STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155707	A. BUILDING 00 B. WING	02/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SWISS VILLAGE	1350 W MAIN ST BERNE, IN 46711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: February 7, 8, 9, 10, 13, and 14, 2023 Facility number: 000280 Provider number: 155707 AIM number: 100274540 Census Bed Type: SNF/NF: 64 SNF: 21 Residential: 50 Total: 135 Census Payor Type: Medicare: 5 Medicaid: 39 Other: 91 Total: 135 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed February 15, 2023	F 0000		
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop			

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

Sierra M Saylor | VP of Operations | 03/08/2023

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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	pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview, and record review the facility failed to ensure a pressure ulcer was accurately assessed and documented for 1 of 2 residents reviewed. (Resident 31) Findings include: During an observation and interview on 02/08/23 at 10:19 AM, LPN 6 (Licensed Practical Nurse), the wound nurse for the facility, observed LPN 6 complete a dressing change to the wound on Resident 31's coccyx. LPN 6 cleaned the area, stool was under the bandage, she applied sure prep to the outer edges, took a picture of the wound, then calculated the dimensions of the wound. LPN 6 compared the measurements to the prior week's measurement. LPN 6 then used a clean firm cotton tipped stick to measure depth. LPN 6 indicated the wound was acquired during a hospital stay in May of 2022. LPN 6 indicated the wound got worse before it got better. LPN 6 denied any other issues with the wound or care. Resident 31's record review began on 02/07/23 at 03:17 PM. The coccyx wound was identified as present on readmission after a 2 hospital stay. The coccyx wound was unstageable on 5/25/22, size was documented as 2.3cm x 2.7cmx 0.2cm. Wound notes from the physician indicated the foillowing: On 9/28/22 indicated to continue with wound care,	F 0686	**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Resident #31 wound assessments were reviewed as listed. Attached are the wound assessments provided during survey. Characteristics were available on these dates in the assessment and documented for all dates except the 12/21/22 date. Depth cannot be measured when wound has more than 50% slough. For the missing depth on 12/21/22, verbal education was provided to the wound nurse on 2/24/23. Beginning at the bottom of page 4 and continued onto page 5, all dates listed should have been for the year 2023. On 2/8/23, listed incorrectly as 2/8/22, the wound was incorrectly marked as a Stage 3 instead of a Stage 4. Verbal education provided to the wound nurse on 2/24/23 regarding this error. **2. How other residents having the potential to be affected by**	03/20/2023

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	On 10/26/22, labs were ordered. The physician noted poor nutritional intake, and scheduled an appointment with hospital wound care On 11/2/22, change the wound dressing daily and change treatment to Sorbact hydrogel gauze. On 11/23/22, hospital wound care refused to see Resident 31 due to being non ambulatory. The Physician documented he wanted Resident 31 to see general surgery. Thefamily declined. The Physician documented to offer hospice care and the family declined. On 11/3022, indicated to contiue the same treatment as prior. On 12/28/22, indicated to change the wound treatment, promote autolytic debridement: apply collagen to wound bed, apply Anasept hydrogel to gauze packing and apply to wound depth. Cover with a super absorbent dressing On 1/20/23, to continue wound care, although poor prognosis. The wound was slightly improved while Resident 31's overall condition declined. The coccyx wound measurements were documented as follows: On 11/23/22, the coccyx wound was unstageable and measured length 6.2 cm x width 3.5 cm x undermining 2.0 cm with no depth or tunneling documented. There were no characteristics of the wound documented. On11/30/22, the coccyx wound was unstageable and measured length 6.0 cm x width 4.6 cm x		**the same deficient practice will be identified and what corrective action(s) will be taken.** All residents who have wounds will be reviewed by the wound nurse and our contracted wound nurse. This nurse plans to be in the facility on 3/15/23 to round with the facility wound nurse and review characteristics documented. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Verbal education provided to wound nurse on 2/24/23. Wound Nurse provided education to Unit Managers on 2/28/23, regarding using the phone for wound measurements through PCC. On March 14th, 2023, there will be education for nurses from the wound nurse on wound documentation. Wounds are reviewed weekly at our IDT meetings and then as needed to ensure appropriate documentation. Monitoring will occur weekly during these IDT meetings regarding documentation. Monitoring will be provided by DON/designee. Any areas of concern will be brought to the QA meeting.	

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	undermining 3.0 cm with no depth or tunneling documented. There were no characteristics of the wound documented. On 12/07/22, the coccyx wound wa unstageable and measured length 6.2 cm x width 2.7 cm x depth 5.0 cm x undermining 2.0 cm with no tunneling documented. There were no characteristics of the wound documented. On12/14/22, the coccyx wound was unstageable and measured length 6.0 cm x width 2.7 cm x depth 3.7 cm x undermining 3.0 cm with no tunneling documented. In the notes section it was documented the wound had changed to a stage 4 from unstageable. There were no characteristics of the wound documented. On 12/21/22, the coccyx wound was documented as a stage 4 pressure area. The wound measured 5.9 cm length x 3.6 cm width with depth, undermining, and tunneling not documented. There were no characteristics of the wound documented. On 12/29/22, the coccyx wound was documented as a Stage 4 pressure area. The wound measured 4.3 cm length x 3.1 cm width x 3.6cm depth x 2.0 undermining with tunneling not documented. There were no characteristics of the wound documented. On 1/4/22, the coccyx wound was documented as a stage 4 pressure area. The wound measured length 4.8cm x width 2.6 cm x depth 3.2 cm with undermining and tunneling not documented. There were no characteristics of the wound documented. On 1/11/22, the coccyx wound was documented as		**4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** Nurses will be inserviced on this deficiency on March 14, 2023. Inservice will be done by contracted wound nurse, Director of Nursing, and Assistant Director of Nursing in person. Nurses including as needed (prn) nurses who are unable to attend the inservice, will be inserviced prior to returning to work. The QAA committee will have a responsibility to oversee and monitor the corrective action plan. The QAA committee will review corrective action plan/interventions quarterly and for at least a period of one year to ensure changes yield the expected results. The goal of compliance is 100% for the first 3 months and thereafter. The QAA committee will review monitoring process and compliance after the first year to determine if monitoring can be stopped or if further monitoring is necessary. All these concerns will also be reviewed and monitored during the facility's quarterly meetings and any concerns with observations will be addressed immediately to prevent these deficiencies going	

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	a stage 4 pressure area. The wound measured length 5.2cm x width 2.6 cm x depth 2.7cm x undermining 2.2cm with no tunneling documented. There were no characteristics of the wound documented. On 1/18/22, the coccyx wound was documented as a stage 4 pressure area. The wound measured length 4.7cm x width 2.4cm x depth 3.2cm x undermining 2.2 cm and no was tunneling documented. There were no characteristics of the wound documented. On 1/25/22, the coccyx wound was documented as a stage 4 pressure area. The wound measured length 4.2cm x width 2.1cm with no depth, undermining, or tunneling documented. The area was documented as improving no longer see bone or feel bone and the staging was changed to stage 3. There were no characteristics of the wound documented. On 2/1/22, the coccyx wound was documented as a stage 4 pressure area. The wound measured length 4.0cm x width 1.6cm x depth 2.5cm x undermining 2.0cm. No tunneling was documented. There were no characteristics of the wound documented. On 2/8/22, the coccyx wound was documented as a stage 3 pressure area. The wound measured length 4.1cm x width 2.5cm with no depth, undermining, or tunnelling documented. There were no characteristics of the wound documented. In an interview on 2/13/23 at 2;46PM, the ADON (Assistant Director of Nursing) indicated the program being used currently was not available until October 2022. The ADON indicated any discrepancies could be due to the difference in		forward. **5. By what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.** By March 20, 2023 the systemic changes for this deficiency will be completed.	

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	human measuring and the program measuring. A policy was provided by the DON on 2/13/22 at 9:00 AM, titled "Skin Assessment Policy and Procedure", dated 8/1/15, most recent update 10/3/22, and indicated this was the policy currently used by the facility. The policy indicated the prevention, identification, treatment, and evaluation of skin breakdown are primary goals for the health and wellbeing of residents .... pressure injury definition.. usually over a bony prominence. The injury occurs as a result of intense and or prolonged pressure or pressure in combination with shear ...." 3.1-40			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review the facility failed to provide fall prevention interventions for 1 of 3 residents reviewed. (Resident 52) Findings include: In an interview on 02/07/23 at 01:56 PM, QMA 2 indicated Resident 52 was a frequent faller. The QMA 2 indicated the 3 residents who were at highest fall risk were to be closely monitored.	F 0689	**1. F 689- Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to**	03/20/2023

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	QMA 2 described closely monitored during her shift as a clinical staff within eyesight of the resident. QMA 2 indicated the high fall risk residents were frequently in the dayroom due to increased need of supervision. During a continuous observation from 02/07/23 01:40 PM to 02/07/23 02:17 PM, Observed 6 transfers completed without use of the gait belt secured around Resident 52's waist. The gait belt was positioned correctly yet was not used in transfers. During a continuous observation and interviews, on 02/09/23 at 10:53 AM to 11:50 AM, observed 6 residents in the dayroom with an agency CNA. In an interview with QMA 4, she indicated the CNA was minimally familiar with the residents. QMA 4 indicated she would call one of the neighboring units for any issues such as falls. QMA 4 indicated she had 3 CNAs and herself on the unit. During an observation on 2/9/23, at 10:48 AM, Resident 52 was observed in a broda chair with eyes closed and head to the right side. At 11:10 AM, Resident 52 woke up and was unable to push herself away from the table. Resident 31 began yelling. Resident 31 continued to become increasingly agitated and made derogatory remarks about staff and other residents. At 11:24 AM, Resident 52 was offered a diversional activity, going to sit by the window so she could look out. Resident 52 refused. Resident 52 was taken to the window area shortly afterwards. At 11:29 AM, Resident 52 was at a table near the window, pulled up all the way to the table with chair wheels locked. At 11:41 AM, Resident 52 began to yell out again,		**prevent accidents. This REQUIREMENT is not met as evidenced by: F 689 SS=D Based on observation, interview, and record review the facility failed to provide fall prevention interventions for 1 of 3 residents reviewed.** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** All residents within the facility had their fall interventions reviewed by the unit managers from 2/14/23 to 2/21/23 for appropriateness. All residents with fall interventions will be reviewed on a monthly schedule during the weekly IDT meeting. All nursing staff were sent a message via Onshift on 2/9/23 regarding proper gait belt usage. On page 9 it was listed that Resident 58 had 28 falls from February 7,2022 to February 9. This should be listed as February 9, 2023. It was then documented that she fell on 2/9/23 with one dietary staff member in the common area. This fall occurred in 2022. On page 9 it was noted that no post fall evaluations were documented and risk assessments were not provided by time of exit. All risk assessments were provided on paper and available under the assessment	

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	"why do I have to sit here while everyone else gets to sit where they want?". She began heavily tapping the table. Resident 52 attempted to get up x3 from the table by moving the broda chair backwards with brakes locked. At 11:43 AM, 9 residents and 1 dietary aid were in large common area. There were no staff within visual range. 3 staff were observed in the hallway talking to each other. No residents were in the hallway. At 11:45 AM, Resident 52 attempted to stand by pushing the table forward. Resident 52 immediately complained loudly of knee pain. At 11:46 AM, Resident 52 was standing up out of the chair with both feet on the ground. 2 staff came around the corner and ran toward Resident 52. Resident 52's had 28 falls From February 7, 2022, to February 9, Of the 28 falls 24 of them were unwitnessed. Resident 52 fell on 2/9/23 about 3 PM. Only one dietary staff was in the common area with the residents. Resident 52's current care plan indicated a risk for falls related to an unsteady gait was initiated on 1/14/23. The interventions were documented as continue the risk plan. Interventions were as follows: 15min checks from 3a to 6am, have resident wear tennis shoes while propelling in broda chair, be sure gripper socks are on, if awake or restless get up and take to nurse's station for closer observation, bed in lowest position, frequent monitoring from 5am to 7:20 am, wide bed for safety, gripper socks on at bedtime, check every 30 min from 6pm to 8pm, and 30 min checks from 8pm to 3am. Post fall evaluations were documented. No fall risk assessments were provided by time of exit.		tab in PCC. Administrator verified during survey that assessments were available to be reviewed and it was confirmed. **2. 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 have falls and interventions will be reviewed on a rotating basis monthly during the IDT meeting based on hall. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** All residents within the facility had their fall interventions reviewed by unit managers from 2/14/23 to 2/21/23 for appropriateness. All residents with fall interventions will be reviewed on a monthly schedule during the weekly IDT meeting. Each week a hall will be selected and current interventions reviewed for appropriateness. The ADON/designee will monitor for compliance. Nursing staff will be educated on meetings scheduled for March 14,, 2023. The gait belt policy will also be reviewed by nursing staff. Any areas of concern will be brought to the QA meeting.	

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	A policy was provided by the DON on 2/13/22 at 8:46AM, titled "Fall Prevention Policy and Procedure", dated 5/23/1997, most recent update 10/6/22, and indicated "it is the policy of Swiss Village that each resident will be assessed for fall risk upon admission, quarterly, and with significant change. ...if falling reoccurs despite initial interventions, staff will implement additional interventions or different interventions or indicate why the current approach remains relevant ..." 3.1-45(a)		**4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** Nursing staff will be inserviced on this deficiency on March 14, 2023. Inservice will be done by the therapy director, Director of Nursing, and Assistant Director of Nursing in person. Nursing staff including as needed (prn) staff who are unable to attend the inservice, will be inserviced prior to returning to work. The QAA committee will have a responsibility to oversee and monitor the corrective action plan. The QAA committee will review corrective action plan/interventions quarterly and for at least a period of one year to ensure changes yield the expected results. The goal of compliance is 100% for the first 3 months and thereafter. The QAA committee will review monitoring process and compliance after the first year to determine if monitoring can be stopped or if further monitoring is necessary. All these concerns will also be reviewed and monitored during the facility's quarterly meetings and any concerns with observations will be addressed immediately to prevent these deficiencies going	

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			forward. **5. By what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.** By March 20, 2023 the systemic changes for this deficiency will be completed.	
F 0758 SS=E Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs			

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	unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on interview and record review the facility failed to ensure side effect monitoring was completed for 4 of 6 residents reviewed. (Resident 31, Resident 52, Resident 72, and Resident 73) Findings include: In an interview with QMA 2 (Qualified Medication Assistant), on 02/07/23 at 01:56 PM, she indicated	F 0758	Plan of Correction for 2023 **1. F 758- Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and**	03/20/2023

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	each medication class a resident received had side effects monitoring, including anticoagulants, insulin, and psych medications. 1) Resident 31's record review, began on 02/08/23 at 10:34 AM. The records indicated her diagnosis included; unspecified dementia, major depressive disorder, generalized anxiety disorder, and pain. Resident 31's medication orders included; Buspar 5mg three times a day for anxiety (an anti-anxiety medication), hydrocodone-acetaminophen 5-325mg three times a day as needed for pain (an opioid medication), Remeron 7.5 mg daily (an antidepressant medication), and Trintellix 10mg daily for depression (an antidepressant). These medications were documented as given as ordered. No documentation of side effect monitoring was provided other then involuntary movement assessments. No daily documentation of side effect monitoring for each drug class was available. Resident 31's current care plan indicated the interventions were to observe for side effects of the medications. 2) Resident 52's record review, began on 02/07/23 at 03:10 PM. The review indicated her diagnosis included: unspecified dementia, anxiety disorder, and mood disorder with depressive features. Resident 52's medication orders were: Klonopin 1mg twice a day (benzodiazepine medication), Ativan 0.5mg tablet twice a day as needed for anxiety (benzodiazepine), Remeron 30 mg tablet at bedtime related to major depressive disorder (antidepressant), and Zyprexa 2.5mg daily with		**behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv). Based on interview and record review the facility failed to ensure side effect monitoring was completed for 4 of 6 residents reviewed.** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** All residents within the facility on an antipsychotic were audited and had an order put in to monitor two times a day for side effects by the Director of Nursing on 2/14/23. Education was provided to the Unit Mangers on 2/28/23 regarding order entry for monitoring side effects. **2. 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 have an order for an antipsychotic have the potential to be affected. An audit was completed on 2/14/23 by the	

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	155707	A. BUILDING 00 B. WING	02/14/2023

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	Zyprexa 5mg given once a day (antipsychotic). Resident 52 had a physician order to monitor for side effects of antipsychotic medication every shift. No documented for monitoring the side effects of her antidepressant or benzodiazepines were available for review. Documentation indicated Resident 52 was administered medication daily as ordered for the month of January 2023. No daily documentation of side effect monitoring for each drug class was available. 3) Resident 72's record review, began on 02/08/2023 at 9:31 AM. The record indicated her diagnosis included; unspecified dementia, bipolar disorder, generalized anxiety disorder, and pain. Resident 72's medication orders included Abilify 2mg daily (antipsychotic) and Buspar 30mg daily (antianxiety). No documentation was available related to monitoring of side effects for Buspar or Abilify. Documentation provided indicated Resident 72 was administered medication as ordered daily during the month of January2023. 4) Resident 73's record review, began on 02/07/2023 at 1:42 PM. The review indicated her diagnosis included; neurocognitive disorder with Levy bodies, dementia with anxiety, dementia with psychotic disturbances, major depressive disorder, anxiety disorder unspecified, and insomnia. Resident 73's medication orders included:		Director of Nursing to ensure that all residents had an order for side effect monitoring. The facility policy titled “Psychotropic Medication Policy and Procedure” was updated and will be uploaded. The policy was changed on 2/22/23, on page 2, to state that “Swiss Village Nursing Department shall monitor antipsychotic drug use daily noting any adverse effects such as increased somnolence or functional decline.” **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** All residents within the facility on an antipsychotic were audited and had an order put in to monitor two times a day for side effects by the Director of Nursing on 2/14/23. Another audit was completed by Assistant Director of Nursing and Administrator on 3/3/23, for order regarding monitoring side effects for antipsychotics. Nursing staff will be educated in meetings scheduled for March 14, 2023 regarding monitoring side effects for residents on antipsychotics. Facility will discuss and audit for orders during monthly behavior committee meetings. The DON/Designee will monitor that these orders are in place during the monthly meeting. Any areas of	

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	fluoxetine 40mg at bedtime (antidepressant), lorazepam intensol 2mg/ml give 0.25ml by mouth daily related to anxiety (antianxiety), melatonin 3mg at bedtime (hypnotic), Morphine Sulfate 20mg/ml give 0.25ml every 2 hours as needed for pain (opiate), and Zypexa 2.5mg at bedtime (antipsychotic). No documentation was available related to monitoring of side effects for the antipsychotic, opiate, antianxiety, and antidepressant medications. Documentation provided indicated Resident 73 was administered medication as ordered daily during the month of January 2023. Resident 73 received Morphine in January 2023 and February 2023. A policy was provided by the DON on 2/13/22 at 8:46AM, titled "Psychotropic Medication Policy and Procedure", dated 9/20/2013, most recent update 12/2/22, and indicated " ...psychopharmacological medications in the long term care facility include regular review for continued need, appropriate dosage, side effects, risks and or benefits ...psychotropic medications include antianxiety, hypnotic, antipsychotic, and antidepressant classes of drugs ... evaluate the effects and side effects of psychoactive medications ...monitor psychotropic drug use daily noting any adverse effects such as increased somnolence or functioning decline...." 3.1-48(a)(3)		concern will be brought to the QA meeting. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** Nurses/QMAs will be inserviced on this deficiency on March 14, 2023. Inservice will be done by the Director of Nursing, and Assistant Director of Nursing in person. Nurses/QMAs including as needed (prn) staff who are unable to attend the inservice, will be inserviced prior to returning to work. The QAA committee will have a responsibility to oversee and monitor the corrective action plan. The QAA committee will review corrective action plan/interventions quarterly and for at least a period of one year to ensure changes yield the expected results. The goal of compliance is 100% for the first 3 months and thereafter. The QAA committee will review monitoring process and compliance after the first year to determine if monitoring can be stopped or if further monitoring is necessary. All these concerns will also be reviewed and monitored during the facility's quarterly meetings and any concerns with observations	

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			will be addressed immediately to prevent these deficiencies going forward. **5. By what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.** By March 20, 2023 the systemic changes for this deficiency will be completed.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: February 7, 8, 9, 10, 13, and 14, 2023 Facility number: 000280 Residential Census: 50 Swiss Village was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.	R 0000		

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	Quality review completed February 15, 2023			