PRINTED: 09/09/2022 FORM APPROVED

| CENTERS FOR MEDICARE & MEDICAID SERVICES |  |   |  |  | OMI                                   | B NO. 0938-039             |
|--|--|---|--|--|---------------------------------------|----------------------------|
|  | IT OF DEFICIENCIES<br>OF CORRECTION  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155525   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING |  | (X3) DATE SURVEY COMPLETED 08/04/2022 |                            |
|  | PROVIDER OR SUPPLIEF   |   | 36 VAL   | ADDRESS, CITY, STATE, ZIP COD<br>LEY DR<br>ENCEBURG, IN 47025  |                                       |                            |
| (X4) ID<br>PREFIX<br>TAG                 | SUMMARY<br>(EACH DEFICIEN  | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION   | ID<br>PREFIX<br>TAG                              | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TE                                    | (X5)<br>COMPLETION<br>DATE |
| F 0000                                   | REGULATORT OF  | CESC IDENTIFTING INFORMATION  | IAG  |  |                                       | DATE                       |
| Bldg. 00                                 | Licensure Survey.  | Recertification and State   | F 0000   |  |                                       |                            |
|  | Facility number: 00 Provider number: 1 AIM number: 1002 Census Bed Type: SNF/NF: 79 Total: 79 Census Payor Type Medicare: 7 Medicaid: 47 Other: 25 Total: 79 These deficiencies accordance with 41 | 55525 66810 : reflect State Findings cited in   |  |  |                                       |                            |
| F 0692<br>SS=D<br>Bldg. 00               | 483.25(g)(1)-(3) Nutrition/Hydration §483.25(g) Assist (Includes naso-ga tubes, both percur gastrostomy and p  | n Status Maintenance ed nutrition and hydration. stric and gastrostomy taneous endoscopic percutaneous endoscopic enteral fluids). Based on a hensive assessment, the re that a resident- |  |  |                                       |                            |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

parameters of nutritional status, such as usual body weight or desirable body weight

> 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 5IVX11 Facility ID: 000304 If continuation sheet Page 1 of 20

| i ´      |  | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY   |                          |        |  |  |            |
|----------|--|---|--------------------------|--------|--|--|------------|
| AND PLAN | OF CORRECTION  | IDENTIFICATION NUMBER   | A. BUILDING 00 COMPLETED |        |  |  |            |
|          |  | 155525  | B. W                     | ING    |  | 08/04  | /2022      |
|          | PROVIDER OR SUPPLIER   |   | •                        | 36 VAL | ADDRESS, CITY, STATE, ZIP COD<br>LEY DR<br>ENCEBURG, IN 47025  | •  |            |
| (X4) ID  | SUMMARY  | STATEMENT OF DEFICIENCIE  |                          | ID     | PROVIDER'S PLAN OF CORRECTION  |  | (X5)       |
| PREFIX   | (EACH DEFICIEN   | CY MUST BE PRECEDED BY FULL   |                          | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE  | ATE  | COMPLETION |
| TAG      | REGULATORY OR  | LSC IDENTIFYING INFORMATION   |                          | TAG    | DEFICIENCY)  | VIE.   | DATE       |
|          | range and electrol resident's clinical of that this is not pospreferences indical states and the states are states and the states are states and the states are states are states are states and the states are s | lyte balance, unless the condition demonstrates is sible or resident ate otherwise;  Iffered sufficient fluid intake r hydration and health;  Iffered a therapeutic diet utritional problem and the er orders a therapeutic diet. On, interview, and record failed to provide nutritional esident with poor meal intake reviewed for nutrition.  It ion and interview on 08/01/22 lent 61 was sitting in her room as admitted in February. The One day she got a tossed salad e wilted. She sent it back. Here she consumed the heal. She indicated she had lost at month.  It is for the previous 30 days he DON (Director of Nursing)  P.M. The record indicated the D-25% on the following days eals:  Ist and lunch,  Ist, lunch, and supper, st and lunch, | FO                       | TAG    | By submitting the enclosed material, we are not admitting truth or accuracy of any specifindings or allegations. We resthe right to contest the finding allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The fact requests that the plan of correction be considered our allegation of compliance effect 8-26-22 to the Recertification State Licensure Survey compliance on August 4, 2022. We respectfully request a paper reand will provide any additional information requested.  F692.  It is the practice of this facility assure that all procedures and services are conducted in a manner that are in accordance with department of health and human services centers for Medicare and Medicaid services. | the fic serve s or existive and leted eview I to decess. |            |
|          | - 07/09/22, breakfas   | si and supper,  |                          |        | those residents found to be  |  |            |
|          | - 07/10/22, lunch,   |   |                          |        | affected by the deficient  |  |            |

| DEPARTMENT OF HEALTH AND HUMAN SERVICES  |  |
|--|--|
| CENTERS FOR MEDICARE & MEDICAID SERVICES |  |

| STATEMEN                         | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                                | (X2) MULTIPLE CONSTRUCTION |                        |  | (X3) DATE | SURVEY     |
|----------------------------------|--|--------------------------------|----------------------------|------------------------|--|-----------|------------|
| AND PLAN                         | OF CORRECTION  | IDENTIFICATION NUMBER          | A. BUILDING <u>00</u>      |                        | 00   | COMPLETED |            |
|                                  |  | 155525                         | B. W                       | NG                     |  | 08/04/    | 2022       |
|                                  |  |                                |                            |                        |  |           |            |
| NAME OF F                        | ROVIDER OR SUPPLIER                                  | 8                              |                            |                        | ADDRESS, CITY, STATE, ZIP COD  |           |            |
|                                  |  |                                |                            |                        | LEY DR   |           |            |
| SHADY                            | NOOK CARE CENT                                       | ER                             |                            | LAWRE                  | NCEBURG, IN 47025  |           |            |
| (X4) ID                          | SUMMARY  | STATEMENT OF DEFICIENCIE       |                            | ID                     |  |           | (X5)       |
| PREFIX                           | (EACH DEFICIEN                                       | CY MUST BE PRECEDED BY FULL    |                            | PREFIX                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIAT |           | COMPLETION |
| TAG                              | REGULATORY OR  | LSC IDENTIFYING INFORMATION    |                            | TAG                    | CROSS-REFERENCED TO THE APPROPRIAT   | IE        | DATE       |
|                                  | - 07/12/22, lunch,                                   |                                |                            |                        | practice include:  |           |            |
|                                  |  | st, lunch, and supper,         |                            |                        | It is the policy of this facility to   |           |            |
|                                  | - 07/15/22, breakfas                                 |                                |                            |                        | ensure residents are reviewed  | for       |            |
|                                  | - 0716/22, breakfast                                 |                                |                            |                        | poor meal intake and ordered   |           |            |
|                                  |  | st, lunch, and supper,         |                            |                        | supplements as advised.  |           |            |
|                                  | - 0722/22, supper,                                   |                                |                            |                        | Resident, 61, has not experien   | nced      |            |
|                                  | - 07/25/22, breakfas                                 | st.                            |                            |                        | negative outcome because of  |           |            |
|                                  | - 07/26/22, breakfas                                 |                                |                            |                        | alleged deficient practice.  |           |            |
|                                  | - 07/27/22, breakfas                                 |                                |                            |                        | Resident receives appropriate  |           |            |
|                                  | - 07/28/22, breakfa                                  | • •                            |                            |                        | supplementation provided by  |           |            |
|                                  | - 07/30/22, breakfas                                 |                                |                            |                        | qualified staff, supplementation   | n         |            |
| - 07/31/22, breakfast and lunch. |  |                                |                            | documentation present. |  |           |            |
|                                  | 07731722, ordaniast and ranon.                       |                                |                            |                        | Other residents that have the  | )         |            |
|                                  | The Weights and Vitals Summary record was            |                                |                            |                        | potential to be affected have  | _         |            |
|                                  | provided by the DON on 08/03/22 at 2:20 P.M. The     |                                |                            |                        | been highlighted by:   |           |            |
|                                  |  | e resident weighed 202.8       |                            |                        | All residents who have poor m  | eal       |            |
|                                  |  | 2, and 190 pounds on 07/20/22. |                            |                        | intake have potential to be  |           |            |
|                                  | •  | •                              |                            |                        | affected. Please see below for   |           |            |
|                                  | The current active p                                 | physician's orders were        |                            |                        | measures implemented to prev   |           |            |
|                                  | -  | ON on 08/03/22 at 2:20 P.M. An |                            |                        | reoccurrence.  |           |            |
|                                  | order, with a start d                                | ate of 02/23/22, indicated the |                            |                        | The measures or systemic   |           |            |
|                                  | staff may provide a                                  | nutritional supplement as      |                            |                        | changes that have been put   |           |            |
|                                  | needed if meal intal                                 | ke was less than 50%.          |                            |                        | into place to ensure that the  |           |            |
|                                  |  |                                |                            |                        | deficient practice does not  |           |            |
|                                  | The EMAR/ETAR  | for July 2022, was provided by |                            |                        | recur include:   |           |            |
|                                  | the DON on 08/03/2                                   | 22 at 2:20 P.M. The record     |                            |                        | All nursing was in-serviced by   | the       |            |
|                                  | lacked documentation                                 | on the resident had an order   |                            |                        | Director of Nursing/ designee  | on        |            |
|                                  | for a nutritional sup                                | plement as needed if meal      |                            |                        | the policies entitled "Food and  |           |            |
|                                  | intake was less than                                 | 1 50%.                         |                            |                        | Nutrition Services" related to n   | neal      |            |
|                                  |  |                                |                            |                        | intake and receiving suppleme  | ents      |            |
|                                  | The Care Plan was j                                  | provided by the DON on         |                            |                        | as ordered. In-service has bee   |           |            |
|                                  | 08/03/22 at 2:20 P.M                                 | M., and indicated the resident |                            |                        | conducted with the IDT team  |           |            |
|                                  | was at risk for altera                               | ations in nutrition.           |                            |                        | related to meal intake and   |           |            |
|                                  |  |                                |                            |                        | providing appropriate supplem  | ents.     |            |
|                                  | The Progress Notes for July 2022 were provided       |                                |                            |                        | Meal intakes will be reviewed a  | as        |            |
|                                  | by the DON on 08/03/22 at 2:20 P.M. The record       |                                |                            |                        | part of the clinical morning   |           |            |
|                                  | lacked any notes in                                  | July indicating the resident   |                            |                        | meeting to ensure that   |           |            |
|                                  | had been offered a r                                 | nutritional supplement on the  |                            |                        | supplements are provided to  |           |            |
|                                  | days and times she                                   | had consumed less than 50%     |                            |                        | residents per physician orders   |           |            |
|                                  | of her meals.  |                                |                            |                        | The corrective action taken to   |           |            |
|                                  |  |                                | 1                          |                        |  |           |            |

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/09/2022 FORM APPROVED OMB NO. 0938-039

|                            | IT OF DEFICIENCIES<br>OF CORRECTION   | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155525  | (X2) MULTIPLE C A. BUILDING B. WING | CONSTRUCTION  00  | (X3) DATE SURVEY COMPLETED 08/04/2022  |
|----------------------------|---|--|-------------------------------------|---|--|
|                            | PROVIDER OR SUPPLIER  |  | 36 VA                               | CADDRESS, CITY, STATE, ZIP COD<br>LLEY DR<br>RENCEBURG, IN 47025  |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIE<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION   | ID<br>PREFIX<br>TAG                 | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)  | (X5) COMPLETION DATE   |
|                            | 11:33 A.M. A Quar assessment, dated 0 was moderately cog diagnoses included, dementia and muscl During an interview (Licensed Practical supplements would would have been a During an interview DON indicated the supplement if meal should have been a EMAR/ETAR.  The current Food ar with a revised date of the Administrator of policy indicated, " | on 08/03/22 at 1:15 P.M., LPN Nurse) 2 indicated nutritional be on the EMAR/ETAR. It PRN (as needed) order.  on 08/03/22 at 1:20 P.M., the order for the nutritional intake was less than 50% PRN order on the  ad Nutrition Services policy, of 10/2017, was provided by an 08/04/22 at 3:33 P.M. The inturitional supplements will 45 minutes of either resident |                                     | monitor performance to assessive compliance through quality assurance is:  A performance improvement has been initiated that observe residents with poor meal inta have been offered a supplement addition to the daily rounds a monitoring for a minimum of months or until substantial compliance is achieved, a Quantification of the daily rounds a monitoring for a minimum of months or until substantial compliance is achieved, a Quantification of the developed and implemented monitor meal intake and recessive supplements as ordered. This will be completed by the DON designee, weekly x3 weeks, monthly for 3 months, then quarterly for 2 quarters. Any identified issues will be immediately addressed. The outcomes will be reviewed the facility Quality Assurance Program. Monitoring will contast planned or will be increased the Quality Assurance Commit if needed to obtain 100% compliance. Additional action be taken by the Quality Assurance Committee if warm based on the outcome of too The date the systemic chan will be completed: 8-26-22 | tool ves ke nent. In nd 3 uality to siving s tool N, or  rough etinue ed by nittee n will ranted ls. |
| F 0758<br>SS=D<br>Bldg. 00 | Use<br>§483.45(e) Psycho  | Psychotropic Meds/PRN  |                                     |   |  |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

5IVX11

Facility ID: 000304

If continuation sheet

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |   | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY         |       |          |   | SURVEY |            |
|--|---|---|-------|----------|---|--------|------------|
| AND PLAN   | OF CORRECTION   | IDENTIFICATION NUMBER                               | A. BU | JILDING  | 00  | COMPL  | LETED      |
|  |   | 155525  | B. W  | ING      |   | 08/04  | /2022      |
|  |   |   |       | STREET A | ADDRESS, CITY, STATE, ZIP COD                                       |        |            |
| NAME OF I  | PROVIDER OR SUPPLIEF  | R   |       |          | LEY DR  |        |            |
| SHADY  | NOOK CARE CENT  | FR  |       |          | ENCEBURG, IN 47025  |        |            |
|  | 1   |   |       |          | I   |        | 1          |
| (X4) ID  | SUMMARY   | STATEMENT OF DEFICIENCIE                            |       | ID       | PROVIDER'S PLAN OF CORRECTION                                       |        | (X5)       |
| PREFIX   | · ·   | ICY MUST BE PRECEDED BY FULL                        |       | PREFIX   | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE     | COMPLETION |
| TAG  |   | R LSC IDENTIFYING INFORMATION                       | +     | TAG      | DEFICIENCY)   |        | DATE       |
|  | "   | orain activities associated                         |       |          |   |        |            |
|  |   | sses and behavior. These                            |       |          |   |        |            |
|  | -   | are not limited to, drugs in                        |       |          |   |        |            |
|  | the following cate  | gories:   |       |          |   |        |            |
|  | (i) Anti-psychotic;   | ht.   |       |          |   |        |            |
|  | (ii) Anti-depressar   |   |       |          |   |        |            |
|  | (iii) Anti-anxiety; a<br>(iv) Hypnotic  | illu  |       |          |   |        |            |
|  | (iv) riyphotic  |   |       |          |   |        |            |
|  | Based on a comp   | rehensive assessment of a                           |       |          |   |        |            |
|  |   | ty must ensure that                                 |       |          |   |        |            |
|  | Toolagin, and lagin   | ty made dilbard that                                |       |          |   |        |            |
|  | §483.45(e)(1) Res   | sidents who have not used                           |       |          |   |        |            |
|  | - , , , ,   | s are not given these drugs                         |       |          |   |        |            |
|  |   | ation is necessary to treat a                       |       |          |   |        |            |
|  | specific condition  |   |       |          |   |        |            |
|  | documented in the   | <del>-</del>  |       |          |   |        |            |
|  |   |   |       |          |   |        |            |
|  | §483.45(e)(2) Res   | sidents who use                                     |       |          |   |        |            |
|  | psychotropic drug   | s receive gradual dose                              |       |          |   |        |            |
|  | reductions, and be  | ehavioral interventions,                            |       |          |   |        |            |
|  | unless clinically co  | ontraindicated, in an effort                        |       |          |   |        |            |
|  | to discontinue the  | se drugs;   |       |          |   |        |            |
|  |   |   |       |          |   |        |            |
|  | . , , ,   | sidents do not receive                              |       |          |   |        |            |
|  |   | s pursuant to a PRN order                           |       |          |   |        |            |
|  |   | ation is necessary to treat                         |       |          |   |        |            |
|  |   | ific condition that is                              |       |          |   |        |            |
|  | documented in the   | e clinical record; and                              |       |          |   |        |            |
|  | \$400.4E(-\/4\\DD   | NI and and fan marrals streets                      |       |          |   |        |            |
|  | §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 |   |       |          |   |        |            |
|  |   |   |       |          |   |        |            |
|  |   |   |       |          |   |        |            |
|  |   | cribing practitioner believes                       |       |          |   |        |            |
|  |   | te for the PRN order to be                          |       |          |   |        |            |
|  |   | 14 days, he or she should tionale in the resident's |       |          |   |        |            |
|  |   | tionale in the resident's                           |       |          |   |        |            |
|  | the PRN order.  | u muicate the duration for                          |       |          |   |        |            |
|  | ule FINN UIUEI.   |   |       |          |   |        |            |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

5IVX11

Facility ID: 000304

If continuation sheet Page 5 of 20

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |   | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY |       |                                 | SURVEY  |            |            |
|--|---|---|-------|---------------------------------|---|------------|------------|
| AND PLAN   | OF CORRECTION   | IDENTIFICATION NUMBER                       | A. BU | A. BUILDING <u>00</u> COMPLETED |   |            |            |
|  |   | 155525                                      | B. W  | ING                             |   | 08/04/     | /2022      |
| STREET ADDRESS, CITY, STATE, ZIP COD                 |   |   |       |                                 |   |            |            |
| NAME OF I  | PROVIDER OR SUPPLIEF  | ζ.  |       | 36 VAL                          | LEY DR  |            |            |
| SHADY I  | NOOK CARE CENT  | TER   |       | LAWRE                           | ENCEBURG, IN 47025  |            |            |
| (X4) ID  |   | STATEMENT OF DEFICIENCIE                    |       | ID                              | PROVIDER'S PLAN OF CORRECTION                                       |            | (X5)       |
| PREFIX   | `   | ICY MUST BE PRECEDED BY FULL                |       | PREFIX                          | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE         | COMPLETION |
| TAG  |   | R LSC IDENTIFYING INFORMATION               |       | TAG                             | DEFICIENCY)   |            | DATE       |
|  | - , , , ,   | N orders for anti-psychotic                 |       |                                 |   |            |            |
|  | _   | to 14 days and cannot be                    |       |                                 |   |            |            |
|  |   | ne attending physician or                   |       |                                 |   |            |            |
|  | prescribing practitioner evaluates the resident for the appropriateness of that medication.  Based on record review and interview, the facility |   |       |                                 |   |            |            |
|  |   |   | E 0'  | 750                             | Dr. and braitting the angle and                                     |            | 00/26/2022 |
|  |   | sidents who received                        | F 0'  | /38                             | By submitting the enclosed  | tha        | 08/26/2022 |
|  |   | eations for Adverse Side                    |       |                                 | material, we are not admitting                                      |            |            |
|  |   | esidents reviewed for                       |       |                                 | truth or accuracy of any specifindings or allegations. We res       |            |            |
|  |   | ations. (Resident 48, 15, and               |       |                                 |   |            |            |
|  | 46)   | ations. (Resident 46, 13, and               |       |                                 | the right to contest the finding allegations as part of any         | 5 UI       |            |
|  | Findings include:  1. The clinical record for Resident 48 was reviewed  |   |       |                                 | proceedings and submit these  |            |            |
|  |   |   |       |                                 | responses pursuant to our   |            |            |
|  |   |   |       |                                 | regulatory obligations. The fac                                     | ility      |            |
|  |   |   |       |                                 | requests that the plan of   | illy       |            |
|  |   | P.M. An Annual MDS                          |       |                                 | correction be considered our  |            |            |
|  |   | t) assessment, dated 07/01/22,              |       |                                 | allegation of compliance effec                                      | tive       |            |
|  | 1   | ent was cognitively intact. The             |       |                                 | 8-26-22 to the Recertification                                      |            |            |
|  |   | , but were not limited to, heart            |       |                                 | State Licensure Survey compl  |            |            |
|  | _   | d depression. The resident had              |       |                                 | on August 4, 2022. We   | otou       |            |
|  | 1   | sant and antianxiety                        |       |                                 | respectfully request a paper re                                     | eview      |            |
|  |   | en of the seven days of the                 |       |                                 | and will provide any additional                                     |            |            |
|  | assessment review   |   |       |                                 | information requested.  |            |            |
|  | ·   | •   |       |                                 | F758.   |            |            |
|  | The EMAR/ETAR   | (Electronic Medication                      |       |                                 | It is the practice of this facility                                 | to         |            |
|  | Administration Rec  | cord/Electronic Treatment                   |       |                                 | assure that all procedures and                                      |            |            |
|  | Administration Rec  | cord) for July and August 2022,             |       |                                 | services are conducted in a   |            |            |
|  |   | e MDS Coordinator on                        |       |                                 | manner that are in accordance                                       | •          |            |
|  | 08/03/22 at 3:57 P.I  | M., and contained the following             |       |                                 | with department of health and                                       |            |            |
|  | orders:   |   |       |                                 | human services centers for  |            |            |
|  |   |   |       |                                 | Medicare and Medicaid servic  | es.        |            |
|  | - Xanax Tablet 0.5 mg (milligram), 1 tablet by  |   |       |                                 | The Corrective Action taken   | <u>for</u> |            |
|  | mouth two times a   | day for anxiety, with an active             |       |                                 | those residents found to be   |            |            |
|  | date of 04/26/22,   |   |       |                                 | affected by the deficient   |            |            |
|  |   |   |       |                                 | practice include:   |            |            |
|  |   | ng by mouth one time a day                  |       |                                 | It is the policy of this facility to                                |            |            |
|  | related to depressiv  | re episodes, with an active date            |       |                                 | ensure residents are monitore                                       | d for      |            |
|  | of 06/17/22, and  |   |       |                                 | and report any side effects an                                      | d          |            |
|  |   |   |       |                                 | adverse consequences of   |            |            |
|  | L - Wellbutrin 100 m  | g. 1 tablet by mouth one time a             |       |                                 | antipsychotic medications to the                                    | ne         |            |

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 08/04/2022 155525 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 36 VALLEY DR SHADY NOOK CARE CENTER LAWRENCEBURG, IN 47025 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE day for depression, with an active date of physician. Monitoring orders implemented for side effect and negative consequence monitoring. The records lacked documentation and an order to Resident(s) 48, 15 and 46 have monitor for ASE (Adverse Side Effects) to the not experienced negative antidepressants and antianxiety medications. outcomes because of the alleged deficient practice. Residents to be The Care plans were provided by the DON on monitored for side effects and 08/04/22 at 10:34 A.M. A care plan indicated the adverse consequences to resident had diagnoses of major depressive antipsychotic medication use. disorder and anxiety. The intervention, with an Other residents that have the initiated date of 04/13/22, indicated staff were to potential to be affected have administer medications as ordered and to monitor been highlighted by: and document side effects and effectiveness. All residents who indicate use of antipsychotic have the potential to During an interview on 08/03/22 at 3:24 P.M., LPN be affected. All residents were (Licensed Practical Nurse) 2 indicated for reviewed for antipsychotic residents who received psychotropic medications medication use to ensure side the staff monitored for ASE and charted on the effect monitoring is in place. ETAR. The ETAR would have an order listing the Please see below for measures possible ASE to each psychotropic medication. implemented to prevent 2. The clinical record for Resident 15 was reviewed recurrence. on 08/03/22 at 1:31 P.M. A Quarterly MDS The measures or systemic assessment, dated 06/06/22, indicated the resident changes that have been put was cognitively intact. The diagnoses included, into place to ensure that the but were not limited to, Alzheimer's dementia, deficient practice does not non-Alzheimer's dementia, anxiety, and recur include: depression. The resident received antipsychotic, All nursing was in-serviced by the antianxiety, and antidepressant medications for Director of Nursing/ designee on seven of seven days of the assessment review the policies entitled "Antipsychotic period. Medication Use" related to side effect monitoring. In-service to IDT The resident's EMAR/ETAR for July 2022 was team to complete clinical review provided by the Administrator on 08/04/22 at on all psychotropic monitoring to 11:22 A.M., and contained the following orders: ensure compliance in accordance with the regulations. New - Abilify tablet (an antipsychotic medication), 5 psychotropic medication orders mg, 1 tablet by mouth one time a day for will be reviewed as part of the depression, with a start date of 07/12/22, and clinical morning meeting to ensure

that side effect monitoring orders

| DEPARTMENT                   | Γ OF HEALTH AND HU    | IMAN SERVICES                    |  |  |                                  | PRIN<br>FOI |         | 09/09/2022<br>ROVED |
|------------------------------|-----------------------|----------------------------------|--|--|----------------------------------|-------------|---------|---------------------|
|                              | R MEDICARE & MEDIC    |                                  |  |  |                                  |             | B NO. 0 |                     |
| STATEMEN                     | NT OF DEFICIENCIES    | X1) PROVIDER/SUPPLIER/CLIA       | (X2) M                                 | IULTIPLE CC  | ONSTRUCTION                      | (X3) DATE   | SURVE   | Y                   |
| AND PLAN                     | OF CORRECTION         | IDENTIFICATION NUMBER            | A. B                                   | UILDING  | 00                               | COMPLETED   |         |                     |
|                              |                       | 155525                           | B. W                                   | 'ING   |                                  | 08/04/2022  |         |                     |
| NAME OF PROVIDER OR SUPPLIER |                       |                                  |  | STREET ADDRESS, CITY, STATE, ZIP COD                                       |                                  |             |         |                     |
| SHADY NOOK CARE CENTER       |                       |                                  | 36 VALLEY DR<br>LAWRENCEBURG, IN 47025 |  |                                  |             |         |                     |
| (X4) ID                      | SUMMARY               | STATEMENT OF DEFICIENCIE         |  | ID   | PROVIDER'S PLAN OF CORRECTION    |             | -       | (X5)                |
| PREFIX                       | (EACH DEFICIE)        | NCY MUST BE PRECEDED BY FULL     |  | PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA |                                  | TE          | COMP    | PLETION             |
| TAG                          | REGULATORY O          | R LSC IDENTIFYING INFORMATION    |  | TAG  | DEFICIENCY)                      |             | D/      | ATE                 |
|                              | - Buspirone HCL t     | ablet (an antianxiety            |  |  | are initiated in accordance wit  | h           | İ       |                     |
|                              | medication), 15 mg    | g, give one tablet by mouth two  |  |  | the regulations.                 |             |         |                     |
|                              | times a day for any   | riety, with a start date of      |  |  | The corrective action taken t    | <u>o</u>    | İ       |                     |
|                              | 11/05/21.             |                                  |  |  | monitor performance to assu      | <u>ire</u>  |         |                     |
|                              |                       |                                  |  |  | compliance through quality       |             |         |                     |
|                              |                       | documentation and an order to    |  |  | assurance is:                    |             |         |                     |
|                              |                       | the antipsychotic and            |  |  | A performance improvement to     |             |         |                     |
|                              | antianxiety medica    |                                  |  |  | has been initiated that random   | ıly         |         |                     |
|                              |                       | ord for Resident 46 was reviewed |  |  | observes 5 residents with        |             |         |                     |
|                              |                       | 17 A.M. An Annual MDS            |  |  | antipsychotic use for            |             |         |                     |
|                              | •                     | 06/30/22, indicated the resident |  |  | documentation of side            |             |         |                     |
|                              |                       | tively impaired. The diagnoses   |  |  | effect/adverse consequence       |             | 1       |                     |
|                              | *                     | not limited to, dementia,        |  |  | monitoring. In addition to the o | daily       | 1       |                     |
|                              | 1                     | ssion. The resident received     |  |  | rounds and monitoring for a      |             | 1       |                     |
|                              | I antipsychotic anti- | anxiety, and antidepressant      |  |  | minimum of 3 months or until     |             | 1       |                     |

The EMAR/ETAR for July 2022 was provided by the Administrator on 08/04/22 at 2:29 P.M., and contained the following order:

medications for seven of seven days of the

assessment review period.

- Ativan tablet (an antianxiety medication), 0.5 mg, give 1 tablet by mouth two times a day for anxiety.

The record lacked documentation and an order to monitor for ASE to the antianxiety medication.

The Care plans were provided by the DON on 08/04/22 at 2:29 P.M. A care plan indicated the resident used psychotropic medications related to behavior management, depression, anxiety, agitation, and dementia. The interventions included, but were not limited to, administer medications as ordered and to monitor and document side effects and effectiveness, with an initiated date of 08/28/2020.

The current facility policy, titled "Antipsychotic Medication Use", with a revised date of December

substantial compliance is achieved, a Quality Assurance tool has been developed and implemented to monitor the compliance of monitoring for side effects, adverse consequences related to antipsychotic use; in accordance with regulation. This tool will be completed by the DON, or designee, weekly x3 weeks, monthly for 3 months, then quarterly for 2 quarters. Any identified issues will be immediately addressed. The outcomes will be reviewed through the facility Quality Assurance Program. Monitoring will continue as planned or will be increased by the Quality Assurance Committee if needed to obtain 100% compliance. Additional action will be taken by the Quality Assurance Committee if warranted based on the outcome of tools.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

5IVX11

Facility ID: 000304

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The date the systemic changes

If continuation sheet Page

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|------------------------------------|-----------------------------------|----------------------|
| CENTERS FOR MEDICARE & MEDICA      | AID SERVICES                      |                      |
| DEPARTMENT OF HEALTH AND HUN       | MAN SERVICES                      |                      |

|                            |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155525   | ì      | JILDING             | nstruction<br><u>00</u>   | (X3) DATE S<br>COMPL<br>08/04/ | ETED                       |
|----------------------------|---|---|--------|---------------------|---|--------------------------------|----------------------------|
|                            | ROVIDER OR SUPPLIER   |   |        | 36 VALI             | NDDRESS, CITY, STATE, ZIP COD<br>LEY DR<br>NCEBURG, IN 47025  |                                |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION  |        | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIAT<br>DEFICIENCY) | Œ                              | (X5)<br>COMPLETION<br>DATE |
| 1110                       | 2016, was provided 08/03/22 at 3:57 P.M "Nursing staff shaside effects and ad   | by the MDS coordinator on M. The policy indicated, ll monitor for and report any liverse consequences of ations to the Attending  |        |                     | will be completed: 8-26-22  |                                | 2.111                      |
| F 0761<br>SS=D<br>Bldg. 00 | Drugs and biologic<br>must be labeled in<br>accepted profession<br>the appropriate ac   | and Biologicals ag of Drugs and Biologicals cals used in the facility accordance with currently onal principles, and include cessory and cautionary ne expiration date when |        |                     |   |                                |                            |
|                            | §483.45(h)(1) In a<br>Federal laws, the f<br>and biologicals in l<br>under proper temp  | e of Drugs and Biologicals ccordance with State and facility must store all drugs locked compartments perature controls, and fized personnel to have                        |        |                     |   |                                |                            |
|                            | separately locked, compartments for listed in Schedule Drug Abuse Preve 1976 and other druexcept when the fapackage drug distribe quantity stored dose can be readily | -   |        |                     | Du oubspitting the condensati   |                                | 09/07/2022                 |
|                            |   | on, interview, and record failed to store medications   | F 07   | 761                 | By submitting the enclosed material, we are not admitting   | the                            | 08/26/2022                 |
| M CMS-2567(02              | 2-99) Previous Versions Ob  | solete Event ID:  | 5IVX11 | Facility I          | D: 000304 If continuation sh  | neet Pag                       | ge 9 of 20                 |

FORM CMS-2567(02-99) Previous Versions Obsolete

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                     | X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY             |             |  |                 |
|--|---------------------|--|-------------|--|-----------------|
| AND PLAN   | OF CORRECTION       | IDENTIFICATION NUMBER                                  | A. BUILDING | 00   | COMPLETED       |
|  |                     | 155525   | B. WING     |  | 08/04/2022      |
|  |                     | 1  | STREET      | ADDRESS, CITY, STATE, ZIP COD                                      |                 |
| NAME OF F  | PROVIDER OR SUPPLIE | R  |             | LEY DR   |                 |
| SHADY N  | NOOK CARE CENT      | ΓER  |             | ENCEBURG, IN 47025   |                 |
| (X4) ID  | Г                   |  | ID          | <u> </u>   | (V5)            |
| PREFIX   |                     | STATEMENT OF DEFICIENCIE  NCY MUST BE PRECEDED BY FULL | PREFIX      | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE | (X5) COMPLETION |
| TAG  | `                   | R LSC IDENTIFYING INFORMATION                          | TAG         | CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)                   | DATE            |
| 1710   |                     | ed to labeling medications in                          | 1710        | truth or accuracy of any speci                                     |                 |
|  | 1                   | s for 3 of 6 medication carts                          |             | findings or allegations. We res                                    |                 |
|  |                     | Medication Cart, C Hall                                |             | the right to contest the finding                                   |                 |
|  | `                   | nd D Hall Medication Cart)                             |             | allegations as part of any   |                 |
|  | ,                   | ,  |             | proceedings and submit these                                       |                 |
|  | Findings include:   |  |             | responses pursuant to our  |                 |
|  |                     |  |             | regulatory obligations. The fac                                    | cility          |
|  | 1. A medication ca  | art on the B hall was observed                         |             | requests that the plan of  | ,               |
|  | on 07/31/22 at 2:28 | P.M., with LPN (Licensed                               |             | correction be considered our                                       |                 |
|  |                     | and contained the following                            |             | allegation of compliance effect                                    | tive            |
|  | medications:        | 2  |             | 8-26-22 to the Recertification                                     |                 |
|  |                     |  |             | State Licensure Survey comp  | leted           |
|  | - A Levamire insul  | in bottle with an opened date of                       |             | on August 4, 2022. We  |                 |
|  |                     | lent 65, the bottle was less than                      |             | respectfully request a paper re                                    | eview           |
|  | half full.          |  |             | and will provide any additiona                                     |                 |
|  |                     |  |             | information requested.   |                 |
|  | - An Albuterol inha | aler had no opened date, for                           |             | F761.  |                 |
|  | Resident 55.        | -  |             | It is the practice of this facility                                | to              |
|  |                     |  |             | assure that all procedures and                                     |                 |
|  | The LPN indicated   | insulin was good for one                               |             | services are conducted in a  |                 |
|  | month after it was  | opened and medications should                          |             | manner that is in accordance                                       | with            |
|  | be labeled with an  | opened date.   |             | the department of health and                                       |                 |
|  |                     |  |             | human services centers for   |                 |
|  | 2. A medication can | rt on the C hall was observed                          |             | Medicare and Medicaid service                                      | es.             |
|  | on 07/31/22 at 2:42 | P.M., with RN 5, and contained                         |             | The Corrective Action taken  | <u>for</u>      |
|  | the following medi- | cations:   |             | those residents found to be  |                 |
|  |                     |  |             | affected by the deficient  |                 |
|  |                     | bottle with an opened date of                          |             | practice include:  |                 |
|  |                     | lent 1, the bottle was less than                       |             | It is the policy of this facility to                               |                 |
|  | 1/4 full.           |  |             | ensure that medications are  |                 |
|  |                     |  |             | stored in a safe, secure, and                                      |                 |
|  |                     | aler had no open date for                              |             | orderly manner in accordance                                       |                 |
|  | Resident 7.         |  |             | federal and state regulations a                                    |                 |
|  |                     |  |             | facility policies. Medication ca                                   |                 |
|  |                     | nsulin was good for 30 days                            |             | audited and all medications no                                     |                 |
|  | _                   | edications should have had an                          |             | labeled with open date or exp                                      |                 |
|  | opened date on the  | m.   |             | were removed. Residents hav  |                 |
|  |                     |  |             | experienced negative outcom  |                 |
|  | 3. A medication car | rt on the D hall was observed                          |             | because of the alleged deficie                                     | nt              |

on 07/31/22 at 2:50 P.M., with QMA (Qualified

practice. Medications to be

09/09/2022 PRINTED: DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 08/04/2022 155525 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 36 VALLEY DR SHADY NOOK CARE CENTER LAWRENCEBURG, IN 47025 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Medication Aide) 6, and contained the following monitored for safe and secure medications: storage. Other residents that have the - An Albuterol inhaler with no opened date for potential to be affected have Resident 27. been highlighted by: All residents who receive - Levamir insulin with a label that indicated it was medication have the potential to to be discarded after 07/21/22, was still in the be affected. Please see below for drawer for Resident 20. measures implemented to prevent recurrence. The OMA indicated she did not administer insulin The measures or systemic to residents but she believed it was good for 30 changes that have been put days after it was opened. The medications should into place to ensure that the have had an opened date. deficient practice does not recur include: The current Medication Storage Policy, with a All nursing was in-serviced by the reviewed date of September 12, 2014, was Director of Nursing/ designee on provided by the DON on 08/04/22 at 10:34 A.M.

The current Medication Storage Policy, with a reviewed date of September 12, 2014, was provided by the DON on 08/04/22 at 10:34 A.M. The policy indicated, "...Medications are to be stored in a safe, secure, and orderly manner in accordance with federal and state regulations and facility policies..."

3.1-25(j) 3.1-25(o) the policies entitled "Medication Storage," ensuring medications are labeled and stored appropriately. Pharmacy to complete medication cart audits monthly.

The corrective action taken to

# The corrective action taken to monitor performance to assure compliance through quality assurance is:

A performance improvement tool has been initiated that randomly audits medication and treatment carts. In addition to the daily rounds and monitoring for a minimum of 3 months or until substantial compliance is achieved, a Quality Assurance tool has been developed and implemented to monitor the compliance of medication storage related to labeling, removal of expired medications; ensuring

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 09/09/2022 FORM APPROVED OMB NO. 0938-039

| CENTERSTOR       | MEDICARE & MEDIC  |  |                  |  | OMB NO. 0936-039              |  |  |
|------------------|---|--|------------------|--|-------------------------------|--|--|
| STATEMEN         | NT OF DEFICIENCIES  | X1) PROVIDER/SUPPLIER/CLIA   | (X2) MULTIPLE CO |  | (X3) DATE SURVEY              |  |  |
| AND PLAN         | OF CORRECTION   | IDENTIFICATION NUMBER  | A. BUILDING      | 00   | COMPLETED                     |  |  |
|                  |   | 155525   | B. WING          |  | 08/04/2022                    |  |  |
|                  | PROVIDER OR SUPPLIER  |  | 36 VAL           | ADDRESS, CITY, STATE, ZIP COD<br>LEY DR<br>ENCEBURG, IN 47025  |                               |  |  |
| (X4) ID          | SUMMARY   | STATEMENT OF DEFICIENCIE   | ID               | PROVIDER'S PLAN OF CORRECTION  | (X5)                          |  |  |
| PREFIX           | (EACH DEFICIEN  | CY MUST BE PRECEDED BY FULL  | PREFIX           | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA   | COMPLETION                    |  |  |
| TAG              | REGULATORY OR   | LSC IDENTIFYING INFORMATION  | TAG              | DEFICIENCY)  | DATE                          |  |  |
| F 0812           | 483.60(i)(1)(2)   |  |                  | safe, secure storage. This tool be completed by the DON, or designee, weekly x3 weeks, monthly for 3 months, then quarterly for 2 quarters. Any identified issues will be immediately addressed. The outcomes will be reviewed throthe facility Quality Assurance Program. Monitoring will continus planned or will be increased the Quality Assurance Commit if needed to obtain 100% compliance. Additional action be taken by the Quality Assurance Committee if warrabased on the outcome of tools The date the systemic change will be completed: 8-26-22 | ough nue d by ttee will anted |  |  |
| SS=E<br>Bldg. 00 | Food<br>Procurement,Store   | e/Prepare/Serve-Sanitary   |                  |  |                               |  |  |
|                  | The facility must -   | afety requirements.  |                  |  |                               |  |  |
|                  | approved or consi<br>federal, state or lo<br>(i) This may include<br>directly from local<br>applicable State a<br>regulations.<br>(ii) This provision<br>facilities from usin<br>gardens, subject t | le food items obtained producers, subject to nd local laws or does not prohibit or prevent g produce grown in facility |                  |  |                               |  |  |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

(iii) This provision does not preclude residents from consuming foods not procured by the

5IVX11

Facility ID: 000304

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If continuation sheet Page 12 of 20

| STATEMENT OF DEFICIENCIES |                                  | X1) PROVIDER/SUPPLIER/CLIA         | (X2) MULTIPLE CONSTRUCTION |          | ONSTRUCTION   | (X3) DATE SURVEY                      |            |  |
|---------------------------|----------------------------------|------------------------------------|----------------------------|----------|---|---------------------------------------|------------|--|
| AND PLAN                  | OF CORRECTION                    | IDENTIFICATION NUMBER              | A. B                       | UILDING  | 00  | COMPL                                 | ETED       |  |
|                           |                                  | 155525                             | B. W                       | B. WING  |   |                                       | 08/04/2022 |  |
|                           |                                  |                                    | -                          | STREET A | ADDRESS, CITY, STATE, ZIP COD   |                                       |            |  |
| NAME OF F                 | PROVIDER OR SUPPLIER             | 8                                  |                            |          | LEY DR  |                                       |            |  |
|                           | NOOK CARE CENT                   | ER                                 |                            | LAWRE    | ENCEBURG, IN 47025  |                                       |            |  |
| (X4) ID                   | SUMMARY STATEMENT OF DEFICIENCIE |                                    |                            | ID       | PROVIDER'S PLAN OF CORRECTION   |                                       | (X5)       |  |
| PREFIX                    | ·                                | ICY MUST BE PRECEDED BY FULL       |                            | PREFIX   | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | ATE                                   | COMPLETION |  |
| TAG                       |                                  | R LSC IDENTIFYING INFORMATION      |                            | TAG      | DETERMET)   |                                       | DATE       |  |
|                           | facility.                        |                                    |                            |          |   |                                       |            |  |
|                           | 8483 60(i)(2) - Sto              | ore, prepare, distribute and       |                            |          |   |                                       |            |  |
|                           | - ',',',                         | ordance with professional          |                            |          |   |                                       |            |  |
|                           | standards for food               | •                                  |                            |          |   |                                       |            |  |
|                           |                                  | on and interview, the facility     | F 0                        | 812      | By submitting the enclosed  |                                       | 08/26/2022 |  |
|                           |                                  | s in a sanitary manner related     | 1 0                        | 012      | material, we are not admitting  | the                                   | 00,20,2022 |  |
|                           |                                  | en soup and tenders) and           |                            |          | truth or accuracy of any speci  |                                       |            |  |
|                           |                                  | ons, mozzarella cheese) foods      |                            |          | findings or allegations. We res   |                                       |            |  |
|                           | during 1 of 3 kitche             |                                    |                            |          | the right to contest the finding  |                                       |            |  |
|                           |                                  |                                    |                            |          | allegations as part of any  | _ 0.                                  |            |  |
|                           | Findings include:                |                                    |                            |          | proceedings and submit these  |                                       |            |  |
|                           | <b>8</b>                         |                                    |                            |          | responses pursuant to our   |                                       |            |  |
|                           | During the initial to            | our of the kitchen with the        |                            |          | regulatory obligations. The fac   | cility                                |            |  |
|                           | 1                                | n 07/31/22 at 2:25 P.M., the       |                            |          | requests that the plan of   | Jy                                    |            |  |
|                           | following was obse               |                                    |                            |          | correction be considered our  |                                       |            |  |
|                           |                                  |                                    |                            |          | allegation of compliance effect   | tive                                  |            |  |
|                           | The large, walk-in r             | refrigerator contained the         |                            |          | 8-26-22 to the Recertification  |                                       |            |  |
|                           | following items:                 | 5                                  |                            |          | State Licensure Survey comp   |                                       |            |  |
|                           |                                  |                                    |                            |          | on August 4, 2022. We   |                                       |            |  |
|                           | - 5 single serving ca            | artons of fat free skim milk with  |                            |          | respectfully request a paper re   | eview                                 |            |  |
|                           | an expired on date of            |                                    |                            |          | and will provide any additiona  | · · · · · · · · · · · · · · · · · · · |            |  |
|                           | 1                                |                                    |                            |          | information requested.  |                                       |            |  |
|                           | - A gallon sized cor             | ntainer 1/3 filled with mozzarella |                            |          | F812.   |                                       |            |  |
|                           |                                  | ared on label dated 07/12/22.      |                            |          | It is the practice of this facility   | to                                    |            |  |
|                           |                                  |                                    |                            |          | assure that all procedures and  |                                       |            |  |
|                           | The Kitchen Manag                | ger indicated the expired milk     |                            |          | services are conducted in a   |                                       |            |  |
|                           |                                  | iscarded. The cheese was           |                            |          | manner that are in accordance   | е                                     |            |  |
|                           |                                  | s after it was opened, and it      |                            |          | with department of health and   |                                       |            |  |
|                           | should be discarded              | -                                  |                            |          | human services centers for  |                                       |            |  |
|                           |                                  |                                    |                            |          | Medicare and Medicaid service   | es.                                   |            |  |
|                           | During a random in               | terview on 07/31/22 at 3:33        |                            |          | The Corrective Action taken   | for                                   |            |  |
|                           | P.M., Resident 29 in             | ndicated she recently received     |                            |          | those residents found to be   |                                       |            |  |
|                           | spoiled milk with h              | er meal. The milk tasted bad; it   |                            |          | affected by the deficient   |                                       |            |  |
|                           | had happened a cou               | ple of times. The milk was         |                            |          | practice include:   |                                       |            |  |
|                           | good today.                      |                                    |                            |          | It is the policy of this facility to  | )                                     |            |  |
|                           |                                  |                                    |                            |          | ensure that food is received a  |                                       |            |  |
|                           | The small refrigerat             | tor contained the following        |                            |          | stored in a manner that compl   | lies                                  |            |  |
|                           | items:                           |                                    |                            |          | with safe food handling praction  |                                       |            |  |
|                           |                                  |                                    |                            |          | all foods stored in the refrigera   |                                       |            |  |

09/09/2022 PRINTED: FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 08/04/2022 155525 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 36 VALLEY DR SHADY NOOK CARE CENTER LAWRENCEBURG, IN 47025 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE - A gallon sized container full of chicken noodle or freezer will be covered, labeled, soup that was not labeled with a prepared on or and dated with use by date. Full use by date. auditing of food storage areas completed, and items discarded if - A gallon sized container full of cooked chicken not in compliance with policy. All tenders that was not labeled with a prepared on or food items with appropriate use by use by date. date. Residents have not experienced negative outcome The kitchen manager indicated she prepared the because of the alleged deficient items in the small refrigerator last night but had practice. not labeled them appropriately. Other residents that have the potential to be affected have The current facility policy, titled "Food Receiving been highlighted by: and Storage", with a revision date of July 2014, All residents who consume food at was provided by the Administrator on 08/04/22 at the facility have the potential to be 11:16 A.M. The policy indicated, "...Foods shall affected. be received and stored in a manner that complies The measures or systemic with safe food handling practices...All foods changes that have been put stored in the refrigerator or freezer will be covered, into place to ensure that the labeled, and dated ("use by" date)..." deficient practice does not recur include: 3.1-21(i)(2)All staff was in-serviced by the 3.1-21(i)(3)HFA/ designee on the policies entitled "Food Receiving and Storage". to ensure food storage, food received and labeling of food items with use by date. See below for monitoring systems for ongoing compliance. The corrective action taken to monitor performance to assure compliance through quality assurance is: In addition to the daily rounds and monitoring for a minimum of 3 months or until substantial compliance is achieved, a Quality Assurance tool has been developed and implemented to monitor the compliance of food

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| CENTERS FO   | R MEDICARE & MEDIC   |  |  |                     |   | OM   | IB NO. 0938-039      |
|--|--|--|--|---------------------|---|--|----------------------|
| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155525 |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING                                   |  |                     | (X3) DATE SURVEY COMPLETED 08/04/2022   |  |                      |
|  | PROVIDER OR SUPPLIER   |  |  | 36 VAL              | ADDRESS, CITY, STATE, ZIP COD<br>LEY DR<br>ENCEBURG, IN 47025   |  |                      |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)   | ATE  | (X5) COMPLETION DATE |
|  |  |  |  |                     | storage related to labeling; for being received properly. This will be completed by the Administrator/Food services director, or designee, weekly weeks, monthly for 3 months, quarterly for 2 quarters. Any identified issues will be immediately addressed. The outcomes will be reviewed that the facility Quality Assurance Program. Monitoring will contias planned or will be increased the Quality Assurance Commif needed to obtain 100% compliance. Additional action be taken by the Quality Assurance Committee if warrabased on the outcome of tools. The date the systemic change will be completed: 8-26-22 | tool  x3 then  rough inue ed by ittee  will ented s. |                      |
| F 0880<br>SS=D<br>Bldg. 00   | infection preventic designed to provide comfortable environthe development a communicable dis §483.80(a) Infection program.  The facility must exprevention and communicable dis section in the facility must exprevention and communicable distributions. | on & Control   |  |                     |   |  |                      |

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|   | OF CORRECTION  | IDENTIFICATION NUMBER  155525  | A. BUILDING B. WING | 00   | COM      | PLETED<br>04/2022          |  |  |  |
|---|--|--|---------------------|--|----------|----------------------------|--|--|--|
| NAME OF PROVIDER OR SUPPLIER SHADY NOOK CARE CENTER |  |  | 36 VAL              | STREET ADDRESS, CITY, STATE, ZIP COD  36 VALLEY DR  LAWRENCEBURG, IN 47025                       |          |                            |  |  |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION SI<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | HOULD BE | (X5)<br>COMPLETION<br>DATE |  |  |  |
|   | identifying, reporting controlling infection diseases for all responsive services under a conducted according following accepted:  §483.80(a)(2) Writted and procedures for include, but are not include, but are not infections before the persons in the faction of infections before the persons in the faction of infections; (iii) When and to work communicable dispersons in the faction of infections; (iv) When and how for a resident; included in the least restrictive under the circumstructure of the infection of infections in the least restrictive under the circumstructure of the infection of infections in the least restrictive under the circumstructure of the infection of infection of infections of the infection of | ing to §483.70(e) and inational standards; iten standards, policies, or the program, which must be limited to: veillance designed to communicable diseases or they can spread to other dility; thom possible incidents of lease or infections should transmission-based followed to prevent spread designed to: duration of the isolation, the infectious agent or and that the isolation should be a possible for the resident trances. The infectious under which the facility |                     |  |          |                            |  |  |  |

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|   |   | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155525   | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING                                 | onstruction<br><u>00</u>  | (X3) DATE SURVEY COMPLETED 08/04/2022           |  |  |  |
|---|---|---|--|---|---|--|--|--|
| NAME OF PROVIDER OR SUPPLIER SHADY NOOK CARE CENTER |   |   | STREET ADDRESS, CITY, STATE, ZIP COD  36 VALLEY DR  LAWRENCEBURG, IN 47025 |   |   |  |  |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)   | (X5) COMPLETION DATE                            |  |  |  |
|   | incidents identified and the corrective facility.  §483.80(e) Linear Personnel must he transport linear so of infection.  §483.80(f) Annual The facility will colits IPCP and update necessary.  Based on observative review, the facility infection control gray urinary catheters for infection control. (Findings include:  1. On 07/31/22 at 5 observed in her room The resident's bed of floormats on either urinary catheter drawing tight side of the bed touching the floor in the bed.  On 08/01/22 at 10:10 observed in bed. The bag was hanging on bottom of the bag we between the bed and the second tight in the bed. | review. Induct an annual review of ate their program, as Indicine related to indwelling ar 2 of 3 residents reviewed for Residents 70 and 175)  124 P.M., Resident 70 was are lying in bed on her left side. It was in a low position, with side of the bed. The resident's inage bag was an between the floor mat and Is A.M., the resident was are resident's catheter drainage at the right side of the bed. The was resting on the floor in | F 0880   | By submitting the enclosed material, we are not admitting truth or accuracy of any specifindings or allegations. We resthe right to contest the finding allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The fact requests that the plan of correction be considered our allegation of compliance effect 8-26-22 to the Recertification as State Licensure Survey compliance on August 4, 2022. We respectfully request a paper reand will provide any additional information requested.  F880.  It is the practice of this facility assure that all procedures and services are conducted in a manner that is in accordance infection control guidelines. | fic serve s or scility  tive and leted seview I |  |  |  |

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observed in bed. The resident was lying on her

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The corrective action taken for

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| STATEMENT OF DEFICIENCIES    |                       | X1) PROVIDER/SUPPLIER/CLIA        | X2) MULTIPLE CONSTRUCTION |           | ONSTRUCTION  | (X3) DATE SURVEY |            |
|------------------------------|-----------------------|-----------------------------------|---------------------------|-----------|--|------------------|------------|
| AND PLAN                     | OF CORRECTION         | IDENTIFICATION NUMBER             | a. building <u>00</u>     |           | COMPLETED  |                  |            |
|                              |                       | 155525                            | B. WING                   |           | 08/04/   | /2022            |            |
|                              |                       |                                   |                           | STREET /  | ADDRESS, CITY, STATE, ZIP COD  |                  |            |
| NAME OF PROVIDER OR SUPPLIER |                       |                                   |                           |           | LEY DR   |                  |            |
| SHADY NOOK CARE CENTER       |                       |                                   |                           |           | ENCEBURG, IN 47025   |                  |            |
|                              | TOOK OF WE OUT        |                                   |                           | L/ \VVI\L |  |                  |            |
| (X4) ID                      | SUMMARY               | STATEMENT OF DEFICIENCIE          |                           | ID        | PROVIDER'S PLAN OF CORRECTION  |                  | (X5)       |
| PREFIX                       | · ·                   | CY MUST BE PRECEDED BY FULL       |                           | PREFIX    | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | TE               | COMPLETION |
| TAG                          |                       | R LSC IDENTIFYING INFORMATION     | 1                         | TAG       | DEFICIENCY)  |                  | DATE       |
|                              | 1 -                   | was in a low position and the     |                           |           | those residents found to be  |                  |            |
|                              | _                     | nging from the bed in such a      |                           |           | affected by the deficient  |                  |            |
|                              | 1 -                   | drainage bag was lying flat on    |                           |           | practice include:  |                  |            |
|                              | 1                     | llow urine was observed in the    |                           |           | Resident 70, 175 are receiving   | 9                |            |
|                              | bag and tubing.       |                                   |                           |           | services in accordance with  |                  |            |
|                              | <b>.</b>              | 00/00/00 + 0.05 + 14 + 1724       |                           |           | infection control standards.   |                  |            |
|                              | _                     | on 08/02/22 at 9:35 A.M., LPN     |                           |           | Catheters were appropriately   |                  |            |
|                              | `                     | Nurse) 6 indicated catheter       |                           |           | secured and positioned to ens  |                  |            |
|                              |                       | ould not touch the floor. This    |                           |           | catheter bag and tubing were   |                  |            |
|                              |                       | w bed and the drainage bag        |                           |           | the floor. Resident 70, 175 have                                       | ve               |            |
|                              |                       | wrong spot on the bed. LPN 6      |                           |           | not experienced negative   |                  |            |
|                              |                       | ag, but it was still touching the |                           |           | outcomes because of the alleg  | gea              |            |
|                              |                       | rieved a plastic basin, placed    |                           |           | deficient practice.  |                  |            |
|                              |                       | or, and placed the drainage       |                           |           | Other Residents that have th   |                  |            |
|                              | _                     | to keep it from touching the      |                           |           | potential to be affected have  |                  |            |
|                              | floor.                |                                   |                           |           | been identified by:  |                  |            |
|                              | 0.00/02/22 4.2.52     | NDM 41 - 11 4                     |                           |           | All residents who have an  |                  |            |
|                              |                       | 2 P.M., the resident was          |                           |           | indwelling catheter have the   |                  |            |
|                              |                       | te bed was in a low position      |                           |           | potential to be impacted by thi  |                  |            |
|                              |                       | inage bag was lying on floor      |                           |           | deficient practice. All residents                                      |                  |            |
|                              | next to the plastic b | asın.                             |                           |           | with catheters have been revie   | ewea             |            |
|                              | The medidant's clinic | cal record was reviewed on        |                           |           | to ensure proper indwelling  |                  |            |
|                              |                       | M. A Quarterly MDS (Minimum       |                           |           | catheter infection control   |                  |            |
|                              |                       | nt, dated 07/12/22, indicated     |                           |           | guidelines are being followed.   |                  |            |
|                              | · ·                   | verely cognitively impaired.      |                           |           | The measures or systemic   |                  |            |
|                              |                       | ided, but were not limited to,    |                           |           | changes that have been put   |                  |            |
|                              | _                     | tension, neurogenic bladder,      |                           |           | into place to ensure that the  |                  |            |
|                              | 1                     | y, and depression. The            |                           |           | deficient practice does not recur include:                             |                  |            |
|                              |                       | tensive staff assistance for all  |                           |           | All nursing was in-serviced on   | the              |            |
|                              | _                     | f Daily Living). The resident     |                           |           | Catheter policy related to   | uic              |            |
|                              | had an indwelling u   |                                   |                           |           | indwelling catheter infection  |                  |            |
|                              | I -                   | :45 P.M., Resident 175 was        |                           |           | control guidelines. The DON,   | or               |            |
|                              |                       | m laying in bed. The resident's   |                           |           | designee, will provide daily vis                                       |                  |            |
|                              |                       | osition. The resident's urinary   |                           |           | rounds to assure that infection  |                  |            |
|                              | _                     | ag was hanging on the left side   |                           |           | control measures are in place.   |                  |            |
|                              | 1                     | neter tubing and drainage bag     |                           |           | The corrective action taken t  |                  |            |
|                              |                       | loor. The bag was bent with       |                           |           | monitor performance to assu  |                  |            |
|                              | 1                     | ag laying on the floor.           |                           |           | compliance through quality   | 41 <del>C</del>  |            |
|                              | two menes of the ba   | ag my mg on the noor.             |                           |           | assurance is:  |                  |            |
|                              | Ī                     |                                   | 1                         |           | a33u1a1100 13.   |                  | I          |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155525 |  | A. BU   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING                           |                     | (X3) DATE SURVEY COMPLETED 08/04/2022   |   |                            |  |
|---|--|---|--|---------------------|---|---|----------------------------|--|
| NAME OF PROVIDER OR SUPPLIER SHADY NOOK CARE CENTER   |  |   | STREET ADDRESS, CITY, STATE, ZIP COD  36 VALLEY DR  LAWRENCEBURG, IN 47025 |                     |   |   |                            |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION   |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA'<br>DEFICIENCY)   | ΓE  | (X5)<br>COMPLETION<br>DATE |  |
| IAU   | On 07/31/22 at 5:11 observed in her roo bed was in a low portion catheter drainage begins of the bed. The catheter touching the fitwo inches of the bed. On 08/01/22 at 09:20 observed sitting up breakfast. The resist was hanging on the catheter tubing and floor. The bag was on the floor.  On 08/02/22 at 10:40 observed in bed. The and the catheter bag side of the bed, both were touching the floor.  On 08/02/22 at 2:50 observed in bed. The resident's cathefrom the right side and drainage bag who bag was bent with the floor.  The resident's clinic 08/02/22 at 10:10 A assessment, dated 0 was severely cognit included, but were hypertension, pneur resident required experience of the side of the president required experience of the side | I P.M., the resident was m laying in bed. The resident's osition. The resident's urinary ag was hanging on the left side neter tubing and drainage bag loor. The bag was bent with ag laying on the floor.  31 A.M., the resident was in bed being assisted with dent's catheter drainage bag left side of the bed. The drainage bag were resting on bent with half of the bag laying  42 A.M., the resident was he bed was in a low position g was hanging from the left the tubing and drainage bag |  | IAU                 | In addition to the daily rounds monitoring for a minimum of 3 months or until substantial compliance is achieved, a Qua Assurance tool has been developed and implemented to monitor the compliance of infection control related to indwelling catheters; ensuring catheters are secured properly and off the floor. This tool will be completed by the DON, or designee, weekly x3 weeks, monthly for 3 months, then quarterly for 2 quarters. Any identified issues will be immediately addressed. The outcomes will be reviewed through the facility Quality Assurance. Program. Monitoring will continue as planned or will be increased the Quality Assurance Committed in the facility Assurance Committed in the date the systemic change will be completed: 8-26-22 | ality  o  ough  nue d by ttee  will  nted | DATE                       |  |

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|   |   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER<br>155525                     | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING |                     | (X3) DATE SURVEY<br>COMPLETED<br>08/04/2022   |    |                            |
|---|---|---|--|---------------------|---|----|----------------------------|
| NAME OF PROVIDER OR SUPPLIER SHADY NOOK CARE CENTER |   |   |  | 36 VALI             | ADDRESS, CITY, STATE, ZIP COD<br>LEY DR<br>ENCEBURG, IN 47025   |    |                            |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | (X5)<br>COMPLETION<br>DATE |
|   | During an interview on 08/03/22 at 12:55 P.M., the MDS coordinator indicated catheter bags and tubing should not touch the floor.  The current facility policy, titled "Catheter Care, Urinary", with a revised date of September 2014, was provided by the Administrator on 08/04/22 at 11:16 A.M. The policy indicated, "The purpose of this procedure is to prevent urinary tract infectionsBe sure the catheter tubing and drainage bag are kept off the floor" |   |  |                     |   |    |                            |

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