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	08/30/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 45122 Based on observation, interview, and record review, the facility failed to provide a dignified dining experience for 1 of 14 residents observed during dining on the secured unit. (Resident 35) Finding includes: During an observation, on 8/26/24 at 12:32 p.m., Resident 35 sat in her wheelchair at the dining table. Her chair was low in comparison to the table height and put the resident at chin level to the table. She took a bowl of food off her tray on the table and put the bowl in her lap to eat. During an observation, on 8/27/24 at 12:17 p.m., CNA 6 assisted the resident in her wheelchair to the dining table. The resident's chin was at the level of the table and close to the table edge. She reached up to the tray on the table to get some potato chips. During an observation, on 8/28/24 at 12:14 p.m., the resident sat at the dining table. Her chin was at table height. She reached up to get a food bowl from her tray and held it while eating. Resident 35's clinical record was reviewed on 8/26/24 at 3:54 p.m. Her diagnoses included Alzheimer's disease with late onset, dementia, visual hallucinations, depression, anxiety disorder, and abnormal weight loss. The current physician's orders included mirtazapine (for appetite stimulant) 7.5 mg daily at bedtime (started 5/7/24) and resident is to have all foods served in bowls at every meal (started 3/13/24). A significant change Minimum Data Set (MDS) assessment, completed on 6/28/24, indicated the resident was moderately cognitively impaired. She required supervision to touching assistance with eating and partial to moderate assistance with transfers. She had experienced a significant weight loss. A care plan for eating, initiated on 3/20/24 and last revised on 7/2/24, indicated the resident required staff assistance for meal consumption. The interventions included ensure resident is seated in an environment which will provide staff assistance and encourage meal consumption. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 8/29/24 at 4:01 p.m., the DON indicated she was aware the resident sat a little low in her chair to the table. She thought they had tried a bedside table for dining but was uncertain if any other interventions had been attempted. During an interview, on 8/30/24 at 8:46 a.m., CNA 7 indicated the resident almost always sat at the regular dining table until today. A lower table had been brought into the dining room for her. The resident may have used a bedside table as her dining table at some time, but CNA 7 did not remember much about it. During an interview, on 8/30/24 at 8:47 a.m., LPN 5 indicated the resident had an order for her food to be placed in bowls so she could put in her lap because she sat low at the table. She had placed her plate in her lap prior to getting the bowls which made it difficult for her to eat. They had briefly tried to have her sit in a regular chair, but she stood up as soon as she was done with her meal and tried to leave. She was a fall risk, so the wheelchair was used to prevent falls. During an interview, on 8/30/24 at 11:16 a.m., the DON indicated she had spoken to the Administrator about the resident's seat height to the table height. They had not thought about it being an issue. During an interview, on 8/30/24 at 11:24 a.m., the Administrator indicated the facility did not have a policy on dining. 3.1-3(t) 3.1-3(v)(1)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 45122 Based on record review and interview, the facility failed to ensure a Preadmission Screening and Resident Review (PASRR) was submitted for a resident with a new mental health diagnosis. (Resident 12) Finding includes: Resident 12's clinical record was reviewed on 8/27/24 at 1:49 p.m. Diagnoses included vascular dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (1/20/23), schizophrenia (1/20/23), major depressive disorder (1/20/23), generalized anxiety disorder (4/28/23), psychotic disorder with delusions due to known physiological condition (5/31/23), and restlessness and agitation (5/31/23). Physician's orders included buspirone (antianxiety) 10 mg twice a day (started 8/13/24), lamotrigine (for schizophrenia) 25 mg twice a day (started 8/18/23), and olanzapine (antipsychotic) 15 mg twice a day (started 8/13/24). A care plan for physical behavior symptoms directed towards others, initiated on 5/11/23 and last revised on 8/8/24, indicated the resident exhibited physical behavioral symptoms directed towards others such as hitting and throwing things. Interventions included psychoactive medications as ordered which included lamotrigine and olanzapine. A care plan for delusions, initiated on 4/25/23 and last revised on 8/8/24, indicated the resident suffered from delusions due to schizophrenia as he believed there was a horse in his room that was trying to hurt him and his roommate, believed people are going to cut off his toes, and thought staff was out to get him. Interventions included notify nurse and social services for further evaluation and possible physician and resident representative notification and administer medications as ordered which included lamotrigine and olanzapine. A mood and behavior communication memo, dated 5/6/24 no time, indicated the resident thought people were out to get him and kill him. He thought someone was going to shoot him and isolated in his room due to those beliefs. A mood and behavior communication memo, dated 5/15/24 at 3:00 p.m., indicated the resident said the dietary personnel had poisoned his dinner the night before. A mood and behavior communication memo, dated 6/20/24 at lunch time, indicated the resident refused to come out of his room from lunch. He said someone one would kill him if he came out of his room with his work shirt on. A PASRR completed on 7/1/23 did not indicate the resident's current mental health diagnoses. During an interview, on 8/28/24 at 4:00 p.m., the DON indicated she would look for the most recent PASRR completed for the resident, including the application. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the PASRR Level 1 Screen Outcome, dated 8/29/24, provided by the Social Services Director on 8/29/24 at 10:38 a.m., indicated the Level 1 had been submitted on 8/28/24. The PASRR Level I Determination indicated a Level II evaluation must be conducted. During an interview, on 8/29/24 at 2:02 p.m., the Corporate Social Services Consultant indicated the facility did not have a policy for PASRR Level I. They followed the PASARR provider guidelines. During an interview, on 8/29/24 at 3:04 p.m., the Social Services Director indicated a new Level I had been submitted on 8/28/24 for the resident because she had noticed he had new psychological diagnoses that required an updated Level I. Review of the Indiana PASRR FAQs for providers [frequently asked questions], revised 2022, accessed on 9/3/24 at 9:48 a.m. at maximusclincalservices.com, indicated the following: .If a significant change in mental health status has occurred since the last approval, a new Level I screening is required When is Status Change review required? Whenever there is a change in the mental status of an individual, since the prior Level 1 review

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 49411 Based on interview and record review, the facility failed to monitor vital signs per physician orders prior to giving medications for 3 of 3 residents reviewed. (Resident 24, 31, and 35) Findings include: 1. Resident 24's clinical record was reviewed on 8/27/24 at 9:45 a.m. Diagnoses included dementia, old myocardial infarction (heart attack), unspecified atrial fibrillation (rapid and irregular heart rate), and hypertension (high blood pressure). Resident orders included metoprolol tartrate (high blood pressure) 25 milligram (mg) tablet twice daily, hold if heart rate is below 60 and/or systolic blood pressure (top number) is below 120. A Consultant Pharmacist's Medication Regimen Review for May 2024, provided by the DON on 8/28/24 at 2:09 p.m., indicated the Medication Administration Report (MAR) showed that in the last couple of weeks, this dose was administered eight times when the residents systolic blood pressure was less than 120. Please make sure to hold when indicated. A Medication Administration Report (MAR), for June 2024, indicated the resident received metoprolol tartrate as follows: On June 4th a.m., with a systolic blood pressure of 80. On June 4th p.m., with a systolic blood pressure of 119. On June 7th p.m., with a systolic blood pressure of 104. On June 9th p.m., with a systolic blood pressure of 107. On June 13th a.m., with a systolic blood pressure of 87. On June 14th p.m., with a systolic blood pressure of 107. On June 15th a.m., with a systolic blood pressure of 106. On June 16th a.m., with a systolic blood pressure of 115. On June 19th a.m., with a systolic blood pressure of 114. On June 27th a.m., with a systolic blood pressure of 118. On June 29th a.m., with a systolic blood pressure of 104. On June 29th p.m., with a systolic blood pressure of 110. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On June 30th a.m., with a systolic blood pressure of 100. A Medication Administration Report (MAR), for August 2024, indicated the resident received metoprolol tartrate as follows: On August 7th p.m., with a systolic blood pressure of 116. On August 11th p.m., with a systolic blood pressure of 113. On August 12th a.m., with a systolic blood pressure of 113. On August 13th a.m., with a systolic blood pressure of 112. On August 13th a.m., with a systolic blood pressure of 105. On August 16th p.m., with a systolic blood pressure of 118. On August 24th p.m., with a systolic blood pressure of 116. On August 25th a.m., with a systolic blood pressure of 93. Resident 24's comprehensive care plan, revised on 7/24/24, indicated she had a diagnosis of hypertension and is at risk for associated complication. Interventions included administering medications as ordered, monitor blood pressure routinely and notify physician and resident representative per call order parameters, metoprolol per doctor order, monitor blood pressure and heart rate per order. 2. Resident 31's clinical record was reviewed on 8/27/24 at 11:08 a.m. Diagnoses included essential (primary) hypertension, unsteadiness on feet, unspecified atrial fibrillation (rapid and irregular heart rate), and unspecified tachycardia (rapid heartbeat). Resident orders included metoprolol tartrate (high blood pressure) 25 mg tablet twice daily, hold if heart rate is below 70. Cozaar (high blood pressure) 25 mg tablet once daily, hold for systolic blood pressure below 120. A Medication Administration Report (MAR), for June 2024, indicated the resident received losartan as follows: On June 1st, with a systolic blood pressure of 114. On June 22nd, with a systolic blood pressure of 118. A Medication Administration Report (MAR), for July 2024, indicated the resident received losartan as follows: On July 9th, with a systolic blood pressure of 115. On July 21st, with a systolic blood pressure of 118. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On July 21st, with a systolic blood pressure of 118. A Medication Administration Report (MAR), for August 2024, indicated the resident received losartan as follows: On August 14th, with a systolic blood pressure of 119. On August 22nd, with a systolic blood pressure of 107. Resident 31's comprehensive care plan, revised on 7/30/24, indicated he had a diagnosis of hypertension and is at risk for associated complication. Interventions included administering medications as ordered, monitor blood pressure routinely and notify physician and resident representative per call order parameters, administer losartan, and check blood pressure and heart rate. 3. Resident 35's clinical record was reviewed on 8/26/24 at 3:54 p.m. Diagnoses included dementia, heart failure, edema, essential (primary) hypertension, repeated falls, and multiple rib fractures. Resident orders included metoprolol succinate (high blood pressure) extended release 75 mg tablet once daily, hold if heart rate is below 60. A Medication Administration Report (MAR), for July 2024, indicated the resident received metoprolol succinate daily July 23rd through July 31st even though her heart rate was not recorded on the MAR. A Medication Administration Report (MAR), for August 2024, indicated the resident received metoprolol succinate daily August 7th through August 14th even though her heart rate was not recorded on the MAR. No vitals were recorded under vital signs from July 23rd through August 8th. Resident 35's comprehensive care plan, revised on 7/23/24, indicated she had a diagnosis of hypertension and is at risk for associated complication. Interventions included administering medications as ordered, monitor blood pressure routinely and notify physician and resident representative per call order parameters. During an interview, on 8/29/24 at 12:02 p.m., LPN 5 indicated for the medications that are ordered with parameters, the computer requires the user to put in those parameters before being able to proceed to administer the medication. If a number is put in outside of the parameter, it will notify the user that it is out of range. The user would need to hit the okay button or cancel the administration altogether. When the user hits the cancel button, then she can put in that the medication was not administered due to condition. When the users clicks on the medication she wants to give it will pop up a box for vital signs if those are needed before administering the medication. Once those have been entered, the user would then click prep. You would then hit complete to indicate the medication was administered. It would be very difficult to accidentally administer the medication when the user has three steps to go through to finalize that the medication was given. On medications that require a blood pressure or heart rate, there is a red star where you must enter the vitals before it lets you proceed to the next step. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, on 8/28/24 at 12:18 p.m., LPN 8 indicated the physician put parameters on certain medications like blood pressure or heart rate. The medication would be held if the vitals were not within the parameter range. She would click that the medication was not given and give a reason why it was held. During an interview, on 8/28/24 at 12:19 p.m., LPN 9 indicated she takes vitals on medications with parameters. If the vitals are not within the parameter range, she would hold the medication and indicate why the medication was not given. During an interview, on 8/29/24 at 3:36 p.m., the DON indicated an in-service on parameters was just completed for the nurses and the Qualified Medication Aides (QMA). They all verbalized they understood and will check vitals prior to administering medications. If they don't give a mediation, they will document a reason why it wasn't given. A current facility policy, revised 4/2017, titled Medication Administration, provided by the DON, on 8/29/24 at 2:04 p.m., indicated the following: .Purpose: To safely administer medications as per physicians' orders. 20. Always take pulse and B/P as indicated if ordered prior to giving certain cardiac or antihypertensive drugs 3.1-37(a)