STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155525	A. BUILDING 00 B. WING	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SHADY NOOK CARE CENTER	36 VALLEY DR LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: July 31, August 1, 2, 3, and 4, 2022. Facility number: 000304 Provider number: 155525 AIM number: 100266810 Census Bed Type: SNF/NF: 79 Total: 79 Census Payor Type: Medicare: 7 Medicaid: 47 Other: 25 Total: 79 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 9, 2022.	F 0000		
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight			

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

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	range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, interview, and record review, the facility failed to provide nutritional supplements for a resident with poor meal intake for 1 of 2 residents reviewed for nutrition. (Resident 61) Findings include: During an observation and interview on 08/01/22 at 9:19 A.M., Resident 61 was sitting in her room in a recliner. She was admitted in February. The food was a shame. One day she got a tossed salad and the greens were wilted. She sent it back. There were days where she consumed the equivalent of one meal. She indicated she had lost 12 pounds in the last month. The meal intake records for the previous 30 days were provided by the DON (Director of Nursing) on 08/03/22 at 2:20 P.M. The record indicated the resident had eaten 0-25% on the following days for the following meals: - 07/05/22, breakfast and lunch, - 07/06/22, supper, - 07/07/22, breakfast, lunch, and supper, - 07/08/22, breakfast and lunch, - 07/09/22, breakfast and supper, - 07/10/22, lunch,	F 0692	By submitting the enclosed material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective 8-26-22 to the Recertification and State Licensure Survey completed on August 4, 2022. We respectfully request a paper review and will provide any additional information requested. **F692.** It is the practice of this facility to 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 Corrective Action taken for those residents found to be affected by the deficient**	08/26/2022

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	- 07/12/22, lunch, - 07/13/22, breakfast, lunch, and supper, - 07/15/22, breakfast and lunch, - 0716/22, breakfast, - 07/21/22, breakfast, lunch, and supper, - 0722/22, supper, - 07/25/22, breakfast, - 07/26/22, breakfast, - 07/27/22, breakfast and supper, - 07/28/22, breakfast and lunch, - 07/30/22, breakfast and supper, and - 07/31/22, breakfast and lunch. The Weights and Vitals Summary record was provided by the DON on 08/03/22 at 2:20 P.M. The record indicated the resident weighed 202.8 pounds on 07/06/22, and 190 pounds on 07/20/22. The current active physician's orders were provided by the DON on 08/03/22 at 2:20 P.M. An order, with a start date of 02/23/22, indicated the staff may provide a nutritional supplement as needed if meal intake was less than 50%. The EMAR/ETAR for July 2022, was provided by the DON on 08/03/22 at 2:20 P.M. The record lacked documentation the resident had an order for a nutritional supplement as needed if meal intake was less than 50%. The Care Plan was provided by the DON on 08/03/22 at 2:20 P.M., and indicated the resident was at risk for alterations in nutrition. The Progress Notes for July 2022 were provided by the DON on 08/03/22 at 2:20 P.M. The record lacked any notes in July indicating the resident had been offered a nutritional supplement on the days and times she had consumed less than 50% of her meals.		**practice include:** It is the policy of this facility to ensure residents are reviewed for poor meal intake and ordered supplements as advised. Resident, 61, has not experienced negative outcome because of the alleged deficient practice. Resident receives appropriate supplementation provided by qualified staff, supplementation documentation present. **Other residents that have the potential to be affected have been highlighted by:** All residents who have poor meal intake have potential to be affected. Please see below for measures implemented to prevent reoccurrence. **The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur include:** All nursing was in-serviced by the Director of Nursing/ designee on the policies entitled “Food and Nutrition Services” related to meal intake and receiving supplements as ordered. In-service has been conducted with the IDT team related to meal intake and providing appropriate supplements. Meal intakes will be reviewed as part of the clinical morning meeting to ensure that supplements are provided to residents per physician orders. **The corrective action taken to**	

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	The clinical record was reviewed on 08/04/22 at 11:33 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 07/13/22, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, dementia and muscle weakness. During an interview on 08/03/22 at 1:15 P.M., LPN (Licensed Practical Nurse) 2 indicated nutritional supplements would be on the EMAR/ETAR. It would have been a PRN (as needed) order. During an interview on 08/03/22 at 1:20 P.M., the DON indicated the order for the nutritional supplement if meal intake was less than 50% should have been a PRN order on the EMAR/ETAR. The current Food and Nutrition Services policy, with a revised date of 10/2017, was provided by the Administrator on 08/04/22 at 3:33 P.M. The policy indicated, "...nutritional supplements will be provided within 45 minutes of either resident request or scheduled meal time..." 3.1-46(a)(2)		**monitor performance to assure compliance through quality assurance is:** A performance improvement tool has been initiated that observes residents with poor meal intake have been offered a supplement. 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 meal intake and receiving supplements as ordered. 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. **The date the systemic changes will be completed:** 8-26-22	
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any			

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	drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.			

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	§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on record review and interview, the facility failed to monitor residents who received psychotropic medications for Adverse Side Effects for 3 of 5 residents reviewed for unnecessary medications. (Resident 48, 15, and 46) Findings include: 1. The clinical record for Resident 48 was reviewed on 08/03/22 at 2:46 P.M. An Annual MDS (Minimum Data Set) assessment, dated 07/01/22, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, heart failure, anxiety, and depression. The resident had received antidepressant and antianxiety medications for seven of the seven days of the assessment review period. The EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) for July and August 2022, was provided by the MDS Coordinator on 08/03/22 at 3:57 P.M., and contained the following orders: - Xanax Tablet 0.5 mg (milligram), 1 tablet by mouth two times a day for anxiety, with an active date of 04/26/22, - Venlafaxine 150 mg by mouth one time a day related to depressive episodes, with an active date of 06/17/22, and - Wellbutrin 100 mg, 1 tablet by mouth one time a	F 0758	By submitting the enclosed material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective 8-26-22 to the Recertification and State Licensure Survey completed on August 4, 2022. We respectfully request a paper review and will provide any additional information requested. **F758.** It is the practice of this facility to 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 Corrective Action taken for those residents found to be affected by the deficient practice include:** It is the policy of this facility to ensure residents are monitored for and report any side effects and adverse consequences of antipsychotic medications to the	08/26/2022

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	day for depression, with an active date of 03/03/22. The records lacked documentation and an order to monitor for ASE (Adverse Side Effects) to the antidepressants and antianxiety medications. The Care plans were provided by the DON on 08/04/22 at 10:34 A.M. A care plan indicated the resident had diagnoses of major depressive disorder and anxiety. The intervention, with an initiated date of 04/13/22, indicated staff were to administer medications as ordered and to monitor and document side effects and effectiveness. During an interview on 08/03/22 at 3:24 P.M., LPN (Licensed Practical Nurse) 2 indicated for residents who received psychotropic medications the staff monitored for ASE and charted on the ETAR. The ETAR would have an order listing the possible ASE to each psychotropic medication. 2. The clinical record for Resident 15 was reviewed on 08/03/22 at 1:31 P.M. A Quarterly MDS assessment, dated 06/06/22, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, Alzheimer's dementia, non-Alzheimer's dementia, anxiety, and depression. The resident received antipsychotic, antianxiety, and antidepressant medications for seven of seven days of the assessment review period. The resident's EMAR/ETAR for July 2022 was provided by the Administrator on 08/04/22 at 11:22 A.M., and contained the following orders: - Abilify tablet (an antipsychotic medication), 5 mg, 1 tablet by mouth one time a day for depression, with a start date of 07/12/22, and		physician. Monitoring orders implemented for side effect and negative consequence monitoring. Resident(s) 48, 15 and 46 have not experienced negative outcomes because of the alleged deficient practice. Residents to be monitored for side effects and adverse consequences to antipsychotic medication use. **Other residents that have the potential to be affected have been highlighted by:** All residents who indicate use of antipsychotic have the potential to be affected. All residents were reviewed for antipsychotic medication use to ensure side effect monitoring is in place. Please see below for measures implemented to prevent recurrence. **The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur include:** All nursing was in-serviced by the Director of Nursing/ designee on the policies entitled “Antipsychotic Medication Use” related to side effect monitoring. In-service to IDT team to complete clinical review on all psychotropic monitoring to ensure compliance in accordance with the regulations. New psychotropic medication orders will be reviewed as part of the clinical morning meeting to ensure that side effect monitoring orders	

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	- Buspirone HCL tablet (an antianxiety medication), 15 mg, give one tablet by mouth two times a day for anxiety, with a start date of 11/05/21. The records lacked documentation and an order to monitor for ASE to the antipsychotic and antianxiety medications. 3. The clinical record for Resident 46 was reviewed on 08/03/22 at 10:17 A.M. An Annual MDS assessment, dated 06/30/22, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, dementia, anxiety, and depression. The resident received antipsychotic, antianxiety, and antidepressant medications for seven of seven days of the assessment review period. 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: - 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		are initiated in accordance with the regulations. **The corrective action taken to monitor performance to assure compliance through quality assurance is:** A performance improvement tool has been initiated that randomly observes 5 residents with antipsychotic use for documentation of side effect/adverse consequence monitoring. 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 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. **The date the systemic changes**	

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	2016, was provided by the MDS coordinator on 08/03/22 at 3:57 P.M. The policy indicated, "...Nursing staff shall monitor for and report any ...side effects and adverse consequences of antipsychotic medications to the Attending Physician..." 3.1-48(a)(3)		**will be completed:** 8-26-22	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to store medications	F 0761	By submitting the enclosed material, we are not admitting the	08/26/2022

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	appropriately related to labeling medications in the medication carts for 3 of 6 medication carts reviewed. (B Hall Medication Cart, C Hall Medication Cart, and D Hall Medication Cart) Findings include: 1. A medication cart on the B hall was observed on 07/31/22 at 2:28 P.M., with LPN (Licensed Practical Nurse) 3, and contained the following medications: - A Levamire insulin bottle with an opened date of 06/30/22, for Resident 65, the bottle was less than half full. - An Albuterol inhaler had no opened date, for Resident 55. The LPN indicated insulin was good for one month after it was opened and medications should be labeled with an opened date. 2. A medication cart on the C hall was observed on 07/31/22 at 2:42 P.M., with RN 5, and contained the following medications: - A Lantus insulin bottle with an opened date of 05/26/22, for Resident 1, the bottle was less than 1/4 full. - An Albuterol inhaler had no open date for Resident 7. The RN indicated insulin was good for 30 days once opened and medications should have had an opened date on them. 3. A medication cart on the D hall was observed on 07/31/22 at 2:50 P.M., with QMA (Qualified		truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective 8-26-22 to the Recertification and State Licensure Survey completed on August 4, 2022. We respectfully request a paper review and will provide any additional information requested. **F761.** It is the practice of this facility to assure that all procedures and services are conducted in a manner that is in accordance with the department of health and human services centers for Medicare and Medicaid services. **The Corrective Action taken for those residents found to be affected by the deficient practice include:** It is the policy of this facility to ensure that medications are stored in a safe, secure, and orderly manner in accordance with federal and state regulations and facility policies. Medication carts audited and all medications not labeled with open date or expired were removed. Residents have not experienced negative outcomes because of the alleged deficient practice. Medications to be	

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	Medication Aide) 6, and contained the following medications: - An Albuterol inhaler with no opened date for Resident 27. - Levamir insulin with a label that indicated it was to be discarded after 07/21/22, was still in the drawer for Resident 20. The QMA indicated she did not administer insulin to residents but she believed it was good for 30 days after it was opened. The medications should have had an opened date. 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)		monitored for safe and secure storage. **Other residents that have the potential to be affected have been highlighted by:** All residents who receive medication have the potential to be affected. Please see below for measures implemented to prevent recurrence. **The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur include:** All nursing was in-serviced by the Director of Nursing/ designee on the policies entitled “Medication Storage,” ensuring medications are labeled and stored appropriately. Pharmacy to complete medication cart audits monthly. **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	

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SHADY NOOK CARE CENTER	36 VALLEY DR LAWRENCEBURG, IN 47025

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			safe, secure storage. 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. **The date the systemic changes will be completed:** 8-26-22	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the			

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	155525	A. BUILDING 00 B. WING	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SHADY NOOK CARE CENTER	36 VALLEY DR LAWRENCEBURG, IN 47025

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	facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation and interview, the facility failed to store foods in a sanitary manner related to unlabeled (chicken soup and tenders) and outdated (milk cartons, mozzarella cheese) foods during 1 of 3 kitchen observations. Findings include: During the initial tour of the kitchen with the Kitchen Manager on 07/31/22 at 2:25 P.M., the following was observed: The large, walk-in refrigerator contained the following items: - 5 single serving cartons of fat free skim milk with an expired on date of 07/28/22. - A gallon sized container 1/3 filled with mozzarella cheese, with a prepared on label dated 07/12/22. The Kitchen Manager indicated the expired milk should have been discarded. The cheese was good for 5 to 7 days after it was opened, and it should be discarded. During a random interview on 07/31/22 at 3:33 P.M., Resident 29 indicated she recently received spoiled milk with her meal. The milk tasted bad; it had happened a couple of times. The milk was good today. The small refrigerator contained the following items:	F 0812	By submitting the enclosed material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective 8-26-22 to the Recertification and State Licensure Survey completed on August 4, 2022. We respectfully request a paper review and will provide any additional information requested. **F812.** It is the practice of this facility to 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 Corrective Action taken for those residents found to be affected by the deficient practice include:** It is the policy of this facility to ensure that food is received and stored in a manner that complies with safe food handling practices, all foods stored in the refrigerator	08/26/2022

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	- A gallon sized container full of chicken noodle soup that was not labeled with a prepared on or use by date. - A gallon sized container full of cooked chicken tenders that was not labeled with a prepared on or use by date. The kitchen manager indicated she prepared the items in the small refrigerator last night but had not labeled them appropriately. The current facility policy, titled "Food Receiving and Storage", with a revision date of July 2014, was provided by the Administrator on 08/04/22 at 11:16 A.M. The policy indicated, "...Foods shall be received and stored in a manner that complies with safe food handling practices...All foods stored in the refrigerator or freezer will be covered, labeled, and dated ("use by" date)..." 3.1-21(i)(2) 3.1-21(i)(3)		or freezer will be covered, labeled, and dated with use by date. Full auditing of food storage areas completed, and items discarded if not in compliance with policy. All food items with appropriate use by date. Residents have not experienced negative outcome because of the alleged deficient practice. **Other residents that have the potential to be affected have been highlighted by:** All residents who consume food at the facility have the potential to be affected. **The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur include:** All staff was in-serviced by the 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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			storage related to labeling; food being received properly. This tool will be completed by the Administrator/Food services director, 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. **The date the systemic changes will be completed:** 8-26-22	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:			

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	§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.			

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	§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview, and record review, the facility failed to follow appropriate infection control guidelines related to indwelling urinary catheters for 2 of 3 residents reviewed for infection control. (Residents 70 and 175) Findings include: 1. On 07/31/22 at 5:24 P.M., Resident 70 was observed in her room lying in bed on her left side. The resident's bed was in a low position, with floormats on either side of the bed. The resident's urinary catheter drainage bag was hanging on the right side of the bed. The drainage bag was touching the floor in between the floor mat and the bed. On 08/01/22 at 10:18 A.M., the resident was observed in bed. The resident's catheter drainage bag was hanging on the right side of the bed. The bottom of the bag was resting on the floor in between the bed and the floor mat. On 08/02/22 at 9:21 A.M., the resident was observed in bed. The resident was lying on her	F 0880	By submitting the enclosed material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective 8-26-22 to the Recertification and State Licensure Survey completed on August 4, 2022. We respectfully request a paper review and will provide any additional information requested. **F880.** It is the practice of this facility to assure that all procedures and services are conducted in a manner that is in accordance with infection control guidelines. **The corrective action taken for**	08/26/2022

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	right side. The bed was in a low position and the catheter bag was hanging from the bed in such a way that half of the drainage bag was lying flat on the floor. Bright yellow urine was observed in the bag and tubing. During an interview on 08/02/22 at 9:35 A.M., LPN (Licensed Practical Nurse) 6 indicated catheter bags and tubing should not touch the floor. This resident was in a low bed and the drainage bag was hanging in the wrong spot on the bed. LPN 6 tried to adjust the bag, but it was still touching the floor. The nurse retrieved a plastic basin, placed the basin on the floor, and placed the drainage bag inside the basin to keep it from touching the floor. On 08/02/22 at 2:52 P.M., the resident was observed in bed. The bed was in a low position and the catheter drainage bag was lying on floor next to the plastic basin. The resident's clinical record was reviewed on 08/04/22 at 9:36 AM. A Quarterly MDS (Minimum Data Set) assessment, dated 07/12/22, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, heart failure, hypertension, neurogenic bladder, malnutrition, anxiety, and depression. The resident required extensive staff assistance for all ADLs (Activities of Daily Living). The resident had an indwelling urinary catheter. 2. On 07/31/22 at 3:45 P.M., Resident 175 was observed in her room laying in bed. The resident's bed was in a low position. The resident's urinary catheter drainage bag was hanging on the left side of the bed. The catheter tubing and drainage bag were touching the floor. The bag was bent with two inches of the bag laying on the floor.		**those residents found to be affected by the deficient practice include:** Resident 70, 175 are receiving services in accordance with infection control standards. Catheters were appropriately secured and positioned to ensure catheter bag and tubing were off the floor. Resident 70, 175 have not experienced negative outcomes because of the alleged deficient practice. **Other Residents that have the potential to be affected have been identified by:** All residents who have an indwelling catheter have the potential to be impacted by this deficient practice. All residents with catheters have been reviewed to ensure proper indwelling catheter infection control guidelines are being followed. **The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur include:** All nursing was in-serviced on the Catheter policy related to indwelling catheter infection control guidelines. The DON, or designee, will provide daily visual rounds to assure that infection control measures are in place. **The corrective action taken to monitor performance to assure compliance through quality assurance is:**	

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	On 07/31/22 at 5:11 P.M., the resident was observed in her room laying in bed. The resident's bed was in a low position. The resident's urinary catheter drainage bag was hanging on the left side of the bed. The catheter tubing and drainage bag were touching the floor. The bag was bent with two inches of the bag laying on the floor. On 08/01/22 at 09:31 A.M., the resident was observed sitting up in bed being assisted with breakfast. The resident's catheter drainage bag was hanging on the left side of the bed. The catheter tubing and drainage bag were resting on floor. The bag was bent with half of the bag laying on the floor. On 08/02/22 at 10:42 A.M., the resident was observed in bed. The bed was in a low position and the catheter bag was hanging from the left side of the bed, both the tubing and drainage bag were touching the floor. On 08/02/22 at 2:56 P.M., the resident was observed in bed. The bed was in low position. The resident's catheter drainage bag was hanging from the right side of the bed. The catheter tubing and drainage bag were touching the floor. The bag was bent with one inch of the bag laying on the floor. The resident's clinical record was reviewed on 08/02/22 at 10:10 A.M. An Admission MDS assessment, dated 07/20/22, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, stroke, hypertension, pneumonia, and anxiety. The resident required extensive staff assistance for all ADLs. The resident had an indwelling urinary catheter.		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 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 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. The date the systemic changes will be completed: 8-26-22	

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	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 infections...Be sure the catheter tubing and drainage bag are kept off the floor..." 3.1-18(b)			