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	11/13/2024

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00446976. Complaint IN00446976 - No deficiencies related to the allegations are cited. Survey dates: November 6, 7, 8, 12, and 13, 2024. Facility number: 000304 Provider number: 155525 AIM number: 100266810 Census Bed Type: SNF/NF: 82 Total: 82 Census Payor Type: Medicare: 1 Medicaid: 65 Other: 16 Total: 82 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on November 21, 2024.	F 0000		
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments Based on record review and interview, the facility failed to ensure the accuracy of Minimum Data Set assessments for 3 of 21 residents reviewed. (Residents 8, 91, and 27) Findings include:	F 0641	**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**	11/14/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lindsey Boltz	Administrator	12/10/2024

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	1. The clinical record for Resident 8 was reviewed on 11/13/24 at 1:15 P.M. A Quarterly Minimum Data Set (MDS) assessment, dated 10/14/24, indicated the resident was cognitively intact. The "Swallowing/Nutritional Status" section of the assessment indicated the resident received parenteral/intravenous feeding and had a feeding tube while he was a resident in the facility during the assessment review period. The resident's physician's orders for October 2024 lacked an order for tube feeding. During an interview on 11/08/24 at 9:45 A.M., the resident indicated he had never had a feeding tube. During an interview on 11/13/24 at 1:36 P.M., the MDS Coordinator indicated the resident didn't have a feeding tube. The Quarterly MDS assessment was incorrect. 2. The clinical record for Resident 91 was reviewed on 11/08/24 at 1:30 P.M. A Discharge MDS assessment, dated 10/04/24, indicated the resident was moderately cognitively impaired. The "Identification" section of the assessment indicated the resident discharged from the facility on 10/04/24. The discharge was planned, and the resident went to a short-term general hospital. During an interview on 11/08/24 at 10:56 A.M., the Therapy Manager indicated the resident went to another Long Term Care (LTC) facility. A Nursing Note, dated 10/4/2024 at 12:00 P.M., indicated the resident was discharging to another facility and was transported by the facility bus. During an interview on 11/13/24 at 1:51 P.M., the		**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 11-14-23 to the Recertification and State Licensure Survey completed on November 6, 7, 8, 12, 13 2024. We respectfully request a paper review and will provide any additional information requested.** ***F0641.*** It is the policy of this facility to ensure accuracy of assessments with reflection of residents' status. **The corrective action taken for those residents found to be affected by the deficient practice includes:** Residents, 8, 91, 27 have not experienced negative outcomes because of the alleged deficit practice. Resident 8's MDS assessment was revised to reflect that residents does not receive parenteral/ intravenous feeding and does not have a feeding tube. Resident 91's MDS assessment revised to reflect that resident was discharged to a nursing home. Resident 27's MDS assessment was revised to reflect that resident	

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	MDS Coordinator indicated the resident did not go to the hospital he went to another LTC facility. The assessment should have accurately reflected the resident's discharge destination. 3. The clinical record for Resident 27 was reviewed on 11/13/24 at 2:02 P.M. A Quarterly MDS assessment, dated 08/22/24, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, diabetes, hypertension, dementia, and chronic obstructive pulmonary disease. Section O "special treatments, procedures, and programs" indicated the resident was receiving Hospice care while he was a resident in the facility during the assessment review period. The August 2024 physician orders, provided by the Director of Nursing (DON) on 11/14/24 at 2:15 P.M., lack documentation that the resident received Hospice care. During an interview on 11/13/24 at 1:36 P.M., the MDS Coordinator indicated the resident didn't receive Hospice care. The Quarterly MDS assessment was incorrect and she referred to the RAI manual for completing MDS assessments. 3.1-31(c)(5) 3.1-31(c)(6) 3.1-31(c)(8)		does not receive hospice services. **Other Residents that have the potential to be affected have been identified by:** Residents who have assessments completed for quality review 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:** MDS coordinator was educated on accuracy of MDS assessment. **The corrective action taken to monitor performance to assure compliance through quality assurance:** A performance improvement tool has been initiated that randomly audits five (5) residents to ensure that patients MDS assessment is accurately completed related to identification, swallowing and nutrition status and special treatments, procedures and programs. This Quality Assurance Audit Tool will be completed by the Director of Nursing/Designee weekly x3 weeks, monthly for 3 months, then quarterly for 2	

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			quarters. Any identified issues will be immediately addressed. The outcomes will be reviewed through the facility Quality Assurance Program. Monitoring will continue as planned or will be increased by the Quality Assurance Committee if needed to obtain 100% compliance. Additional action will be taken by the Quality Assurance Committee if warranted based on the outcome of tools. **The date the systemic changes will be completed: 11/14/2024.**	
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on record review and interview, the facility failed to obtain physician ordered vital signs prior to medication administration for 1 of 21 residents reviewed for Quality of Care. (Resident 1) Findings include: The clinical record for Resident 1 was reviewed on 11/07/24 at 1:33 P.M. A Quarterly Minimum Data Set (MDS) assessment, dated 10/24/24, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, hypertension, diabetes, and dementia.	F 0684	Tag F684 - Quality of Care It is the facility policy to follow physician's orders 1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • Residents 1 immediately had accounts audited by DON and reviewed vital signs with the medical director. Medical director and DON aligned vital sign parameters with resident needs.	11/14/2024

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	The Electronic Medication Administration Records (EMAR) for September and October 2024, were provided by the DON on 11/13/24 at 12:54 P.M., and included, but were not limited to, the following: The September EMAR indicated the resident received the following medications: - Lisinopril, for hypertension, 20 milligrams (mg) one time a day. Staff were to hold (not give) the medication if the resident's systolic blood pressure (the top number) was less than 100 or if their heart rate was less than 60 beats per minute. The medication had a start date of 11/14/23. The record had places to document the resident's blood pressure (BP) and heart rate at 9:00 A.M., when the medication was due to be administered. The EMAR documents were left blank from September 3 through September 30, 2024. - Propranolol, for hypertension, 10 mg two times a day, at 7:00 A.M. and 7:00 P.M. Staff were to hold the medication if the resident's systolic blood pressure was less than 100 or if their heart rate was less than 60 beats per minute. The medication had a start date of 01/17/22. The record had places to document the resident's BP and heart rate, two times a day, that were left blank for the entire month of September 2024. The Vitals records for September 2024, were provided by the DON on 11/13/24 at 12:54 P.M., and indicated the resident's blood pressure and heart rate were documented on the following dates and times:		Medical director and DON found no adverse effects related to vital signs. Resident 1 had no negative outcomes. 2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. Residents with vital signs or hold parameters have the potential to be effected. All current inhouse residents were audited on 11/18/2024 by the DON/Designee for vital signs or hold parameters related to medication administration .Medical Director reviewed any vital signs with DON and no adverse effects . 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The DON educated licensed nursing staff and QMA's on the policy titled "medication administration". 4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? • DON/designee will initiat a preformance improvement tool that audits residents with vital signs or hold parameters has been completed timely and per physician orders. This quality assurnace tool will be completed	

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	- 09/01/24 at 7:10 A.M., - 09/01/24 at 8:28 P.M., - 09/02/24 at 7:17 A.M., - 09/03/24 at 12:20 A.M., - 09/03/24 at 6:45 A.M., - 09/04/24 at 11:46 P.M., - 09/05/24 at 11:03 P.M., - 09/10/24 at 7:31 A.M., - 09/14/24 at 8:13 P.M., - 09/19/24 at 11:42 P.M., and - 09/24/24 at 11:06 P.M. The Progress Notes for September and October 2024, were provided by the DON on 11/13/24 at 12:54 P.M. A Progress Note, dated 09/10/24 at 8:30 A.M., indicated the resident's medications, Propranolol and Lisinopril, had been held due to the resident's heart rate of 56, which was below the prescribed limit. The record lacked documentation of any refusals by the resident, or any other vital signs related to the prescribed times the medications were due to be administered. The Interdisciplinary Notes indicated the resident had falls on 09/03/24 and 09/24/24. No other falls were documented in the Progress Notes. Neurological Evaluation Flow Records for the falls on 09/03/24 and 09/24/24 were provided by the DON on 11/13/24 at 10:22 A.M. The records indicated the resident's blood pressure and heart rate were documented on the following dates and times that were within the two hour time frame the medications were to be administered: - 09/03/24 at 7:05 A.M., - 09/04/24 at 7:05 A.M., - 09/05/24 at 7:05 A.M., - 09/06/24 at 7:05 A.M., - 09/24/24 at 7:15 P.M., and		weekly x3 weeks, monthly x 3 months then quarterly for 2 quarters. Any identified issues will be immediately addressed. The outcomes will be reviewed through the facility QA program. Monitoring will continue as planned or will be increased by the QA committee if needed to obtain 100% compliance. Additional action will be taken by the QA Committee if warranted based on outcome of tools. 5. Date of completion: 11/14/2024	

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	from 09/25/24 through 09/29/24, the vital signs were documented twice a day, in the morning, "AM", and in the evening, "PM", with no specific times listed. The resident's clinical record lacked any vitial signs of BP or heart rate related to the administration of Lisinopril and Propranolol for the following dates: September 6, 7, 8, 9, 11, 12. 13, 20, 21, 22, 23 and 30, 2024. The October EMAR indicated the resident received the following medications: - Lisinopril, for hypertension, 20 mg one time a day. Staff were to hold the medication if the resident's systolic blood pressure was less than 100 or if their heart rate was less than 60 beats per minute. The medication had a start date of 11/14/23. The record had places to document the blood pressure and heart rate that were left blank from October 1, through October 25, 2024. - Propranolol, for hypertension, 10 mg two times a day, at 9:00 A.M., and 8:00 P.M. Staff were to hold the medication if the resident's systolic blood pressure was less than 100 or if their heart rate was less than 60 beats per minute. The medication had a start date of 01/17/22. The record had places to document the blood pressure and heart rate, twice a day, that were left blank from October 1, 2024, through the 9:00 A.M. dose on October 25, 2024. The Vitals records for October 2024, were provided by the DON on 11/13/24 at 12:54 P.M. The resident's blood pressure and heart rate were			

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	documented on the following dates and times: - 10/02/24 at 2:44 P.M., - 10/25/24 at 8:20 P.M., and from 10/26/24 through 10/31/24, the vital signs were documented twice a day, once in the morning, and once in the evening. The resident's clinical record lacked any vitial signs of BP or heart rate related to the administration of Lisinopril and Propranolol for the following dates: October 1 and October 3 through 24, 2024. During an interview on 11/08/24 at 9:47 A.M., RN 4 indicated the facility no longer used hard (paper) charts. During an interview on 11/12/24 at 3:29 P.M., RN 4 indicated there was a place on the EMAR for vital signs to be recorded if a medication required a parameter. Staff were to obtain the vital sign prior to the administration of the medication. There was a notation staff could put on the EMAR as to why the medication was held. Staff had to notify the physician if the medication was held. The current "Administering Medications" policy, with a revised date of December 2012, was provided by the DON on 11/13/24 at 10:45 A.M. The policy indicated, "...Medications shall be administered in a safe and timely manner, and as prescribed...The individual administering the medication must check the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication...information must be checked/verified for each resident prior to administering medications...Vital signs, if necessary...As			

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	required or indicated for a medication, the individual administering the medication will record in the resident's medical record..." 3.1-37(a)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI Based on observation, interview, and record review, the facility failed to follow appropriate infection control guidelines related to indwelling urinary catheters for a resident who had a Urinary Tract Infection for 1 of 2 residents reviewed for urinary catheters. (Resident 7) Findings include: During an observation on 11/07/24 at 1:39 P.M., Resident 7 was in their wheelchair in the main dining room. Five to six inches of their indwelling urinary catheter tubing was laying on the floor under their wheelchair. During an observation on 11/08/24 at 11:57 A.M., Resident 7 was in their wheelchair in the main dining room eating lunch, five to six inches of their indwelling urinary catheter tubing was laying on the floor under their wheelchair. During an observation on 11/08/24 at 2:56 P.M., Resident 7 was in their wheelchair in the main dining room propelling herself, five to six inches of their indwelling urinary catheter tubing was dragging on the floor under their wheelchair. During an observation and interview on 11/08/24 at 2:58 P.M., the Director of Nursing (DON) indicated the indwelling urinary catheter tubing should not be touching the floor.	F 0690	Tag F690 - Bowel/Bladder Incontinence, Catheter, UTI It is the facility policy to ensure catheters are properly positioned 1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • Residents 7 immediately had infection control audited by DON and reviewed all recent infections with the medical director. Medical director and DON found no adverse effects related to catheter tubing noted to be touching the floor. The Medical Director and DON reviewed medical diagnosis and comorbidities related to urinary tract infection. 2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.. • current in-house residents with catheters were audited on 11/18/2024 by the DON/Designee for infection control related to indwelling catheters. The DON and Medical director reviewed all infections r/t UTI monthly and	11/14/2024

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	During an interview on 11/08/24 at 3:30 P.M., Certified Nurse Aide (CNA) 2 indicated the urinary catheter bag and tubing should not be touch the floor. The clinical record was reviewed on 11/08/24 at 3:00 P.M. A Quarterly Minimum Data Set (MDS) assessment, dated 10/21/24, indicated the resident was cognitively intact. The residents diagnoses included, but were not limited to, hypertension, renal insufficiency, obstructive uropathy (a condition where the flow of urine is blocked), and diabetes. The resident had an indwelling urinary catheter. The November 2024 Electronic Medication Administration Record (EMAR) indicated the resident was to receive Bactrim (an antibiotic) 800-160 milligrams (mg) 1 tablet every morning for a Urinary Tract Infection (UTI) for 7 days, with a start date of 11/09/24, and Bactrim 400-80 mg 1 tablet every evening for a UTI for 7 days, with a start date of 11/08/24. The current "Catheter Care, Urinary" policy, with a revised date of December 2007, was provided by Administrator on 11/13/24 at 10:48 A.M. The policy indicated, "...To prevent infection of the resident's urinary tract...Be sure the catheter tubing and drainage bag are kept off the floor..." 3.1-41(a)(2)		found no adverse effects r/t infection control and indwelling catheters on the floor. • 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The DON educated all licensed nursing staff on the UTI and indwelling catheter infection prevention policy and procedure with concentration on, but not limited to, catheter care and prevention of infection. Education provided: • Infection control of Catheter Care, Prevention of Catheter Infection. • Notification of Provider related to signs and symptoms of UTI. 4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? DON/designee will initiate a performance improvement tool that audits residents with infection control for in dwelling catheters has been completed timely and per physician orders. This quality assurance tool will be completed weekly x3 weeks, monthly x 3 months then quarterly for 2 quarters. Any identified issues will be immediately addressed. The outcomes will be reviewed through the facility QA program. Monitoring will continue	

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			as planned or will be increased by the QA committee if needed to obtain 100% compliance. Additional action will be taken by the QA Committee if warranted based on outcome of tools. 5. Date of completion: 11/14/2024	
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs Based on record review and interview, the facility failed to follow the physician's orders related to hold parameters for a medication for 1 of 5 residents reviewed for unnecessary medications. (Resident 72) Findings include: The clinical record for Resident 72 was reviewed on 11/07/24 at 1:28 P.M. A Quarterly Minimum Data Set (MDS) assessment, dated 09/18/24, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, Parkinson's disease and ventricular fibrillation (irregular contraction of the heart muscle). The Electronic Medication Administration Records (EMAR) for October and November 2024, were provided by the Director of Nursing (DON) on 11/13/24 at 10:45 A.M. The records indicated the resident had the following current physician's order: - Metoprolol 25 milligrams (mg), give 12.5 mg by mouth, two times a day related to ventricular fibrillation. The medication was to be held (not given) if the resident's heart rate was less than 60 beats per minute. The start date for the medication	F 0757	Tag F757 - Drug Regimen is free from unnecessary drugs It is the policy of this facility to follow physician orders 1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • Residents 72 immediately had accounts audited by DON and reviewed all missed physician orders for holding medication with the medical director. Medical director and DON aligned vital sign hold parameters with resident needs at this time. Medical director and DON found no adverse effects related to missed vital signs. 2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. • All current inhouse residents were audited on 11/18/2024 by the DON/Designee forvital signs or hold parameters related to medication administration	11/14/2024

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	was 10/04/24. The record indicated the medication had been administered outside of the ordered parameters, when the resident's heart rate was less than 60 beats per minute, on the following dates and times: - 10/06/24, at 9:00 A.M., the heart rate was 42, - 10/06/24, at 9:00 P.M., the heart rate was 56, - 10/11/24, at 9:00 A.M., the heart rate was 49, - 10/14/24, at 9:00 A.M., the heart rate was 52, - 10/19/24, at 9:00 A.M., the heart rate was 48, - 11/02/24, at 9:00 A.M., the heart rate was 46, - 11/02/24, at 9:00 P.M., the heart rate was 57, - 11/03/24, at 9:00 A.M., the heart rate was 58, and - 11/07/24, at 9:00 P.M., the heart rate was 51. During an interview on 11/08/24 at 9:47 A.M., RN 4 indicated the facility no longer used hard (paper) charts. During an interview on 11/12/24 at 3:29 P.M., RN 4 indicated there was a place on the EMAR for vital signs to be recorded if a medication required a parameter. Staff were to obtain the vital sign prior to the administration of the medication. There was a notation staff could put on the EMAR as to why the medication was held. Staff had to notify the physician if the medication was held. The current "Administering Medications" policy, with a revised date of December 2012, was provided by the DON on 11/13/24 at 10:45 A.M. The policy indicated, "...Medications shall be administered in a safe and timely manner, and as prescribed...The individual administering the medication must check the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of		.Medical Director reviewed vital signs with DON and no adverse effects were noted nor vital signs/ hold parameters were missed. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The DON educated all licensed nursing staff on the medication administration policy and procedure with concentration on, but not limited to, vital signs and hold parameters. Education provided: • Medication Administration • Notification of Provider for any vital signs that are out of parameter setting. 4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance programs will be put into place? DON/designee will initiate a performance improvement tool that audits residents with vital signs or hold parameters has been completed timely and per physician orders. This quality assurance tool will be completed weekly x3 weeks, monthly x 3 months then quarterly for 2 quarters. Any identified issues will be immediately addressed. The outcomes will be reviewed through the facility QA program. Monitoring will continue as planned or will be increased by the QA committee if needed to obtain	

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	155525	A. BUILDING 00 B. WING	11/13/2024

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	administration before giving the medication...information must be checked/verified for each resident prior to administering medications...Vital signs, if necessary..." 3.1-48(a)(6)		100% compliance. Additional action will be taken by the QA Committee if warranted based on outcome of tools. 5. Date of completion: 11/14/2024	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation and interview, the facility failed to appropriately store medications for 3 of 4 medication carts reviewed. (C Street Medication Cart 1, C Street Medication Cart 2, and B Street Medication Cart 1) Findings include: 1. On 11/12/24 at 9:59 A.M., C Street Medication Cart 1 was observed with RN 4 and contained the following: - A small round yellow pill and a small oblong pale green pill were lying loose in the bottom of the second drawer, and - A small round white pill was lying loose in the bottom of the third drawer. 2. On 11/12/24 at 10:03 A.M., C Street Medication Cart 2 was observed with RN 4 and contained the following: - One small round white pill and one half of a small round white pill were lying loose in the bottom of the second drawer. 3. On 11/12/24 at 10:11 A.M., Unit Manager 7 was observed removing a small round pink pill and a small round white pill from the bottom of the	F 0761	Tag F761 - Label/Store Drugs and Biologicals “It is the facility policy to follow medication storage policy." 1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • Residents immediately had accounts audited by DON and reviewed all medications stored in medication carts with the medical director. Medical director and DON aligned medication administration with resident needs at this time. Medical director and DON found no adverse effects related to medication storage. 2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. • All current inhouse residents were audited on 11/18/2024 by the DON/Designee for medication administration and medication storage in medication carts .Medical Director reviewed all medication storage with DON and	11/14/2024

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	second drawer of the B Street Medication Cart 1. The pills were loose and not in a secured medication sheet. During an interview on 11/12/24 at 10:26 A.M., the Director of Nursing (DON) indicated loose pills should not be lying in the bottom of the medication carts. She was unaware of which residents the loose medications would have belong too. The current undated facility policy, titled "MEDICATION STORAGE IN THE FACILITY", was provided by the DON on 11/13/24 at 10:23 A.M. The policy indicated, "...Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier..." 3.1-25(o)		no adverse effects were noted. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The DON educated all licensed nursing staff on the medication storage policy and procedure with concentration on, but not limited to, proper storage, medication expiration dates. Education provided: • Medication storage • Medication Cart cleanliness, expiration dates for medication. 4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? DON/designee will initiate a performance improvement tool that audits residents with medication storage has been completed timely and per physician orders. This quality assurance tool will be completed weekly x3 weeks, monthly x 3 months then quarterly for 2 quarters. Any identified issues will be immediately addressed. The outcomes will be reviewed through the facility QA program. Monitoring will continue as planned or will be increased by the QA committee if needed to obtain 100% compliance. Additional action will be taken by the QA Committee if warranted based on outcome of tools. 5. Date of completion: 11/14/2024	

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F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview, and record review, the facility failed to prepare and store foods in a sanitary manner for 2 of 2 kitchen observations and failed to maintain resident snack refrigerators in a sanitary manner related to the storage of non-food items and outdate foods for 3 of 3 snack refrigerators observed. This deficient practice had the potential to affect on 82 of 82 residents who receive food from the kitchen or snack refrigerators. Findings include: 1. During the initial kitchen tour on 11/06/24 at 11:14 A.M., with the Dietary Manager (DM), the following was observed: - The dry storage room floor was littered with pieces of dry cereal, a package of crackers; a line of white powder, one and a half inches wide by two feet long running along the wall behind a wire rack of shelves; bits of white paper and straw; a large plastic bag, open to air, of white powder was sitting inside of an open cardboard box; and there was a large silver scoop laying in the bag on top of the powder. The DM indicated the white powder was food thickener and a scoop should not have been left in the bag with the thickener. - Two silver bowls, inverted and covering plates in the plate warmer had a brown/yellow sticky residue in the edges of the bowls, - Two black wheeled carts, with three shelves, were sticky and littered with crumbs. One cart held trays of the lunchtime dessert, and one cart held stacks of clean trays to be used for the meal	F 0812	By submitting the enclosed material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective 11-14-23 to the Recertification and State Licensure Survey completed on November 6, 7, 8, 12, 13 2024. We respectfully request a paper review and will provide any additional information requested. F812. It is the policy of this facility to store, prepare, distribute and serve food in accordance with current standards for food service safety. The corrective action taken for those residents found to be affected by the deficient practice includes: There have been no negative outcomes because of this alleged deficit practice. The facility dry storage room and all kitchen flooring is clean and in compliance with current standards for food service safety. Food thickener is in a storage container without a scoop. Two silver bowls covering plate warmer are clean and in	11/14/2024

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	service, - The lower shelves of three food preparation tables were littered with crumbs and crumbs along the floor under them, - The metal shelf unit holding the juice machine had several black, six inch by two inch, mechanical apparatuses attached to the back of the cart that were covered in gray dust as were the wires on the rack, and - Two black chunks of debris, one inch by two inches in length, were noted by the wall under food prep table near the door to the main dining room. The cleaning schedule for the week was posted on the wall in the kitchen and was provided by the DM on 11/06/24 at 11:41 A.M. The DM indicated staff would initial the area on the cleaning schedule after they had completed the tasks on their shift. The DM opened a drawer in her office that contained several older cleaning schedules, none of which were dated to indicate what week they applied to. The cleaning schedule for the week of 11/03/24 though 11/09/24 indicated no cleaning had been completed since day shift on Monday, 11/04/24. Cleaning tasks to be completed by the morning and evening shift staff members were listed for each day of the week. 2. During the second tour of the kitchen on 11/12/24 at 11:05 A.M., the following was observed: - The metal shelf unit holding the juice machine had several black, six inch by two inch, mechanical apparatuses attached to the back of the cart that were covered in gray dust as were the		compliance with current standards for food service safety. All black wheeled carts are clean and in compliance with current standards for food service safety. Food preparation tables are clean and in compliance with current standards for food service safety. Metal shelving holding the juice machine clean and in compliance with current standards for food service safety. Small shelf under the steam table clean, with no present paper clips and in compliance with current standards for food service safety. Residents' snack refrigerators hold no ice packs or cold therapy. Resident snack refrigerator for D- street contains no plastic grocery bag labeled, "Pam C." A regular cleaning schedule was updated for systemic changes. Other Residents that have the potential to be affected have been identified by: Residents have the potential to be affected by the alleged deficit practice. 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 kitchen staff in-serviced on updated cleaning checklist labeled, "Deep Clean Checklist." Educated on policies for, "Unit Kitchenettes and Pantries",	

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	wires on the rack, - One black wheeled cart with three shelves had sticky spots and was littered with crumbs. The top two shelves of the cart held stacks of clean trays to be used for residents' meal service, - Two silver bowls, inverted to cover the top of stacks of plates in the plate warmer, had a brown/yellow residue in the edges of the bowls, and - A small shelf under the steam table contained stacks of small bowl sized plastic lids sitting with four loose paper clips. A nearby cup held several paperclips. 3. Residents' snack refrigerators were observed on 11/13/24 at 11:32 A.M., with the Assistant Director of Nursing (ADON), and contained the following: - The C-Street refrigerator contained a soft sided dark colored cold pack in the freezer that had no resident identifying marks. The pack was approximately 12 inches by 12 inches in size. The ADON indicated it had been in there for at least as long as she could remember, but did not know who or what it was for. The soft covered ice pack was labeled "Cold Therapy", and - The resident snack refrigerator used for "A" and "B" Streets contained a plastic bag of small cups of ice cream in the freezer that were leaning against a large soft covered ice pack, labeled "Cold Therapy". The pack was approximately 12 inches by 12 inches in size. 4. The resident snack refrigerator for D-Street was observed on 11/13/24 at 11:42 A.M., with Licensed Practical Nurse (LPN) 6, and contained the		"Foods brought by Family/Visitors" and "Cleaning and Sanitation of Food Service Areas." Dietary manager educated on maintaining kitchen according to food service safety. The corrective action taken to monitor performance to assure compliance through quality assurance: A performance improvement tool has been initiated that audits the kitchen and maintains current standards for food service safety. A Quality Assurance Audit Tool will be completed by the food service director daily x3 weeks, weekly X3 weeks, monthly for 3 months, then quarterly for 2 quarters. Any identified issues will be immediately addressed. The outcomes will be reviewed through the facility Quality Assurance Program. Monitoring will continue as planned or will be increased by the Quality Assurance Committee if needed to obtain 100% compliance. Additional action will be taken by the Quality Assurance Committee if warranted based on the outcome of tools. The date the systemic changes will be completed: 11/14/2024.	

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	following: - A gray plastic grocery bag, labeled "Pam C.", that contained a bowl of coleslaw with a lid, dated 08/02/24, a small paper sack containing onion rings and a dirty spoon, and a sandwich box with 1/2 of a sandwich. LPN 6 indicated residents' items should be dated when put in the refrigerator and disposed of after 48 hours. During an interview on 11/13/24 at 11:50 A.M., the ADON indicated she did not know what the facility policy was related to having cold therapy ice packs in the residents' snack refrigerators. During an interview on 11/13/24 at 2:09 P.M., the Therapy Manager indicated they stored ice packs for residents in their therapy gym. The Nursing Manager had the code to enter the Therapy Gym should they need to. The therapy staff did not place resident ice packs in the resident snack refrigerators. The ice packs were soft sided and blue in color. During an interview on 11/13/24 at 2:21 PM., the ADON indicated all of the residents in the building received food from the facility kitchen. The undated "Cleaning Schedule" policy was provided by the Administrator on 11/13/24 at 1:46 P.M. The record indicated, "...All small equipment...appliances...counters...dishes...Delive ry carts..." were to be cleaned after each use. The current "Unit Kitchenettes and Pantries" policy, with a reviewed date of 07/2023, was provided by the Administrator on 11/13/24 at 1:46 P.M. The policy indicated, "...The food service manager will...remove outdated items..."			

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	The current "Foods Brought by Family/Visitors" policy, with a revised date of October 2017, was provided following the Entrance Conference. The policy indicated, "...Food brought...that is left with the resident to consume later will be labeled and stored in a manner that is clearly distinguishable from facility-prepared food...Perishable foods must be stored in re-sealable containers with tightly fitting lids in a refrigerator. Containers will be labeled with the resident's name, the item and the "use by" date...The nursing and/or food service staff will discard any foods...that show obvious signs of potential food borne danger...for example...mold...past due package expiration dates..." The current "Cleaning and Sanitation of Food Service Areas" policy, with a reviewed date of 07/2023, was provided by the Administrator on 11/13/24 at 1:46 P.M. The policy indicated, "...The food service staff will maintain the sanitation of the...food service areas through compliance with a writen [sic], comprehensive cleaning schedule...A cleaning schedule will be posted for all cleaning tasks...Staff will be held accountable for cleaning assignments..." 3.1-21(i)(3)			