STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155521	A. Building B. Wing	07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alexandria Care Center	1912 S Park Ave Alexandria, IN 46001

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview and record review, the facility failed to prevent a significant medication error, resulting in the hospitalization of a resident for altered mental status. (Resident B) Findings include: Resident B's closed clinical record was reviewed on 7/2/25 at 11:08 a.m. Diagnoses included displaced fracture of right femur, atrial fibrillation (irregular heartbeat), heart disease. The resident admitted to the facility from the hospital on 6/27/25. Current physician orders include buprenorphine-naloxone (treats narcotic dependence) 8-2 milligram (mg) sublingual twice a day, tramadol (opiate pain medication) 50 mg every six hours, ciprofloxacin (antibiotic) 500 mg one tablet twice a day for three days for urinary tract infection (UTI), iron 325 mg one tablet daily for anemia, and potassium gluconate 595 mg daily for hypokalemia. A current care plan, dated 6/27/25, indicated Resident B was at risk for atrial fibrillation. Interventions included administering medication as ordered, aspirin as ordered, Eliquis as ordered, monitor vital signs as needed, notify physician if any concerns, and obtain her pulse as indicated. A current care plan, dated 6/27/25, indicated Resident B had a recent history of a fracture and was at risk for pain and infection due to right femur fracture. Interventions included assess pain location, duration, intensity, and frequency, assess the residents level of pain as needed, monitor of signs and symptoms of infection/complications such as: elevated temperature, redness, swelling, and or warmth. Notify the nurse of any problems for further evaluation and possible physician and resident representative notification, offer pain medication as ordered and monitor effectiveness. Review of a pharmacy consolidated delivery sheet dated 6/27/25 indicated naloxone (Narcan) hcl 4 mg nasal spray was administered and checked off as being received by LPN 8 on 6/27/25. On 6/28/25 at 10:58 a.m., Resident B was alert and oriented. Resident B's speech was clear and she was able to make her needs known. Resident B's pulse was strong and regular. Resident B denied any chest pain, feeling of her heart racing, or being fatigued. Resident B complained of right hip pain that was relieved with prescribed medications. A June 2025 Medication Administration Report (MAR) indicated buprenorphine-naloxone 8-2 mg was administered by LPN 4 on 6/27/25 between 6:30 p.m. and 10:30 p.m. (continued on next page)

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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note, dated 6/28/25 at 9:01 p.m., indicated Resident B had complaints of being hot and yawning. Resident B's blood pressure was 180/100 millimeters of mercury (mmHg). Staff were unable to obtain her oxygen saturation. A new order was received to send Resident B to the hospital for evaluation and treatment. A call was placed to 911. Emergency Medical Technicians (EMTs) arrived and transported Resident B to the hospital. Hospital Records, dated 6/28/25 and 6/29/25, indicated Resident B admitted with complaints of altered mental status after receiving 4 mg of intranasal Narcan. Resident B had a history of atrial fibrillation (abnormal heart rhythm) and had been off her Eliquis (blood thinner) due to an upcoming surgery. Resident B was cardioverted (shocked) back into normal sinus rhythm after the third attempt. Resident B continued to be agitated after the cardioversion, but her blood pressure had initially been stable afterward. A hospital physician note indicated Resident B was in shock with a blood pressure of 79/31 mmhg. Resident B was admitted to the ICU due to cardiogenic shock (heart cannot pump well) with acute cystitis (kidney infection) without hematuria with shock. During an interview, on 7/2/25 at 12:06 p.m., the facility's Pharmacist indicated naloxone (Narcan) nasal spray was sent to the nursing facility. If naloxone was administered, a residents blood pressure would need to be monitored. Side effects from the naloxone include sweating or flushing, hot flashes, abdominal cramping, vomiting, disorientation or dizziness. Side effects could also affect the heart rate. When someone is in pain, symptoms include body sweats and increased heart rate. The resident's symptoms could have been from pain, withdrawal, or the medication. On 7/2/25 at 12:54 p.m., LPN 4 indicated Resident B was playing cards at the time of the medication administration. The naloxone nasal spray was in the bottom of the medication cart. Resident B received tramadol then administered the naloxone instead of the ordered buprenorphine- naloxone. LPN 4 helped Resident B administer the naloxone nasal spray. The nurse indicated she normally checked the label against the medication. She had noticed the buprenorphine- naloxone was ordered as a film and the naloxone was a nasal spray, but was unable to recall when she noticed that. Roughly 10 minutes later, another nurse advised LPN 4 to assess Resident B, as she was experiencing symptoms. Resident B was displaying trembling, complaint of being hot. She was oriented and able to state she was shaking and trembling. Her blood pressure was low. On 7/2/25 at 1:30 p.m., the facility's Medical Director indicated Resident B was discharged from the hospital on 6/27/25 following hip surgery with an order for buprenorphine- naloxone, but the hospital did not send in a prescription to the pharmacy. If buprenorphine- naloxone was stopped abruptly, one would start experiencing withdrawal symptoms. Withdrawal symptoms would not happen several hours after her hospital discharge. Naloxone's effect would not be long lasting in a person's system, which is why the medication can be administered every few minutes. The two most common causes of cardiogenic shock were heart attack or sepsis. A person's age, along with other commodities including anemia, which Resident B could have experienced due to her surgery, would affect her heart. Within the first 90 days following hip surgery, those resident become very bedridden, not wanting to move around. Age, anemia, and dehydration increased the risk of developing deep vein thrombosis (DVT) or pulmonary embolism (PE). From his medical standpoint, he felt Resident B likely suffered from sepsis, heart attack, or maybe even a PE. Any of these three conditions could put someone into cardiogenic shock. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/2/25 at 3:09 p.m., RN 7 indicated the Nurse Practitioner (NP) discontinued the naloxone order upon the resident's admission to the facility. RN 6 was unaware the naloxone was ordered through the pharmacy. The naloxone was never ordered through the facility. It only existed on Resident B's hospital discharge medication summary. On 7/2/25 at 3:34 p.m., LPN 8 indicated she did not recall receiving naloxone from the pharmacy. She placed medication in the resident's drawer; any medication overflow would be placed in the bottom drawer of the mediation cart. A current facility policy, dated 4/2017, titled Medication Administration, provided by the Administrator, on 7/3/25 at 3:37 p.m., indicate the following: Guidelines for medication administration: 1. Medications are administered to residents only as prescribed and only by person licensed or qualified to do so. 10. Always observe the six rights of giving each medication: right resident, right medicine, right time, right dose, right route, right documentation. 11. Read the label and MAR three times when preparing the medication This citation relates to Complaints IN00462642 and IN00462522. 3.1-25(b)(9)