PRINTED: 03/20/2025 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER				ONSTRUCTION	(X3) DATE		
			JILDING	00	COMPI		
		155525	B. W	ING		02/19	/2025
NAME OF I	PROVIDER OR SUPPLI	ER			ADDRESS, CITY, STATE, ZIP COD		
SHADY I	NOOK CARE CEN	ITER			AGE DRIVE ENCEBURG, IN 47025		
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	ENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE	E	COMPLETION
TAG	REGULATORY (OR LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
F 0000							
Bldg. 00							
2.49.00			F 00	000			
	This visit was for	the Investigation of Complaints					
		0451861, IN00450888, and					
	IN00450653.						
	Complaint INIO04	53427 - No deficiencies related to					
	the allegations are						
	Complaint IN00451861 - Federal/State deficiency related to the allegation is cited at F690.						
	Complaint IN00450888 - No deficiencies related to the allegations are cited.						
	the allegations are	e cited.					
	Complaint IN004	50653 - No deficiencies related to					
	the allegations are						
	Survey dates: Fel	bruary 18 and 19, 2025					
	Facility number: 000304						
	Provider number:						
	AIM number: 100						
	Census Bed Type	:					
	SNF/NF: 85						
	Total: 85						
	Census Payor Typ	ne.					
	Medicare: 7	<i>5</i> C.					
	Medicaid: 62						
	Other: 16						
	Total: 85						
		0 - 0 - F' 1' - ' 1'					
	-	eflects State Findings cited in					
	accordance with 4	HU IAC 16.2-3.1.					
	Quality review co	ompleted on February 26, 2025					

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

TITLE (X6) DATE

Lindsey Boltz Administrator 03/13/2025

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

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 347H11 Facility ID: 000304 If continuation sheet Page 1 of 4

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/19/2025	
NAME OF PROVIDER OR SUPPLIER SHADY NOOK CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 36 VILLAGE DRIVE 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	REGULATORY OF 483.25(e)(1)-(3) Bowel/Bladder Incomplete Failed to ensure a reincontinence received continence in a time reviewed for urinary Findings include: An Admission Min assessment, dated 1 was cognitively intained, but were arthritis, and retenting incontinent of bower with urinary retenting scheduled appointment at 2:00 P.M., as we of her abdomen, on During an interview the Director of Nurresident B's appointment been rescheduled to attending, and that a series of the series of th	continence, Catheter, UTI and record review, the facility esident with urinary ed services to maintain ely manner for 1 of 5 residents y incontinence. (Resident B) imum Data Set (MDS) 1/15/24, indicated Resident B act. The resident's diagnoses not limited to, malnutrition, con of urine. The resident was el and bladder. Instructions, dated 11/11/24, B had an ongoing problem on. The resident had a nent with Urology for 12/04/24 ell as an ultrasound scheduled, 12/04/24 at 1:00 P.M. In on 02/19/2025 at 10:35 A.M., sing (DON) indicated that attments for 12/04/24 had all ocally to accommodate family		By submitting the enclosed material, we are not admitting truth or accuracy of any specifindings or allegations. We rest the right to contest the finding allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The fact requests that the plan of correction be considered our allegation of compliance effect 3/1/2025 to the complaint Sur completed on February 18 and 2025. We respectfully request paper review and will provide additional information request paper review and will provide additional information request maintain continence in a timel manner. The corrective action taken to those residents found to be affected by the deficient practice include:	the fic serve s or e cility etive vey d 19, t a any led.	
	indicated that on di Resident B was sup appointment, an up cardiology appoint	s Note, dated 12/05/24, scharge from the hospital posed to have a urology coming abdominal ultrasound, ment, and optometry nly one visualized as		It is the policy of this facility to ensure that physician-ordered appointments are scheduled a completed on a timely basis. Resident, B, has not experien a negative outcome because the alleged deficit practice. Residents with physician order	l and ced of	

scheduled was a cardiology appointment for that

appointments are scheduled for

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155525 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, JIP COD 36 VILLAGE DRIVE LAWRENCEBURG, IN 47025 LAWRENCEBURG	STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
NAME OF PROVIDER OR SLIPPLIER SHADY NOOK CARE CENTER STRIPT ADDRESS, CITY, STATE, AIP COD 36 VILLAGE DRIVE LAWRENCEBURG, IN 47025 LAWRENCEBURG, IN 4				ſ ′			î '	
STREET ADDRESS, CITY, STATE, 2IP COD 36 VILLAGE DRIVE SHADY NOOK CARE CENTER XI MANY STATIMENT OF DEFICURCIE (IACH DEFICIENCY MIST BE PERCEDED BY BILL TAG AND DEFICIENCY MIST BE PERCEDED BY BILL TAG AND Appointment Detail Document, provided by the DON on 02/19/25 at 11:20 A.M., indicated that a new patient urology appointment for Resident B was scheduled on 12/05/24 at 3:25 P.M. The appointment was scheduled for 01/07/25 prior to 02/19/25. During an interview, on 02/19/25 at 11:20 A.M., the DON indicated that due to weather conditions on 01/07/25 brought provided by the DON on 02/19/25 at 1:09 P.M. indicated that a urology appointment. An Appointment Detail Document, provided by the DON on 02/19/25 at 1:09 P.M. indicated that a urology appointment was rescheduled that day for 04/09/25 at 9:10 A.M. During an interview, on 02/19/25 at 1:35 P.M., the DON indicated that the facility scheduler had received a call from the urologist office today to reachedule the appointment for Resident B. When asked if there was proof of additional contact being made prior to today in the progress notes were made prior to 02/19/25 at 2:50 P.M. No progress notes were made prior to 02/19/25 at 02/19/25 at 2:50 P.M. No progress notes were made prior to 02/19/25 at 2:50 P.M. No progress notes were made prior to 02/19/25 at 2:50 P.M. No progress notes were made prior to 02/19/25 at 2:50 P.M. No progress notes were made prior to 02/19/25 at 2:50 P.M. No progress notes were made prior to 02/19/25 at 2:50 P.M. No progress notes were made prior to 02/19/25 at 2:50 P.M. No progress notes were made prior to 02/19/25 at 2:50 P.M. No progress notes were made prior to 02/19/25 at 2:50 P.M. No progress notes were made prior to 02/19/25 abused to a contact the proper to 20/19/25 and 2:50 P.M. No progress notes were made prior to 02/19/25 at 2:50 P.M. No progress notes were made prior to 02/19/25 at 2:50 P.M. No progress notes were made prior to 02/19/25 abused to a contact the appointment to a contact the definition of the progress made to t	AND ILANOI CORRECTION							
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		office.	2,			monitor performance to ass		
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During an interview with the Urology Office, on assurance:		During an interview with the Urology Office. on				l		

PRINTED: 03/20/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING 00		COMPLETED			
		155525	B. WING		02/19/2025			
NAME OF PROVIDER OR SUPPLIER SHADY NOOK CARE CENTER			36 VILL	STREET ADDRESS, CITY, STATE, ZIP COD 36 VILLAGE DRIVE				
SHADY	NOOK CARE CENT	IER	LAWRE	ENCEBURG, IN 47025				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NOY MUST BE PRECEDED BY FULL DUE OF DEFITE YORK OF THE OWN ACTION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY				
TAG	02/19/25 at 1:36 P. urology appointme scheduled today, ar appointment they have the 01/07/25 at 1:36 P. During an interview 2 indicated that the made it to schedule appointment was cashould be reschedured. The current facility Orders", with a reversible provided by the DC policy indicated, ". follow and carry or accordance with all guidelines" The current facility Infections/Bacterius revised date of App DON on 02/19/25 a indicated, "The principle individuals with a lexample, an indwessiones, urinary out-Physician will help contributing to In the physician treatment based of the schedule of the provided by the DC policy indicated, "The principle individuals with a lexample, an indwessiones, urinary out-Physician will help contributing to In the physician treatment based of the provided by the DC policy indicated, "The physician treatment based of the provided by the DC policy indicated, "The physician treatment based of the provided by the DC policy indicated, "The physician treatment based of the provided by the DC policy indicated, "The physician treatment based of the provided by the DC policy indicated, "The physician treatment based of the provided by the DC policy indicated, "The physician treatment based of the provided by the DC policy indicated, "The physician treatment based of the provided by the DC policy indicated, "The physician treatment based of the provided by the DC policy indicated, "The physician treatment based of the provided by the DC policy indicated, "The physician treatment based of the provided by the DC policy indicated by the DC policy indicated, "The physician treatment based of the provided by the DC policy indicated by the D	w on 02/19/25 at 2:30 P.M., LPN facility would ensure residents and appointments, and if an anceled due to weather it	TAG	A performance improvement thas been initiated that audits residents with physician order needed appointments, as well a tool that audits residents with scheduled and completed appointments. Daily monitorin occur for a minimum of 3 monor until substantial compliance achieved. The tool(s) will be completed by the DON or designee, weekly X 3 weeks, monthly X 3 months, then quarterly for 2 quarters. Any identified issues will immediate be addressed. The outcomes be 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 be taken by the Quality Assurance Committee, if warranted, based on the outcomes of the tools. The date the systemic change will be completed: 03/01/202	DATE OOI s for as h g to ths e is ely will by y the , if will ome			

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 347H11 Facility ID: 000304 If continuation sheet Page 4 of 4