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	09/25/2023

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. This visit included the Investigation of Complaint IN00416797. Complaint IN00416797 - Federal/State deficiency related to the allegation is cited at F689. Survey dates: September 19, 20, 21, 22, and 25, 2023 Facility number: 000304 Provider number: 155525 AIM number: 100266810 Census Bed Type: SNF/NF: 81 Total: 81 Census Payor Type: Medicare: 8 Medicaid: 57 Other: 16 Total: 81 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 1, 2023.	F 0000		
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive			

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

Lindsey Boltz | Administrator | 10/16/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview, and record review, the facility failed to follow physician orders related to insulin administration, notification, and hold parameters for 1 of 21 residents reviewed for quality of care. (Resident 48) Findings include: 1.a. During an observation and interview on 09/20/23 at 9:58 A.M., Resident 48 was lying in her bed. She indicated she had problems with her blood glucose levels being high and low. A Quarterly MDS (Minimum Data Set) assessment, dated 08/12/23, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, diabetes, hypertension, renal insufficiency, anxiety, and depression. A physician's order with a start date of 04/10/23 and discontinue date of 09/13/23, indicated the resident was to receive Novolog (an insulin medication), 18 units before meals for diabetes, give after the meal was eaten and hold for blood glucose < (less than) 100. The provider MUST be notified if blood glucose is < 60 and/or >(greater) 450 and documented. A physician's order with a start date of 09/14/23 and discontinue date of 09/21/23, indicated the resident was to receive Novolog, 14 units before meals for diabetes, give after the meal was eaten and hold for blood glucose < 100. The provider MUST be notified if blood glucose is < 60 and/or	F 0684	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 10-16-23 to the Recertification and State Licensure Survey completed on September 19, 20, 21, 22, 25 2023. We respectfully request a paper review and will provide any additional information requested. ***F684.*** It is the policy of this facility to ensure that insulin medications be administered in accordance with the physician orders, including but not limited to time frame. **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 physician orders are followed related to insulin administration, including but not limited to physician notification and hold parameters. Resident, 48, has not experienced negative outcomes because of the alleged	10/16/2023

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	> 450 and documented. The June, July, August, and September 2023 Insulin Administration Record from the EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) indicated the resident had received the insulin mediation when the blood sugar was less than 100 and staff were to notify the physician of the blood glucose being greater than 450 on the following dates and times: - On 06/1/23 at 4:30 P.M., the medication was administered when the blood glucose level was 56, - On 06/15/23 at 11:30 A.M., the blood glucose was 475 with no indication the physician was notified, - On 06/17/23 at 4:30 P.M., the medication was administered when the blood glucose level was 92, - On 6/19/23 at 11:30 A.M., the blood glucose was 487 with no indication the physician was notified, - On 07/06/23 at 4:30 P.M., the medication was administered when the blood glucose was 97, - On 07/10/23 at 11:30 A.M., the blood glucose was 520 with no indicated the physician was notified, - On 07/15/23 at 4:30 P.M., the blood glucose was 557 with no indication the physician was notified, - On 07/20/23 at 4:30 P.M., the medication was administered when the blood glucose level was 78,		deficit practice. Residents' insulin is administered in accordance with physician orders. **Other Residents that have the potential to be affected have been identified by:** All residents who are insulin dependent have the 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 were in-serviced by the DON/designee on the policies, "Insulin Administration," "Administering Medications" and "Change in residents' condition or status." The IDT team was educated on the policy, "Insulin Administration," "Administrating Medications," and "Change in residents' condition or status." Blood glucose monitoring, notification, and medication administration to be reviewed as part of the clinical morning meeting to ensure insulin is administered in accordance with physician order. **The corrective action taken to monitor performance to assure compliance through quality assurance:** A performance improvement tool has been initiated that observes that physician orders have been	

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	- On 07/28/23 at 11:30 A.M., the blood glucose was 586 with no indication the physician was notified, - On 08/10/23 at 7:30 A.M., the medication was administered when the blood glucose level was 93, - On 08/14/23 at 7:30 A.M., the blood glucose was 553 with no indication the physician was notified, - On 08/17/23 at 4:30 P.M., the medication was administered when the blood glucose level was 96, - On 08/18/23 at 11:30 A.M., the blood glucose was 520 with no indication the physician was notified, - On 08/24/23 at 11:30 A.M., the blood glucose was 499 with no indication the physician was notified, - On 09/03/23 at 7:30 A.M., the blood glucose was 490 with no indication the physician was notified, - On 09/09/23 at 7:30 A.M., the medication was administered when the blood glucose level was 97, - On 09/10/23 at 7:30 A.M., the medication was administered when the blood glucose level was 79, and - On 09/14/23 at 7:30 A.M., the medication was administered when the blood glucose level was 87. The clinical record lacked documentation that the		followed with supporting documentation present for residents who are insulin dependent. In addition to 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 compliance of physician orders being followed as ordered related to insulin administration. This tool will be completed by the DON or designee, weekly X 3 weeks, monthly X 3 months, then quarterly for 2 quarters. Any identified issues will immediately be 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 the tools. **The date the systemic changes will be completed:** 10/16/2023	

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	medication was held or that the provider was notified of the above blood glucose levels. During an interview on 09/22/23 at 10:08 A.M., LPN (Licensed Practical Nurse) 3 indicated if a resident had hold parameters for a medication, then the medication would be documented as held in the EMAR and it should be documented in a progress note. If the order had call parameters, then she would call the provider if it was indicated, and it should be documented in a progress note that they were notified. During an interview on 09/25/23 at 2:05 P.M., RN 6 indicated a check mark on the EMAR would mean the medication was given. 1.b.. An EMAR Progress Note, dated 08/10/23 at 8:36 P.M., indicated the resident's MD orders related to their blood glucose parameters were that staff were to call the physician if above 450 or below 70. The blood sugar (glucose) was 33. A soda and sugar packet were provided, and the resident was alert. She was diaphoretic and shaky. The blood sugar was checked at 15-minute intervals. Yogurt, cheese, and Glucerna were provided, and the blood sugar was steadily rising. At 11:30 P.M., the blood sugar was 189. The provider was aware. A Triage Note, dated 08/10/23, indicated a message was dispatched from the nurse at the facility, calling to report that the resident's blood glucose level was low. New orders were sent to monitor the residents accucheck (blood glucose) every 2 hours X (times) 3, then every 4 hours until the resident was seen by the primary care provider, continue to monitor for change in condition, and place in the acute book for the primary care provider.			

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The clinical record lacked any documented blood glucose levels from 08/10/23 at 11:30 P.M., until 08/11/23 at 5:08 A.M., when the blood glucose was 225.

The record lacked documentation that the every 4 hour blood glucose checks were entered into the resident record and followed.

The primary care provider had not seen the resident from 08/10/23 until 08/31/23.

A Care Plan that indicated the resident had diabetes with a start date of 11/04/21, included but was not limited to the following interventions:

- administer diabetes medications as ordered with a start date of 11/04/21, and
- fasting serum blood sugar as ordered by the doctor with a start date of 11/04/21.

During an interview on 09/25/23 at 3:40 P.M., the DON and Administrator indicated if the order was to recheck the blood sugar, then it should have been documented.

The current "Insulin Administration" policy, with a revised date of September 2014 and was provided by the Administrator on 09/25/23 at 4:58 P.M., indicated "...to provide guidelines for the safe administration of insulin to residents with diabetes...The type of insulin, dosage requirements, strength, and method, of administration must be verified before administration, to assure that it corresponds with the order on the medication sheet and the physician's order...The nurse shall notify the Director of Nursing Services and Attending Physician of any

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	discrepancies...Documentation...The resident's blood glucose result, as ordered..." The current facility policy titled, "Administering Medications", with a revised date of December 2012, was provided by the Administrator on 09/22/23 at 1:45 P.M. The policy indicated, "...Medications must be administered in accordance with the orders, including any required time frame..." The current facility policy titled, "Change in a Resident's Condition or Status" with a revised date of 12/16/21, was provided by the Administrator on 09/22/23 at 1:45 P.M. The policy indicated, "...Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.)...The nurse will notify the resident's Attending Physician or physician on call when there has been a(an):...need to alter the resident's medical treatment significantly..." 3.1-37(a)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and	F 0689	By submitting the enclosed	10/16/2023

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	interview, the facility failed to ensure appropriate fall interventions were implemented for 1 of 4 residents reviewed for falls. (Resident C) Findings include: On 09/21/23 at 11:03 A.M., Resident C was observed at a table during the bingo activity in the common area on the locked unit. The resident was in a wheelchair and was wearing a sling on her left arm. An Incident Note, dated 09/04/23 at 1:13 P.M., indicated a staff member was assisting the resident with getting dressed. The staff member bent down to pull up the resident's pants and the resident began to fall forward. The staff member stood and grabbed the resident, attempting to prevent a fall. The resident did fall, and landed head first on the floor on their left side. During the fall assessment, the resident was increasingly lethargic with decreased movement and her pupil size appeared to be decreasing. Neurological assessments were initiated, and abnormalities were noted. Pressure was held to the laceration on the resident's head. 911 was contacted and the resident was sent out to the local hospital for evaluation. Hospital documentation, dated 09/04/23 at 11:23 A.M., indicated the resident presented to the facility after a fall. Facility staff were changing the resident's clothes when she fell out of bed and hit the left side of her head and left shoulder. The resident was holding her shoulder and appeared to be in pain. The hospital assessment indicated the resident sustained a traumatic subdural hematoma without loss of consciousness and a 3-part fracture of the surgical neck of the left humerus.		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 10-16-23 to the Recertification and State Licensure Survey completed on September 19, 20, 21, 22, 25 2023. We respectfully request a paper review and will provide any additional information requested. ***F689.*** It is the practice of this facility to ensure that the resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistive devices to prevent accidents. **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 appropriate fall interventions are implemented, and that each resident receives adequate supervision and assistive devices to prevent accidents. Resident, C, has experienced negative outcome due to the alleged deficit practice. Residents to be provided appropriate assistive devices to prevent	

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	During an interview on 09/21/23 at 11:21 A.M., CNA (Certified Nurse Aide) 2 indicated she was with the resident when she fell. The resident was on the bed and the CNA was assisting her with getting dressed. The resident stood up just fine. The CNA was standing behind the resident and her hand was around the resident's hip. The resident's pants were down at her ankles and when the CNA went to pull up her pants, the resident bent down to pull up her pants too. The resident reached down and lost her balance, and the CNA couldn't catch her. The CNA was not using a gait belt. She didn't know why she didn't use one, she didn't have one on her. The resident required the assistance of one staff member with ADLs (Activities of Daily Living) . The resident's record was reviewed on 09/22/23 at 2:27 P.M. An Annual MDS (Minimum Data Set) assessment, dated 06/16/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to Alzheimer's disease, hypertension, and anxiety. The resident required the extensive assistance of two staff members for most ADLs including dressing, toileting, bed mobility, and transfers. During an interview on 09/25/23 at 10:40 A.M., CNA 5 indicated staff were to always use a gait belt if a resident needed assistance during transferring. If a resident required limited to extensive assistance, staff were to use a gait belt. During an interview on 09/25/23 at 10:54 A.M., the DON (Director of Nursing) indicated before the resident fell, she required the extensive assistance of one and sometimes two staff members. The CNA should have been using a gait belt and she didn't.		accidents. **Other Residents that have the potential to be affected have been identified by:** Any residents who indicate as high fall risk and/or indicate needing one or more person(s) for transferring and ambulation. All residents were reviewed for mobility, transfer and fall risk status to ensure appropriate assistive device is utilized. Please see below 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 “Gait Belt Use” and “Falls prevention-potential interventions” related to gait belt use. In-service with IDT team completed with clinical review of all residents indicating need for one or more person(s) for assistance, as well as residents indicating high fall risk. Residents who are new to the facility or with a change in mobility or transfer status will be reviewed as part of the clinical morning meeting to ensure that a gait belt is utilized. **The corrective action taken to monitor performance to assure compliance through quality assurance:**	

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	The current facility policy, titled "GAIT BELT USE", with a revision date of 05/27/21, was provided by the Administrator on 09/25/23 at 1:19 P.M. The policy indicated, "...Nursing staff may utilize gait belts on residents who need one person assist or more for transferring and ambulation...using a gait belt while transferring or walking with a resident can provide you and the resident with increased safety and security. You can help control a resident's balance and keep the resident from falling using a gait belt..." The current facility policy, titled "Falls Prevention -- Potential Interventions", with a revision date of April 2012, was provided by the Administrator on 09/25/23 at 1:19 P.M. The policy indicated, "...Staff Education...Gait belt for transfers and ambulation, as appropriate..." This Federal tag relates to Complaint IN00416797. 3.1-45(a)(2)		A performance improvement tool has been initiated that randomly observes (5) residents with the need for one or more for transfers/mobility, high fall risk residents. In addition to 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 gait belt use in accordance with regulations. The tool will be completed by the DON or designee, weekly X 3 weeks, monthly X 3 months, then quarterly for 2 quarters. Any identified issues will immediately be 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 the tools. **The date the systemic changes will be completed:** 10/16/2023	
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and			

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	assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.			
	Based on observation, interview, and record review, the facility failed to ensure a resident who provided self care with an indwelling urinary catheter was educated on catheter care and infection control guidelines related to transmission based precautions for a urinary tract infection that required transmission base precautions for 1 of 4 residents reviewed for urinary tract infections. (Resident 77)	F 0690	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	10/16/2023

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	Findings include: During an interview in his room on 09/19/23 at 1:39 P.M., Resident 77 indicated he had an indwelling urinary catheter. He had had several UTIs (urinary tract infections) and was currently being treated for a UTI with two different types of bacteria. Staff did not clean his catheter insertion site. He received a shower twice a week and it got cleaned at that time. He did not clean his urinary catheter insertion site himself. There were times that staff would empty his catheter drainage bag and the other times he would empty the bag himself and tell the staff how much urine there was. During the interview, the resident picked up his catheter drainage bag that was hanging on his walker with his bare hand, attempted to hang it on his bed frame, and then hung it back on his walker. The resident's urine was amber colored and there was no sediment observed. The resident did not perform hand hygiene before or after touching his catheter bag. There was no indication the resident was in TBP (transmission based precautions). The resident was observed in the therapy room on 09/21/23 at 9:45 A.M. The resident's catheter drainage bag was hanging on his walker. The resident's room was observed. There was no indication the resident was in TBP. The resident was observed in the therapy room on 09/22/23 at 9:23 A.M. The resident's room was observed. There was no indication the resident was in TBP. The resident's clinical record was reviewed on 09/22/23 3:35 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 07/11/23, indicated the resident was cognitively intact. The diagnoses		requests that the plan of correction be considered our allegation of compliance effective 10-16-23 to the Recertification and State Licensure Survey completed on September 19, 20, 21, 22, 25 2023. We respectfully request a paper review and will provide any additional information requested. ***F690.*** It is the policy of this facility to ensure that residents receive education for completing self-catheter care, as well as receive services and assistance to maintain catheter. It is the policy of the facility to ensure that residents are placed in appropriate precautions and that physician orders are followed in accordance with regulation. **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 residents who provide self-care with an indwelling catheter are educated on catheter care and infection control guidelines related to transmission-based precautions. Resident, 77, has not experienced negative outcome because of the alleged deficit practice. Residents with indwelling catheters who perform their own catheter care are educated on catheter care and residents who require isolation for active infection are placed in	

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	included, but were not limited to, renal failure, obstructive uropathy, diabetes, and depression. The resident had a UTI in the last 30 days. The resident had an indwelling urinary catheter and was continent of bowel. The resident required the limited assistance of 1 staff member for toileting and personal hygiene. During an interview on 09/25/23 at 10:40 A.M., CNA (Certified Nurse Aide) 5 indicated she routinely worked on the hall and was familiar with Resident 77. The staff did not provide peri-care or clean the resident's catheter insertion site for the resident. He emptied his catheter drainage bag by himself and would let them know his output. He did a lot of his bathroom stuff by himself. They might provide "set up" for care at times, meaning they might give him gloves and wipes, but he did it himself. The aides did routinely provide catheter care for the residents, but not for this resident. During an interview on 09/25/23 at 10:55 A.M., the DON (Director of Nursing) indicated the resident had the urinary catheter on admission, but he was fairly new to having one. He had to be educated on not pulling on the catheter and keeping the catheter off of the floor. If a resident was going to provide their own catheter care, they would be educated on the care needed and they should be able to provide a return demonstration of their ability to care for their own catheter. The education and return demonstration should be documented in the resident's record. Staff should still periodically check to make sure the resident was doing it correctly. A Nursing Note, dated 09/14/23 at 2:12 A.M., indicated the resident called staff and indicated he was burning in his catheter area. A new order was entered to obtain a urine sample.		appropriate isolation and educated on transmission-based precautions. **Other Residents that have the potential to be affected have been identified by:** All residents who have an indwelling catheter and perform self-catheter care have the potential to be affected. All residents in contact with a resident not in proper transmission based precautions has the potential to be affected. Please see below 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 DON/designee on the policy, “Infection Control, prevention, control and antibiotic stewardship.” The IDT team was educated on the policy, “Infection Control, prevention, control and antibiotic stewardship.” All residents with catheters, as well as antibiotic stewardship, to be reviewed as part of the clinical morning meeting to ensure residents who perform self-catheter care have been provided education on catheter care. As well as ensuring that residents who require transmission based precautions have appropriate measures in	

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	An Infection Note, dated 09/17/23 at 1:30 A.M., indicated the UA (urinalysis) results were received and staff were awaiting the culture and sensitivity results. A Lab Results Report, dated 09/17/23 at 2:31 P.M., indicated the resident had greater than 100,000 cfu/ml (colony forming unit per milliliter) of Pseudomonas Aeruginosa and greater than 100,000 cfu/ml of Methicillin Resistant Staphylococcus Aureus. The report indicated "...***STAPH AUREUS IS MRSA***..." The report listed the appropriate antibiotics for the types of bacteria to treat the infection. During an interview on 09/25/23 at 2:51 P.M., the DON indicated the resident had two different types of bacteria in his urine, including MRSA. The resident should have been placed in contact isolation TBP and was not. Staff should have been wearing a gown, gloves, and a face shield when they were handling the resident's urine. The facility could provide no documentation of education provided to the resident related to urinary catheter care. The resident's complete Care Plan was provided by the Administrator on 09/25/23 at 3:00 P.M. and included a care plan that indicated the resident had an ADL Self Care Performance Deficit, that was initiated on 06/22/23. Interventions included, but were not limited to, an intervention that was initiated on 06/19/23, that indicated the resident required one staff member's participation to use the toilet. The current facility policy, titled "INFECTION CONTROL, Prevention, Control, and Antibiotic Stewardship" was provided by the Administrator		place, as well as been provided education in accordance with regulation. **The corrective action taken to monitor performance to assure compliance through quality assurance:** A performance improvement tool has been initiated that audits residents with catheters, as well as a tool that audits residents with active infection requiring transmission based precautions. In addition to 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 education being provided related to self-catheter care and for monitoring of appropriate precautions related to active infections. The tool(s) will be completed by the DON or designee, weekly X 3 weeks, monthly X 3 months, then quarterly for 2 quarters. Any identified issues will immediately be 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	

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	on 09/19/23 at 1:00 P.M. The policy indicated, "...The purpose...is to provide a safe, sanitary, and comfortable environment, to help prevent the development and transmission of communicable diseases and infections...A Resident newly diagnosed with MDRO [Multi Drug Resistant Organism] infection is evaluated for appropriate precautions and room placement..." 3.1-18(b)(2) 3.1-41(a)(2)		warranted, based on the outcome of the tools. **The date the systemic changes will be completed:** 10/16/2023	
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 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 follow a physician's order related to weight monitoring for 2 of 21 residents reviewed for hydration status.	F 0692	By submitting the enclosed material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve	10/16/2023

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	(Residents 29 and 71) Findings include: 1. During an observation on 09/25/23 at 10:39 A.M., Resident 29 was sitting in the dining room with staff. The clinical record for Resident 29 was reviewed on 09/25/23 at 9:45 A.M. A Quarterly MDS (Minimum Data Set) assessment, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, anemia, heart failure, hypertension, and depression. An open-ended physician's order, with a start date of 07/01/23, indicated the resident was to have daily weights, once a day for health monitoring. The MD was to be notified of a 4 pound or greater weight gain. The July, August, and September 2023 EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) indicated the resident lacked a documented weight or had a weight gain of 4 or more pounds on the following dates with no indication the physician was notified: - On 07/05/23 the resident weighed 204.8 pounds and on 07/06/23 the resident weighed was 210.8 pounds, a 6-pound weight gain, - On 07/07/23, no weight was documented, - On 07/17/23, no weight was documented, - On 07/19/23, no weight was documented, - On 07/20/23, no weight was documented,		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 10-16-23 to the Recertification and State Licensure Survey completed on September 19, 20, 21, 22, 25 2023. We respectfully request a paper review and will provide any additional information requested. ***F692.*** It is the policy of this facility to ensure that residents maintain acceptable parameters of nutritional status, such usual body weight or desirable body weight range and electrolyte balance, unless the residents clinical condition demonstrates that this is not possible or resident preferences indicate otherwise, that physician orders are followed related weight monitoring. **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 physician orders are followed related to weight monitoring. Resident, 29 and resident, 71 have not experienced negative outcome because of the alleged deficit practice. Residents' physician orders related to weight monitoring are followed.	

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	- On 08/10/23, the resident weighed 197.8 pounds and on 08/11/23 the resident weighed 206.6, an 8.8-pound weight gain, - On 08/17/23, the resident weighed 200.2 pounds and on 08/18/23 the resident weighed 205.2, a 5.2-pound weight gain, - On 09/07/23, the resident weighed 196.6 and on 09/08/23 the resident weighed 205.6, a 9-pound weight gain, - On 09/15/23, the resident weighed 196.2 and on 09/16/23 the resident weighed 205.6, a 9.4-pound weight gain. The clinical record lacked documentation that the physician was notified or that the weights were obtained for the above dates. 2. During an observation on 09/21/23 at 10:52 A.M., Resident 71 was sitting in her room watching the television. There were no concerns. The clinical record for Resident 71 was reviewed on 09/22/23 at 2:46 P.M. A Quarterly MDS assessment, dated 08/16/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, heart failure, anemia, hypertension, and diabetes. A physician's order, with a start date of 06/13/23 and stop date of 08/04/23, indicated the resident was to be weighed daily. The MD was to be notified if the weight was up or down by 2 pounds in a day. The June, July, and August, 2023 EMAR/ETAR indicated the resident lacked a documented weight on the following dates.		**Other Residents that have the potential to be affected have been identified by:** All residents who have physician orders related to weight monitoring have the potential to be affected. See below 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 DON/designee on the policy, “Heart Failure.” The IDT team was educated on the policy, “Heart Failure.” All residents who require weight monitoring to be reviewed as part of the clinical morning meeting to ensure that notification and documentation is present for weight monitoring in accordance with regulation. **The corrective action taken to monitor performance to assure compliance through quality assurance:** A performance improvement tool has been initiated that audits residents who require weight monitoring. In addition to 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 weight monitoring and physician notification with	

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	- On 06/17/23, no weight was documented, - On 06/20/23, no weight was documented, - On 06/24/23, no weight was documented, - On 06/25/23, no weight was documented, - On 06/30/23, no weight was documented, - On 07/15/23, no weight was documented, - On 07/24/23, no weight was documented. An open ended physician's order, with a start date of 09/12/23, indicated the resident was to be weighed daily at 5:30 A.M. for congestive heart failure. The MD was to be notified for a weight gain of 3 pounds in a day or 5 pounds in a week. - On 09/12/23 the resident weighed 116 pounds and on 09/16/23 the resident weighed 123.8 pounds, a weight gain of 7.8 pounds in 4 days. - On 09/22/23 the resident weighed 121.8 pounds and on 09/23/23 the resident weighed 127.2 pounds, a weight gain of 5.4 pounds in 1 day. The clinical record lacked documentation that the physician was notified of the weights for the above dates. The current facility policy titled, "Heart Failure - Clinical Protocol" with a revised date of July 2013, was provided by the Administrator on 09/25/23 at 4:58 P.M. The policy indicated "...In addition the nurse will assess and document/report the following: a. Vital signs;...The physician will review and make recommendations for relevant		documentation present. The tool will be completed by the DON or designee, weekly X 3 weeks, monthly X 3 months, then quarterly for 2 quarters. Any identified issues will immediately be 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 the tools. **The date the systemic changes will be completed:** 10/16/2023	

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	aspects of the nursing care plan; for example, what symptoms to expect, how often and what (weights, renal function, digoxin level, etc.) to monitor, when to report findings to the physician, etc..." 3.1-46(1)			
F 0699 SS=D Bldg. 00	483.25(m) Trauma Informed Care §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. Based on record review and interview, the facility failed to ensure resident specific interventions to provide trauma informed care were in place for 1 of 1 resident with a diagnosis of Post Traumatic Stress Disorder. (Resident 11) Findings include: Resident 11's clinical record was reviewed on 09/22/23 at 3:46 P.M., and indicated the following: - A Quarterly MDS (Minimum Data Set) assessment, dated 03/18/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, Alzheimer's dementia, anxiety, depression, and PTSD (Post Traumatic Stress Disorder). - A Quarterly MDS assessment, dated 03/24/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to,	F 0699	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 10-16-23 to the Recertification and State Licensure Survey completed on September 19, 20, 21, 22, 25 2023. We respectfully request a paper review and will provide any additional information requested. ***F699.*** It is the policy of this facility to ensure that residents who are	10/16/2023

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	Alzheimer's dementia, anxiety, depression, and PTSD. - An Annual MDS assessment, dated 06/23/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, Alzheimer's dementia, anxiety, depression, and PTSD. - A Quarterly MDS assessment, dated 06/30/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, Alzheimer's dementia, anxiety, depression, and PTSD. - A Quarterly MDS assessment, dated 07/17/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, Alzheimer's dementia, anxiety, depression, and PTSD. A Psychiatry Progress Note, dated 08/29/22, indicated the resident was being seen to assess and manage her chronic psychiatric diagnoses. The resident had a psychiatric history of anxiety, major depressive disorder, PTSD, Alzheimer's disease, and personality behaviors. The Assessment and Plan indicated the resident's PTSD was stable, and staff were to offer supportive measures. During an interview on 09/22/23 at 2:14 P.M., the Social Services Director indicated the resident did have a diagnosis of PTSD. The diagnosis was part of the resident's clinical record when she arrived at this facility. The resident had not really exhibited any signs of distress since admission to the facility. If a resident had a diagnosis of PTSD, she would investigate to try and determine what caused the PTSD and would create a care plan		trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and that residents experiences and preferences are accounted for, in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. **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 residents with a diagnosis of PTSD/trauma have resident specific interventions in place. Resident, 11, has not experienced negative outcome due to the alleged deficit practice. Residents with a diagnosis of PTSD/trauma to have resident specific interventions in place. **Other Residents that have the potential to be affected have been identified by:** All residents with a diagnosis of PTSD/trauma have the potential to be affected. See below 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 DON/designee on the policy, “Behavior Assessment, Intervention and Monitoring.” The	

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	with resident specific interventions to try and minimize triggers and re-traumatization. She did not know what the resident's PTSD was related to. The resident had a Care Plan that listed PTSD as a diagnosis, but there were no specific interventions related to the PTSD. The resident's Care Plans were reviewed and included a Care Plan, initiated on 07/04/22 and revised on 06/02/23, that indicated the resident was at risk for an alteration in mood state related to depression, personality disorder, and PTSD along with anxiety. The Care Plan listed the following interventions: - Administer medications as ordered. Observe for and document side effects and effectiveness. - Allow the resident time to talk and encourage the expression of feelings. - Arrange for the resident's clergy or spiritual leader of choice to visit as requested. - Discuss with the resident/family/caregivers any concerns, fears, and issues regarding health. - Psychiatric consult as needed. - The resident needs adequate rest periods. - The resident needs to be reminded/escorted/encouraged to attend activities. The Care Plan lacked resident specific interventions related to their PTSD diagnosis. The current facility policy, titled "Behavior Assessment, Intervention, and Monitoring", with		IDT team was educated on the policy, “Behavior Assessment, Intervention and Monitoring.” All residents reviewed for diagnosis of PTSD/trauma. Ongoing for new admissions and new diagnosis of PTSD/trauma to be reviewed as part of clinical morning meeting to ensure resident specific interventions are present in accordance with regulation. **The corrective action taken to monitor performance to assure compliance through quality assurance:** A performance improvement tool has been initiated that audits residents who have or receive a diagnosis of PTSD/trauma for resident specific interventions. In addition to 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 auditing for residents with a diagnosis of PTSD/trauma, newly admitted residents or residents with a new diagnosis of PTSD/trauma in that they have resident specific interventions in place. The tool will be completed by the social service director or designee, weekly X 3 weeks, monthly X 3 months, then quarterly for 2 quarters. Any identified issues will immediately be addressed. The outcomes will be reviewed through the facility	

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	a most recent revision date of September 2022, was provided by the Administrator on 09/25/23 at 4:42 P.M. The policy indicated, "...Behavior symptoms will be identified using facility-approved behavioral screening tools and the comprehensive assessment...Interventions will be individualized and part of an overall care environment that supports physical, functional and psychological needs..." 3.1-37(a)		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 the tools. **The date the systemic changes will be completed:** 10/16/2023	
F 0760 SS=D Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. Based on observation, interview, and record review, the facility failed to prevent a significant medication error related to insulin administration for 1 of 4 residents reviewed for medication administration. (Resident 48) Findings include: During an observation on 09/21/23 at 11:20 A.M., QMA (Qualified Medication Aide) 4 obtained Resident 48's blood glucose level. The glucometer read a value of 255. QMA 4 indicated she was to call the C Street Nurse to give the insulin injection, she was not certified to give insulin injections. During an observation and record review on 09/21/23 at 11:38 A.M., LPN (Licensed Practical Nurse) 3 drew up 6 units of Novolog insulin into a syringe, assisted Resident 48 from the dining room, where she was waiting for lunch, to her room. LPN 3 started to walk into the resident's	F 0760	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 10-16-23 to the Recertification and State Licensure Survey completed on September 19, 20, 21, 22, 25 2023. We respectfully request a paper review and will provide any additional information requested. ***F760.*** It is the policy of this facility to ensure that residents are free of any significant medication errors	10/16/2023

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	09/25/2023

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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	room to administer the insulin when she was asked to verify the insulin order prior to administration of the insulin. The insulin was not administered to the resident. LPN 3 provided the current open-ended physician's order, with a start date of 09/21/23, that indicated the resident was to receive Novolog insulin 6 units subcutaneously after meals for diabetes, give after the resident had eaten her meal, hold for a blood glucose less than 100. The provider "MUST be notified" if blood glucose was less than 60 and/or greater than 450 and documented. During an interview on 09/21/23 at 11:39 A.M., LPN 3 indicated she usually gave the insulin injections prior to the resident eating her meal. During an interview on 09/21/23 at 11:41 A.M., the DON (Director of Nursing) called the NP (Nurse Practitioner) and clarified the insulin order. The insulin was to be given after the resident had finished eating. The clinical record for Resident 48 was reviewed on 09/21/23 at 1:22 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 08/12/23, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, diabetes, Alzheimer's disease, hypertension, anxiety, and depression. Review of the resident's history of blood glucose levels, the resident had blood sugar levels below the hold parameters on multiple occupancies (6/2, 6/17, 7/6, 7/20, 8/10, 8/18, 9/9, 9/10, and 9/14/23). The current "Insulin Administration" policy, with a revised date of September 2014, was provided by the Administrator on 09/25/23 at 4:58 P.M. The		related to medication/insulin administration. **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 residents receive insulin/medication per physician order(s). Resident, 48, did not experience negative outcome d/t the alleged deficient practice. Residents with insulin medication orders are to have insulin administered in accordance with the physician order. **Other Residents that have the potential to be affected have been identified by:** All residents who receive insulin have the potential to be affected. See below 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 DON/designee on the policy, “Insulin Administration.” The IDT team was educated on the policy, “Insulin Administration.” All residents who receive insulin to be reviewed as part of the clinical morning meeting to ensure insulin is administered per physician orders, proper physician notification and documentation is present as indicated in	

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	policy indicated "...to provide guidelines for the safe administration of insulin to residents with diabetes...The type of insulin, dosage requirements, strength, and method, of administration must be verified before administration, to assure that it corresponds with the order on the medication sheet and the physician's order...The nurse shall notify the Director of Nursing Services and Attending Physician of any discrepancies...Documentation...The resident's blood glucose result, as ordered..." 3.1-48(c)(2)		accordance with regulation. **The corrective action taken to monitor performance to assure compliance through quality assurance:** A performance improvement tool has been initiated that audits residents who receive insulin. In addition to 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 insulin administration. The tool will be completed by the DON or designee, weekly X 3 weeks, monthly X 3 months, then quarterly for 2 quarters. Any identified issues will immediately be 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 the tools. **The date the systemic changes will be completed:** 10/16/2023	