 p.m. and 7:22 p.m. 2/7/22 at 2:04 p.m. and 8:54 p.m. 2/8/22 at 7:01 a.m., 12:40 p.m., and 8:09 p.m. 2/9/22 at 8:23 a.m., 12:38 p.m., and 6:49 p.m. 2/10/22 at 5:42 a.m., 12:52 p.m., and 11:52 p.m. 2/11/22 at 9:49 p.m. 2/12/22 at 11:12 a.m. and 9:50 p.m. The order for Oxycodone - Schedule II, tablet; 5		affected by the alleged deficient practice. -DNS/designee reviewed residents who received pain medication to ensure pain assessments were completed, MAR was completed and effectiveness of medication was documented. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** · Residents to be assessed for pain upon admission, readmission, weekly and during medication administration of pain medications. A numerical scale of 1-10 will be used to describe pain intensity for interviewable residents. A nursing assessment will be completed on non-interviewable residents with pain with descriptions to include but not limited to: nonverbal sounds, vocal complaints, facial expressions, protective body movements or postures and wong-baker faces scale. · Education provided by DNS/Nursing Support Staff to all QMA's, LPN's and RN's on Pain Management will be completed by 3/15/22.**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place.** ·Ongoing	

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	mg; amount: 10 mg; oral Indications: severe pain (7 out of 10) Every 4 Hours - PRN was continued on 2/13/22, and was given on these days without monitoring the severity of the pain: 2/13/22 at 12:42 p.m. and 10:43 p.m. 2/14/22 at 9:01 a.m. and 10:58 p.m. 2/15/22 at 9:59 a.m. 2/16/22 at 6:13 p.m. 2/17/22 6:14 p.m. 2/18/22 at 5:54 p.m. On 2/21/22 at 11:38 a.m., LPN 1 indicated Resident 61's pain management is doing very well, she just still has a little pain in her ribs and she receives the oxycodone for severe pain. LPN 1 puts in 'severe pain' then a number like '9'. It is documented on the MARs and she can put it in a nursing note too. She said there is a box that comes up in the computer to show them what to do, [how to document] like if it is pain, loose stools, or upset stomach. 2. The medication record for Resident 48 was reviewed on 2/18/2022 at 12:58 p.m. The diagnoses included, but were not limited to, low back pain, repeated falls, and chronic pain syndrome. A Significant Change Minimum Data Set, dated 10/16/2021, indicated Resident 48 was cognitively intact and used as needed pain medication. A pain care plant, dated 10/10/2021, indicated Resident 48 was to receive as needed pain medications as ordered and to document the effectiveness of pain medications. A physician order for Resident 48, dated 1/4/2022, indicated Tylenol 650 milligrams (mg) every 6 hours as needed for pain.		compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. ·Pain Management QAPI tool will be completed weekly x 4 weeks, monthly x 6 months, and quarterly there after until compliance is achieved. ·If Threshold of 90% is not met, an action plan will be developed to ensure compliance. **By what date the systemic changes will be completed;Completion date: 3/15/22**	

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	A physician order for Resident 48, dated 1/4/2022, indicated Norco 5/325 mg every 6 hours as needed for moderate to severe pain. The medication administration record (MAR) indicated Resident 48 received 7 doses of Tylenol between 1/1/2022 and 2/18/2022. No indicated of severity of pain documented with these administrations of Tylenol. The MAR indicated Resident 48 received 101 doses of Norco between 1/1/2022 and 2/18/2022. No indicated of severity of pain documented with these administrations of Norco. An interview with LPN 3, on 2/17/2022 at 10:53 a.m., indicated that the pain severity, either with numeric value or nonverbal pain scale, should be documented in the administration comments for as needed pain medication. An interview with Director of Nursing Services on 2/21/2022 at 3:38 p.m., indicated that the pain severity, either with numeric value or nonverbal pain scale, should be documented in the administration comments for as needed pain medication. Resident 49 received Norco without prior assessment for indication of use or post assessment for effectiveness of pain medication 12 times between 1/1/2022 and 2/8/2022. On 2/13/2022, Norco was administered at 9:30 a.m. At 2:49 p.m., QMA 7 marked that as needed dose as effective then administered a subsequent dose of Norco at 2:50 p.m. A policy entitled, Paint Management, was provided by the Director of Nursing Services on			

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	2/17/2022 at 10:35 a.m. The policy, last revised on 10/20, indicated that residents should be assessed for pain during medication administration. For interviewable residents, pain medication was to be prescribed and given based on the intensity of the pain using a verbal description, numerical scale (1-10), or Wong-Baker FACES Scale. For Non-Interviewable Residents, pain medication was to be prescribed and given based on nursing assessment of non-verbal sounds, vocal complaints, facial expressions, protective body movements, and Wong-Bake FACES Scale. The policy also indicated that document of the administration of as needed medications for pain would be initiated on the MAR. 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 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			

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	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 record review and interview, the facility failed to ensure a clinical rationale was documented after a recommendation for a gradual dose reduction was declined, for 1 of 5 residents reviewed for unnecessary medications. (Resident 61) Findings include: Resident 9's record was reviewed on 2/16/22 at 2:02 p.m. The record indicated Resident 9 had diagnoses that included, but were not limited to, Alzheimer's disease with late onset, wedge compression fracture of T11-T12 vertebra, vascular dementia, anorexia, major depressive	F 0756	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** · A new pharmacy recommendation will be completed for resident 9 regarding mirtazapine by 3/7/22. · MD reviewed GDR for resident 9 and completed the necessary documentation to support the declination of the GDR.**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective**	03/15/2022

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	disorder, psychotic disorder with delusions, cognitive communication deficit, high blood pressure, and aphasia. A Quarterly Minimum Data Set assessment, dated 12/3/21, Resident 9 was severely cognitively impaired, and received antidepressants. A pharmacy review, dated August 23, 2021 through August 24, 2021, indicated a recommendation to reevaluate the continued need for mirtazapine, or consider a trial discontinuation. The physician responded on 8/25/21 to decline the recommendation and did not provide a rational for the declination. On 2/21/22 at 4:10 p.m., the Administrator indicated it is not part of their policy to have a rationale. A policy for "Medication Regimen Reviews and Pharmacy Recommendations" was provided by the Director of Nurses on 2/21/22. The policy included, but was not limited to, "Purpose: 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 minimizes 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...Pharmacy recommendations should be reviewed with follow up by the physician within 30 days of the facility receiving...." 3.1-25(i)		**action(s) will be taken;** ·All residents who are prescribed medications have the potential to be affected by the alleged deficient practice. · All residents receiving psychotropic medications were reviewed to ensure any GDR which was declined had the appropriate documentation by MD to support the decision. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** · Pharmacy to provide recommendations and NP/MD will review all GDR recommendations. NP/MD will list a rationale on every pharmacy recommendation. · Education provided to physician service providers by DNS/Nursing Support Staff by 3/15/22. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place;** · On going compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. · Pharmacy Services	

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			and Recommendations QAPI tool will be completed weekly x 4 weeks, monthly x 6 months, and quarterly there after until compliance is achieved. · If Threshold of 90% is not met, an action plan will be developed to ensure compliance. **By what date the systemic changes will be completed;** · **Completion date: 3/15/22**	
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; Based on interview, observation, and record review, the facility failed to follow special instructions to avoid drug reactions between tetracycline and Caltrate resulting in a medication error rate of 21.88% for 1 of 3 residents reviewed for urinary tract infections. (Resident 72) Findings include: The medical record for Resident 72 was reviewed on 12/18/2022 at 2:09 p.m. The diagnoses included, but were not limited to, hemiplegia and dementia. A Quarterly Minimum Data Set, dated 11/5/2021, indicated Resident 72 was cognitively impaired and needed total assistance with toileting and hygiene tasks. A urinary incontinence care plan, dated 5/4/2015,	F 0759	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** · Resident 72 was assessed by nursing staff, a new urine analysis was completed and reviewed by NP/MD with no new orders. 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 are prescribed antibiotic therapy medications have the potential to be affected by the alleged deficient practice.	03/15/2022

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	indicated an intervention to observe Resident 72 of signs or symptoms of a urinary tract infection, including but not limited to, abdominal pain, painful urination, and change in mental status. A physician order for Resident 72, dated 1/10/2022, indicated to give tetracycline capsule (antibiotic) 500 mg (milligrams) by mouth every 6 hours for 40 doses. Special instructions included to give Caltrate 3 hours after administration of antibiotic until completed. A physician order for Resident 72, dated 9/22/2020, indicated to give Caltrate 600 mg by mouth once a day. The medication administration record for Resident 72 indicated administration dates and times for tetracycline included, but were not limited to the following: 1/13/2022 at 7:26 a.m., 1/14/2022 at 6:34 a.m., 1/15/2022 at 12:10 p.m., 1/16/2022 at 8:19 a.m., 1/17/2022 at 9:16 a.m., 1/18/2022 at 7:48 a.m., and 1/19/2022 at 7:24 a.m. The medication administration record for Resident 72 indicated administration dates and times for Caltrate included, but were not limited to the following: 1/13/2022 at 7:26 a.m., 1/14/2022 at 8:16 a.m., 1/15/2022 at 12:10 p.m., 1/16/2022 at 9:53 a.m., 1/17/2022 at 9:16 a.m., 1/18/2022 at 7:48 a.m., and		· Audit completed to ensure that no other residents are prescribed antibiotic therapies in conjunction with Caltrate. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** · Education provided by DNS/Nursing Support Staff to all LPN's, RN's and QMA's related to general dose preparation and medication administration by 3/15/22. · Medication Error QAPI tool and Antibiotic Therapy QAPI tool will be completed by DNS or designee. · DNS/designee will review antibiotic medications orders during IDT review to ensure physician orders are being followed **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place;** · Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. · Medication Error QAPI tool and Antibiotic Therapy QAPI tool will be completed weekly x 4 weeks, monthly x 6 months, and quarterly there after	

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	1/19/2022 at 7:24 a.m. Resident 72 received Caltrate within the 3 hour window post administration of tetracycline on 7 occurrences. A policy last entitled, General Dose Preparation and Medication Administration, was provided by the Director of Nursing Services on 2/18/2022 at 10:30 a.m. The policy, last revised on 1/1/2013, indicated that staff should verify the correct medication at the correct time, as well as confirm the medication administration record reflects the most current order. 3.1-48(c)(1)		until compliance is achieved. · If Threshold of 90% is not met, an action plan will be developed to ensure compliance. **By what date the systemic changes will be completed;** · **Completion date: 3/15/22**	