STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155676	A. Building B. Wing	08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milner Community Health Care	370 E Main St Rossville, IN 46065

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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. 49891 Based on interview and record review, the facility failed to ensure a new Preadmission Screening and Resident Review (PASARR) was completed when a new mental health diagnosis or a new psychiatric medication was added for 2 of 2 residents reviewed for PASARR. (Resident 31 and 34) Findings include: 1. The clinical record for Resident 31 was reviewed on 8/14/24 at 10:42 a.m. The diagnoses included, but were not limited to, pain, major depressive disorder, and generalized anxiety disorder. A PASARR level I screen, dated 9/17/20, did not include a diagnosis of depression or anxiety. There were no medications listed on the PASARR. A social services progress note, dated 10/10/22, indicated the resident was taking Cymbalta (an anti-depressant medication) 60 milligram (mg) daily and had depression and anxiety. The diagnosis of major depressive disorder was added to the resident's list of diagnoses on 11/14/22 and again on 1/17/23. The diagnosis of generalized anxiety disorder was added to the resident's diagnosis list on 12/8/22. A physician's order, dated 4/20/21, indicated to give Cymbalta 60 (mg) once a day on Monday through Saturday. A physician's order, dated 2/20/23, indicated to give Cymbalta 40 mg every Sunday. A psychiatry progress note, dated 8/10/23, indicated Resident 31 had a diagnosis of recurrent moderate major depressive disorder and to continue Cymbalta as prescribed. A gradual dose reduction of the Cymbalta was denied due to symptom instability. A psychiatry progress note, dated 2/8/24, indicated the resident was taking Cymbalta with a diagnosis of major depressive disorder. A social services progress note, dated 7/1/24, indicated the resident was referred for ongoing treatment of anxiety and depression. (continued on next page)

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

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A care plan, initiated on 10/9/20 and revised on 8/9/24, indicated the resident was at risk of having symptoms of depression and was at risk for side effects related to her antidepressant medication. During an interview, on 8/14/24 at 3:00 p.m., the Social Services Director indicated she had missed the diagnoses of depression and anxiety and anti-depressant medication for the resident was not listed on the original PASARR. She indicated she should have initiated a new PASARR when the diagnoses and medication were added originally. 48525 2. The clinical record for Resident 34 was reviewed on 8/13/24 at 10:33 a.m. The diagnoses included, but were not limited to, general anxiety disorder, major depressive disorder, and cognitive communication deficit. A PASARR level 1 screen, dated 3/25/24, indicated no level 2 was required. No serious mental illnesses were present and the current mental health diagnoses included anxiety disorder. If changes occurred or new information refuted these findings, a new screen must be submitted. A PASARR level 1 screen, dated 4/15/24 indicated the level 1 was negative. No signs of serious mental illnesses were present and the current mental health diagnoses included anxiety disorder. If a status change occurred, then an updated level 1 must be submitted. A facility diagnosis report indicated the resident had major depressive disorder with an onset date of 4/1/24. The PASARR did not include the resident's diagnosis for major depressive disorder. A psychiatry progress note, dated 8/8/24, indicated the resident had a diagnosis of major depressive disorder. During an interview, on 8/13/24 at 1:09 p.m., the Social Services Director (SSD) indicated she did not know the resident had the diagnosis of major depressive disorder. During an interview, on 8/16/24 at 12:29 p.m., the SSD indicated she did not have a PASARR policy but followed the Indiana regulations. 3.1-16(d)(1)(A) 3.1-16(d)(1)(B)

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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. 48525 Based on observation, interview and record review, the facility failed to follow the physician ordered hold parameters for medications, to notify the physician of a high blood sugar reading as ordered, and to monitor and document bowel movements for 4 of 4 residents reviewed for quality of care. (Resident 34, 44, 25 and 40) Findings include: 1. The clinical record for Resident 34 was reviewed on 8/13/24 at 10:33 a.m. The diagnoses included, but were not limited to, chronic diastolic heart failure, major depressive disorder, essential hypertension, and stage 3 chronic kidney disease. A physician's order, dated 4/3/24, indicated to give metoprolol (a medication used to treat high blood pressure) 50 mg (milligram) twice daily. Hold if the resident's pulse was below 60 and/or the systolic blood pressure (top number on a blood pressure reading) was below 115. A physician's order, dated 5/9/24, indicated to give midodrine HCL (a medication used to treat orthostatic blood pressure) 5 mg three (3) times a day. Hold for a systolic blood pressure greater than 140. A physician's order, dated 4/2/24, indicated to take torsemide (a diuretic medication) 40 mg twice per day. Hold if the systolic blood pressure was less than 110. An electronic medication administration record indicated the following: On 6/11/24 in the a.m., the systolic blood pressure was 94. Metoprolol 50 mg was administered. On 6/24/24 in the p.m., the systolic blood pressure was 110. Metoprolol 50 mg was administered. On 7/3/24 at 4:00 p.m., the systolic blood pressure was 105. Torsemide 40 mg was administered. On 7/6/24 at 8:00 a.m., the systolic blood pressure was 141. Midodrine 5 mg was administered. On 7/21/24 in the p.m., the systolic blood pressure was 84. Metoprolol 50 mg was administered. On 8/5/24 at 8:00 a.m., the systolic blood pressure was 145. Midodrine 5 mg was administered. On 8/6/24 in the a.m., the systolic blood pressure was 112. Metoprolol 50 mg was administered. On 8/7/24 in the p.m., the systolic blood pressure was 112. Metoprolol 50 mg was administered. During an interview, on 8/14/24 at 1:28 p.m., the Assistant Director of Nursing (ADON) indicated the medications were administered on those dates due to the nurses thought both the blood pressure and the pulse had to be out of the parameters to hold the medications. The orders needed clarified. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. The clinical record for Resident 44 was reviewed on 8/13/24 at 2:23 p.m. The diagnoses included, but were not limited to, chronic systolic heart failure, type 2 diabetes mellitus, stage 3 chronic kidney disease, dysuria, and primary adrenocortical insufficiency. A physician's order, dated 6/11/24, indicated to take lispro insulin per sliding scale and if the blood sugar was above 450 or less than 60 then to notify the physician. A physician's order, dated 7/28/24, indicated to take 22 units of glargine insulin at bedtime. Per the resident's request, please check blood sugar. The electronic medication administration record indicated, on 8/9/24, the resident's blood sugar was 500. There was no documentation in the clinical record to indicate the physician was notified. During an interview, on 8/15/24 at 2:52 p.m., the Director of Nursing (DON) indicated there were no hold orders related to checking the blood sugar at night, but the doctor should have been notified of the high blood sugar. 38872 3. The clinical record for Resident 25 was reviewed on 8/13/24 at 11:20 a.m. The diagnoses included, but were not limited to, delusional disorder, unspecified dementia, and constipation. A physician's order, initiated on 5/29/18, indicated to give docusate sodium and senna 50 milligrams-8.6 milligrams (mg) as needed twice a day for constipation. A care plan, initiated 8/2/22, indicated Resident 25 was at risk for constipation related to medication use and increased reminders to eat and drink. An intervention indicated to monitor the resident's bowel movements and to administer the ordered medication(s) as needed. The resident did not have a documented bowel movement from 7/27/24 to 8/7/24 (12 days). There was no documentation of an abdominal assessment in the record. There was no documentation to show the resident was provided the as needed medication to promote a bowel movement in the record. 4. The clinical record for Resident 40 was reviewed on 8/13/24 at 10:33 a.m. The diagnoses included, but were not limited to, dementia, major depressive disorder, and constipation. A physician's order, initiated 5/9/24, indicated to give Miralax (a medication to promote bowel movement) 17 grams in eight (8) ounces of water as needed every day for constipation. The resident did not have a care plan for constipation in the record. The resident did not have a documented bowel movement from 7/19/24 to 7/22/24 (4 days) and 7/27/24 to 7/30/24 (4 days). There was no documentation of an abdominal assessment in the record. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no documentation to show the resident was provided the as needed medication to promote a bowel movement in the record. During an interview on 8/15/24 at 9:08 a.m., RN 3 indicated if a resident did not have a bowel movement within 24 hours, the resident or CNA were asked if they had a bowel movement, after 48 hours of no bowel movement the resident was put on the list. At 48 to 72 hours, the nurse would check with the CNA to ensure they did not forget to chart a bowel movement. The nurse would then perform and chart a bowel/abdominal assessment and treat the resident (provide a medication to promote a bowel movement). The nurses were responsible to check the bowel movement list. During an interview, on 8/15/24 at 11:01 a.m., the Assistant Director of Nursing indicated no assessments for the residents had been completed or documented. The bowel movements had not been documented on the days reviewed and the residents were not given medications to promote a bowel movement. The staff should have completed the assessments. A current facility policy, titled Medication Administration, dated as last reviewed 2/10/16 and received from the Assistant Director of Nursing on 8/16/24 at 2:00 p.m., indicated .Read each medication order entirely . Read and follow any special instructions written on labels A current facility policy, titled Change of Condition Notification, dated as last revised 3/14/17 and received from the Assistant Director of Nursing on 8/16/24 at 2:00 p.m., indicated .It is the policy of this facility to notify the .Resident's Physician .when there is a change in the Resident's condition .Areas that require notification of the Physician .Hypo/hyperglycemic (high/low blood sugar) episodes A current facility policy, titled POLICY AND PROCEDURE FOR MONITORING BOWEL MOVEMENTS, dated as last reviewed 1/30/16 and received from the Assistant Director of Nursing on 8/15/24 at 11:01 a.m., indicated .Nurses are to observe for any problems with elimination such as .A resident's abdomen is bloated or swollen and they have not had a bowel movement in the last three days .At the beginning of each noc (night) shift, the nurse will check .for residents have no BM (bowel movement) in 72 hours and add to BM list . Those listed on the BM list will be given a laxative on the Day shift 3.1-37(a)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 38872 Based on observation, interview and record review, the facility failed to ensure an accurate bed rail assessment was completed for 1 of 1 resident reviewed for bed rails. (Resident 102) Finding includes: During an observation, on 8/12/24 at 7:49 a.m., Resident 102 was observed to have bilateral (both sides) bed rails at the head of the bed. The clinical record for Resident 102 was reviewed on 8/14/24 at 11:09 a.m. The diagnoses included, but were not limited to, aphasia following a cerebral infraction (stroke), hemiparesis and hemiplegia (weakness and paralysis to one side of the body), and hypertension. A facility document, titled Bed Rail Appropriateness assessment, dated 8/6/24, indicated the resident did not use bed rails to promote independent mobility, he was not able to push himself away from the rail if he rolled against it and he did not have a medical reason which required bed rails. During an interview, on 8/15/24 at 12:07 p.m., the Director of Nursing indicated the resident should have had a new assessment completed. A facility policy, titled Bed Rail Policy, updated 5/6/21 and received from the Director of Nursing on 8/15/24 at 12:07 p.m., indicated .If resident and or POA (Power of Attorney) and facility feel bed rails might benefit resident a bed rail assessment will be done 3.1-45(a)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38872 Based on observation, interview and record review, the facility failed to ensure refrigerated medications in a multidose bottle had an open date, failed to ensure a multidose supplement had a resident name/label and failed to ensure a controlled substance had an open date in 2 of 2 medication carts and 1 of 1 medication refrigerators. Findings include: 1. During an observation of the Talyst (automated medication machine) room, on 8/13/24 at 12:31 p.m., a 100-milliliter bottle of gabapentin 250 mg/5 ml (milligram to milliliter) was found, in the refrigerator, with approximately 10 ml remaining. The bottle did not have a date to indicated when it had been opened. During an interview, on 8/13/24 at 12:33 p.m., the Director of Nursing indicated the medication should have had an open date. The record for Resident 102 was reviewed on 8/14/24 at 11:09 a.m. The diagnoses included, but were not limited to, aphasia following a cerebral infraction (stroke), hemiparesis and hemiplegia (weakness and paralysis to one side of the body), and hypertension. A physician's order, initiated on 4/22/24, indicated to give gabapentin 250 mg/5 ml twice a day. 2. During an observation, on 8/13/24 at 12:40 p.m., the A hall medication cart was found to have a bottle of cherry flavored Prostat (liquid protein) which had been previously opened. The bottle did not indicate which resident was on the protein supplement. The clinical record for Resident 2 was reviewed on 8/16/24 at 9:07 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, hyperlipidemia, and heart failure. A physician's order, initiated on 8/13/24, indicated to give Prostate 30 ml daily. The order had a start time of 2:32 p.m., on 8/13/24. 3. During an observation, on 8/13/24 at 12:45 p.m., the East End medication cart was found to have a 15 ml bottle of morphine sulfate (a narcotic pain reliever), without an open date. A sticker on the bottle and box indicated to discard the medication 90 days after opening. There was 12 ml left in the bottle. During an interview, on 8/13/24 at 12:45 p.m., QMA 1 indicated the bottle should have had an open date. The clinical record for Resident 26 was reviewed on 8/14/24 at 10:40 a.m. The diagnoses included, but were not limited to, type 2 diabetes, anxiety, and fibromyalgia. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order, initiated 4/5/24, indicated to give morphine sulfate 0.25 ml at bedtime. A current facility policy, titled Storage of Medications, dated 2023 and received from the Director of Nursing on 8/14/24 at 8:30 a.m., indicated .Refrigerated medications are kept in .labeled containers .Expiration Dating .Once opened, these will be good to use until the manufacturer's expiration date is reached unless . the manufacturer has specified a usable life after opening .When the original seal of a manufacturer's container or vial is initially [NAME], the container or vial will be dated by nursing A current facility policy, titled Storage of Medications, dated 2023 and received from the Director of Nursing on 8/14/24 at 8:30 a.m., indicated .Resident-specific nonprescription medications .that are not labeled by the pharmacy are .identified with the resident's name 3.1-25(j) 3.1-25(l)(1) 3.1-25(m)