10/16/2023

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155525		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/25/2023		
	PROVIDER OR SUPPLIE		36 VAL	STREET ADDRESS, CITY, STATE, ZIP COD 36 VALLEY DR LAWRENCEBURG, IN 47025		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
F 0000						
F 0684 SS=D Bldg. 00	Licensure Survey. Investigation of Co Complaint IN00416 related to the allega Survey dates: Septe 2023 Facility number: 00 Provider number: 1 AIM number: 1002 Census Bed Type: SNF/NF: 81 Total: 81 Census Payor Type Medicare: 8 Medicaid: 57 Other: 16 Total: 81 These deficiencies accordance with 41 Quality review con 483.25 Quality of Care § 483.25 Quality of Quality of care is	reflect State Findings cited in 0 IAC 16.2-3.1. Inpleted on October 1, 2023. of care a fundamental principle that timent and care provided to	F 0000			
	comprehensive a	ssessment of a resident, the re that residents receive				
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SIG	GNATURE	TITLE	(X6) DATE	

Any defiency statement 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 disclodely sollowing 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.

Lindsey Boltz

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Administrator

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIE		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			ETED
		155525	B. W	B. WING 09/25/2023			2023
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIER	2			LEY DR		
SHADY	NOOK CARE CENT	ER			ENCEBURG, IN 47025		
	1				, · · · · ·	Т	OUE)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
TAG		CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
mo	treatment and care in accordance with			1710			DATE
		dards of practice, the					
	comprehensive person-centered care plan, and the residents' choices.						
	Based on observation	on, interview, and record	F 06	584	By submitting the enclosed		10/16/2023
	review, the facility	failed to follow physician			material, we are not admitting	the	
	orders related to ins	sulin administration,			truth or accuracy of any speci		
	notification, and ho	ld parameters for 1 of 21			findings or allegations. We res	serve	
	residents reviewed	for quality of care. (Resident			the right to contest the finding	s or	
	48)				allegations as part of any		
					proceedings and submit these)	
	Findings include:				responses pursuant to our		
					regulatory obligations. The fac	cility	
	_	rvation and interview on			requests that the plan of		
		M., Resident 48 was lying in her			correction be considered our		
		she had problems with her			allegation of compliance effect		
	blood glucose level	s being high and low.			10-16-23 to the Recertification		
	A O A LAMBO	M:			State Licensure Survey comp		
		Minimum Data Set)			on September 19, 20, 21, 22,		
		8/12/23, indicated the resident			2023. We respectfully request		
		enitively impaired. The			paper review and will provide	-	
	_	but were not limited to,			additional information request	ea.	
		ion, renal insufficiency,			F684.		
	anxiety, and depres	SIUII.			It is the policy of this facility to ensure that insulin medication		
	A physician's ardam	with a start date of 04/10/23			administered in accordance w		
		e of 09/13/23, indicated the			the physician orders, including		
		e of 09/13/23, indicated the vive Novolog (an insulin			not limited to time frame.	y Duit	
		ts before meals for diabetes,			The corrective action taken t	for	
	· ·	was eaten and hold for blood			those residents found to be		
		1) 100. The provider MUST be			affected by the deficient		
		acose is < 60 and/or >(greater)			practice include:		
	450 and documente				It is the policy of this facility to	,	
					ensure residents physician or		
	A physician's order	with a start date of 09/14/23			are followed related to insulin		
		e of 09/21/23, indicated the			administration, including but n	ot	
		eive Novolog, 14 units before			limited to physician notification		
		give after the meal was eaten			and hold parameters. Resider		
		glucose < 100. The provider			48, has not experienced nega		
	MUST be notified if blood glucose is < 60 and/or				outcomes because of the aller		

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155525		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 09/25/2023		
NAME OF P	ROVIDER OR SUPPLIER	•		ADDRESS, CITY, STATE, ZIP COD	•	
				LLEY DR		
SHADY N	NOOK CARE CENT	EK	LAWR	ENCEBURG, IN 47025		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	> 450 and documen	ted.		deficit practice. Residents' in		
	TTI TILA	1.5 4 1 2022		is administered in accordance	e with	
		gust, and September 2023 ion Record from the		physician orders.	ı	
	EMAR/ETAR (Elec			Other Residents that have t		
	,	ord/Electronic Treatment		potential to be affected have been identified by:	e	
		ord) indicated the resident had		All residents who are insulin		
		mediation when the blood		dependent have the potential	I to be	
		100 and staff were to notify		affected. Please see below for		
	_	blood glucose being greater		measures implemented to pro		
	than 450 on the following dates and times:			reoccurrence.		
				The measures or systemic		
	- On 06/1/23 at 4:30	P.M., the medication was		changes that have been put	:	
	administered when the blood glucose level was			into place to ensure that the	•	
	56,			deficient practice does not		
				recur include:		
		:30 A.M., the blood glucose		All nursing were in-serviced by	by the	
		lication the physician was		DON/designee on the policies,		
	notified,			"Insulin Administration,"		
				"Administering Medications" a	I	
		80 P.M., the medication was		"Change in residents' condition	on or	
		the blood glucose level was		status." The IDT team was		
	92,			educated on the policy, "Insu		
	On 6/10/22 at 11:2	30 A.M., the blood glucose was		Administration," "Administrati	•	
		ion the physician was notified,		Medications," and "Change ir residents' condition or status.		
	467 With no marcat	ion the physician was notified,		Blood glucose monitoring,	•	
	- On 07/06/23 at 4·3	30 P.M., the medication was		notification, and medication		
		the blood glucose was 97,		administration to be reviewed	las	
		6 //,		part of the clinical morning		
	- On 07/10/23 at 11	:30 A.M., the blood glucose		meeting to ensure insulin is		
		licated the physician was		administered in accordance v	vith	
	notified,			physician order.		
				The corrective action taken	to	
		30 P.M., the blood glucose was		monitor performance to ass	ure	
	557 with no indicate	ion the physician was notified,		compliance through quality		
				assurance:		
		30 P.M., the medication was		A performance improvement		
		the blood glucose level was		has been initiated that observ		
	78,			that physician orders have be	een l	

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155525		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/25/2023	
	PROVIDER OR SUPPLIER		36 VAI	ADDRESS, CITY, STATE, ZIP COD LLEY DR ENCEBURG, IN 47025	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION
1.40	- On 07/28/23 at 11 was 586 with no incontified, - On 08/10/23 at 7:3 administered when 93, - On 08/14/23 at 7:3 553 with no indicate on 08/17/23 at 4:3 administered when 96, - On 08/18/23 at 11 was 520 with no incontified, - On 08/24/23 at 11 was 499 with no incontified, - On 09/03/23 at 7:3 490 with no indicate on 09/09/23 at 7:3 administered when 97, - On 09/10/23 at 7:3 administered when 97, - On 09/10/23 at 7:3 administered when 79, and - On 09/14/23 at 7:3 administered when 87.	30 A.M., the blood glucose dication the physician was the blood glucose level was don't he physician was notified, and physician was notified, and physician was notified, and physician was notified, and physician was dication the physician was dication was d		followed with supporting documentation present for residents who are insulin dependent. In addition to da rounds and monitoring for a minimum of 3 months or un substantial compliance is achieved, a Quality Assurant tool has been developed an implemented to monitor compliance of physician or being followed as ordered in to insulin administration. The will be completed by the DO designee, weekly X 3 week monthly X 3 months, then quarterly for 2 quarters. Any identified issues will immed be addressed. The outcome be reviewed through the fact Quality Assurance program Monitoring will continue as planned or will be increased Quality Assurance Committeneded to obtain 100% compliance. Additional actic be taken by the Quality Assurance Committee, if warranted, based on the out of the tools. The date the systemic chawill be completed: 10/16/2	aily til nce nd ders elated nis tool DN or s, / iately es will cility - d by the ee, if on will tcome inges

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155525	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	COM	E SURVEY PLETED 5/2023	
NAME OF I	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP C	COD		
SHADY I	NOOK CARE CENT	TER	36 VALLEY DR LAWRENCEBURG, IN 47025				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE , DEFICIENCY)	RRECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE	
		d or that the provider was re blood glucose levels.					
	LPN (Licensed Praresident had hold potenthem the medication in the EMAR and it progress note. If the then she would call indicated, and it she progress note that the						
	_	v on 09/25/23 at 2:05 P.M., RN 6 nark on the EMAR would mean given.					
	8:36 P.M., indicate related to their blood that staff were to cabelow 70. The blood soda and sugar packersident was alert. The blood sugar waintervals. Yogurt, c provided, and the b At 11:30 P.M., the provider was aware						
	message was dispat facility, calling to r glucose level was le monitor the residen every 2 hours X (tin the resident was see provider, continue	ed 08/10/23, indicated a teched from the nurse at the eport that the resident's blood ow. New orders were sent to attacheck (blood glucose) mes) 3, then every 4 hours until en by the primary care to monitor for change in e in the acute book for the der.					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155525	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COM	re survey ipleted 25/2023		
NAME OF F	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP C	COD			
SHADY N	NOOK CARE CENT	ER	36 VALLEY DR LAWRENCEBURG, IN 47025					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
	glucose levels from	lacked any documented blood 08/10/23 at 11:30 P.M., until M., when the blood glucose						
		documentation that the every 4 checks were entered into the followed.						
	The primary care primary resident from 08/10	rovider had not seen the 1/23 until 08/31/23.						
	diabetes with a star	dicated the resident had t date of 11/04/21, included but he following interventions:						
	a start date of 11/04	od sugar as ordered by the						
	DON and Administ	v on 09/25/23 at 3:40 P.M., the trator indicated if the order was d sugar, then it should have						
	a revised date of Se provided by the Ad P.M., indicated "t safe administration diabetesThe type requirements, streng administration must	gth, and method, of t be verified before						
	the order on the me physician's order	ssure that it corresponds with dication sheet and the The nurse shall notify the g Services and Attending						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155525		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/25/2023	
	ROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	discrepanciesDocumentationThe 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"				
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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIE		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155525	B. W	ING		09/25/	2023
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	8			LEY DR		
CHADY N	JOOK CARE CENT	·CD			ENCEBURG, IN 47025		
SHADY NOOK CARE CENTER			LAWKE	ENCEBURG, IN 47025			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG DEFICIENCY)		DATE		
	interview, the facili	ty failed to ensure appropriate			material, we are not admitting	the	
	fall interventions were implemented for 1 of 4				truth or accuracy of any specif	ic	
	residents reviewed	for falls. (Resident C)			findings or allegations. We res	erve	
					the right to contest the finding	s or	
	Findings include:				allegations as part of any		
					proceedings and submit these	:	
	On 09/21/23 at 11:0	3 A.M., Resident C was			responses pursuant to our		
	observed at a table	during the bingo activity in			regulatory obligations. The fac	ility	
	the common area or	n the locked unit. The resident			requests that the plan of		
	was in a wheelchair	and was wearing a sling on			correction be considered our		
	her left arm.				allegation of compliance effect	tive	
					10-16-23 to the Recertification		
	An Incident Note, dated 09/04/23 at 1:13 P.M.,				State Licensure Survey compl	eted	
	indicated a staff me	mber was assisting the			on September 19, 20, 21, 22,	25	
	resident with getting	g dressed. The staff member			2023. We respectfully request	а	
	bent down to pull u	p the resident's pants and the			paper review and will provide	any	
	resident began to fa	ll forward. The staff member	additional information requested.				
	stood and grabbed t	he resident, attempting to			<u>F689.</u>		
	prevent a fall. The r	esident did fall, and landed			It is the practice of this facility	to	
	head first on the flo	or on their left side. During the			ensure that the resident		
	fall assessment, the	resident was increasingly			environment remains as free of	of	
	lethargic with decre	eased movement and her pupil			accident hazards as is possibl	е	
	size appeared to be	decreasing. Neurological			and each resident receives		
	assessments were in	nitiated, and abnormalities			adequate supervision and ass	istive	
	were noted. Pressur	e was held to the laceration on			devices to prevent accidents.		
	the resident's head.	911 was contacted and the			The corrective action taken f	or	
	resident was sent or	at to the local hospital for			those residents found to be		
	evaluation.				affected by the deficient		
					practice include:		
	-	ntion, dated 09/04/23 at 11:23			It is the policy of this facility to		
	· ·	resident presented to the			ensure that appropriate fall		
		Facility staff were changing the			interventions are implemented	l,	
		hen she fell out of bed and hit			and that each resident receive	es :	
		nead and left shoulder. The			adequate supervision and ass	istive	
		g her shoulder and appeared			devices to prevent accidents.		
	_	ospital assessment indicated			Resident, C, has experienced		
	the resident sustaine	ed a traumatic subdural			negative outcome due to the		
	hematoma without	loss of consciousness and a			alleged deficit practice. Reside	ents	
	3-part fracture of th	e surgical neck of the left			to be provided appropriate		
	humerus.				assistive devices to prevent		

11/01/2023 PRINTED: FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 09/25/2023 155525 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 36 VALLEY DR SHADY NOOK CARE CENTER LAWRENCEBURG, IN 47025 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE accidents. During an interview on 09/21/23 at 11:21 A.M., Other Residents that have the CNA (Certified Nurse Aide) 2 indicated she was potential to be affected have with the resident when she fell. The resident was been identified by: on the bed and the CNA was assisting her with Any residents who indicate as getting dressed. The resident stood up just fine. high fall risk and/or indicate The CNA was standing behind the resident and needing one or more person(s) for her hand was around the resident's hip. The transferring and ambulation. All resident's pants were down at her ankles and residents were reviewed for when the CNA went to pull up her pants, the mobility, transfer and fall risk resident bent down to pull up her pants too. The status to ensure appropriate resident reached down and lost her balance, and assistive device is utilized. Please the CNA couldn't catch her. The CNA was not see below measures implemented using a gait belt. She didn't know why she didn't to prevent reoccurrence. use one, she didn't have one on her. The resident The measures or systemic required the assistance of one staff member with changes that have been put ADLs (Activities of Daily Living). into place to ensure that the deficient practice does not The resident's record was reviewed on 09/22/23 at recur include: 2:27 P.M. An Annual MDS (Minimum Data Set) All nursing was in-serviced by the assessment, dated 06/16/23, indicated the resident Director of Nursing/ designee on was severely cognitively impaired. The diagnoses the policies entitled "Gait Belt included, but were not limited to Alzheimer's Use" and "Falls disease, hypertension, and anxiety. The resident prevention-potential interventions" required the extensive assistance of two staff related to gait belt use. In-service members for most ADLs including dressing, with IDT team completed with toileting, bed mobility, and transfers. clinical review of all residents indicating need for one or more During an interview on 09/25/23 at 10:40 A.M., person(s) for assistance, as well CNA 5 indicated staff were to always use a gait as residents indicating high fall belt if a resident needed assistance during risk. Residents who are new to the transferring. If a resident required limited to facility or with a change in mobility extensive assistance, staff were to use a gait belt. or transfer status will be reviewed as part of the clinical morning

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didn't.

During an interview on 09/25/23 at 10:54 A.M., the

DON (Director of Nursing) indicated before the

of one and sometimes two staff members. The

CNA should have been using a gait belt and she

resident fell, she required the extensive assistance

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assurance:

is utilized.

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meeting to ensure that a gait belt

The corrective action taken to

compliance through quality

monitor performance to assure

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155525		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/25/2023		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 36 VALLEY DR LAWRENCEBURG, IN 47025				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF The current facility USE", with a revisi provided by the Ad	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION policy, titled "GAIT BELT on date of 05/27/21, was ministrator on 09/25/23 at 1:19		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) A performance improvement to has been initiated that random observes (5) residents with the need for one or more for	ool ly	(X5) COMPLETION DATE
	utilize gait belts on person assist or more ambulationusing a walking with a resident with increase can help control a resident from falling. The current facility Potential Interver April 2012, was pro 09/25/23 at 1:19 P.J.	licated, "Nursing staff may residents who need one re for transferring and a gait belt while transferring or dent can provide you and the sed safety and security. You esident's balance and keep the g using a gait belt" policy, titled "Falls Prevention ntions", with a revision date of ovided by the Administrator on M. The policy indicated, "Staff lt for transfers and ambulation,			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. Tool will be completed by the Dor designee, weekly X 3 weeks monthly X 3 months, then quarterly for 2 quarters. Any identified issues will immediate	he OON s,	
	This Federal tag rel 3.1-45(a)(2)	ates to Complaint IN00416797.			be addressed. The outcomes of the reviewed through the facility Quality Assurance program. Monitoring will continue as planned or will be increased by Quality Assurance Committee, needed to obtain 100% compliance. Additional action of the taken by the Quality Assurance Committee, if warranted, based on the outco of the tools. The date the systemic change will be completed: 10/16/2023	y the if will ome	
F 0690 SS=D Bldg. 00	§483.25(e) Incont §483.25(e)(1) The resident who is co	continence, Catheter, UTI inence. If facility must ensure that intinent of bladder and on receives services and					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155525	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/25/2023		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	or her clinical con- that continence is	ntain continence unless his dition is or becomes such not possible to maintain. a resident with urinary					
	comprehensive as ensure that- (i) A resident who	ed on the resident's seessment, the facility must enters the facility without					
	unless the resider demonstrates that necessary;	eter is not catheterized nt's clinical condition t catheterization was enters the facility with an					
	indwelling cathete one is assessed for	r or subsequently receives or removal of the catheter de unless the resident's					
	receives appropriate to prevent urinary	necessary; and o is incontinent of bladder ate treatment and services tract infections and to e to the extent possible.					
	incontinence, bas comprehensive as ensure that a residuously bowel receives ap	a resident with fecal ed on the resident's esessment, the facility must dent who is incontinent of epropriate treatment and e as much normal bowel					
	Based on observation review, the facility provided self care was educated infection control gutransmission based infection that requires	on, interview, and record failed to ensure a resident who with an indwelling urinary ed on catheter care and idelines related to precautions for a urinary tract red transmission base 4 residents reviewed for	F 0690	By submitting the enclosed material, we are not admitting truth or accuracy of any specifindings or allegations. We re the right to contest the finding allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The fa	fic serve is or		

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Event ID:

K1NP11

Facility ID: 000304

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
		155525	B. W	ING		09/25/2	023
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	t .			LEY DR		
SHADY N	NOOK CARE CENT	ER			ENCEBURG, IN 47025		
	Г		1		I	Т	
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTIO			(X5)
PREFIX	ì ·	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG		+	DATE
	E' 1' ' 1 1				requests that the plan of		
	Findings include:				correction be considered our		
	D	. 1			allegation of compliance effec		
	_	y in his room on 09/19/23 at 1:39			10-16-23 to the Recertification		
		ndicated he had an indwelling			State Licensure Survey compl		
	1	had had several UTIs (urinary			on September 19, 20, 21, 22,		
		I was currently being treated			2023. We respectfully request		
		different types of bacteria. Staff			paper review and will provide	-	
		theter insertion site. He			additional information request	ed.	
		wice a week and it got cleaned			<u>F690.</u>		
		not clean his urinary catheter			It is the policy of this facility to		
		lf. There were times that staff			ensure that residents receive		
		theter drainage bag and the			education for completing		
		d empty the bag himself and			self-catheter care, as well as		
		uch urine there was. During the			receive services and assistan		
		ent picked up his catheter			maintain catheter. It is the poli	icy	
		as hanging on his walker with			of the facility to ensure that		
		npted to hang it on his bed			residents are placed in approp		
		ng it back on his walker. The			precautions and that physician		
		amber colored and there was			orders are followed in accorda	ance	
		ed. The resident did not			with regulation.		
		ne before or after touching his			The corrective action taken f	or	
	_	was no indication the resident			those residents found to be		
	was in TBP (transm	nission based precautions).			affected by the deficient		
	7E1 '1 . 1	1: 4 4			practice include:		
		oserved in the therapy room on			It is the policy of this facility to		
		M. The resident's catheter			ensure that residents who pro	vide	
		anging on his walker. The			self-care with an indwelling	. [
		observed. There was no			catheter are educated on cath	eter	
	indication the reside	ent was in 1BP.			care and infection control		
	Th				guidelines related to		
		oserved in the therapy room on			transmission-based precaution		
		M. The resident's room was			Resident, 77, has not experien		
		s no indication the resident			negative outcome because of		
	was in TBP.				alleged deficit practice. Reside	ents	
	7E1 '1 4 1''	1 1			with indwelling catheters who		
		cal record was reviewed on			perform their own catheter car		
		A Quarterly MDS (Minimum			are educated on catheter care		
	· ·	nt, dated 07/11/23, indicated			residents who require isolation	n for	
l	I the resident was cos	enitively intact. The diagnoses	1		active infection are placed in		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLI	ETED
		155525	B. W	ING		09/25/	2023
			<u> </u>	CTREET	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD		
OLIA DV. A	JOOK OADE OENT	TED.			LEY DR		
SHADY	NOOK CARE CENT	EK		LAWRE	ENCEBURG, IN 47025		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOVIDED'S DI AN OE CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	included, but were i	not limited to, renal failure,			appropriate isolation and educ	ated	
	obstructive uropathy	y, diabetes, and depression.			on transmission-based		
	The resident had a U	UTI in the last 30 days. The			precautions.		
	resident had an indy	welling urinary catheter and			Other Residents that have th	e	
	was continent of bo	wel. The resident required the			potential to be affected have		
	limited assistance o	f 1 staff member for toileting			been identified by:		
	and personal hygier				All residents who have an		
					indwelling catheter and perfor	m l	
	During an interview	on 09/25/23 at 10:40 A.M.,			self-catheter care have the		
	CNA (Certified Nu	rse Aide) 5 indicated she			potential to be affected. All		
		n the hall and was familiar with			residents in contact with a		
	Resident 77. The sta	aff did not provide peri-care or			resident not in proper transmis	ssion	
	clean the resident's catheter insertion site for the				based precautions has the		
	resident. He emptie	d his catheter drainage bag by			potential to be affected. Pleas	e l	
	himself and would l	let them know his output. He			see below measures impleme		
	did a lot of his bath	room stuff by himself. They			to prevent reoccurrence.		
	might provide "set i	up" for care at times, meaning			The measures or systemic		
	they might give him	gloves and wipes, but he did		changes that have been put			
	it himself. The aide	s did routinely provide catheter			into place to ensure that the		
	care for the resident	ts, but not for this resident.			deficient practice does not		
					recur include:		
	During an interview	w on 09/25/23 at 10:55 A.M.,			All nursing was in-serviced by	the	
	the DON (Director	of Nursing) indicated the			DON/designee on the policy,		
	resident had the urin	nary catheter on admission,			"Infection Control, prevention,		
	but he was fairly ne	w to having one. He had to be			control and antibiotic		
	educated on not pul	ling on the catheter and			stewardship." The IDT team w	as as	
	keeping the catheter	r off of the floor. If a resident			educated on the policy, "Infect	tion	
	was going to provid	le their own catheter care, they			Control, prevention, control an	nd	
	would be educated	on the care needed and they			antibiotic stewardship." All		
	should be able to pr	ovide a return demonstration			residents with catheters, as we	ell	
	of their ability to ca	re for their own catheter. The			as antibiotic stewardship, to be	е	
	education and return	n demonstration should be			reviewed as part of the clinical	ı	
	documented in the 1	resident's record. Staff should			morning meeting to ensure		
	still periodically che	eck to make sure the resident			residents who perform		
	was doing it correct	ily.			self-catheter care have been		
					provided education on cathete	er	
	A Nursing Note, da	ted 09/14/23 at 2:12 A.M.,			care. As well as ensuring that		
		nt called staff and indicated he			residents who require		
	was burning in his o	catheter area. A new order was			transmission based precaution	ns	
	entered to obtain a t				have appropriate measures in		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	COMPLETED				
		155525	B. WING	00	09/25/2023			
			STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>			
NAME OF P	PROVIDER OR SUPPLIE	3						
SHADV	NOOK CARE CENT	FR		36 VALLEY DR LAWRENCEBURG, IN 47025				
SHADIL	TOOK OAKE CENT		LAWK					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA				
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE			
				place, as well as been provide	ed			
		dated 09/17/23 at 1:30 A.M.,		education in accordance with				
	·	nrinalysis) results were		regulation.				
		vere awaiting the culture and		The corrective action taken to				
	sensitivity results.			monitor performance to assi	ure			
	ATID 1: P	4 1 4 100/17/22 + 2 21 B 3 5		compliance through quality				
		ort, dated 09/17/23 at 2:31 P.M.,		assurance:				
		ent had greater than 100,000		A performance improvement t	:001			
	, ,	ning unit per milliliter) of		has been initiated that audits				
		ginosa and greater than		residents with catheters, as w				
	· · · · · · · · · · · · · · · · · · ·	Methicillin Resistant		as a tool that audits residents	WILLI			
	Staphylococcus Aureus. The report indicated "***STAPH AUREUS IS MRSA***" The			active infection requiring				
				transmission based precautions. In addition to daily rounds and				
	types of bacteria to	propriate antibiotics for the		monitoring for a minimum of 3				
	types of bacteria to	ucat the infection.		monitoring for a minimum of 3	'			
	During an interview	v on 09/25/23 at 2:51 P.M., the		compliance is achieved, a Qu	ality			
	-	resident had two different		Assurance tool has been	anty			
		his urine, including MRSA.		developed and implemented t	0			
		I have been placed in contact		monitor the compliance of	~			
		was not. Staff should have		education being provided rela	ted to			
		vn, gloves, and a face shield		self-catheter care and for				
		ndling the resident's urine. The		monitoring of appropriate				
		de no documentation of		precautions related to active				
		to the resident related to		infections. The tool(s) will be				
	urinary catheter car			completed by the DON or				
				designee, weekly X 3 weeks,				
	The resident's comp	olete Care Plan was provided		monthly X 3 months, then				
		or on 09/25/23 at 3:00 P.M. and		quarterly for 2 quarters. Any				
	-	n that indicated the resident		identified issues will immediat	ely			
	-	are Performance Deficit, that		be addressed. The outcomes	· I			
	was initiated on 06/	/22/23. Interventions included,		be reviewed through the facili	ty			
	but were not limited	d to, an intervention that was		Quality Assurance program.				
		23, that indicated the resident		Monitoring will continue as				
	required one staff n	nember's participation to use		planned or will be increased b	y the			
	the toilet.			Quality Assurance Committee	e, if			
				needed to obtain 100%				
	The current facility	policy, titled "INFECTION		compliance. Additional action	will			
	CONTROL, Prever	ntion, Control, and Antibiotic		be taken by the Quality				

Stewardship" was provided by the Administrator

Assurance Committee, if

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155525		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 09/25/2023	
	PROVIDER OR SUPPLIER		36 VAL	ADDRESS, CITY, STATE, ZIP COD LEY DR ENCEBURG, IN 47025	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	"The purposeis to comfortable environ development and tradiseases and infection diagnosed with MD	P.M. The policy indicated, to provide a safe, sanitary, and ament, to help prevent the ansmission of communicable onsA Resident newly RO [Multi Drug Resistant a is evaluated for appropriate m placement"		warranted, based on the outco of the tools. The date the systemic chang will be completed: 10/16/202	ges
F 0692 SS=D Bldg. 00	§483.25(g) Assiste (Includes naso-ga tubes, both percut gastrostomy and p jejunostomy, and o	n Status Maintenance ed nutrition and hydration. stric and gastrostomy aneous endoscopic percutaneous endoscopic enteral fluids). Based on a mensive assessment, the e that a resident-			
	usual body weight range and electrol resident's clinical of that this is not pos preferences indica	ritional status, such as or desirable body weight yte balance, unless the condition demonstrates sible or resident			
	to maintain proper §483.25(g)(3) Is o	hydration and health; ffered a therapeutic diet			
	health care provide Based on observation review, the facility to	ntritional problem and the er orders a therapeutic diet. on, interview, and record failed to follow a physician's ght monitoring for 2 of 21 for hydration status.	F 0692	By submitting the enclosed material, we are not admitting truth or accuracy of any speci findings or allegations. We res	fic

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K1NP11 Facility ID: 000304

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	00	COMPLE	ETED
		155525	B. W	ING		09/25/2	2023
		.		CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			LEY DR		
	NOOK CARE CENT	TEB			ENCEBURG, IN 47025		
SHADTI	NOOK CARE CENT	I EN		LAWINE			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	(Residents 29 and 7	71)			the right to contest the finding	s or	
					allegations as part of any		
	Findings include:				proceedings and submit these	:	
					responses pursuant to our		
	_	vation on 09/25/23 at 10:39			regulatory obligations. The fac	cility	
		was sitting in the dining room			requests that the plan of		
	with staff.				correction be considered our		
					allegation of compliance effec		
		for Resident 29 was reviewed			10-16-23 to the Recertification		
		A.M. A Quarterly MDS			State Licensure Survey comp		
	,	t) assessment, indicated the			on September 19, 20, 21, 22,		
	_	ively intact. The diagnoses			2023. We respectfully request		
		not limited to, anemia, heart		paper review and will provide any			
	failure, hypertensio	n, and depression.			additional information request	ed.	
					<u>F692.</u>		
		vsician's order, with a start		It is the policy of this facility to			
		adicated the resident was to			ensure that residents maintair	1	
		once a day for health			acceptable parameters of		
	_	D was to be notified of a 4			nutritional status, such usual t	,	
	pound or greater we	eight gain.			weight or desirable body weig		
		1.0			range and electrolyte balance	,	
		and September 2023			unless the residents clinical		
	EMAR/ETAR (Ele				condition demonstrates that the	IIS IS	
		cord/Electronic Treatment			not possible or resident		
		cord) indicated the resident			preferences indicate otherwise		
		ed weight or had a weight gain			that physician orders are follo	wed	
	_	s on the following dates with			related weight monitoring.		
	no maication the pr	nysician was notified:			The corrective action taken f	or	
	On 07/05/22 the m	esident weighed 204.8 pounds			those residents found to be		
		e resident weighed was 210.8			affected by the deficient		
	pounds, a 6-pound	_			practice include:		
	poulius, a 0-poullu	weight gain,			It is the policy of this facility to		
	- On 07/07/23, no. 19	veight was documented,			ensure that physician orders a followed related to weight	ii e	
	- On 07/07/25, 110 V	vergnt was documented,			monitoring. Resident, 29 and		
	- On 07/17/23 no n	veight was documented,			resident, 71 have not experier	nced	
	- On 0 // 1 // 25, 110 V	vergnt was documented,			negative outcome because of		
	- On 07/10/23 no n	veight was documented,			alleged deficit practice. Reside		
	- On 07/13/23, 110 V	vergnt was documented,			physician orders related to we		
	- On 07/20/23 no n	veight was documented,			1 7 7	igiit	
1	- On 07/20/23, 110 V	vergin was documented,	1		monitoring are followed.		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER	l í	JILDING	00	COMPL	LETED
		155525	B. W			09/25	
		<u> </u>		CTD PPT	ADDRESS CITY STATE ZIP COP		
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
SHVDA V	NOOK CARE CENT	TED .			LEY DR		
SHADY	NOUN CARE CENT	IER		LAWKE	ENCEBURG, IN 47025		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					Other Residents that have t		
		resident weighed 197.8 pounds			potential to be affected hav	е	
		e resident weighed 206.6, an			been identified by:		
	8.8-pound weight g	gain,			All residents who have physi		1
	0.00/:-:				orders related to weight mon	-	
		resident weighed 200.2 pounds			have the potential to be affect		1
		e resident weighed 205.2, a			See below measures implem	ented	
	5.2-pound weight g	gain,			to prevent reoccurrence.		
	0 00/05/20 1	.1			The measures or systemic		
		resident weighed 196.6 and on			changes that have been pu		
		nt weighed 205.6, a 9-pound			into place to ensure that the	9	
	weight gain,				deficient practice does not		
					recur include:	a.	
		resident weighed 196.2 and on			All nursing was in-serviced b	-	
		nt weighed 205.6, a 9.4-pound		DON/designee on the policy,			
	weight gain.				"Heart Failure." The IDT tear		
	The clinical massed	lacked documentation that the			educated on the policy, "Hea		1
		fied or that the weights were			Failure." All residents who re	-	
	obtained for the abo				weight monitoring to be revie as part of the clinical morning		
		vation on 09/21/23 at 10:52			meeting to ensure that notific	-	
	_	was sitting in her room			and documentation is preser		
		sion. There were no concerns.			weight monitoring in accorda		
		There were no concerns.			weight monitoring in accorda	1100	
	The clinical record	for Resident 71 was reviewed			The corrective action taken	to	
		6 P.M. A Quarterly MDS			monitor performance to ass		1
		08/16/23, indicated the resident			compliance through quality		
		act. The diagnoses included,			assurance:		
		d to, heart failure, anemia,			A performance improvement	tool	1
	hypertension, and d				has been initiated that audits		
					residents who require weight		
	A physician's order	with a start date of 06/13/23			monitoring. In addition to dai		
	and stop date of 08	/04/23, indicated the resident			rounds and monitoring for a	-	
	was to be weighed	daily. The MD was to be			minimum of 3 months or unti		
	notified if the weig	ht was up or down by 2 pounds			substantial compliance is		
	in a day.				achieved, a Quality Assuran	ce	
					tool has been developed and		
	The June, July, and	August, 2023 EMAR/ETAR			implemented to monitor the		1
	indicated the reside	ent lacked a documented			compliance of weight monito	ring	
	weight on the follo	wing dates.			and physician notification wit	-	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPL	ETED
		155525	B. W	B. WING 09/25/2023		/2023	
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			LEY DR		
CHVDA I	NOOK CARE CENT	ED			ENCEBURG, IN 47025		
SHADTI	NOOK CARE CENT	ER		LAWKE	ENCEBURG, IN 47025		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					documentation present. The to	ool	
	- On 06/17/23, no v	veight was documented,			will be completed by the DON	or	
					designee, weekly X 3 weeks,		
	- On 06/20/23, no v	veight was documented,			monthly X 3 months, then		
					quarterly for 2 quarters. Any		
	- On 06/24/23, no v	veight was documented,			identified issues will immediate	•	
					be addressed. The outcomes	will	
	- On 06/25/23, no v	veight was documented,			be reviewed through the facilit	у	
					Quality Assurance program.		
	- On 06/30/23, no v	veight was documented,			Monitoring will continue as		
					planned or will be increased by	-	
	- On 07/15/23, no w	veight was documented,			Quality Assurance Committee	, if	
					needed to obtain 100%		
	- On 07/24/23, no v	weight was documented.			compliance. Additional action	will	
					be taken by the Quality		
		sician's order, with a start date			Assurance Committee, if		
		ted the resident was to be			warranted, based on the outco	me	
		30 A.M. for congestive heart			of the tools.		
		as to be notified for a weight			The date the systemic chang		
	gain of 3 pounds in	a day or 5 pounds in a week.			will be completed: 10/16/2023	3	
	0.00/10/201						
		esident weighed 116 pounds					
		e resident weighed 123.8					
	pounds, a weight ga	nin of 7.8 pounds in 4 days.					
	0 00/22/22 41	:					
		esident weighed 121.8 pounds e resident weighed 127.2					
	pounds, a weight ga	nin of 5.4 pounds in 1 day.					
	The clinical record	lacked documentation that the					
		ied of the weights for the					
	above dates.	ica of the weights for the					
	acove dates.						
	The current facility	policy titled, "Heart Failure -					
	1	with a revised date of July 2013,					
		e Administrator on 09/25/23 at					
		cy indicated "In addition the					
	_	d document/report the					
		signs;The physician will					
		commendations for relevant					
	10 10 w and make 10	commendations for relevant					

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

Event ID:

K1NP11 Facility ID: 000304

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155525	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(x3) date survey COMPLETED 09/25/2023	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 36 VALLEY DR LAWRENCEBURG, IN 47025			
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
F 0699 SS=D Bldg. 00	what symptoms to e (weights, renal function monitor, when to reference" 3.1-46(1) 483.25(m) Trauma Informed §483.25(m) Trauma Informed §483.25(m) The facility must e are trauma survive competent, trauma accordance with practice and accordance with a diasert raumatization of Based on record revisited to ensure resiprovide trauma info 1 resident with a diasert stress Disorder. (Reference in the practice of the practice	care insure that residents who cors receive culturally aninformed care in professional standards of cunting for residents' coreferences in order to the triggers that may cause of the resident. The wand interview, the facility dent specific interventions to the triggers that may cause of the resident. The wand interview, the facility dent specific interventions to the triggers of Post Traumatic esident 11) all record was reviewed on M., and indicated the following: (Minimum Data Set) 3/18/23, indicated the resident that. The diagnoses included, and PTSD (Post Traumatic consistency of the professional profes	F 0699	By submitting the enclosed material, we are not admitting truth or accuracy of any specififindings or allegations. We rest the right to contest the findings allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The fact requests that the plan of correction be considered our allegation of compliance effect 10-16-23 to the Recertification State Licensure Survey comple on September 19, 20, 21, 22, 2023. We respectfully request paper review and will provide a additional information requested. F699. It is the policy of this facility to	ic erve s or ility ive and eted 25 a anny	
	diagnoses included,	but were not limited to,		ensure that residents who are		

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION (X3) DATE			•	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLETED	
		155525	B. WI	NG		09/25/2023	
		<u> </u>	-	STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	8			LEY DR		
SHADY N	NOOK CARE CENT	ER		LAWRENCEBURG, IN 47025			
	1				1	T .	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(3	X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPI	LETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	 	+	TE
Alzheimer's dementia, anxiety, depression, and				trauma survivors receive cultu	· ·		
	PTSD.				competent, trauma-informed of		
	A A IMPO	1 1 106/22/22			in accordance with profession	al	
		assessment, dated 06/23/23,			standards of practice and that		
		nt was severely cognitively			residents experiences and	:	
	-	noses included, but were not			preferences are accounted for	, 111	
	depression, and PTS	er's dementia, anxiety,			order to eliminate or mitigate		
	depression, and PTS	ου.			triggers that may cause re-traumatization of the reside	nt	
	- A Quartarly MDC	assessment, dated 06/30/23,			The corrective action taken f		
		nt was severely cognitively			those residents found to be	or	
		noses included, but were not			affected by the deficient		
	-	er's dementia, anxiety,			practice include:		
	depression, and PTS	•			It is the policy of this facility to		
	depression, and 1 1				ensure that residents with a		
	- A Quarterly MDS	assessment, dated 07/17/23,			diagnosis of PTSD/trauma hav	/ <u>P</u>	
		nt was severely cognitively		resident specific interventions in			
		noses included, but were not			place. Resident, 11, has not	""	
	-	er's dementia, anxiety,			experienced negative outcome	e due	
	depression, and PTS				to the alleged deficit practice.	, ado	
	,				Residents with a diagnosis of		
	A Psychiatry Progre	ess Note, dated 08/29/22,			PTSD/trauma to have residen		
		nt was being seen to assess			specific interventions in place.		
		onic psychiatric diagnoses.	Other Residents that have the			e	
	The resident had a p	osychiatric history of anxiety,			potential to be affected have		
		sorder, PTSD, Alzheimer's			been identified by:		
		ality behaviors. The			All residents with a diagnosis	of	
	Assessment and Pla	an indicated the resident's			PTSD/trauma have the potent		
	PTSD was stable, a	nd staff were to offer			be affected. See below measu		
	supportive measure	s.			implemented to prevent		
					reoccurrence.		
	During an interview	y on 09/22/23 at 2:14 P.M., the			The measures or systemic		
	Social Services Dire	ector indicated the resident did			changes that have been put		
	have a diagnosis of	PTSD. The diagnosis was part			into place to ensure that the		
		nical record when she arrived			deficient practice does not		
		resident had not really			recur include:		
	, , ,	of distress since admission to			All nursing was in-serviced by	the	
		dent had a diagnosis of PTSD,			DON/designee on the policy,		
	she would investiga	ate to try and determine what			"Behavior Assessment,		
	caused the PTSD ar	nd would create a care plan			Intervention and Monitoring "	he	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155525	B. W	ING		09/25/	2023
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
CLIADV	NOOK CARE CENT	TED			LEY DR		
SHADYI	NOOK CARE CEN	IER		LAWRE	ENCEBURG, IN 47025		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	with resident speci	fic interventions to try and			IDT team was educated on th	e	
	minimize triggers a	and re-traumatization. She did			policy, "Behavior Assessmen	t,	
	not know what the	resident's PTSD was related to.			Intervention and Monitoring."	All	
	The resident had a	Care Plan that listed PTSD as a			residents reviewed for diagno	sis of	
	diagnosis, but there	e were no specific			PTSD/trauma. Ongoing for ne	ew	
	interventions relate	ed to the PTSD.			admissions and new diagnos	is of	
					PTSD/trauma to be reviewed	as	
	The resident's Care	Plans were reviewed and			part of clinical morning meeting	ng to	
	included a Care Pla	an, initiated on 07/04/22 and			ensure resident specific		
	revised on 06/02/23	3, that indicated the resident			interventions are present in		
	was at risk for an a	lteration in mood state related			accordance with regulation.		
	to depression, personality disorder, and PTSD				The corrective action taken	to	
	along with anxiety. The Care Plan listed the				monitor performance to ass	ure	
	following intervent	tions:			compliance through quality		
					assurance:		
	- Administer medic	cations as ordered. Observe for			A performance improvement	tool	
	and document side	effects and effectiveness.			has been initiated that audits		
					residents who have or receive	e a	
		t time to talk and encourage the			diagnosis of PTSD/trauma for	•	
	expression of feeling	ngs.			resident specific interventions	s. In	
					addition to daily rounds and		
	_	esident's clergy or spiritual			monitoring for a minimum of 3	3	
	leader of choice to	visit as requested.			months or until substantial		
					compliance is achieved, a Q	uality	
		resident/family/caregivers any			Assurance tool has been		
	concerns, fears, and	d issues regarding health.			developed and implemented		
					monitor the compliance of au	-	
	- Psychiatric consu	lt as needed.			for residents with a diagnosis		
					PTSD/trauma, newly admitted		
	- The resident need	ls adequate rest periods.			residents or residents with a ।		
					diagnosis of PTSD/trauma in	that	
	- The resident need				they have resident specific		
		encouraged to attend			interventions in place. The to		
	activities.				be completed by the social se		
					director or designee, weekly 2		
		red resident specific			weeks, monthly X 3 months,	hen	
	interventions relate	ed to their PTSD diagnosis.			quarterly for 2 quarters. Any		
					identified issues will immedia	•	
		policy, titled "Behavior			be addressed. The outcomes		
	Assessment, Interv	ention, and Monitoring", with			be reviewed through the facili	ty	

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CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED 09/25/2023	
		155525	B. WING			
			CTREET	ADDRESS CITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIER	8		ADDRESS, CITY, STATE, ZIP COD LLEY DR		
SHADY	NOOK CARE CENT	ER		ENCEBURG, IN 47025		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	a most recent revisi	on date of September 2022,		Quality Assurance program.		
	was provided by the	e Administrator on 09/25/23 at		Monitoring will continue as		
	4:42 P.M. The police	ey indicated, "Behavior		planned or will be increased b	y the	
	symptoms will be id	dentified using		Quality Assurance Committee	-	
	facility-approved be	ehavioral screening tools and		needed to obtain 100%		
	the comprehensive	assessmentInterventions will		compliance. Additional action	will	
	be individualized ar	nd part of an overall care		be taken by the Quality		
	environment that su	pports physical, functional		Assurance Committee, if		
	and psychological n	needs"		warranted, based on the outco	ome	
3.1-37(a)			of the tools.			
			The date the systemic chang	jes		
				will be completed: 10/16/202	3	
F 0760	483.45(f)(2)					
SS=D	,,,,,	e of Significant Med Errors				
Bldg. 00	The facility must e	_				
J	§483.45(f)(2) Residents are free of any					
	significant medica					
	•	on, interview, and record	F 0760	By submitting the enclosed	10/16/2023	
		failed to prevent a significant	1 0700	material, we are not admitting		
	I	lated to insulin administration		truth or accuracy of any speci		
	for 1 of 4 residents	reviewed for medication		findings or allegations. We res		
	administration. (Res	sident 48)		the right to contest the finding		
				allegations as part of any		
	Findings include:			proceedings and submit these	.	
				responses pursuant to our		
	During an observati	ion on 09/21/23 at 11:20 A.M.,		regulatory obligations. The fac	cility	
	QMA (Qualified M	edication Aide) 4 obtained		requests that the plan of		
	Resident 48's blood	glucose level. The glucometer		correction be considered our		
	read a value of 255.	QMA 4 indicated she was to		allegation of compliance effect	tive	
	call the C Street Nu	rse to give the insulin		10-16-23 to the Recertification	n and	
	injection, she was n	ot certified to give insulin		State Licensure Survey comp	leted	
	injections.			on September 19, 20, 21, 22,	I	
				2023. We respectfully request		
	During an observati	ion and record review on		paper review and will provide		
	_	A.M., LPN (Licensed Practical		additional information request	-	
	Nurse) 3 drew up 6	units of Novolog insulin into a		<u>F760.</u>		
		esident 48 from the dining		It is the policy of this facility to)	
	1 ' -	as waiting for lunch to her		ensure that residents are free		

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room. LPN 3 started to walk into the resident's

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any significant medication errors

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155525	B. W	ING		09/25/	/2023
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIE	R			LEY DR		
SHADY	NOOK CARE CEN	TER			ENCEBURG, IN 47025		
OHADII				LAWILL			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	IATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		the insulin when she was			related to medication/insulin		
		insulin order prior to			administration.		
		he insulin. The insulin was not			The corrective action taken		
	administered to the	e resident.			those residents found to be)	
					affected by the deficient		
	_	e current open-ended			practice include:		
		with a start date of 09/21/23,			It is the policy of this facility to		
		esident was to receive Novolog			ensure that residents receive		
		cutaneously after meals for			insulin/medication per physic		
	_	the resident had eaten her			order(s). Resident, 48, did no		
		ood glucose less than 100. The			experience negative outcome		
	provider "MUST be notified" if blood glucose				the alleged deficient practice		
	was less than 60 and/or greater than 450 and				Residents with insulin medica	ation	
	documented.				orders are to have insulin		
	.	00/01/02 + 11 00 + 15			administered in accordance v	vith	
	_	w on 09/21/23 at 11:39 A.M.,			the physician order.	_	
		e usually gave the insulin			Other Residents that have t		
	injections prior to t	he resident eating her meal.			potential to be affected have	е	
	D	00/21/22 4 11 41 4 3 4 4			been identified by:		
	_	w on 09/21/23 at 11:41 A.M., the			All residents who receive ins		
	· ·	Nursing) called the NP (Nurse			have the potential to be affect		
	· · · · · · · · · · · · · · · · · · ·	arified the insulin order. The			See below measures implem	ented	
	finished eating.	iven after the resident had			to prevent reoccurrence.		
	illisticu cating.				The measures or systemic		
	The clinical record	for Resident 48 was reviewed			changes that have been put into place to ensure that the		
		2 P.M. A Quarterly MDS			deficient practice does not	;	
		et) assessment, dated 08/12/23,			recur include:		
	1	ent was moderately cognitively			All nursing was in-serviced b	v the	
		noses included, but were not			DON/designee on the policy,	-	
		, Alzheimer's disease,			"Insulin Administration." The		
		ety, and depression. Review of			team was educated on the po		
		ry of blood glucose levels, the			"Insulin Administration." All	J.1.∪y ,	
		sugar levels below the hold			residents who receive insulin	to be	
		tiple occupancies (6/2, 6/17, 7/6,			reviewed as part of the clinical		
	_	(9, 9/10, and 9/14/23).			morning meeting to ensure in		
	20, 5, 10, 6, 10, 5,	-,,			is administered per physician		
	The current "Insuli	n Administration" policy, with			orders, proper physician	1	
		eptember 2014, was provided			notification and documentation	nn is	
		or on 09/25/23 at 4:58 P.M. The			present as indicated in	10	
	1 ,		1				1

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

PRINTED: 11/01/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155525		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 09/25/2023			
	PROVIDER OR SUPPLIER		36 V	ET ADDRESS, CITY, STATE, ZIP COD ALLEY DR RENCEBURG, IN 47025	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	safe administration diabetesThe type requirements, streng administration must administration, to a the order on the me physician's orderT Director of Nursing Physician of any	gth, and method, of the verified before ssure that it corresponds with dication sheet and the The nurse shall notify the Services and Attending umentationThe resident's		accordance with regulation. The corrective action taken monitor performance to ass compliance through quality assurance: A performance improvement has been initiated that audits residents who receive insulinaddition to daily rounds and monitoring for a minimum of 3 months or until substantial compliance is achieved. A Quantification of the compliance of insuministration. 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 immediate be addressed. The outcomes be reviewed through the facility Quality Assurance program. Monitoring will continue as planned or will be increased to obtain 100% compliance. Additional action be taken by the Quality Assurance Committee needed to obtain 100% compliance. Additional action be taken by the Quality Assurance Committee, if warranted, based on the outcof the tools. The date the systemic change will be completed: 10/16/202	tool In Balality Boulin Belly Will Boy the Be, if Will Come Bes

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